



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

If Agency/State entity is not in the list, enter here with the [organization code](#). N/A

2. **Proposal Name:** Medi-Cal Provider Enrollment Online Application

3. **Proposal Description:** (Provide a brief description of your proposal in 500 characters or less.)

The Department of Health Care Services (DHCS), Provider Enrollment Division (PED), proposes to replace the existing system and vendor, Provider Application and Validation for Enrollment (PAVE) by Digital Harbor (DH), for provider management and monitoring processes to enable more timely and cost-efficient provider management. This will improve the Department's ability to quickly meet the changing landscape of health care delivery that supports adaptability and rapid response time to changes in enrollment requirements, provider types and benefits. In return, this will benefit Medi-Cal members by ensuring only qualified providers can be enrolled in the Medi-Cal program and receive payment to provide services to Medi-Cal members. This will also allow the Department to provide data that is timely, accurate and accessible to support decision making.

4. **Proposed Project Execution Start Date:** 12/1/2026

5. **S1BA Version Number:** Version 1

1.2 Submittal Information

1. **Contact Information**

Contact Name: Adrianna Alcalá-Beshara

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

Contact Phone: 916-345-8629

2. **Submission Type:** New Submission

If Withdraw, select Reason: [Choose an item](#).

If Other, specify reason here: [N/A](#)

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 (Sponsors)

Title: [Chief Operating Officer for Programs](#)

Name: [Chris Riesen](#)

Business Program Area: [Program Integration and Operations Support](#)

Title: [Chief Deputy Director, Program Operations](#)

Name: [Bill Otterbeck](#)

Business Program Area: [Program Operations](#)

2. Business Owner

Title: [Chief, Provider Enrollment Division](#)

Name: [Mistie Chiddick](#)

Business Program Area: [Provider Enrollment](#)

Title: [Chief, CA-MMIS Operations Division](#)

Name: [Brian Kentera](#)

Business Program Area: [CA-MMIS Operations](#)

Title: [Chief, Medi-Cal Dental Services Division \(CD-MMIS\)](#)

Name: [Dana Durham](#)

Business Program Area: Medi-Cal Dental Services

Title: Chief, Office of Family Planning

Name: Sarah Gilbert

Business Program Area: Family Planning

Title: Chief, Home and Community Based Services Operations Branch

Name: Xiomara Watkins-Breschi

Business Program Area: Integrated Systems of Care

Title: Chief, Contracts and Enrollment Review Division

Name: Brian Vu

Business Program Area: Audits and Investigations

3. Product Owner

Title: Chief, Contracts and Vendor Management Branch

Name: William "Brian" Mays

Business Program Area: Contracts and Vendor Management

TIP: Copy and paste or click the + button in the lower right corner on any section to add additional Executive Champions, Business Owners, or Product Owners with their related Business Program Areas as needed.

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: No

Federal Entities: Yes

Governor's Office: No

Legislature: No

Media: No

Local Entities: No

Special Interest Groups: No

Other: Yes

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

The DHCS PED, in conjunction with the DHCS Procurement and Contracting Division (PCD), will be responsible for the planning and execution of the transition to the new vendor.

Other State Departments/State Entities

The California Health and Human Services Agency (CalHHS) will be involved with reviewing project plans and related artifacts. They will also work with the Department and 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, CalHHS will engage in the planning process to understand the technical approach that might be leveraged or enhanced by other CalHHS efforts.

Federal Entities

DHCS will seek enhanced federal funding through the Advanced Planning Document (APD) process. The Centers for Medicare and Medicaid Services (CMS) will review the APD and determine eligibility for planning and implementation funding. CMS will monitor progress but will not be directly involved in the project planning work.

Other – Providers

Providers will have an interest in the new technology; however, they will not be involved in the planning process.

1.5 Business Program

1. **Business Program Name:** Department of Health Care Services, Provider Enrollment Division

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

DHCS provides Californians with access to affordable, integrated, high-quality health care, including medical, dental, mental health, substance use treatment services, and long-term care. DHCS in partnership with the Centers for Medicare and Medicaid Services (CMS) funds health care services for the care of low-income families, children, pregnant women, seniors, and persons with disabilities who are enrolled in the Medi-Cal Program. These services are provided by

medical professionals, referred to as Providers, who meet the Eligibility and Enrollment (E&E) requirements established by California's Welfare and Institutions Code for the Medi-Cal Program.

