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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 Health Services (DHCS)**
2. **Proposal Name and Acronym: Managed Care Final Rule (MCFR) - Fiscal Stewardship**
3. **Proposal Description: (Provide a brief description of your proposal in 500 characters or less.)**

   The Department of Health Care Services (DHCS) is proposing to develop a process to collect, analyze and report on data for financial expenditures related to: State Directed Payments (SDPs) to ensure payment transparency and equitable funding for Medi-Cal members to ultimately improve health outcomes; In Lieu of Services (ILOS), to ensure the responsible and ethical management of financial resource to enable effect financial oversight of Medicaid payments; Medical Loss Ratio (MLR) for ensuring that maximum ratios for plan administrative expenditures are followed to maximize federal access for members and best practices for fiscal stewardship are followed. This proposal complies with the CMS Managed Care Final Rule, focusing on Financial oversight is being strengthened to transparently validate provider payments, prevent fund misallocation. transparently validate provider payments, prevent fund misallocation.

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   If withdrawn, select Reason: Choose an item.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

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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

Title: Deputy Director
Name: Bruce Lim
Business Program Area: Audits and Investigations

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.

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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: Yes

   Other Departments/State Entities: No

   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.**

   State Entity Only

   The successful implementation of the Managed Care Final Rule (MCFR) requires active and ongoing engagement from various stakeholders within the Department of Health Care Services (DHCS). DHCS will lead a coordinated planning effort, involving internal divisions and external stakeholders, such as the public, the Governor's office, the legislature, local and federal entities, special interest groups, and oversight bodies like CalHHS and the California Department of Technology. A Project Steering Committee (PSC) will be established within DHCS to oversee governance, guide coordination, and ensure transparency throughout the project. The PSC will also manage a structured communication plan to provide timely updates and engagement with executive leadership, CMS, the Governor's Office, and the Legislature. Through this collaborative framework, DHCS will integrate stakeholder contributions into the MCFR implementation strategy, ensuring compliance, accountability, and department-wide readiness.

   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

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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 the 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).

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

DHCS oversees Medi-Cal, delivering healthcare to nearly 15 million Californians. To improve access, quality, and fiscal integrity, the Centers for Medicare & Medicaid Services (CMS) issued the Managed Care Final Rule (CMS-2439-F), codified at 42 CFR Part 438. This rule mandates stricter oversight of State Directed Payments (SDPs), In Lieu of Services (ILOSs), provider incentives, and payment adequacy. DHCS must ensure SDPs have CMS approval, ILOSs are actuarially sound, incentives are tied to performance, and payments support access and equity. Noncompliance risks federal funding and service disruptions. DHCS is mobilizing key divisions to

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strengthen compliance, improve data reporting, enforce Medical Loss Ratio (MLR) standards, and align provider payments with federal expectations – all to advance equitable, fiscally responsible, and value-based care across Medi-Cal.

At DHCS, Health Care Delivery Systems, Enterprise Data Information Management, Quality Population Health Management, Health Care Benefits Eligibility, and Health Care Financing oversee various areas to comprise the main provision areas impacted by the new Final Rules.

Health Care Delivery Systems (HCDS): This division includes the Integrated Systems of Care Division (ISCD), Medi-Cal Quality & Monitoring Division (MCQMD), and Managed Care Operations Division (MCOD). These units ensure Medi-Cal members receive coordinated, high-quality care through managed care organizations (MCOs). MCOD will oversee SDP-related contractual compliance with MCOs, ensuring that directed payments align with quality incentives and support network adequacy. Additionally, HCDS will lead the operational oversight and implementation of ILOSs, ensuring that these alternative services are used appropriately, meet CMS criteria for cost-effectiveness and medical appropriateness, and are actuarially sound. In alignment with provider incentive standards, MCQMD will monitor contracts to ensure incentives are tied to measurable performance outcomes and support equitable care delivery. The division will also support Provider Payment Analysis by evaluating MCO payment methodologies across provider types to ensure payment levels are sufficient to maintain access, particularly in high-need areas such as primary care and behavioral health, while promoting transparency and consistency in rate setting.

Quality Population Health Management (QPHM): This includes the Population Health Management Division (PHMD) and the Quality Health and Equity Division (QHED). SDPs must be structured to support quality improvement goals, including incentivizing MCOs to implement health equity initiatives and achieve quality benchmarks. QPHM ensures SDP funding is utilized effectively to improve patient outcomes and reduce disparities in care. In addition, QPHM will help guide the implementation and oversight of quality measures tied to any financial incentive payments by ensuring these services contribute to whole-person care, align with population health goals, and reduce avoidable utilization. The division will also play a role in defining and monitoring provider incentive arrangements to ensure they are linked to performance metrics that promote equity and quality. Furthermore, QPHM may contribute to Provider Payment Analysis by assessing how payment structures influence quality outcomes and identifying disparities in payment that may impact access to high-quality care across different populations.

