Stage 1 Business Analysis

California Department of Technology, SIMM 19A.3 (Ver. 3.0.9, 02/01/2022)

1.1 General Information

1. **Agency or State Entity Name: 4260 - Health Care Services, Department of**
2. **Proposal Name and Acronym: Managed Care Final Rule: Service Quality and Member Informed Decision Empowerment**
3. **Proposal Description: (Provide a brief description of your proposal in 500 characters or less.)**

   The Department of Health Care Services (DHCS) proposes to collect, analyze, and report data from secret shopper surveys, provider directory accuracy checks, and appointment wait time monitoring to comply with federal regulations, safeguard Medi-Cal funding, improve member access and care, and ensure essential services through improved managed care delivery by increased State monitoring. Per the CMS Managed Care Final Rule, DHCS will implement a Quality Rating System process by integrating data, assigning ratings, and reporting performance to enhance member care quality through improved State monitoring and accountability processes.
4. **Project Planning Start Date: 1/23/2025**
5. **Proposed Project Execution Start Date: 1/1/2026**
6. **S1BA Version Number: Version 1**

1.2 Submittal Information

1. **Contact Information**

   Contact Name: Adrianna Alcala-Beshara

   Contact Email: Adrianna.Alcala-Beshara@dhcs.ca.gov

Contact Phone: (916) 345-8629

2. **Submission Type: New Submission**

   If withdrawn, select Reason: Choose an item.

   If Other, specify reason here: Click or tap here to enter text.

   Sections Changed, if this is a Submission Update: (List all sections changed.)

   N/A

   Summary of Changes: (Summarize updates made.)

   N/A

3. **Attach Project Approval Executive Transmittal** to your email submission.

4. **Attach Stage 1 Project Reportability Assessment** to your email submission.

1.3 Business Sponsorship

1. Executive Champion (Sponsor)

Title**:** Chief Deputy Director

Name**:** Tyler Sadwith

Business Program Area: Health Care Programs

Title: Chief Operating Officer for Programs

Name: Chris Riesen

Business Program Area: Program Integration and Operations Support

Title: Deputy Director

Name: Susan Philip

Business Program Area: Health Care Delivery Systems

Title: Deputy Director & Chief Information Officer

Name: Crystal Taylor

Business Program Area: Enterprise Technology Services

Title: Deputy Director

Name: Rafael Davtian

Business Program Area: Health Care Financing

Title: Deputy Director & Chief Data Officer

Name: Linette Scott

Business Program Area: Enterprise Data and Information Management

2. **Business Owner**

Title: Deputy Director

Name: Susan Philip

Business Program Area: Health Care Delivery Systems

Title: Deputy Director

Name: Yingjia Huang

Business Program Area: Health Care Benefits and Eligibility

Title: Deputy Director & Chief Quality and Medical Officer

Name: Palav Babaria

Business Program Area: Quality and Population Health Management

Title: Deputy Director

Name: Paula Wilhelm

Business Program Area: Behavioral Health

3. **Product Owner**

Title: Business Operations Technology Services Chief

Name: Steve Trimble

Business Program Area: Business Operations Technology Services

Title: Medi-Cal Enterprise System Modernization Chief

Name: Ryan Mosley

Business Program Area: Medi-Cal Enterprise System Modernization

1.4 Stakeholder Assessment

The Stakeholder Assessment is designed to give the project team an overview of communication channels that the state entity needs to manage throughout the project. More stakeholders may result in increased complexity to a project.

1. **Indicate which of the following are interested in this proposal and/or the outcome of the project. (Select 'Yes' or 'No' for each.)**

   State Entity Only: No

   Other Departments/State Entities: Yes

   Public: Yes

   Federal Entities: Yes

   Governor's Office: Yes

   Legislature: Yes

   Media: No

   Local Entities: Yes

   Special Interest Groups: Yes

   Other: No

2. **Describe how each group marked 'Yes' will be involved in the planning process.**

   Other Departments/State Entities

   DHCS is proposing to mature or establish the ability to obtain and report required data generated through its and other program operations on behalf of the State. Other State departments, including CDSS, CDPH, DDS, and CDA, will be required to provide this information in a format that is mutually acceptable. This will require that they implement the programmatic activities and processes necessary to provide the required data and that they collaborate with DHCS to provide the federally required data elements.

Other Programs within DHCS will be engaged in the planning process as applicable and appropriate. These Programs are likely to be consulted during this project to better understand the potential enterprise needs.

CalHHS Agency will be involved by reviewing planning efforts and related artifacts, and will work with the department and with the California Department of Technology to align planning requirements with project risk. Additionally, to the extent that the work being proposed represents a Strategic Capability for CalHHS, CalHHS will engage in the planning process to understand the technical approaches that might be leveraged or enhanced by other CalHHS efforts.

These other entities will be expected to participate in governance activities. This will include a DHCS-sponsored Project Steering Committee (PSC), which will develop and implement a governance plan, ensuring collaboration and support among state departments and involved stakeholders in the planning process. The PSC will manage a communication plan, emphasizing stakeholder engagement and structured outreach. As appropriate, communications will be reviewed and approved by the PSC and sent to CMS, CalHHS Agency, the Governor's Office, and the Legislature.

The Public

The Public will benefit from the outcome of this work but will not participate directly in the project planning effort.

Governor’s Office

The Governor’s Office may be interested in this project to the extent that it results in California’s compliance with Federal Law. The Governor’s Office will not be directly involved in the Project planning work.

Legislature

DHCS has submitted a budget proposal for this effort; approval of that proposal will provide DHCS with the necessary funding for the project. The Legislature will not be directly involved in the Project planning work.

Federal Entities

The Centers for Medicare and Medicaid Services (CMS) established the Final Rule and will monitor readiness and compliance. They will provide matching funding to support this project and will monitor progress accordingly.

Local Entities

Local entities provide HCBS services and may be required to provide data needed to achieve compliance. They will likely do so through the specific programs that they support, but there is potentially a need for them to submit data in a specific format in support of this project’s objectives.

