

California OHCA Proposes New Regulations to Implement AB 1415's Expanded Pre-Transaction Notice Requirements for Health Care Transactions

Insights

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The California Office of Health Care Affordability (“OHCA”) released [proposed regulations](#) dated May 15, 2026, to update its material change transaction notice and cost and market impact review (“CMIR”) requirements to implement the changes enacted by [AB 1415](#), which took effect on January 1, 2026. The proposed regulations implement AB 1415’s extension of the material change transaction notice framework to “noticing entities” – private equity groups, hedge funds, newly created business entities created for the purpose of entering into agreements or transactions with a health care entity, and certain management services organizations (“MSOs”), and significantly expand disclosure requirements. Comments on OHCA’s proposed regulations are accepted until June 11, 2026.

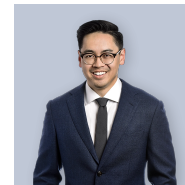
We previously discussed AB 1415’s statutory changes ([here](#)) and OHCA’s initial guidance on the new notice requirements for noticing entities ([here](#)). This article focuses on the key changes in the proposed regulations and their implications for health care industry participants.

Regulatory Narrowing of the MSO Definition

While the proposed regulations define “management services organization” by reference to the statutory definition in Health and Safety Code § 127500.2(o), it narrows the scope of MSOs subject to noticing by adding additional requirements. Under proposed § 97431(k), an entity qualifies as an MSO for purposes of the material change transaction notice regulations only if it meets the statutory definition *and* is additionally at least one of the following:

1. Owned by a hospital and has two or more physician organizations as clients or affiliates;
2. Employs or otherwise has an agreement with the physician-owner of one or more physician organizations;
3. Shares directors, officers, investors, or other natural persons with the ability to exercise control with respect to a health care entity; or
4. Affiliated with at least two of the following: (a) a health plan, (b) two or more physician organizations, or (c) a hospital.

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This may reflect OHCA's attempt to focus its initial regulatory attention on MSOs more likely to present consolidation concerns while still casting a wide net. For example, stakeholders have previously commented to OHCA that the MSO concerns originally animating AB 1415 were grounded in corporate practice of medicine ("CPOM") issues, but the proposed regulatory definition does not confine itself to just MSOs used to navigate CPOM. For example, the "shared directors/officers/investors" criterion in subsection (k)(3) could still capture administrative service organizations serving skilled nursing facilities or other non-CPOM arrangements.

This narrowing also creates a potential gap. An entity that meets the statutory MSO definition but does not satisfy any of the four regulatory criteria would not be subject to the notice requirements under the proposed regulations, even though the statute may independently impose data submission obligations on the MSO under Health and Safety Code § 127501.5.

New "Submitter" Filing Requirements

Until AB 1415, only "health care entities" meeting certain thresholds were potential submitters. The proposed regulations add a fourth submitter category, § 97435(b)(4), for noticing entities. Specifically, a submitter also includes a noticing entity that meets one of the following:

- **(b)(4)(A):** A private equity group or hedge fund that is a party to a transaction identified in circumstance (c)(10) with an MSO or a health care entity satisfying (b)(1), (2), or (3) (a "**potential health care entity submitter**").
- **(b)(4)(B):** An MSO that is a party to a transaction identified in circumstance (c)(11) with an MSO or a potential health care entity submitter.
- **(b)(4)(C):** A newly created business entity formed for the purpose of entering into transactions with a health care entity that is a party to a transaction with a potential health care entity submitter.

AB 1415 defines entities that own, operate, or control a provider, regardless of whether the provider is currently operating, providing health care services, or has a pending or suspended license, to constitute a "noticing entity." OHCA's proposed regulations, however, appear to go beyond AB1415 by considering a parent entity of a provider as both a "health care entity" and a "noticing entity" though a parent entity of a provider would appear to only be a submitter itself if it meets one or more of the "health care entity" thresholds set forth in § 97435(b)(1) through (3).

The proposed regulations also expand § 97435(b)(2) to capture smaller health care entities (those with at least \$10 million in annual revenue or California assets) that transact with a noticing entity satisfying (b)(4).

Notably, noticing entities do not have independent revenue or asset thresholds. Rather, their filing obligation is triggered by the counterparty's qualification under § 97435(b)(1)–(3). The references to "management services organization" in § 97435(b)(4)(A) and (b)(4)(B) similarly appear to create a standalone filing obligation for the noticing entity regardless of the MSO's own revenue.