Health Care Benefits Eligibility (HCBE): This includes the Eligibility Division, Benefits Division, and Medi-Cal Dental Services Division. SDPs play a role in expanding access to providers who serve Medi-Cal beneficiaries. HCBE ensures that beneficiaries continue receiving care from providers supported through directed payment models, maintaining provider networks that serve Medicaid populations. Furthermore, HCBE will contribute to Provider Payment Analysis by identifying coverage and access gaps tied to inadequate reimbursement, particularly for essential benefits

such as dental and specialty services, and by supporting efforts to ensure payment levels are sufficient to maintain robust provider networks.

Behavioral Health (BH): This includes the Behavioral Health Oversight and Monitoring Division, Licensing and Certification Division, and Community Services Division. SDPs can be leveraged to support providers offering behavioral health services, ensuring that mental health and substance use treatment providers receive adequate reimbursement to maintain accessibility and quality standards in Medi-Cal's behavioral health system. BH will further contribute to Provider Payment Analysis by identifying disparities in behavioral health reimbursement, assessing how current rates impact access to care, and recommending adjustments to support an adequate and sustainable behavioral health provider network.

Health Care Financing (HCF): This division oversees Fee-For-Service, Local Government Financing, and Capitated Rates Development Divisions. HCF is responsible for the financial oversight of SDPs, ensuring payment structures remain compliant with CMS requirements and ensuring directed payments do not disrupt actuarial soundness within Medi-Cal managed care rates. This division conducts audits, reviews financial reports, and ensures that SDPs contribute to overall program sustainability. HCF plays a key role in the financial evaluation of ILOSs, ensuring that these services are actuarially sound, cost-effective, and appropriately incorporated into rate development. HCF also supports the validation of provider incentive arrangements, verifying that financial incentives are linked to performance and included in capitation rates in compliance with federal standards. In support of Provider Payment Analysis, HCF is responsible for assessing payment adequacy across provider types and ensuring that reimbursement structures are aligned with access goals, fiscal integrity, and long-term program viability.

Enterprise Data and Information Management (EDIM): This includes the Data Analytics Division and the Program Data Reporting Division. EDIM supports SDP implementation by maintaining accurate provider payment data, ensuring transparency in SDP allocation, and validating compliance with 42 CFR 438.6(c). Data integrity and reporting mechanisms are essential for tracking SDP utilization, financial impacts, and provider participation. EDIM also plays a vital role in monitoring and analyzing ILOSs, including tracking utilization trends, assessing cost-effectiveness, and ensuring alignment with managed care reporting requirements. EDIM also supports oversight of provider incentive standards by collecting and validating performance data tied to incentive payments, ensuring that metrics are measurable, reportable, and used to drive quality improvement. Furthermore, EDIM is central to Provider Payment Analysis by aggregating and analyzing payment data across plans and provider types, identifying payment disparities, and supporting data-driven policy and rate-setting decisions.

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

The proposed project will significantly improve the products and services supported by DHCS by aligning Medi-Cal managed care operations with the federal requirements outlined in the MCFR

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regulation. By strengthening fiscal integrity, enhancing provider payment transparency, and establishing robust compliance protocols, the project ensures that Medi-Cal services are financially sustainable, equitable, and performance-driven. It will improve provider accountability, promote access to cost-effective care alternatives, and support the stability and expansion of provider networks, particularly in underserved communities. In doing so, the project advances the State's health equity goals and safeguards federal funding, directly enhancing service delivery and outcomes for Medi-Cal beneficiaries.

1. **Enhancing Fiscal Integrity and Provider Payment Transparency:** SDPs align with CMS financial oversight requirements, helping prevent fund misallocation and maintain actuarial soundness within Medi-Cal managed care. It supports the implementation of In Lieu of Services and Settings (ILOSs) by requiring that these alternative services are both cost-effective and actuarially sound. The rule also mandates robust analysis of provider payment rates to confirm their adequacy and comparability across plans and service types, helping to identify and address disparities in access. Additionally, it establishes standardized financial tracking measures to promote equitable, transparent, and accurate provider reimbursements, thereby safeguarding California's federal matching funds.