Special Interest Groups

Special Interest groups are not likely to be directly involved in the project planning work but may be interested in both the nature of the rule and the State's ability to achieve timely compliance.

1.5 Business Program

1. **Business Program Name:**

   A. Health Care Delivery Systems (HCDS), B. Quality Health and Population Management (QPHM), C. Health Care Eligibility & Benefits (HCBE), D. Behavioral Health (BH), E. Health Care Financing (HCF), F. Enterprise Data Information Management (EDIM), G. Enterprise Technology Services (ETS)

2. **Program Background and Context: Provide a brief overview of the entity's business program(s) current operations.**

   The Department of Health Care Services (DHCS) administers the Medicaid and CHIP Managed Care Final Rule (CMS-2439-F), which is designed to improve the access, quality, and financial integrity of Medicaid and CHIP services.

   DHCS must implement new policies and leverage resources across various divisions to comply with federal requirements, ensuring continued federal funding and maintaining health insurance coverage for millions of Californians.

   Health Care Delivery Systems (HCDS): This portfolio manages and oversees the delivery of medical services to Medi-Cal members through three key divisions: the Medi-Cal Quality & Monitoring Division (MCQMD), the Managed Care Operations Division (MCOD), and the Integrated Systems of Care Division (ISCD). MCQMD focuses on promoting high-quality, coordinated care for Medi-Cal enrollees by monitoring plan performance and leading quality improvement initiatives. MCOD manages contracts with Medi-Cal managed care organizations (MCOs), ensuring operational compliance with state and federal standards. ISCD supports high-risk populations by administering programs that deliver specialized services through counties, home- and community-based services (HCBS) providers, and Program of All-Inclusive Care for the Elderly (PACE) organizations. Across these functions, HCDS leverages quality rating system standards to assess managed care plan performance and drive improvements in care delivery.

   Quality Population Health Management (QPHM): This portfolio oversees statewide efforts to improve care quality and advance health equity for Medi-Cal members. It comprises the Population Health Management Division (PHMD) and the Quality Health and Equity Division (QHED). PHMD leads DHCS's population health strategy, including the implementation of CalAIM's population health management and Enhanced Care Management initiatives to

strengthen member care coordination. QHED manages clinical quality functions across DHCS, drives health equity initiatives, and collaborates with internal and external partners to promote equitable, high-quality care. QPHM's operations are closely aligned with Quality Rating System (QRS) and Quality Assessment and Performance Improvement (QAPI) standards, using these frameworks to identify performance measures and guide continuous quality improvement activities in population health management.

Health Care Benefits Eligibility Division (HCBE): This portfolio is responsible for managing Medi-Cal eligibility, benefits administration, and dental services. It includes the Eligibility Division, which oversees the determination and redetermination of Medi-Cal eligibility to ensure that qualified individuals receive timely access to services. The Benefits Division focuses on ensuring that Medi-Cal enrollees receive the correct scope of benefits while also working to simplify and improve the efficiency of application and renewal processes. The Medi-Cal Dental Services Division administers dental care delivery, including oversight of Dental Managed Care programs. HCBE's operations are informed by 42 CFR § 438.330, which requires the integration of quality assessment strategies into managed care. This ensures that eligibility processes align with quality standards and contribute to the delivery of high-quality, effective health care services.

Behavioral Health (BH): This portfolio is directly tied to MCFR regulations through its role in supporting QRS, QAPI, secret shopper surveys, and enrollee experience surveys. BH must ensure that behavioral health services are incorporated into DHCS's quality strategy and comply with federal standards under 42 CFR § 438. Under QRS, BH contributes behavioral health quality measures to support plan ratings and ensure transparency. Through QAPI, BH leads performance improvement efforts and aligns county behavioral health programs with federal quality standards. BH also ensures behavioral health providers are included in secret shopper surveys to validate directory accuracy and timely access to care. Additionally, enrollee experience surveys must capture feedback on behavioral health access and quality, helping identify disparities and areas for improvement. To meet these requirements, BH strengthens data systems, supports interoperability, and provides technical assistance to counties, ensuring compliance and improved behavioral health outcomes under Medi-Cal managed care for behavioral health-based managed care plans.

Enterprise Data and Information Management (EDIM): This portfolio is closely tied to MCFR regulations through its role in supporting QRS, QAPI, secret shopper surveys, and enrollee experience surveys. EDIM oversees data governance, integration, and reporting across DHCS, ensuring the accuracy and validation of performance measures required under 42 CFR § 438.358(c)(6). For QRS and QAPI, EDIM ensures that quality measures and performance improvement data are reliable, standardized, and validated for reporting and plan assessment. It supports secret shopper surveys by managing data collection and integration needed to evaluate provider directory accuracy and appointment wait times. EDIM also enables timely reporting and analysis of enrollee experience survey results to identify access and quality issues.

Enterprise Technology Services (ETS): This portfolio supports compliance with MCFR regulations by providing the IT infrastructure and tools needed to implement QRS, QAPI, secret shopper surveys, and enrollee experience surveys. Through its divisions—ITSSD, MESMD, and BOTSD—ETS ensures technology is effectively integrated into DHCS's managed care quality strategy. For QRS and QAPI, ETS enables the collection, exchange, and analysis of performance data through interoperable systems. It supports secret shopper and enrollee experience surveys by ensuring secure data platforms, system availability, and integration with analytics tools. ETS also provides technical assistance and training to promote consistent use of IT systems across all managed care quality initiatives.

By maintaining a reliable and scalable IT infrastructure, ETS helps DHCS meet federal quality requirements and supports continuous improvement in Medi-Cal service delivery.

3. How will this proposed project impact the products or Services supported by the state entity?

The proposed Service Quality and Member Informed Decision Empowerment project will significantly enhance the products and services supported by DHCS by embedding federal quality and transparency requirements into Medi-Cal managed care operations under the MCFR. By strengthening oversight of quality performance, increasing transparency of plan information, and institutionalizing member feedback mechanisms, the project ensures that Medi-Cal services are equitable, person-centered, and outcomes-driven. It will promote plan accountability, support continuous improvement, and empower enrollees to make informed healthcare decisions. In doing so, the project advances the State's quality strategy, improves access to high-performing providers, and ensures sustained compliance with federal oversight standards.