The DHCS PED is responsible for the review and approval of Provider applications seeking to participate in the Medi-Cal program, including ensuring that all applicants meet licensure requirements and participation standards defined by federal and state statutes and regulations. Additionally, PED conducts revalidation functions of current Providers to ensure continued compliance with program requirements and standards of participation. PED currently receives between 5,400 – 8,000 Provider applications per month and manages over 350,000 active Providers consisting of more than 100 different Provider types, and approximately 22,000 enrolled Medi-Cal Dental providers with approximately 65,000 applications per year processed. Examples of provider types include physicians, nurses, pharmacists, medical suppliers, hospitals, and other medical facilities serving Medi-Cal members.

PED is also responsible for screening and monitoring providers to ensure ongoing compliance with provider integrity mandates under the Patient Protection and Affordable Care Act (ACA), 42 CFR 455.410, 455.414, and 455.436.

DHCS currently utilizes the PAVE service. The Software-as-a-Service (SaaS) cloud solution is based on the current vendor's proprietary SaaS offering. The PAVE service provides a public-facing web portal to enroll and monitor DHCS Providers. The PAVE service also interfaces with systems such as CD-MMIS and CA-MMIS mainframe for two-way data transmission and synchronization to facilitate claims processing that are performed out of the Medi-Cal Dental Services Division and CA-MMIS Divisions.

PAVE consists of four modules. The PAVE public-facing module is:

- Portal – The public facing portal component provides a secure web-based platform through which the Providers can submit their applications and initiate the enrollment process into the Medi-Cal program.

The PAVE internal modules, used by PED, Audits and Investigations, and the Office of Family Planning, are:

- Enrollment – The enrollment component contains a workflow, document management, and decision support features. The component captures unified information about practices, credentials, organizational relationships and affiliated parties and uses this information to verify and validate the enrollment process.
- Screening – The screening component executes an automated workflow in real-time against multiple data sources to create a Provider risk score to assist the enrollment analyst in identifying the most high-risk Providers to maintain program integrity.
- Monitoring – The monitoring component uses a platform to match all enrolled entities (providers and affiliated parties) against dozens of negative "lists" and generate alerts for potential change in status of current enrollees.

The Screening and Monitoring components are used by DHCS to ensure on-going compliance of providers. Screening is completed every time a full application is submitted. Monitoring of enrolled providers is completed on a monthly basis. Screening of the applicant and the reported owners, officers, managing employees and those with controlling interest against federal and state exclusionary boards, namely, Office of Inspector General (OIG), Medicaid and Children's Health Insurance Program State Information Sharing System (MCSIS), currently known as CMS Data Exchange System (DEX), System for Award Management (SAM), and the California Suspended &

Ineligible list (S&I). Additionally, PAVE screens and monitors the provider's licenses and permits, Social Security Administration Death Master File (SSA DMF), and National Plan and Provider Enumeration System (NPES). Monthly alerts are generated using mandatory compliance and risk data sources (at a minimum, based on PPACA compliance) to indicate potential risk of fraud, program vulnerability or non-compliance issues for provider and all parties associated with the provider.

The availability of accurate and current provider data is critical to ensure program integrity and to curtail potential fraud, waste, or abuse in order to preserve Medicaid funds.

3. How will this proposed project impact the product or services supported by the state entity?

This project is to secure a replacement service that will result in the deployment of a complete SaaS web-based enterprise-wide process for provider management (Medi-Cal enrollment and monitoring service) that meets state and federal compliance standards and ensures that only qualified providers are enrolled in Medi-Cal to be able to be compensated for providing services for Medi-Cal Members. By preventing ineligible providers from enrolling and receiving payment, the system will strengthen program integrity and protect Medi-Cal members from unqualified or fraudulent service providers. The Statewide provider directory will also improve member experiences by ensuring members are informed about providers that are available within the Medi-Cal Program, and which providers are not. Reliable access to real-time provider information through an online provider directory allows for more informed Medi-Cal members which can increase access by connecting members to providers closer to their residences, learning about additional providers that they can select for services which in turn gives them more information to shop providers and access services. Additionally, providers will have an improved self-service and overall experience by having Portal access through a variety of devices, applications being able to pre-populate information, access to reporting features and real-time enrollment information. Providers will receive training through webinars, videos, and on-demand application walkthroughs. Additionally, technical assistance will be available throughout the life of the project.