2. **Strengthening Compliance with Federal Requirements for Financial Controls:** MCFR supports accurate tracking and reporting of SDP allocations, ensuring adherence to CMS-mandated payment structures. It requires detailed documentation and reporting on the provider's incentive arrangements, which must be tied to measurable performance outcomes in line with federal regulations. The rule also establishes compliance protocols for ILOSs, ensuring they meet CMS standards for medical appropriateness, voluntary use, and cost-effectiveness. Collectively, these provisions enhance federal oversight capabilities and reduce compliance risks that could threaten Medi-Cal's access to federal funding.

3. **Supporting Provider Networks and Member Access to Care:** MCFR ensures timely and adequate provider reimbursement, which is critical to sustaining network stability and preventing provider attrition. By maintaining and expanding provider participation, the rule helps reduce access barriers for Medi-Cal beneficiaries, especially in rural and underserved areas. It promotes provider engagement through structured incentives that reward improvements in care quality, outcomes, and access. Additionally, the rule supports expanded use of cost-effective alternatives through ILOSs, addressing gaps in traditional service delivery and helping to reduce avoidable institutional care.

4. **Advancing Equity and Social Determinants of Health (SDOH):** MCFR aligns SDP allocations with health equity goals by incentivizing providers who serve high-need, limited-access populations. It also addresses disparities in care delivery by ensuring sustainable funding for safety net providers and specialty care services, thereby promoting more equitable access to care across the Medi-Cal population.

Implementation of this project will directly impact the quality, accessibility, and sustainability of services supported by DHCS by embedding federally required standards into Medi-Cal managed care operations. It strengthens core service delivery functions—such as provider reimbursement, payment accuracy, and incentive alignment—while ensuring compliance with CMS oversight. The project's focus on fiscal transparency, access equity, and performance-based care will not only enhance the efficiency of DHCS programs but also improve outcomes for enrollees through stronger program integrity and fiscal oversight controls.

TIP: Copy and paste or click the + button in the lower right corner to add Business Programs, with background and context and impact descriptions as needed.

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 Goals & Alignment

Goal 1: Put People First – Design Programs and Services for Whole-Person Care in the Community

Alignment: The Managed Care Final Rule (CMS-2439-F) emphasizes a member-centric approach, ensuring that State Directed Payments (SDPs) support equitable access to high-quality care. By enhancing provider payment structures, the project directly aligns with whole-person care principles, ensuring timely access to essential healthcare services while maintaining financial sustainability.

Goal 2: Increase Meaningful Access – Strengthen Health Care Coverage and Provider Capacity

Alignment: State-Directed Payments (SDPs) play a critical role in ensuring financial incentives support adequate provider networks, particularly in underserved and high-need areas. By aligning with CMS transparency requirements, SDPs enhance Medi-Cal member access to services while maintaining financially sustainable provider participation.

Goal 5: Strengthen Operations – Enhance Program Administration and Compliance

Alignment: This initiative establishes standardized payment methodologies for SDPs, reinforcing fiscal oversight, compliance auditing, and payment validation processes. Leveraging structured

reporting frameworks, DHCS ensures that SDP allocations align with federal requirements while reducing administrative burdens on providers.

Goal 6: Leverage Data to Improve Outcomes

Alignment: DHCS will implement advanced data tracking and analytics to improve real-time monitoring of SDP allocations. By enhancing transparency and automated best-use reporting, this initiative supports long-term financial oversight and equitable provider reimbursement strategies.

Mandates: Federal State Directed Payments

Medicaid Citation	Description	Applicability Date in Final Rule
§ 430.3	Requires DHCS to file an appeal with the Departmental Appeals Board in accordance with the procedures outlined in 45 CFR Part 16 if CMS disapproves a State Directed Payment submitted under 42 CFR 438.6 (c)(2)(i). This ensures that DHCS has a formal mechanism to contest disapprovals and seek reconsideration of CMS's decision.	July 9, 2024
§ 438.6(c)(3)	Requires DHCS to submit a formal request and justification for multi-year approval—up to three rating periods—for any State Directed Payment. This includes providing detailed documentation of the payment structure, an evaluation plan, and how the SDP aligns with the State's quality strategy, as SDPs are not automatically renewed without this submission.	July 9, 2024
§ 438.6(a)	Requires DHCS to apply standardized definitions for State Directed Payments (SDPs) as outlined in federal regulations. This includes clearly identifying payment methodologies (such as condition-based, population-based, and uniform increases), rate benchmarks (such as minimum or maximum fee schedules and average commercial rates), and performance measures. DHCS must also use these definitions to calculate total payment rates for CMS approval and accurately classify services and provider types included in SDP arrangements.	July 9, 2024
§ 438.6(c)(2)(iii)	Requires DHCS to demonstrate that total payment rates for inpatient, outpatient, nursing facility, and qualified academic medical center services under State Directed Payments do not exceed the average commercial rate (ACR). To comply, DHCS must submit an ACR analysis using recent, service-specific, State-based commercial payment data and provide a detailed comparison of total payment rates to ACRs for each provider class and managed care program. This analysis must be included with the initial CMS approval request and updated regularly—at least every three years for the ACR demonstration and with each renewal or amendment for the rate comparison.	First rating period beginning on or after July 9, 2024. (January 1, 2025)