1. Aligning Quality Rating System (QRS) with CMS Framework: MCFR requires updating DHCS's Quality Rating System and websites and aligning it to the modified CMS measures that display plan performance ratings stratified by demographic factors such as race, disability, and language. This framework improves transparency and allows members to compare managed care plans using validated, accessible, and publicly available quality data, promoting informed plan selection and stimulating competition among plans to improve care.

2. Strengthening Performance Improvement through QAPI: MCFR mandates that managed care plans implement QAPI programs aligned with the State's quality goals. By standardizing performance reporting, requiring measurable outcomes, and enabling oversight of plan-specific improvement projects, DHCS can drive system-wide quality improvements and address disparities in care delivery.

3. Enhancing Provider Accountability via Secret Shopper Surveys: The project supports the implementation of annual Secret Shopper Surveys to evaluate provider directory accuracy and

compliance with timely appointment standards. This strengthens the accuracy of enrollee-facing information, improves access to care, and ensures that plans maintain reliable and responsive provider networks.

4. Capturing and Acting on Member Experience Data: MCFR requires the integration of Enrollee Experience Surveys into quality monitoring efforts. These surveys enable DHCS to collect feedback on timely access, cultural responsiveness, and overall satisfaction. The resulting insights support quality improvement initiatives, feed into the QRS, and help identify equity gaps in service delivery.

Implementation of this project will directly improve service quality, equity, and transparency in Medi-Cal managed care. By integrating member experience, clinical outcomes, and compliance data into public-facing tools and oversight, DHCS will strengthen its ability to deliver high-value care. The project supports a data-driven, member-informed approach to quality management, ensuring that members receive timely, culturally responsive, and high-quality services across all plans and regions.

1.6 Project Justification

1. **Strategic Business Alignment**

Enterprise Architect

Title: IT Manager II

Name: Andrew Nunes

Strategic Plan Last Updated: 7/25/2024

Strategic Business Goal 1: Put California residents first and design programs and services for whole person care in the community.

Alignment: The goals of the Managed Care Final Rule directly align with DHCS's goal of putting California residents first and designing programs and services for whole-person care in the community. By implementing tools like the Quality Rating System (QRS), Enrollee Experience Surveys, and Secret Shopper Surveys, DHCS is creating a more transparent, equitable, and responsive managed care environment. These efforts ensure that Medi-Cal members have access to clear, actionable information to make informed decisions about their care, while also holding plans accountable for delivering high-quality, person-centered services. Additionally, strengthening oversight of QAPI programs ensures that health plans focus on holistic improvements that reflect the physical, behavioral, and social needs of the populations they serve. Altogether, this work supports a more inclusive, data-driven, and community-rooted approach to Medi-Cal that reflects the principles of whole-person care.

Strategic Business Goal 2: Increase meaningful access - Ensure the residents of the State of California get care when, where, and how they need it by strengthening health care coverage, benefits, and provider and service capacity.

Alignment: MCFR Project advances DHCS's goal of increasing meaningful access by strengthening the process that ensures individuals receive care when, where, and how they need it. Through tools like Secret Shopper Surveys, DHCS is validating provider directory accuracy and appointment wait times to ensure that enrollees can access timely care across all plans and regions. The implementation of the QRS further supports access by enabling members to compare plans based on performance, service availability, and member satisfaction—empowering them to choose options that best meet their needs. Additionally, Enrollee Experience Surveys provide critical feedback on barriers to care, which DHCS uses to identify gaps and drive improvements in provider networks, cultural responsiveness, and service delivery. Together with enhanced oversight of QAPI initiatives, these efforts strengthen coverage, improve service capacity, and ensure that Medi-Cal members can access the right care at the right time in the right way.

Strategic Business Goal 5: Strengthen operations – Enhance our organizational structures, processes, and procedures to improve program administration.

Alignment: This effort aims to support DHCS's goal of strengthening operations by streamlining the structures, processes, and procedures used to oversee and administer Medi-Cal managed care quality. By implementing a CMS-compliant QRS, DHCS is establishing a standardized, data-driven framework for measuring and publicly reporting plan performance, streamlining how quality is tracked and communicated. The project also introduces consistent processes for conducting and responding to Enrollee Experience Surveys and Secret Shopper Surveys, enabling more reliable monitoring of access and member satisfaction. Additionally, by enhancing oversight of QAPI programs, DHCS is improving how it evaluates plan accountability and drives system-wide improvement. These coordinated efforts not only strengthen internal operations but also reinforce transparency, efficiency, and continuous improvement in program administration.

Strategic Business Goal 6: Leverage data to improve outcomes.

Alignment: Through data, this effort aligns with DHCS's goal of leveraging data to improve outcomes by establishing robust, standardized mechanisms for collecting, analyzing, and acting on quality and access data across Medi-Cal managed care. Through the implementation of the QRS, DHCS is using validated performance measures and stratified data to identify disparities, benchmark plan performance, and inform member choice. Secret Shopper Surveys and Enrollee Experience Surveys generate real-time insights into provider access, directory accuracy, and member satisfaction, which are then used to drive targeted improvements. Additionally, the strengthened oversight of QAPI ensures that managed care plans implement data-informed performance initiatives with measurable outcomes. Together, these efforts build a comprehensive quality infrastructure that uses data not only for compliance but as a tool to guide continuous improvement and deliver better, more equitable health outcomes for Medi-Cal members.