Additional Material Change "C" Circumstances

The proposed regulations expand the so-called "c" circumstance filing circumstances found in § 97435(c) from eight to eleven by adding three new categories that target private equity, MSO, and real estate sale-leaseback transactions.

Private Equity and Hedge Fund Transactions

Proposed § 97435(c)(9) designates a transaction as a material change transaction if it involves a private equity group or hedge fund and does one of the following:

- **(c)(9)(A):** The transaction results in the private equity group or hedge fund holding 5% or more of the assets, equity, debt, or liabilities of a health care entity satisfying (b)(1), (2), or (3) or an MSO. This includes groups of investors investing collectively to reach the 5% threshold.
- **(c)(9)(B):** The transaction results in the acquisition of assets, equity, debts, or liabilities of a qualifying health care entity or MSO, including, but not limited to, agreements where the private equity group or hedge fund has authority

to engage in eight enumerated activities, such as appointing leadership, vetoing decisions, altering operations, purchasing and leasing back real property, causing indebtedness, managing or operating through Management Services Agreements (“MSAs”) or similar agreements, charging fees, or spending capital and net income.

The 5% threshold in (c)(9)(A) is remarkably low; well below the transfer of control, responsibility, or governance threshold applicable to health care entities under (c)(4) and other customary change-of-control triggers, and could reach even passive minority investments.

The control indicia in (c)(9)(B) are extremely broad. Even relatively nominal activities such as charging fees to a health care entity, managing through administrative services agreements, or spending net income could arguably capture ordinary-course management arrangements. Moreover, there is a significant drafting ambiguity (or mistake): read literally, (c)(9)(B)’s base trigger (“results in the acquisition of assets, equity, debts, or liabilities”) contains no minimum threshold and the eight control indicia are introduced by the clause “including, but not limited to” that arguably makes them merely illustrative rather than limiting. This literal reading would render (c)(9)(A)’s 5% threshold superfluous, as **any** acquisition of assets or equity would satisfy (c)(9)(B). We expect OHCA intended (c)(9)(A) to capture passive ownership and (c)(9)(B) to capture control-based arrangements, but the current drafting does not achieve that distinction and casts an incredibly wide net, arguably at odds with the language of AB 1415 that requires noticing entities to provide notice of transactions that involve transfers of a “material amount” of the assets or operations of a health care entity or MSO. This is another area where we expect to see revisions during the comment period.

Together, the low ownership threshold and broad control indicia could have a chilling effect not only on private equity investment in California health care but also on MSOs’ and health care entities’ access to needed capital more broadly.

MSO Transactions

Proposed § 97435(c)(10) designates a transaction as a material change transaction if it involves an MSO and does one of the following:

- **(c)(10)(A):** The transaction results in an MSO providing management and administrative support services for a health care entity satisfying (b)(1).
- **(c)(10)(B):** The transaction results in an MSO providing services for two or more providers that collectively generate \$10 million annually from California patients.
- **(c)(10)(C):** The transaction involves a transfer of control, responsibility, or governance of the MSO, or a change in 25% or more of the MSO’s ownership.

Circumstance (c)(10)(A) is incredibly broad. It would capture any new management services agreement between an MSO and a qualifying health care entity, regardless of the scope, nature, or value of the management and administrative services to be provided. Notably, (c)(10)(A) does not include any limiting criteria; there is no requirement that the MSA give the MSO a threshold level of control over the health care entity’s operations or governance.

Circumstance (c)(10)(B) takes a different approach from the health care entity submitter thresholds in (b)(1)–(3): it measures the collective revenue of the providers served by the MSO, not the MSO’s own revenue. This means an MSO with only modest revenue could nevertheless trigger this circumstance simply by contracting with multiple smaller providers that together generate \$10 million annually from California patients.

Both (c)(10)(A) and (c)(10)(B) raise questions about their interaction with the “usual and regular course of business” exclusion in § 97431(l)(1), which excludes transactions “typical in the day-to-day operations of the health care entity.” Whether a new MSA or an expansion of existing MSO services constitutes “usual and regular course of business” will likely generate discussion during this comment period.

Real Estate Sale-Leasebacks

Proposed § 97435(c)(11) adds a new standalone “material change transaction” circumstance for real estate transactions where: (A) the real estate where a health care entity provides services is sold or transferred to an entity other than the entity acquiring the health care entity or its direct parent, and (B) the surviving health care entity will be required to lease or pay rent for the property. This provision appears targeted at private equity-driven sale-leaseback strategies, which have drawn regulatory scrutiny nationally as a mechanism that can extract value from health care operations while leaving providers with long-term lease obligations. However, it is not unusual for health care entities (“op cos”) to place real estate assets in a separate “prop co” entity that is affiliated, but not a direct “parent” of the op co. It is not clear why OHCA would scrutinize such customary op co / prop co structures where the entities are under common control.

