CALIFORNIA UPDATE

October 16, 2026

Welcome to America's Physician Groups' *California Update*. Each week APG reports the latest on health care happenings in the Golden State.

Here's what you'll find in this week's edition:

- **OHCA, Losing The Forest For The Trees**
- **Vote No On Proposition 44: Protect Community Access To Care**
- **APG California Policy & Advocacy 2026 Meeting Dates**
- **APG California Advocacy Member Resources**

OHCA, Losing The Forest For The Trees

APG requests member input on OHCA's proposed spending target enforcement regulations before the October 30 comment deadline. Please send observations and operational examples to wbarcellona@apg.org, preferably by October 23, so we can incorporate them into APG's response.

California's Office of Health Care Affordability has released draft spending target enforcement regulations dated October 8, 2026, accompanied by a Performance Improvement Plan Submission Guide and Spending Target Performance Measurement Manual. Staff reviewed the proposed framework at the October 14 Advisory Committee meeting; members can review the October 14 staff presentation here. OHCA is accepting informal comments through October 30, 2026. The proposal has significant implications for California's delegated physician organizations, including IPAs, medical groups, and restricted Knox-Keene licensees.

APG supports meaningful accountability for affordability. But measuring spending growth does not, by itself, explain what produces that spending or identify who possesses the authority to change it. An enforcement framework that concentrates on the result without adequately addressing its drivers risks losing the forest for the trees.

Affordability depends on payment and delivery structure

California's capitated, delegated HMO arrangements align prospective payment with responsibility for defined patient populations. Physician organizations use that structure to support primary care relationships, coordinate services, manage chronic conditions, and reduce avoidable

utilization. Traditional FFS PPO arrangements emphasize provider choice without establishing the same degree of integrated clinical and financial accountability.

These differences have measurable consequences. IHA's May 2025 California analysis, which excluded Permanente physician groups, found that APG HMO organizations outperformed PPO non-ACO arrangements by 15 percentage points on a composite of nine clinical quality measures and had adjusted total cost of care that was $2,304 lower per member annually. Average annual cost growth from 2019 through 2023 was 6.46% for the HMO cohort, compared with 8.02% for PPO ACOs and 8.32% for PPO non-ACO arrangements. PPO members also incurred greater out-of-pocket spending.

OHCA should use this evidence to examine the structures that generate affordability. It should also distinguish delivery-system efficiency from reductions in plan liability achieved through greater enrollee cost sharing. Transferring costs to patients does not itself lower the underlying cost of delivering care. Higher cost sharing can discourage necessary as well as unnecessary care, creating particular risks for patients with limited incomes or significant health needs.

California's affordability policies should preserve and expand arrangements that demonstrate better cost and quality performance. Enforcement should reinforce those objectives.

Accountability must follow authority

OHCA's proposed measurement manual includes all covered medical spending for attributed members, including care delivered by providers outside the attributed physician organization. That measure extends beyond the services for which a delegate receives payment or accepts financial responsibility.

As APG emphasized in its June 25 comments and September 1 meeting with OHCA leadership, responsibility for managing care is not equivalent to authority over every expenditure associated with a patient. A physician organization may manage professional services while a health plan retains responsibility for hospital contracting, pharmacy benefits, or behavioral health services.

A delegated organization could therefore improve quality and manage its responsibilities efficiently, yet exceed its attributed spending target because of hospital rate increases, drug costs, or other expenditures it

lacks the contractual authority to control. Requiring that organization to correct those increases would neither address their source nor produce an effective affordability strategy.

APG will continue to seek an RBO adjustment mechanism recognizing demonstrated value-based performance and spending outside delegated control. Corrective requirements should address expenditures the organization can meaningfully influence, with responsibility assigned to the entity that controls the underlying spending driver.

The draft raises serious due process concerns

The proposed regulations would give an entity 45 calendar days from the date of OHCA's preliminary determination to respond. An entity disputing the spending calculation would need to provide its own calculation and supporting facts. The draft further provides that OHCA may modify its calculation if the entity demonstrates, by clear and convincing evidence, that it is incorrect.

That is a substantially higher burden than preponderance of the evidence. Preponderance requires a showing that a fact is more likely true than not true; clear and convincing evidence requires establishing that it is highly probable.

The heightened burden is compounded by a fundamental procedural gap: the draft does not establish an enforceable disclosure mechanism requiring OHCA to provide physician organizations with the complete underlying health plan information and other evidence supporting its preliminary determination before the response period begins.

A physician organization cannot reasonably investigate discrepancies, reconcile records, and prepare a rebuttal within 45 days if it must first spend that period attempting to obtain the evidence against it. An opportunity to respond is not meaningful when the affected organization cannot examine and challenge the information on which the agency relies.

Hill Physicians' experience demonstrates the need for validation

This concern is grounded in member experience. **Hill Physicians Medical Group has reported that its review of an early test analysis supplied by OHCA staff identified errors in the number of attributed lives and health plan contracts associated with Hill.**

Although a test analysis is not a final enforcement determination, these discrepancies demonstrate why OHCA cannot presume that its underlying data accurately describe a physician organization's population and contractual relationships. Errors in those foundational elements can undermine the resulting spending analysis. Hill's experience raises a concrete question about whether OHCA's understanding of an individual organization's attributed population and contracts has been sufficiently validated to support enforcement.