2. Mandate(s): Federal

Rule Medicaid	Description	Compliance Date
438.310(c)(2)	Quality Rating Systems (QRS) Quality Rating Systems (QRS) – Exemption - Requires DHCS to obtain and review all findings from the most recent accreditation review of any exempted MCO that has undergone evaluation by a private accrediting organization, particularly if the review was used to meet Medicare external review requirements. The findings must include compliance evaluation results, identified deficiencies, corrective action plans, and summaries of any unmet accreditation requirements.	July 9, 2024
438.362(b)(2)	QRS: EQR – Exemption - Requires DHCS to obtain and review all findings from the most recent accreditation review of any exempted MCO that has undergone evaluation by a private accrediting organization, particularly if the review was used to meet Medicare external review requirements. The findings must include compliance evaluation results, identified deficiencies, corrective action plans, and summaries of any unmet accreditation requirements.	July 9, 2024
438.364(a)(2)(iii)	QRS – EQR: Information that must be produced - Requires DHCS to collect and analyze validated performance measures, outcomes data, and results from quantitative assessments related to each activity conducted under § 438.358(b)(1)(i), (ii), and (iv). This data must be used to provide a comprehensive overview of the quality, effectiveness, and outcomes of care provided by MCOs, PIHPs, and PAHPs.	No later than one year from the issuance of the associated protocol
438.358(b)(1)	QRS: EQR - Mandatory activities - Requires DHCS to ensure completion of all mandatory External Quality Review (EQR) activities annually for each MCO, PIHP, and PAHP. These activities include validating performance improvement projects and performance measures, reviewing compliance with federal regulatory standards, and assessing network adequacy. All required reviews must be conducted within 12 months prior to the submission of the final annual EQR report.	Starting December 31, 2025
438.360(a)(1)	QRS: - EQR - Nonduplication of mandatory activities -Requires DHCS to recognize that MCOs, PIHPs, and PAHPs may demonstrate compliance with Medicare Advantage standards through one of two pathways: either by undergoing a direct assessment conducted by CMS or its designated contractor, or by obtaining accreditation from a CMS-recognized private accrediting organization. This approach ensures that these entities meet the required quality and performance standards for delivering healthcare services.	July 9, 2024
438.364(c)(2)(i)-(ii)	QRS - Notifying CMS - Requires DHCS to post the most recent annual External Quality Review (EQR) technical report on the designated public website by April 30th of each year. Additionally, DHCS must notify the Centers for Medicare & Medicaid Services (CMS) within 14 calendar days of the report being posted, using the form and manner specified by CMS.	July 9, 2024
438.358(c)	QRS: EQR - Optional activities: Allows DHCS to perform optional External Quality Review (EQR) activities for each MCO, PIHP, PAHP,	July 9, 2024

	and PCCM entity described in § 438.310(c)(2). These activities may include: (1) validation of encounter data; (2) administration or validation of consumer or provider surveys on quality of care; (3) calculation of additional performance measures beyond those validated under § 438.358(b)(1)(ii); (4) implementation of additional performance improvement projects beyond those validated under § 438.358(b)(1)(i); (5) conducting focused quality studies on specific clinical or nonclinical services; (6) assisting with the quality rating of plans as outlined in subpart G; and (7) supporting evaluations required under §§ 438.16(e)(1), 438.340(c)(2)(i), and 438.6(c)(2)(iv) and (v), relating to outcomes, quality, or access to care.	
438.358(c)(7)	QRS: EQR - Optional activities for evaluations: Requires DHCS to provide support for evaluations related to §§ 438.16(e)(1), 438.340(c)(2)(i), and 438.6(c)(2)(iv) and (v), which focus on outcomes, quality, and access to healthcare services. This assistance ensures that evaluations are effectively conducted and address critical elements of service delivery, performance measurement, and compliance with federal Medicaid managed care requirements.	July 9, 2024
438.358(c)(6)	QRS: EQR - Optional activities for quality rating: Requires DHCS to assist with the quality rating of MCOs, PIHPs, and PAHPs in accordance with the requirements set forth in 42 CFR Part 438, Subpart G. This includes supporting the development, calculation, validation, and reporting of quality measures and ratings to ensure transparency and help members make informed choices among managed care plans.	July 9, 2024
438.364(c)(2)(iii)	QRS: EQR - Report archiving requirements: Requires DHCS to maintain and make publicly accessible on the website specified under § 438.10(c)(3) at least the five most recent years of External Quality Review (EQR) technical reports. This ensures transparency and ongoing access to historical quality review data for stakeholders and the public.	December 31, 2025
438.358(a)(3)	QRS: EQR - Review period: Requires DHCS to post the most recent annual External Quality Review (EQR) technical report on the public website specified under § 438.10(c)(3) by April 30th each year. Additionally, DHCS must notify CMS within 14 calendar days of the posting, using the form and manner specified by CMS.	December 31, 2025
438.340(b)(4)	QRS: Managed care quality strategy: Requires DHCS to arrange for annual, external, independent reviews in accordance with § 438.350 to evaluate the quality outcomes, timeliness, and access to services provided under each MCO, PIHP, and PAHP contract. These reviews must be conducted by a qualified External Quality Review Organization (EQRO) to ensure objective assessment and compliance with federal standards.	July 9, 2024
438.340(c)(1) 438.340(c)(3)	QRS: Strategy: Requires DHCS to make its Medicaid Quality Strategy available for public comment—including input from stakeholders and Tribes, where applicable—prior to submission to CMS. DHCS must submit the initial quality strategy and any updates to CMS for review, with updates required at least every three years or when significant program changes occur.	July 9, 2025
438.340(c)(2)(ii)	QRS: Transparency: Requires DHCS to make the results of the review—including the evaluation conducted under § 438.340(c)(2)(i)—publicly available on the website specified under § 438.10(c)(3). This ensures transparency and accessibility of quality strategy evaluations for stakeholders and the public.	July 9, 2025