§ 438.6(c)(2)(iv)	Requires DHCS to submit a written evaluation plan as part of the initial CMS approval request for any State Directed Payment, and to update the plan with each amendment and renewal. The evaluation plan must include at least two metrics—one of which must be a defined performance measure—to assess how the payment supports the goals of the State's quality strategy. It must also provide baseline statistics, performance targets demonstrating maintenance or improvement (with at least one target showing improvement), and a commitment to submit an evaluation report if the final cost percentage of the SDP exceeds 1.5%.	First rating period beginning on or after July 9, 2027 (January 1, 2028)
§ 438.6(c)(2)(v)	Requires DHCS to submit an evaluation report for any State Directed Payment requiring CMS prior approval if the final cost percentage exceeds 1.5%. The report must be based on the approved evaluation plan and include all required evaluation elements, along with results from the past three years for each metric. DHCS must also publish the report on its public-facing website. The initial report is due within two years after the end of the three-year evaluation period, with subsequent reports submitted every three years.	First rating period beginning on or after July 9, 2027 (January 1, 2028)
§ 438.6(c)(2)(vii)	Requires DHCS to ensure that State Directed Payments based on fee schedules or condition-based methodologies are strictly tied to services delivered within the specific rating period for which CMS approval is requested. Payments must not be based on utilization outside the approved timeframe, nor can they be retrospectively reconciled to align with services provided during that period.	First rating period beginning on or after July 9, 2027 (January 1, 2028)
§ 438.6(c)(7)	Requires DHCS to annually calculate and certify the final State-directed payment cost percentage for each State Directed Payment requiring prior CMS approval. This percentage represents the portion of the capitation rate attributable to the approved SDP. If the final cost percentage is below 1.5% and DHCS does not voluntarily submit an evaluation report, it must still provide CMS with a certified cost percentage report.	First rating period beginning on or after July 9, 2027 (January 1, 2028)
§ 438.6(c)(1)	Requires DHCS to ensure that any State Directed Payment adopting a minimum fee schedule directs MCOs, PIHPs, or PAHPs to pay providers either at rates equivalent to 100% of a total published Medicare payment rate from within the past three years, or at alternative rates not based on the State plan or Medicare, provided these rates are clearly specified in the contract and comply with all applicable federal requirements..	First rating period beginning on or after July 9, 2024 (January 1, 2025)
§ 438.6(c)(2)(i)	Requires DHCS to obtain written prior approval from CMS for any State Directed Payment, confirming that all applicable standards and requirements under this section are met, even when the payment methodology is based on Medicare rates.	First rating period beginning on or after July 9, 2024 (January 1, 2025)

§ 438.6(c)(1)(iii)	Requires DHCS to establish minimum fee schedule arrangements that direct MCOs, PIHPs, or PAHPs to pay providers at rates equal to 100% of a total published Medicare payment rate in effect within the past three years, or at alternative rates not tied to the State plan or Medicare rates. These payment arrangements, including those for non-network providers, must be clearly specified in the contract and comply with all applicable federal requirements.	First rating period beginning on or after July 9, 2024 (January 1, 2025)
§ 438.6(c)(6)	Requires DHCS to include all SDPs in the final capitation rates paid to MCOs, PIHPs, and PAHPs, using base data or actuarially appropriate adjustments as permitted under §§ 438.5 and 438.7(b). DHCS must ensure that these payments are not made or retained separately from the capitation rates.	First rating period beginning on or after July 9, 2027 (January 1, 2028)
§ 438.6(c)(4)	Requires DHCS to submit detailed State Directed Payment data to CMS through the Transformed Medicaid Statistical Information System (T-MSIS) or its successor within one year after the end of each rating period. The report must include expenditures by each MCO, PIHP, and PAHP, broken down by provider, enrollee, service codes, and payment amounts, beginning after CMS issues official reporting instructions.	Date specified in the T-MSIS reporting instructions released by CMS
§ 438.6(c)(2)(vi)(C)(2)	Requires DHCS to meet specific attribution requirements for population-based or condition-based State Directed Payments. When using enrollee attribution, DHCS must rely on data no older than three years, preserve existing provider-enrollee relationships, take enrollee preferences into account, and clearly define the timing, frequency, and method of communicating panel updates to providers.	First rating period beginning on or after July 9, 2024 (January 1, 2025)
§ 438.6(c)(2)(vi)(C)(1)	Requires DHCS to ensure that any population-based or condition-based State Directed Payment is directly tied either to the delivery of specified Medicaid-covered services or to the attribution of enrollees to a provider for treatment, both occurring within the same rating period for which the payment is approved.	First rating period beginning on or after July 9, 2024 (January 1, 2025)
§ 438.6(c)(2)(vi)(C)(4)	Requires DHCS to include at least one provider class-level performance metric in the evaluation plan for any population-based or condition-based State Directed Payment. The metric must have a performance target that demonstrates improvement over baseline performance.	First rating period beginning on or after July 9, 2026 (January 1, 2027)
§ 438.6(c)(2)(vi)(C)(3)	Requires DHCS to ensure that any population-based or condition-based State Directed Payment fully replaces the negotiated rate for the covered services. MCOs, PIHPs, or PAHPs may not make any additional payments to the same provider for the same enrollee and services beyond the approved SDP amount.	First rating period beginning on or after July 9, 2026 (January 1, 2027)