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: Enterprise Architect

Name: Andrew Nunes

Strategic Plan Last Updated? 7/25/2024

Strategic Business Goal: DHCS Strategic Goal #5 - Strengthen Operations

Alignment: Implement sustainable improvements to critical organizational infrastructure by increasing the use of automation to improve compliance, accountability, and consumer-centered performance outcomes.

Strategic Business Goal: DHCS Strategic Goal #6 - Leverage Data

Alignment: DHCS will have a centralized data process for Medi-Cal (CA-MMIS) and Medi-Cal Dental (CD-MMIS) providers. It will automatically generate monthly Alerts using mandatory compliance and risk data sources (at a minimum, based on Patient Protection and Affordable Care Act (ACA) compliance) to indicate potential risk of fraud, program vulnerability or non-compliance issues for provider and all parties associated with the provider. This shall include the following types of Alerts:

- HHS-OIG Exclusions (LEIE): Generate Alerts on all active providers and businesses that match parties sanctioned by HHS-OIG
- GSA Exclusions (System of Award Management (SAM)): Generate Alerts on all active providers that are excluded by SAM
- NPI Issues (NPPES): Generate Alerts on all entities if their NPI has been deactivated, the NPI disclosed is found in NPPES with a different Provider Name, the NPI disclosed is not found in NPPES, the NPI disclosed is invalid
- Death Master File (SSA-DMF): Generate Alerts on providers and affiliated parties who are deceased
- License Sanctions: Generate Alerts on providers who have received any adverse actions from their medical boards
- License Expirations: Generate Alerts on providers whose licenses are expired
- MCSIS Alerts: Generate Alerts on providers that are found on the MCSIS list
- S&I Exclusion list: Generate Alerts on providers that are found on the S&I Exclusion list

TIP: Copy and paste or click the + button in the lower right corner to add Strategic Business Goals and Alignments as needed.

Mandate(s): Both

Bill Number/Code, if applicable: 42 CFR 455

Add the Bill language that includes system-relevant requirements:

The new service must be compliant with the mandates listed below and 42 CFR 455. These mandates are in effect today and will be required by the new vendor at assumption of operations.

The proposed solution will lay the foundation to incorporate other DHCS Provider Enrollment Programs to align and increase the Department’s MITA maturity to a level three (3) for Provider Management at full deployment.

Code	Requirement
CFR Part 455 - Program Integrity: Medicaid 445.434	Requires that providers screening shall “(i) shall include a licensure check, which may include such checks across States; and “(ii) may, as the Secretary determines appropriate based on the risk of fraud, waste, and abuse described in the preceding sentence, include— “(I) a criminal background check; “(II) fingerprinting; “(III) unscheduled and unannounced site visits, including pre-enrollment site visits; “(IV) database checks (including such checks across States); and “(V) such other screening as the Secretary determines appropriate.
Rehabilitation Act of 1973, 508	Requires that federal departments and agencies make reasonable efforts to provide information via systems that are equally accessible to the disabled. If they cannot do so, it requires they provide individuals with disabilities with an alternative means for equivalent access to the information and data.
CA Government Code, 7405	Requires that state government entities’ websites and other electronic and information technology systems comply with the accessibility requirements of Section 508 of the Federal Rehabilitation Act of 1973.
CFR Title 42	Protects “[r]ecords of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance use disorder education, prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States.” Confidentiality protections help address concerns that discrimination and fear of prosecution deter people from entering treatment for SUD.
CFR Part 455 - Program Integrity: Medicaid 445.10	Program Integrity: Medicaid sets forth requirements for a State fraud detection and investigation program, and for disclosure of information on provider business structure ownership and control.
CFR Part 455, -- Revalidation of enrollment 455.414	The State Medicaid agency must revalidate the enrollment of all providers regardless of provider type at least every 5 years.
CFR Part 455 --	The State Medicaid agency must do all of the following:

Code	Requirement
Federal database checks 455.436	<p>(a) Confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of Federal databases.</p> <p>(b) Check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any such other databases as the Secretary may prescribe.</p> <p>(c) (1) Consult appropriate databases to confirm identity upon enrollment and reenrollment; and</p> <p>(2) Check the LEIE and EPLS no less frequently than monthly.</p>

Bill Number/Code, if applicable:

Add the Bill language that includes system-relevant requirements:

TIP: Copy and paste or click the + button in the lower right corner to add Bill Numbers/Codes and relevant language as needed.