438.500	QRS: Definition: Requires DHCS to adopt and apply standardized definitions related to Medicaid and healthcare quality rating systems, including terms such as “measurement period,” “quality rating,” and “validation.” DHCS must also align its practices with established frameworks, such as the Medicaid Managed Care Quality Rating System (QRS) Framework, the Medicare Advantage 5-Star Rating System, and the Qualified Health Plan (QHP) QRS. Additionally, DHCS must utilize the Technical Resource Manual as a reference for implementing these systems in accordance with federal guidance.	July 9, 2024
438.505(a)(1)	QRS: General rule and applicability: Requires DHCS to adopt the Quality Rating System (QRS) framework developed by CMS, which must include implementation of either the Medicaid and CHIP (MAC) QRS methodology established by CMS, or an alternative MAC QRS rating methodology approved by CMS in accordance with § 438.515(c). Additionally, DHCS may implement enhanced website features beyond those specified in § 438.520(a), as permitted under § 438.520(c), to improve user experience and support informed plan selection by members.	December 31, 2028
438.510	QRS: Mandatory Measure Set: Requires DHCS to implement a Quality Rating System (QRS) for Medicaid and CHIP managed care programs using the mandatory measure set defined by CMS. DHCS must follow CMS procedures for updating, adding, or removing measures and engage stakeholders throughout the process. The department must also ensure sufficient time is allotted for implementing any changes and for accurately displaying quality rating results to the public.	July 9, 2024
438.515	QRS: Methodology: Requires DHCS to collect and validate data from Medicaid managed care plans with 500 or more enrollees—and from other sources if needed—to calculate quality ratings. Ratings must be based on validated data with no conflict of interest and must be issued for each plan and program, reflecting the quality of services provided to members. DHCS may request CMS approval to use an alternative rating methodology, provided it ensures comparability across states. DHCS may also request implementation extensions by demonstrating good-faith efforts and actionable plans. Additionally, CMS will implement domain-level ratings for key areas of care, which DHCS must incorporate as part of the quality rating system.	July 9, 2024
438.520(a)(6)	QRS: Website display: Requires DHCS, beginning no sooner than two years after the Quality Rating System (QRS) implementation date, to publicly display stratified quality ratings for each managed care plan. These ratings must be broken down by factors such as race, disability, and language. DHCS must also provide interactive tools on its website that allow users to view these ratings and search for plans that cover specific prescription drugs or include specific providers in their networks.	By a date specified by CMS, which shall be no earlier than 2 years after the implementation date for the quality rating system specified in 438.505
438.520(a)(1)-(5), (b), and (c)	QRS: Website display: Requires DHCS to maintain a publicly accessible Medicaid managed care Quality Rating System (QRS) website that meets CMS standards and accessibility requirements. The website must prominently display quality ratings and provide tools for members to compare plans based on standardized information such as provider directories, drug coverage, cost-sharing, and plan	July 9, 2024

	performance. This information must be stratified by demographics including race, disability, and language. The site must also include clear explanations, interactive features, and links to enrollment resources to support informed member decision-making.	
438.530	QRS: Annual technical resource manual: Requires DHCS, starting in 2027, to use the annually published CMS Medicaid managed care Quality Rating System (QRS) Technical Resource Manual as the authoritative source for implementing QRS requirements. The manual will identify all mandatory quality measures, provide calculation and rating guidance, and include technical specifications. It will also outline any updates to measures, required demographic stratifications (such as by race, age, or disability), and summarize public feedback, ensuring DHCS aligns with federal standards and methodologies.	Jan 1, 2027
438.535	QRS: Annual reporting: Requires DHCS to submit a detailed Medicaid managed care Quality Rating System (QRS) report to CMS upon request, no more than once annually. The report must include lists of all applicable and additional quality measures, attestations of compliance, descriptions of the rating methodologies used, any technical adjustments made, details on publication and display, and documentation of any CMS-approved alternative QRS methodologies.	July 9, 2024
438.330(d)(4)	QAPI: Technical change to incorporate correct citations to QAPI program: Allows DHCS to permit an MCO, PIHP, or PAHP that exclusively serves dual-eligible members to substitute one or more required Performance Improvement Projects (PIPs) with a Chronic Care Improvement Program (CCIP) conducted in accordance with Medicare Advantage regulations at 42 CFR § 422.152(c). This ensures alignment with Medicare requirements while maintaining a focus on improving care for dual-eligible populations.	July 9, 2024
438.66(b)(4)	Enrollee experience surveys: Requires DHCS to evaluate and report on the performance of each MCO, PIHP, PAHP, and PCCM entity (if applicable) in the areas of enrollee materials, enrollee experience, and customer service, including the effectiveness and responsiveness of the member support system.	First rating period beginning on or after July 9, 2027
438.66(e)(2)(vii)	Enrollee experience surveys: Include enrollee experience surveys in MCPAR -Requires DHCS to include in the program report detailed information and assessments on the operation of the managed care program, including the results of any sanctions, corrective action plans, or other formal or informal interventions taken by the State to improve the performance of contracted MCOs, PIHPs, PAHPs, or PCCM entities.	First rating period beginning on or after July 9, 2027
438.207(e)	Secret shopper surveys Secret Shopper Survey: CMS right to inspect documentation Requires DHCS to make available to CMS, upon request, all documentation obtained from MCOs, PIHPs, or PAHPs, as well as all materials related to secret shopper surveys conducted in accordance with § 438.68(f). This ensures federal oversight and transparency in evaluating appointment availability and access standards.	First rating period beginning on or after July 10, 2028
438.68(f)	Secret shopper surveys -Requires DHCS to contract with an independent entity to conduct annual secret shopper surveys that assess each MCO's, PIHP's, and PAHP's compliance with provider directory accuracy requirements and appointment wait time standards. The surveys must use statistically valid random sampling across all covered geographic areas and evaluate critical provider information, including network participation status, address, phone number, and	First rating period beginning on or after July 10, 2028