The regulation must establish OHCA's affirmative responsibility to produce an accurate, validated analysis before imposing enforcement measures. Physician organizations should not bear the consequences of unresolved errors in third-party submissions.

Disclosure must precede the response deadline

APG will seek an express requirement that OHCA provide **all underlying evidence supporting its preliminary determination**, including relevant health plan submissions, member and expenditure attribution records, health plan contract mappings, adjustments, calculations, methodologies, and other materials relied upon. OHCA should be responsible for securing and disclosing those materials, subject to appropriate confidentiality protections.

The 45-day response period should begin only after OHCA has provided the complete supporting record. If information is incomplete, supplied later, or materially revised, the response period should be suspended and extended as necessary to preserve a full and fair opportunity to respond.

APG will also recommend replacing the clear-and-convincing standard for calculation challenges with a preponderance-of-the-evidence standard. At a minimum, if OHCA retains the heightened burden for a physician organization's rebuttal, OHCA should bear a corresponding burden to establish, by clear and convincing evidence, the accuracy of the attribution and calculations supporting its final determination of noncompliance before imposing enforcement measures.

These are safeguards APG seeks in the regulation. Accurate attribution, complete disclosure, and a meaningful opportunity to challenge the agency's analysis are essential when a determination can lead to public findings, corrective obligations, and financial penalties. The proposal also includes substantial procedural penalties for specified failures involving PIP submission and information requirements, making reasonable

opportunities to cure and protections for good-faith participation particularly important.

APG needs member input!

Please review the linked draft regulations, accompanying guides, and October 14 staff presentation, and share examples addressing:

- **Spending outside delegated control:** Hospital rates, drug costs, behavioral health expenditures, or other spending your organization does not negotiate or financially manage.
- **Attribution accuracy:** Errors or discrepancies involving attributed members, health plan contracts, spending categories, or organizational relationships.
- **Access to evidence:** Whether your organization can obtain the information needed to validate OHCA's findings, and how long reconciliation with health plans typically takes.
- **Existing affordability performance:** Total cost of care, quality, utilization, and patient financial-burden results demonstrating the value of your delegated arrangements.
- **Feasible corrective actions and compliance requirements:** Spending drivers your organization can address, those requiring another entity's action, and concerns about response periods, confidentiality, staffing resources, or penalties.

Please send input to wbarcellona@apg.org, preferably by October 23, ahead of OHCA's October 30 deadline.

California already has physician organizations operating under the prospective payment and population-based accountability structures OHCA seeks to expand. Its enforcement framework should recognize their demonstrated performance, address the actual causes of spending growth, and provide fair procedures grounded in accurate evidence. Affordability requires understanding how the system works—not simply measuring what it spends.

Vote No On Proposition 44: Protect Community Access To Care

APG urges members to oppose Proposition 44 on the November 3 ballot. The measure would require nonprofit federally qualified health centers and look-alike clinics to spend at least 90 percent of annual revenue on qualifying program services, with financial penalties for falling short. The Legislative Analyst reports that affected clinics currently spend an average of approximately 80 percent of revenue on health care services. This new

requirement would impose a substantial financial adjustment on California's safety net.

For APG members, the operational concern is straightforward: effective patient care requires investment in the people, technology, and infrastructure that make coordinated care possible. A rigid spending ratio risks constraining those investments while diverting clinic resources to penalties. The No on Proposition 44 campaign warns that the measure could jeopardize services and supports such as referral coordination, translation, medical records, workforce development, and clinic expansion. The Attorney General would further define which expenditures qualify under the measure, adding uncertainty to clinic planning.

Weakening community clinics would also affect the broader delivery system. Reduced clinic capacity could disrupt continuity of care, complicate referrals, and increase pressure on other providers. California should support the infrastructure needed to deliver accessible, coordinated care. Proposition 44's financial penalties risk undermining that goal.

APG members can help explain these concerns within their communities. The No on Proposition 44 Action Center provides downloadable fact sheets, frequently asked questions, flyers, posters, social media graphics, and customizable materials for organizations. Members can also share the campaign's Patient Services at Risk resource to illustrate the operational stakes. Please use these materials to help colleagues and community partners understand why a **No vote on Proposition 44** matters for patient access.

2026 APG California Policy & Advocacy Meeting Dates
*Members, please mark your calendars for APG's California Policy Forum and California Medi-Cal Forum meetings. You can download APG's 2026 events calendar **here**.*

California Policy Forum
2:00 - 3:00 pm

- December 3

California Medi- Cal Forum
4:00 - 5:00 pm

- November 10 - ***Register***
- December 8

APG California Advocacy Member Resources

- 2025 Legislative Implementation Guide
- **Tracked Health Care** Bills 2025-26: bills we're following in the California State Legislature

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For more news and resources, please visit APG's website or contact a member of APG's California advocacy team.

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