2. Business Driver(s)

Financial Benefit: [Yes](#)

Increased Revenue: [No](#)

Cost Savings: [Yes](#)

Cost Avoidance: [No](#)

Cost Recovery: [No](#)

Will the state incur a financial penalty or sanction if this proposal is not implemented? [Yes](#)

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

DHCS must comply with the accessibility requirements of Sections 7405 and 11135 of the California Government Code, Section 508 of the Rehabilitation Act of 1973 as amended (29 U.S.C. § 794d), Failure to comply may result in sanctions.

Government Code § 11141 allows a state agency to withhold funds, terminate funding, or take other appropriate action if an entity is found to be in violation of § 11135. Government Code § 11142 allows any person aggrieved to file a civil action to seek enforcement, including injunctive relief.

DHCS must comply with Title 42 CFR, specifically parts 424 and 455, for Provider screening and enrollment into the Medicaid Program. Failure to comply would result in a financial loss of 25% enhanced federal funding and possible sanctions if the State cannot meet provider application processing timelines. Due to the current solutions limitations, DHCS has had to implement work arounds to meet Federal and State regulations/mandates and avoid financial penalties.

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: **Yes**

Improved Business Continuity: **Yes**

Improved Technology Recovery: **Yes**

Technology Refresh: **Yes**

Technology End of Life: **No**

1.7 Business Outcomes Desired

Executive Summary of the Business Problem or Opportunity:

Business Problem

The Department of Health Care Services (DHCS) currently relies on a vendor that leverages a proprietary SaaS service utilizing the PAVE solution, owned and maintained by Digital Harbor (DH) through a multi-year sole source contract. However, this solution does not meet all state and federal requirements and requires enhancements to comply with new regulations. Over the contract term, DHCS has raised compliance concerns through formal correspondence, payment withholds, and a corrective action plan. Despite ongoing negotiations since 2021, DHCS and DH have not yet reached an Agreement in Principle for a three-year bridge contract starting April 1, 2026, with early termination provisions to allow for a transition to a new vendor. Without a replacement service, the Provider Enrollment Division (PED) would revert to manual, paper-based processing, significantly impacting the provider community, increasing application processing times, and risking the loss of enhanced federal funding. Additionally, manually monitoring providers and owners monthly would substantially increase workload, jeopardizing federal compliance.

The current system for provider enrollment and payment processing at DHCS is outdated and inefficient. Provider enrollment information is updated nightly. As this is not updated in real-time, there are opportunities to enhance the timeliness of system information to further strengthen program integrity to operate at a more mature and optimal state. The onboarding process for new provider

types is inefficient, taking 6 to 12 months from policy approval to operational readiness. The system also lacks robust reporting functionality, requiring each staff member (56 employees) to spend significant time preparing daily reports, requiring staff to spend approximately 1.6 hours each day (which aggregates to 21,504 hours per year or 1,792 hours per month) compiling individual reports due to limitations in current automation workflows. This underscores the need for a modernized solution that supports the DHCS objective to enable timely, accurate, and accessible reporting that empowers data-driven decision making. DHCS is committed to complying with state and federal accessibility requirements, HIPAA, and the Affordable Care Act. Given the procurement and contractual history, DHCS has determined that procuring a new service contract is in the program's best interest for long-term vision and strategic alignment.

This project aims to enable efficient changes to provider enrollment policy without significant costs to the state, helping DHCS adapt to changes in federal and state law more effectively. It will prevent payments to sanctioned or unqualified providers at the moment of the transaction, eliminate the lag between provider status changes and enforcement actions, reduce administrative burden from retroactive payment recovery, and improve member safety by ensuring only qualified providers are reimbursed for care. The project will also provide DHCS with timely, accurate, and accessible data to support decision-making processes. The procurement of a contract with a new vendor will improve federal compliance with screening, monitoring, and revalidation of providers, increase automation processes including real-time integration with payment systems, and enhance efficiencies with cost-effective changes. This will ultimately support DHCS in making timely, data-driven decisions.

Business Opportunity

The procurement of a contract with a new vendor will allow DHCS to do the following:

1. Improve federal compliance with screening, monitoring and revalidation of providers. This increases member safety by allowing members to check the directory and confirm if a provider is eligible to provide Medi-Cal covered services to Medi-Cal members.
2. Increase automating processes including real-time integration with payment systems. This will allow for increased accuracy in the claims payment systems.
3. Increase efficiencies with cost-effective changes. This project will allow for configuration with little to no code, which allows for efficient changes without significant costs to the state to adapt to changes to federal and state law.
4. Access to timely, accurate data to support DHCS in decision making.