	whether the provider is accepting new patients. DHCS must ensure that errors and survey results are reported promptly to the State, CMS, and made publicly available.	
438.10(d)(2)	Secret shopper surveys: Interpretation, translation and tagline criteria - Requires DHCS to ensure that oral interpretation services are available in all languages and that written translations are provided for each prevalent non-English language. All critical written materials, including those used for secret shopper surveys and enrollee experience surveys, must include prominently displayed taglines in these languages. These taglines must inform individuals how to access translation services, request auxiliary aids and services, and contact the toll-free number for choice counseling, as required by § 438.71(a).	First rating period beginning on or after July 9, 2027
438.10(h)(1) 438.10(h)(1)(ix)	Provider Directory Provider Directory: Requires DHCS to ensure that each MCO, PIHP, PAHP, and, when appropriate, makes provider directory information available in both searchable electronic format and paper format upon request. The directories must include detailed information about the network providers to support member access and informed plan selection, in accordance with federal accessibility and transparency requirements.	July 1, 2025
438.214(d)(2)	Provider Directory: Excluded providers - Requires DHCS to ensure, through its managed care contracts, that MCOs, PIHPs, and PAHPs terminate and exclude from their provider networks any individuals or entities that have been terminated from participation under Medicaid (Title XIX), Medicare (Title XVIII), or CHIP (Title XXI). This ensures compliance with federal program integrity requirements and protects members from ineligible providers.	July 9, 2024
438.10(h)(3)(iii)	Provider directories: Information from secret shopper surveys - Requires DHCS to ensure that MCOs, PIHPs, and PAHPs use appointment wait time data obtained from secret shopper surveys, as specified in § 438.68(f)(1)(iii), to update their provider directories. These updates must be completed within 30 calendar days for paper and PDF directories and within 15 calendar days for online directories, in accordance with § 438.10(h)(3)(i) and (ii).	First rating period beginning on or after July 10, 2028
438.207(f)	Remedy Plans Remedy plans to improve access - Requires DHCS to submit a remedy plan to CMS within 90 days when an access issue is identified in an MCO, PIHP, or PAHP by either the State or CMS. The plan must outline specific, measurable, and sustainable actions to resolve the issue within 12 months. If access is not sufficiently improved within that period, CMS may require DHCS to revise and extend the remedy plan for an additional 12 months.	First rating period beginning on or after July 10, 2028.
457.1230(b)	Remedy plans to improve access: Requires DHCS to ensure, through its contracts, that each MCO, PIHP, and PAHP serving CHIP enrollees maintains adequate capacity to meet expected enrollment in accordance with § 438.207. This includes meeting standards for provider network sufficiency, service availability, and timely access to care. While the requirement to report actions taken when standards are not met under § 438.207(d)(3)(i) is excluded, DHCS must incorporate findings from the most recent annual enrollee experience survey into its network adequacy analysis to support continuous access improvement.	First rating period beginning on or after July 10, 2028.

2. Business Driver(s)

Financial Benefit: No

Increased Revenue: No

Cost Savings: No

Cost Avoidance: No

Cost Recovery: No

Sanctions. Yes

If the answer to the above question is “Yes,” please explain:

If states fail to implement the federal regulations outlined in the Managed Care Final Rule and the Access Final Rule, they can face several consequences. These are generally outlined in Title 42 CFR Part 430 (Medicaid Program) and Title 42 CFR Part 438 (Medicaid Managed Care) and include but are not limited to the following adverse consequences:

1. Sanctions, including the withholding of Federal Funds: States may face sanctions, including penalties or restrictions on their ability to participate in federal programs. CMS can withhold federal funds from states that do not comply with the regulations. This can impact the state's ability to fund Medicaid programs and services.

2. Reduced Federal Support: Non-compliance can lead to reduced federal support and assistance, making it more challenging for states to meet the needs of their Medicaid members.

Improvement. Yes

Better Services to the People of California: Yes

Efficiencies to Program Operations: Yes

Improved Equity, Diversity, and/or Inclusivity: Yes

Improved Health and/or Human Safety: Yes

Improved Information Security: No

Improved Business Continuity: Yes

Improved Technology Recovery: No

Technology Refresh: No

Technology End of Life: No

1.7 Business Outcomes Desired

Executive Summary of the Business Problem or Opportunity:

Problem: The Managed Care Final Rule imposes sweeping requirements to improve service quality, transparency, and enrollee empowerment in the Medi-Cal managed care program. Core provisions—Quality Rating System (QRS), Quality Assessment and Performance Improvement (QAPI), Secret Shopper Surveys, and Enrollee Experience Surveys—require the Department of Health Care Services (DHCS) to modernize its quality oversight infrastructure and process to ensure enrollees can make informed, value-based decisions about their care which in turn improve the quality of services that members in a managed care plan can receive.

The QRS mandates the development of a CMS-aligned rating that publicly displays plan quality data stratified by demographic factors such as race, disability, and language. This necessitates the integration of clinical and experience data, advanced data validation protocols, and interactive, accessible digital tools. The core purpose of this initiative is to support the foundational goal of Medicaid managed care: delivering high-quality, equitable, and person-centered care. By increasing visibility into plan performance, the State can help members make more informed choices, incentivize plan accountability, and reduce disparities in access and outcomes. Ultimately, it moves the Medi-Cal program toward a more data-driven, outcomes-oriented system that prioritizes member needs and strengthens public trust in program integrity.

QAPI requires plans to execute continuous quality improvement projects, submit validated performance data, and demonstrate measurable improvement aligned with the State's quality strategy, demanding enhanced evaluation and monitoring processes within DHCS. The ultimate purpose of this requirement is to foster a culture of accountability and continuous improvement in Medi-Cal managed care. By using validated QAPI metrics to guide oversight, the State not only complies with federal regulation but also ensures that resources are directed to improving care delivery for the populations who need it most. This is especially critical for individuals with complex health needs, such as dually eligible beneficiaries, where aligned performance improvement efforts reduce redundancy and strengthen care integration. Over time, this approach promotes system-wide improvements in access, equity, and health outcomes—advancing the core mission of Medi-Cal to serve vulnerable populations effectively. Secret Shopper Surveys must be conducted annually by an independent entity to assess the accuracy of provider directories and compliance with appointment wait time standards across all contracted plans. This requires DHCS to implement statistically sound sampling, standardized survey tools, and robust data reporting mechanisms. The ultimate goal of this regulation is to improve access to care, equity, and informed plan choice for Medicaid beneficiaries. When directory data is accurate and appointment wait times are within standard, it means members can actually access the care they're promised—when, where, and how they need it. More importantly, this empowers enrollees—many of whom face systemic barriers to care—to choose a plan based on real provider availability and proximity, not misleading listings. It also creates a feedback loop that drives transparency, corrective action, and plan accountability. For DHCS, these surveys provide

actionable insight to support managed care plan performance enforcement and protect enrollees—especially in underserved communities—by ensuring that care isn't just available in theory, but in practice.