§ 438.6(c)(5)(i)-(iv)	Requires DHCS to include specific documentation in Medicaid managed care contracts when implementing State Directed Payments. This documentation must detail the payment methodology, applicable provider classes, performance metrics (if applicable), and assurances that the arrangement complies with federal requirements under 42 CFR §438.6(c)	First rating period beginning on or after July 9, 2026
§ 438.6(c)(5)(v)	Requires DHCS to submit Medicaid managed care contract amendments or rate certifications that include State Directed Payments to CMS no later than 90 days prior to the start of the rating period.	First rating period beginning on or after July 10, 2028
§ 438.6(c)(2)(ii)(F)	Requires DHCS to ensure that each State Directed Payment aligns with and achieves the goals specified in the State's evaluation plan. DHCS must also provide an evaluation report to CMS upon request, demonstrating that the established goals have been met.	First rating period beginning on or after July 9, 2027
§ 438.6(c)(2)(ii)(C)	SDP: Standard for the advancement of goals and objectives in the quality strategy Each SDP must be designed to advance at least one goal or objective from the State's quality strategy as outlined in § 438.340.	July 9, 2024
§ 438.6(c)(2)(ii)(H)	Requires DHCS to obtain attestations from providers receiving State Directed Payments confirming they are not involved in any hold harmless arrangement related to health care-related taxes. DHCS must provide these attestations to CMS upon request or submit an explanation if certain providers are unable or unwilling to provide them.	First rating period beginning on or after January 1, 2028 (January 1, 2028)
§ 438.6(c)(2)(ii)(J)	Requires DHCS to ensure that each State Directed Payment is actuarially sound, fully documented in the development of capitation rates, and included in CMS rate certification submissions. Additionally, SDPs must comply with Medical Loss Ratio (MLR) requirements to uphold transparency and maintain fiscal integrity.	July 9, 2024
§ 438.6(c)(2)(ii)(B)	Requires DHCS to apply each State Directed Payment equally and under identical performance terms to all providers within the same class who are delivering the contracted service, ensuring fairness and consistency across the provider network.	July 9, 2024
§ 438.6(c)(2)(ii)(D)	Requires DHCS to include an evaluation plan for each State Directed Payment that measures how the payment advances at least one goal from the State's quality strategy.	First rating period beginning on or after July 9, 2027 (January 1, 2028)
§ 438.6(c)(2)(ii)(G)	Requires DHCS to ensure that each State Directed Payment complies with all federal regulations governing the financing of the non-federal share, including the requirements set forth in 42 CFR Part 433, Subpart B.	July 9, 2025