Objective ID: 1

Objective: Improve Medi-Cal program integrity and member safety by ensuring real-time verification of provider eligibility, preventing improper payments at the point of service, and reducing administrative burden through timely, automated enforcement of provider status.

Metric: Percentage of provider payment transactions validated in real time prior to authorization.

Baseline: 0% as DHCS does not currently have the ability to validate payment transactions in real time.

Target Result: Within 6 months of implementation, 100% of provider payment transactions will be validated against the most current enrollment data in real-time.

Objective ID: 2

Objective: Accelerate the onboarding of new provider types eligible for Fee-for-Service reimbursement, enabling DHCS to respond more quickly to policy changes, provider shortages, and emerging health needs.

Metric: Average number of months to operationalize a new provider type for billing.

Baseline: Currently, it takes 6 to 12 months (current range of time) to add a new provider type from policy approval to operational readiness.

Target Result: Within 14 months of implementation, enable DHCS to add new Fee-for-Service provider types within 3 months or less from policy approval to operational readiness.

Objective ID: 3

Objective: Increase operational efficiency and free staff capacity for higher-value program priorities by reducing the time and cost required to generate weekly reports.

Metric: Reduce the amount of staff hours needed to prepare daily reports.

Baseline: It currently takes each of the 56 assigned staff members 1.6 hours daily to create individual daily reports. This aggregated is equal to 1,792 hours per month. System reporting functionality is currently a manual process and very limited with the current solution.

Target Result: Within 12 months of implementation, enable DHCS to decrease the time to prepare daily reports by 40%.

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

1. Project Management Risk Score: 0.7

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.

2. 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 this proposal will result in the creation of new business processes or changes to existing business processes?

Answer (No, New, Existing, or Both): No

1.9 Initial Complexity Assessment

1. Complexity Assessment (Business Score): 1.1

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.

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.

HIPAA/CIIS/FTI/PII/PCI: No

Security: No

ADA: Yes

Noncompliance Description:

Accessibility: The existing service does not comply with the accessibility requirements of Sections 7405 and 11135 of the California Government Code, Section 508 of the Rehabilitation Act of 1973 as amended (29 U.S.C. § 794d), regulations implementing the Rehabilitation Act of 1973 as set forth in Title 36 Part 1194 of the Code of Federal Regulations, and the Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 et seq.). In 1998, Congress amended the Rehabilitation Act of 1973 to require Federal agencies to make their electronic and information technology (EIT) accessible to people with disabilities. California Government Code Sections 7405 and 11135 codifies Section 508 of the Rehabilitation Act of 1973 requiring accessibility of EIT.

DHCS has managed this risk by requiring the vendor to submit scan reports for 508 compliance and to correct any found deficiencies.

Not Applicable: No

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: [The service will be accessed by DHCS users \(including PED, Office of Family Planning, Audits & Investigations\) and providers statewide.](#)

Estimated Number of Transactions/Business Events (per cycle): [5,000-8,000 new applications/month, this includes enrollments and re-validations](#)

Approximate number of internal end-users: [250](#)

Approximate number of external end-users: [370,000](#)

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? [No](#)

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

[Click or tap to enter a date.](#)

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

[Click or tap here to enter text.](#)

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:

[75% Federal Funding Participation will be requested for maintenance and operations activities.](#)
[90% Federal Funding Participation will be requested for planning, vendor onboarding, and implementation activities.](#)

Will a budget action be submitted to your Agency/DOF? [No](#)

If "Yes" is selected, specify when BCP will be submitted: [Click or tap here to enter text.](#)

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

- [\\$24-28M for Configuration and Implementation of Enrollment and Credentialing Services, over 18-24 months.](#)
- [\\$16-20M per year for maintenance and operation of the service.](#)

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: [12/29/2025](#)

Form Received Date: [12/29/2025](#)

Form Accepted Date: [12/29/2025](#)

Form Status: [Completed](#)

Form Status Date: [12/29/2025](#)

Form Disposition: [Approved](#)

If Other, specify: [Click or tap here to enter text.](#)

Form Disposition Date: [12/29/2025](#)

Department of Technology Project Number (0000-000): [4260-257](#)