Similarly, Enrollee Experience Surveys must be designed to capture the lived experience of members, including timely access, cultural responsiveness, and satisfaction—serving as a direct input into both QRS and access improvement initiatives. The purpose of remedy plans is to ensure that when a managed care plan fails to meet critical access or quality standards, there is a structured, enforceable path to corrective action.

At its core, this requirement exists to ensure that Medicaid managed care programs are not just technically compliant on paper but are functionally equitable, accessible, and responsive to the people they serve. Disparities in care—especially across race, ethnicity, language, and disability—can often go unrecognized in conventional data systems. Enrollee experience surveys are a critical equity tool, helping DHCS identify and address disparities in access and quality of care that disproportionately affect underserved communities. By using this data to inform enforcement, contract oversight, network adequacy assessments, and quality strategies, the State is better positioned to ensure that managed care plans maintain the capacity, cultural responsiveness, and service quality expected under federal rules. Just as importantly, transparent reporting of these survey results empowers Medi-Cal beneficiaries to make more informed decisions when choosing a health plan, fostering trust and engagement in the system.

Lastly, The purpose of remedy plans is to ensure that when a managed care plan fails to meet critical access or quality standards, there is a structured, enforceable path to corrective action. Remedy plans are not punitive—they are a tool for accountability and improvement. They ensure that deficiencies identified through enrollee experience surveys, secret shopper audits, or other oversight mechanisms are addressed in a timely and transparent manner. For DHCS, remedy plans provide a formal mechanism to protect beneficiaries—especially those in underserved communities—by requiring plans to take measurable steps toward compliance. Remedy plans also reinforce the integrity of the Medi-Cal program by demonstrating that performance standards are not just aspirational, but enforceable. Over time, this approach builds trust in the system and ensures that all plans are held to the same expectations for access, equity, and quality.

Meeting these requirements will demand that DHCS establish a coordinated, data-driven quality infrastructure that integrates performance measurement, reporting, oversight monitoring, and member-facing transparency tools. Significant investment in processes related to technology, data governance, contract oversight, and stakeholder engagement will be essential to elevate service quality, close equity gaps, and empower Medi-Cal members to make informed decisions based on clear and comparative plan information.

Opportunity: MCFR presents a strategic opportunity for DHCS to elevate service quality and strengthen enrollee empowerment through the integrated implementation of the Quality Rating System (QRS), Quality Assessment and Performance Improvement (QAPI), Secret Shopper Surveys, and Enrollee Experience Surveys. By building a data-driven, member-focused quality infrastructure,

DHCS can ensure regulatory compliance, improve service delivery, and empower members to make informed decisions about their care. Specifically, DHCS can:

1. **Establish an Integrated Quality Measurement and Rating Platform:** Build centralized process to collect, validate, and display quality measures across all Medi-Cal managed care plans. This will support CMS-aligned QRS implementation, including domain- and demographic-level stratification, interactive comparison tools, and public reporting that enhances plan accountability and member choice.
2. **Strengthen QAPI Oversight and Impact:** Standardize QAPI reporting and evaluation processes to ensure managed care plans demonstrate measurable improvement aligned with the State's quality strategy. Enhanced oversight mechanisms will support the identification of underperforming plans, track progress over time, and inform targeted technical assistance and contract enforcement actions.
3. **Enhance Network Transparency through Secret Shopper Survey Integration:** Institutionalize the use of Secret Shopper Survey data to regularly assess provider directory accuracy and appointment availability. Incorporating survey findings into plan oversight and public transparency efforts will strengthen accountability and support timely, accurate information for members.
4. **Leverage Enrollee Experience Surveys for Equity and Access Improvement:** Use stratified enrollee experience data to monitor and address disparities in member satisfaction, access to culturally responsive care, and perceived quality of services. Insights from these surveys will be integrated into QRS ratings, quality improvement initiatives, and broader CalAIM equity strategies.
5. **Embed Quality and Transparency Provisions in Contracts and Public Tools:** Update managed care contracts to include specific QRS, QAPI, and survey-based requirements, such as performance metrics, reporting timelines, and response protocols. Public-facing platforms must incorporate these inputs to provide accessible, meaningful plan comparison tools for members.
6. **Corrective Actions Through Remedy Plan:** Enables DHCS to systematically identify, monitor, and resolve managed care plan access standard violations through a standardized corrective action process, ensuring federal compliance and protecting member access to care.

By institutionalizing these reforms into processes, DHCS can move beyond compliance to deliver a more transparent, equitable, and member-centered Medi-Cal program—one that empowers enrollees, rewards performance, and improves outcomes statewide.

Objective ID: 1 -- **Quality Rating Systems**

Objective: Support Medi-Cal members' ability to identify managed care plans that align with their needs by providing transparent quality rating data regarding the plans'

Metric: The ability to collect and analyze quality rating data for publishing.

Baseline: 0% as DHCS does not currently collect, analyze, and publish this data

Target Result: DHCS will demonstrate its ability to comply with this measure by publishing quality rating data for Medi-Cal members to compare plans.

Objective ID: 2 -- **Quality Assessment and Performance Improvement (QAPI)**

Objective: Inform the identification of underperforming plans, track improvement/progress over time, and inform targeted technical assistance and contract enforcement actions.

Metric: The availability of required QAPI data for plan oversight purposes

Baseline: Currently, tracking and reporting is inconsistent across managed care plans.