Enhanced Disclosure and Document Requirements

The proposed regulations substantially expand the information and documentation that submitters must provide as part of the material change transaction notice filing. Key additions include:

- **MSO-specific disclosures:** MSOs must disclose all types of services offered, the types of services provided to any health care entity involved in the transaction, and geographic service areas.
- **PE/hedge fund disclosures:** Private equity groups and hedge funds must disclose the names of all health care entities and MSOs owned or financed by participating asset managers and the funds they manage. They must also provide documentation showing debt-to-enterprise-value or debt-to-equity ratios, the source of any debt, and post-recapitalization debt ratios for any acquired health care entity or MSO.
- **Affiliates, parents, and subsidiaries:** Submitters must disclose the names of all affiliates, parents, and subsidiaries, as well as all members of the submitter’s governing body.
- **Organizational charts:** The proposed regulations replace the existing organizational chart requirement with a more specific three-part requirement: (A) a current chart for any party up through the ultimate parent entity, (B) a chart showing all entities or persons with 5% or more ownership, and (C) proposed post-transaction charts.
- **Post-transaction governance changes:** Submitters must describe potential post-transaction changes to voting rights, decision-making authority, and management and compliance structures.
- **Post-transaction real estate changes:** Submitters must describe potential post-transaction changes to real estate where health care services are provided, including sales, transfers to affiliates, encumbrances, and updates to landlord-tenant agreements.
- **Quality metrics:** Submitters must provide any CMS “Star Ratings” or similar quality assessments.
- **Forward-looking disclosures:** Submitters must describe anticipated cost savings, quality investments, price reductions, and service expansions resulting from the transaction.

The disclosure burden is substantially heavier under the proposed regulations, particularly for private equity groups and hedge funds (which must provide debt ratios and portfolio-wide identification) and for any transaction involving an MSO. The expanded organizational chart requirements – particularly the 5% ownership threshold – may also raise confidentiality concerns for PE and hedge funds, as ownership details at that level may be commercially sensitive.

Procedural and Timing Changes

The proposed regulations make several notable changes to the CMIR process:

- **New CMIR factor – REIT transactions:** Proposed § 97441(a)(1)(G) adds a new factor for OHCA to consider when deciding whether to initiate a CMIR: whether the transaction involves a real estate investment trust and could weaken the financial status of the health care entity or place access to care at risk.
- **Director remand authority:** Under the existing regulations, the Director’s review of a CMIR determination results in a binary outcome—either upholding the determination or waiving the CMIR. The proposed regulations add a third option: the Director may remand the determination for up to 30 additional calendar days of review, with tolling available if OHCA needs additional information. This remand authority would add a layer of uncertainty to the CMIR determination process and timeline, and may result in submitters needing to make a difficult choice between

foregoing their right to request a redetermination of CMIR or risking further substantial delays to closing.

- **Post-determination document submissions:** The proposed regulations add a new structured process for document and information submissions after OHCA determines to conduct a CMIR, including a response log requirement.
- **New expedited review ground:** Proposed § 97439(b)(3) adds a new basis for requesting expedited review: an urgent situation (including public health emergencies, natural disasters, or legal mandates) not of the submitter's own making, where the public interest would be best served by expedited review.

Key Takeaways

The proposed regulations represent OHCA's first attempt to implement AB 1415's expansion of the material change transaction notice framework to noticing entities, including MSOs. Several aspects of the proposed regulations are likely to generate significant industry comment, including:

- The regulatory narrowing of the MSO definition from the statutory definition;
- The 5% ownership threshold for private equity and hedge fund transactions, the broad control indicia in (c)(9)(B), and the enhanced disclosure requirements for PE/hedge funds (including debt ratios and portfolio-wide identification); and
- The breadth and ambiguity of the MSO filing circumstances, and their interaction with the "usual and regular course of business" exclusion.

OHCA is accepting comments on these proposed regulations until **June 11, 2026**. Interested parties can submit comments to CMIR@HCAI.CA.GOV. The proposed regulations will be discussed at the [OHCA Board meeting on June 24, 2026](#) and we will continue to monitor developments as OHCA moves toward finalizing these regulations.

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