§ 438.6(c)(2)(ii)(E)	Requires DHCS to ensure that provider participation in any State Directed Payment is not conditioned on the provider entering or complying with intergovernmental transfer agreements.	July 9, 2024
§ 438.6(c)(2)(ii)(I)	Requires DHCS to ensure that total payment rates under each State Directed Payment, by service and provider class, are reasonable, appropriate, and attainable. DHCS must maintain supporting documentation and make it available to CMS upon request.	July 9, 2024
§ 438.6(c)(2)(ii)(A)	Requires DHCS to ensure that each State Directed Payment is directly tied to the actual utilization and delivery of Medicaid-covered services.	July 9, 2024
§ 438.6(c)(2)(viii)	Requires DHCS to submit all necessary documentation for each State Directed Payment, including any amendments requiring CMS prior approval, before the proposed payment or amendment start date.	First rating period beginning on or after July 9, 2026 (January 1, 2027)
§ 438.6(c)(2)(vi)(B)	Requires DHCS to ensure that State Directed Payments tied to provider performance are based on measurable service outcomes rather than administrative tasks. These payments must use a consistent set of performance measures, include defined baseline data, and establish targets that demonstrate maintenance or improvement within a performance period aligned to the rating period.	First rating period beginning on or after July 9, 2024 (January 1, 2025)
§ 438.6(c)(2)(vi)(A)	Requires DHCS to ensure that State Directed Payments tied to value-based purchasing, delivery system reform, or performance improvement are offered on equal terms to all providers within the relevant provider class.	July 9, 2024
§ 438.16	Requires DHCS to apply Medicaid managed care access standards to all In Lieu of Services and Settings (ILOSs) that are not classified as Institutions for Mental Diseases (IMDs). Under the Managed Care Final Rule (MCFR), ILOS must meet the same access requirements as other Medicaid-covered services included in managed care contracts.	First rating period beginning on or after September 9, 2024.
§ 438.2	Requires DHCS to adopt and apply the federal definitions of key terms—such as In Lieu of Services or Settings (ILOS), Primary Care Case Management Entity (PCCM entity), and State Directed Payment—as outlined in 42 CFR Part 438. These definitions are foundational to the implementation of the Managed Care Final Rule (MCFR) and must guide DHCS's policies, contracts, and compliance efforts.	July 9, 2024
§ 438.3 (c)(1)(ii)	Requires DHCS to include In Lieu of Services and Settings (ILOS) in the standard contract provisions for Medicaid managed care payments, ensuring that ILOS arrangements are properly documented, actuarially sound, and incorporated into	July 9, 2024

	capitation rate development in compliance with the Managed Care Final Rule.	
§ 438.3 (e)(2)(i)-(iv)	Requires DHCS to ensure that any In Lieu of Services and Settings (ILOS) offered by an MCO, PIHP, or PAHP is medically appropriate, cost-effective, and explicitly approved in the managed care contract. Enrollee participation in ILOS must be voluntary and must not impact access to State plan-covered services.	July 9, 2024
§ 438.3 (e)(2)(v)	Requires DHCS to ensure that all In Lieu of Services and Settings (ILOS), except for short-term IMD stays permitted under § 438.6(e), comply with the access and availability requirements specified in § 438.16. This ensures that ILOS offerings maintain the same standards for service access as other Medicaid-covered benefits.	First rating period beginning on or after September 9, 2024.
§ 438.7(b)(6)	Requires DHCS to include in the Medicaid managed care contract and rate certification detailed descriptions of any special payment provisions under § 438.6 and any In Lieu of Services and Settings (ILOS) arrangements under § 438.3(e)(2) that are applied.	First rating period beginning on or after September 9, 2024. (January 1, 2025)
§ 438.7(c)(4)	Requires DHCS to submit a revised rate certification for any changes to capitation rates that involve special payment provisions under § 438.6 or In Lieu of Services and Settings (ILOS) under § 438.3(e)(2), regardless of whether the change is minor or was previously excluded from the original rate certification.	July 9, 2024
§ 438.10(g)(2)(ix)	Requires DHCS to ensure that Medicaid managed care plans—MCOs, PIHPs, PAHPs, and PCCM entities—include information about enrollee rights related to In Lieu of Services and Settings (ILOS) in the enrollee handbook provided after enrollment. This ensures beneficiaries are informed about their options, the voluntary nature of ILOS, and their right to access all covered State plan services.	July 9, 2024
§ 438.66(e)(2)(vi)	Requires DHCS to include information on In Lieu of Services and Settings (ILOS) in its annual Managed Care Program Annual Report (MCPAR). This includes reporting on ILOS utilization, cost, and how these services support the goals of the Medicaid managed care program, ensuring transparency and compliance with federal reporting requirements.	July 9, 2024

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2. **Business Driver(s)**

Financial Impact

Financial Benefit: Yes

Increased Revenue: No

Cost Savings: Yes

Cost Avoidance: No

Cost Recovery: No

Sanctions: Yes

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

The Managed Care Final Rule (CMS-2439-F) introduces several changes related to State Directed Payments (SDPs), In Lieu of Services (ILOS), Provider Incentive Standards, and Provider Payment Analysis, which collectively create financial benefits for DHCS (California Department of Health Care Services) through enhanced oversight, fiscal efficiency, and alignment of payments with outcomes. There is a strong likelihood of increased costs savings through these strengthened financial mechanisms and controls.