Target Result: DHCS will demonstrate its ability to provide the required QAPI data for purposes of identifying and addressing quality issues, reducing disparities, and improving health outcomes for Medi-Cal members

Objective ID: 3 -- **Secret Shopper Surveys**

Objective: Provide Medi-Cal members' the information necessary to inform plan selection, specifically related to proximity, availability and responsiveness, as provided through a Secret Shopper Survey program.

Metric: The ability to collect and analyze Secret Shopper Survey information for publishing.

Baseline: Secret Shopper Survey information is not currently available for public use.

Target Result: DHCS will demonstrate its ability to comply with this measure by tracking and reporting Secret Shopper Survey performance information, allowing Medi-Cal members to compare providers and plans.

Objective ID: 4 - **Enrollee Experience Surveys**

Objective: Support the State's ability monitor and address disparities in member satisfaction, access to culturally responsive care, and perceived quality of services *using information gained through Enrollee Experience Surveys.*

Metric: The ability to collect and analyze Enrollee Experience Survey data to improve managed care plan services, specifically with regards to member satisfaction, culturally responsive care and perceived quality.

Baseline: Current enrollees' experience data is fragmented and not fully integrated into managed care plan monitoring.

Target Result: DHCS will demonstrate its ability to comply with this measure by tracking and reporting Enrollee Experience Survey performance data for Medi-Cal members to compare plans and CMS monitoring.

Objective ID: 5 - **Remedy Plan**

Objective: *Support the collection and reporting of Remedy Plan data to support enforcement when managed care plans fail to meet contractual requirements, and to strengthen oversight, transparency, and member-facing accountability.*
Metric: The ability to assess and submit Remedy Plans to CMS and publicly for issues in network sufficiency, service availability, and timely access to care.

Baseline: Remedy plan collection, analysis, and reporting is not fully integrated into managed care plan monitoring.

Target Result: DHCS will demonstrate its ability to comply with this measure by tracking and reporting Remedy data for CMS reporting and supporting Medi-Cal members to compare plans.

1.8 Project Management

Project Management Risk Score: 0.6

Follow the instructions in the Statewide Information Management Manual (SIMM) Section 45 Appendix B Project Management Risk Assessment Preparation Instructions.
Attach a completed Statewide Information Management Manual (SIMM) Section 45 Appendix A Project Management Risk Assessment Template to the email submission.

Enclosed Risk Assessment: SIMM_45_Appendix_A_Project Management Risk Assessment - MCFR Service Quality and Member Informed Decision Empowerment.xlsx

Project Approval Lifecycle Completion and Project Execution Capacity Assessment

Does the proposal development or project execution anticipate sharing resources (state staff, vendors, consultants, or financial) with other priorities within the Agency/state entity (projects, PALs, or programmatic/technology workload)?

Answer: No

Does the Agency/state entity anticipate that this proposal will result in the creation of new business processes or changes to existing business processes?

Answer (No, New, Existing, or Both)**:** Both New and Existing Processes

1.9 Initial Complexity Assessment

1. **Complexity Assessment (Business Score): 1.5**

   Enclosed Complexity Assessment: SIMM-45-Appendix-C-Complexity-Assessment-MCFR Quality Systems.xlsx

   NOTE: Business complexity is initially completed in PAL Stage 1. Technical complexity is initially completed in PAL Stage 2.

2. **Noncompliance Issues:** Indicate if your current operations include noncompliance issues and provide a narrative explaining how the business process is non-compliant.

   Programmatic regulations: Yes

   HIPAA/CIIS/FTI/PII/PCI: No

   Security: No

   ADA: No

   Other: No

   Not Applicable: Choose Yes or No.

   Noncompliance Description:

   The work effort is necessary to maintain federal compliance that is required for federal funding for California's Medicaid program (Medi-Cal).

3. **Additional Assessment Criteria**

   If there is an existing Privacy Threshold Assessment/Privacy Information Assessment, include it as an attachment to your email submission.

   How many locations and total users is the project anticipated to affect?

   Number of locations: Statewide

   Estimated Number of Transactions/Business Events (per cycle): TBD

   Approximate number of internal end-users: TBD

   Approximate number of external end-users: TBD

1.10 Funding

Planning

1. Does the Agency/state entity anticipate requesting additional resources through a budget action to ***complete planning*** through the project approval lifecycle framework? Yes

   If yes, when will a budget action be submitted to your Agency/DOF for planning dollars?

   TBD, next available budget cycle is the target.

2. Please provide the Funding Source(s) and dates funds for planning will be made available:

   DHCS is requesting funding, contracted services, and positions to implement the requirements of the Managed Care Final Rule project. It is anticipated that DHCS will be able to draw down federal funding for this effort in addition to the state general fund being requested. Once approved the federal share would include up to 90 percent federal funding and 10 percent general funds toward the expenses of this project. The costs include any necessary infrastructure modifications and interfaces to work with contracted services. Additionally, DHCS requests ongoing funding and positions to maintain the program.

   General Fund = 50% / Federal Fund = 50%, FY 2025-26 through FY 2030-31 and ongoing.

Project Implementation Funding

1. Has the funding source(s) been identified for ***project implementation***? Yes

   If known, please provide the Funding Source(s) and dates funds for implementation will be made available:

   TBD

   Will a budget action be submitted to your Agency/DOF? Yes

   If "Yes" is selected, specify when this BCP will be submitted: TBD

2. Please provide a rough order of magnitude (ROM) estimate as to the total cost of the project: Between $10 Million and $50 Million

End of agency/state entity document.

Please ensure ADA compliance before submitting this document to CDT.

When ready, submit Stage 1 and all attachments in an email to ProjectOversight@state.ca.gov.

Department of Technology Use Only

Original “New Submission” Date: 09/15/2025

Form Received Date: 09/15/2025

Form Accepted Date: 09/15/2025

Form Status: Completed

Form Status Date: 09/15/2025

Form Disposition: Approved

If Other, specify: Click or tap here to enter text.

Form Disposition Date:09/15/2025

Department of Technology Project Number (0000-000): 4260-256