1. Enhanced Budget Predictability and Rate Transparency – Increased controls and matured processes for actuarial integration of SDPs and ILOS into capitation rates improves budgeting accuracy and financial forecasting. Provider Payment Analysis ensures payments are adequate and appropriately targeted, reducing unexpected cost overruns due to underpayment-driven access issues or inefficient contracting.
2. Incentivizing Value Over Volume - Provider Incentive Standards shift payments toward performance-based reimbursement, ensuring funds are directed toward high-performing, efficient providers. This results in better value for money spent, reducing waste and promoting higher quality care with the same or lower financial input.
3. Improved Federal Financial Participation (FFP) Compliance - By aligning SDPs, ILOS, and incentive arrangements with CMS requirements (e.g., documentation, actuarial soundness, rate certification), DHCS reduces the risk of CMS disallowances and enhances access to full federal matching funds.

Failure to comply with federal requirements may result in:

1. Sanctions, including withholding of federal funds – CMS may penalize California for non-compliance, directly impacting Medi-Cal reimbursement and funding stability.
    - Relevant Regulation: 42 CFR § 430.35

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2. Reduced federal support – Non-compliance with State Directed Payment (SDP) regulations may result in corrective action plans, financial penalties, or reductions in Medicaid reimbursements, impacting provider stability and service availability for Medi-Cal beneficiaries.
   - 42 CFR § 438.70 – Requires implementation of a quality rating system for managed care plans, ensuring that SDPs are structured to improve provider performance, meet quality benchmarks, and maintain financial accountability. Failure to integrate SDPs within the quality rating framework may lead to CMS enforcement actions, affecting funding allocations and managed care reimbursement structures.

Improvement

Better Services to the People of California: Yes

Efficiencies to Program Operations: Yes

Improved Equity, Diversity, and/or Inclusivity: No

Improved Health and/or Human Safety: Yes

Improved Information Security: No

Improved Business Continuity: No

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 comprehensive fiscal accountability and transparency requirements that necessitate significant changes to DHCS's financial oversight and managed care operations. Key provisions—SDPs, ILOS, Provider Incentive Standards, and Provider Payment Analysis – demand rigorous planning, documentation, and system upgrades to ensure compliance with federal standards. DHCS must ensure that SDPs are properly incorporated into actuarially sound capitation rates, tied to performance goals, and subject to ongoing evaluation. ILOS must be demonstrated as medically appropriate and cost-effective, with associated expenditures accurately reflected in capitation rate development. Provider incentive payments must be based on measurable outcomes aligned with the State's quality strategy, requiring robust performance tracking mechanisms. Additionally, DHCS must conduct systematic Provider Payment Analysis to assess payment adequacy, identify disparities, and inform fiscally sound rate setting and fiscally responsible enforcement. Meeting these mandates will require enhanced financial infrastructure, advanced data

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analytics capabilities, and stronger contractual and programmatic controls to align public spending with value, quality, and cost-efficiency across the Medi-Cal managed care program.

Opportunity: MCFR presents a strategic opportunity for DHCS to strengthen fiscal stewardship through the development of dedicated, data-driven processes for managing SDPs, ILOS, Provider Incentive Standards, and Provider Payment Analysis. Implementing comprehensive data collection, evaluation, and reporting mechanisms will enable DHCS to ensure compliance with federal requirements, support actuarial soundness, enhance transparency, and optimize the use of Medi-Cal funds. By institutionalizing these reforms, DHCS can:

1. **Establish Centralized Oversight and Real-Time Monitoring of SDPs and ILOS:** Build infrastructure to track SDP allocations and ILOS utilization in real time, ensuring payments align with contract terms, quality goals, and rate development standards. This supports transparent, performance-based funding and helps direct resources to high-need or underserved populations.

2. **Strengthen Evaluation and Accountability for Provider Incentive Payments:** Develop standardized evaluation plans that tie incentive payments to clearly defined performance metrics, ensuring payments are linked to outcomes and not administrative activities. This drives value-based care and enables fiscal accountability for incentive-driven spending.

3. **Implement a Comprehensive Provider Payment Analysis Framework:** Leverage data analytics to assess the adequacy and equity of provider payments across plans and services, enabling rate-setting decisions that ensure access, eliminate disparities, and reflect true service costs. This also helps CMS validate payment sufficiency and maintain compliance.

4. **Integrate Financial Data into MCPAR and Rate Certification:** Standardize reporting across all payment mechanisms—including ILOS, SDPs, and incentive arrangements—and ensure seamless integration into the Managed Care Program Annual Report (MCPAR) and actuarial rate certifications, reinforcing transparency and compliance with CMS expectations.

5. **Update Managed Care Contracts and Spending Protocols:** Embed SDP, ILOS, and incentive provisions into managed care contracts with clearly defined payment terms, performance requirements, and spending caps. Regular updates based on data-driven insights will help DHCS optimize funding allocations and ensure consistent alignment with program goals and federal limits.

By operationalizing these opportunities, DHCS can not only meet the regulatory mandates of the Final Rule but also build a financially resilient and outcomes-driven Medicaid managed care program.

Project Objectives and Metrics

Objective ID: 1.1 – State Directed Payments

Objective: Enable program to submit annual SDP expenditure data to CMS within the 1-year rating period in T-MSIS as necessary.

Metrics: The ability to analyze SDP against performance metrics for required CMS reporting.

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Baselines: 0% as DHCS does not currently collect and analyze this data

Target Results: DHCS is able to submit the annual SDP expenditure data in T-MSIS within the 1-year rating period.

Objective ID: 1.2 – State Directed Payments

Objective: Enable program to evaluate SDPs representing 1.5% or more of capitation and apply corrective action as necessary.

Metrics: The ability to analyze SDP capitation payments

Baselines: 0% as DHCS does not currently collect and analyze this data

Target Results: DHCS is able to compile and submit the evaluation of these large SDPs once every three years to CMS.

Objective ID: 2 – In Lieu of Services and Settings

Objective: Enable program to monitor and report on ILOS payments that exceed 5% of capitation.

Metrics: The ability for program to analyze and report on ILOS payments

Baselines: 0% as DHCS does not currently collect and analyze this data

Target Results: In accordance with CMS established requirements the State will demonstrate its ability to report compliance with this provision.

Objective ID: 3 – Provider Payment Analysis

Objective: Enable program to review payment analyses and to submit them to CMS within required timeframes.

Metric: The ability to analyze and report on payments to all the managed care plans.

Baseline: 0% as DHCS does not currently report on this data.

Target Result: In accordance with CMS established requirements the State will demonstrate its compliant ability to report compliance with this provision.

Objective ID: 4 – Overpayment Reporting

Objective: Enable program to report and investigate overpayment issues resulting from fraud, waste, and abuse within their provider networks.

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Metric: The ability to analyze overpayment data and address issues within their provider networks

Baseline: 0% as DHCS does not currently collect this data in a centralized manner.

Target Result: Development and utilization of the automated process to review overpayment information and enable states to apply corrective action.

TIP: Copy and paste or click the + button in the lower right corner to add Objectives as needed. Please number for reference.

TIP: Objectives should identify WHAT needs to be achieved or solved. Each objective should identify HOW the problem statement can be solved and must have a target result that is specific, measurable, attainable, realistic, and time bound. Objective must cover the specific. Metric and Baseline must detail how the objective is measurable. Target Result needs to support the attainable, realistic, and time-bound requirements.

1.8 Project Management

Project Management Risk Score: 0.6

Follow the instructions in 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.

SIMM_45_Appendix_A_Project Management Risk Assessment - MCFR - Fiscal Stewardship.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

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1.9 Initial Complexity Assessment

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

   Follow the instructions in the Statewide Information Management Manual (SIMM) Section 45 Appendix D Complexity Assessment Instructions.

   Attach a completed Statewide Information Management Manual (SIMM) Section 45 Appendix C Complexity Assessment Template to the email submission.

   SIMM-45-Appendix-C-Complexity-Assessment-MCFR - Fiscal Stewardship.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

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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 Spring Finance BCP for 2025-26 funds

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 Final Rules for Access and Managed Care. It is expected that DHCS will be able to secure substantial federal funding for this effort, in addition to the requested state General Fund. The funding breakdown would be up to 90 percent federal funding and 10 percent state General Fund for the project's expenses. These costs include any necessary infrastructure modifications and interfaces to work with contracted services. Additionally, DHCS is requesting ongoing funding and positions to maintain the program.

   General Fund = 25% / Federal Fund = 75%, FY 2025-26 through FY 2030-2031 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:

   The General Fund is 25%, and the federal Fund is 75%, from FY 2025-2026 to FY 2030-2031 and beyond.

   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: Greater than $100 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.

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Original “New Submission” Date: 09/02/2025.

Form Received Date: 09/02/2025.

Form Accepted Date: 09/02/2025.

Form Status: Complete.

Form Status Date: 09/02/2025

Form Disposition: Approved.

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

Form Disposition Date: 09/02/2025.

Department of Technology Project Number (0000-000): 4260-255.