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: 4150 - Managed Health Care, Department of**

   If Agency/State entity is not in the list, enter here with the organization code.

   Click or tap here to enter text.

Proposal Name and Acronym: Electronic Filing and Analysis of Claims Settlement Data (eFACS)

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

   The Department of Managed Health Care (DMHC) seeks to implement an Electronic Filing and Analysis of Claims Settlement data solution enabling the Office of Financial Review (OFR) to improve program efficiencies for electronic filing of all documents by health plans and their delegated entities. The resultant solution will allow OFR to review claims payment timeliness data in a faster manner, identify and categorize claims payment timeliness issues more efficiently, and analyze the claims payment timeliness trends to determine the appropriate action. While the scope of this proposal is focused on the implementation of a complete solution for the Electronic Filing and Analysis of Claims Settlement Data, DMHC proposes to first implement an interim solution (a Maintenance and Operations – M&O – effort that is not within the scope of this project proposal) to meet the statutory requirements of AB 3275. Effective January 1, 2026, this bill has the following statutory requirements:

   - Health plans and capitated providers, including Medi-Cal and specialized plans, are required to reimburse complete claims within 30 calendar days (instead of the current limit of 45 working days)
   - Health plans and capitated providers are required to contest or deny claims in writing within 30 calendar days.
   - Health plans and capitated providers are required to file quarterly and annual reports in compliance with the updated requirements of the new law.

3. **Proposed Project Execution Start Date: 7/1/2026**

4. **S1BA Version Number:** Version 1

1.2 Submittal Information

1. **Contact Information**

   Contact Name: Ralph Cesena

   Contact Email: ralph.cesena@dmhc.ca.gov

   Contact Phone: +1 916-879-5792

2. **Submission Type: New Submission**

   If Withdraw, 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.)

   Click or tap here to enter text.

   Summary of Changes: (Summarize updates made.)

   Click or tap here to enter text.

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: Deputy Director Office of Technology and Innovation - Chief Information Officer

   Name: Ralph Cesena

   Business Program Area: Office of Technology and Innovation

   Title: Deputy Director Office of Financial Review

   Name: Pritika Dutt

   Business Program Area: Office of Financial Review

2. **Business Owner**

   Title: Deputy Director – Office of Financial Review (OFR)

   Name: Pritika Dutt

Business Program Area: Office of Financial Review (OFR)

3. **Product Owner**

   Title: Deputy Director – Office of Financial Review (OFR)

   Name: Pritika Dutt

   Business Program Area: Office of Financial Review (OFR)

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: Yes

   Other Departments/State Entities: No

   Public: No

   Federal Entities: No

   Governor's Office: No

   Legislature: No

   Media: No

   Local Entities: No

   Special Interest Groups: No

   Other: No

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

   The DMHC – Office of Technology and Innovation (OTI) will participate in the PAL process and seek approval from CHHS Agency and the California Department of Technology. The DMHC-OTI team will manage the project, identify the requirements, procure / develop / configure the technology solution, identify resources, including possible use of external consultants, who will be members of this project team performing these activities.

   The Department of Managed Health Care – Office of Financial Review (OFR) will identify project team resources including subject matter experts (SMEs), participate in the PAL process, identify

business requirements for the project, participate in Solution Development Sprints / User Acceptance Testing / Project Sign Offs and other critical project activities.

1.5 Business Program

1. **Business Program Name:** Office of Financial Review (OFR)

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

   The Office of Financial Review (OFR) monitors health plan financial statements and filings, and analyzes health plan reserves, financial management systems and administrative arrangements. The OFR conducts routine financial examinations of each health plan every three to five years and initiates non-routine financial examinations as needed. Financial examinations focus on health plan compliance with financial and administrative requirements that include reviewing the plan's claims payment practices and provider dispute resolution processes.

   In addition, the OFR monitors the financial viability of Risk Bearing Organizations (RBOs) and claims timeliness requirements for all capitated providers. The OFR conducts claims and/or financial examinations of the RBOs every five years.

   The OFR also administers the Department's premium rate review program, which has saved Californians hundreds of millions of dollars in health care premiums. The DMHC's rate review program holds health plans accountable through transparency and ensures consumers get value for their premium dollar. When the DMHC finds a proposed rate change to be unreasonable, the health plan must notify impacted members of the unreasonable finding.

   Under the current law, health plans are required to submit quarterly, and annual claims settlement practices reports to the DMHC, which includes claims and provider dispute resolution compliance information for the health plans and their capitated providers. The OFR currently uses the Claims Settlement Practices and Dispute Resolution Report system to track claims payment and provider dispute resolution timeliness issues reported by health plans and capitated providers, as well as the associated corrective action plans. It is a manual process to develop reports and analyze trends for each health plan and capitated provider, which takes resources to compile.

   The AB 3275 updated timeframes would require the DMHC to update the quarterly and annual claims settlement practices reporting templates to capture new and updated data. The increased number of claims payment timeliness issues will add to this process and place an additional strain on resources.

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

   The following is a summary of the modifications effected to existing law, by AB 3275:
   - Beginning 1/1/26, amends Sections 1371 and 1371.35 of the Health and Safety Code as follows:

- Requires a health plan, including Medi-Cal and specialized plans, to reimburse complete claims within 30 calendar days. Requires health plans to contest or deny claims in writing within 30 calendar days.
- Changes penalty for failure to include interest payable on a claim to $15 *or 10 percent of the accrued interest*.

- Makes consistent amendments to the Insurance Code.

Potential Impacts:

- Office of Financial Review (OFR) –Update current workbooks, guides, and materials to reflect the new claims timeliness requirements. Review updated claims processing policies and provider contracts for compliance. Update reports and examinations to reflect and enforce the new standards for claim reimbursement.

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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: Vijay Mopuru

Strategic Plan Last Updated? 4/29/2020

Strategic Business Goal: Ensure the stability of healthcare delivery system

Alignment: To ensure that health plans and capitated providers make timely payments to providers for healthcare services

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

Mandate(s): State

Bill Number/Code, if applicable: AB 3275

Add the Bill language that includes system-relevant requirements:

AB 3275 does not mandate DMHC to implement an IT solution, but does require the DMHC to meet specific statutory requirements as described below.

AB 3275 Bill Language: Commencing January 1, 2026, this bill instead would require a health care service plan, including a Medi-Cal managed care plan, or health insurer to reimburse a

complete claim or a portion thereof within 30 calendar days after receipt of the claim, or, if a claim or portion thereof does not meet the criteria for a complete claim or portion thereof, to notify the claimant as soon as practicable, but no later than 30 calendar days that the claim or portion thereof is contested or denied. The bill would authorize the departments to issue guidance and regulations related to these provisions. The bill would exempt the guidance and amendments from the Administrative Procedure Act until December 31, 2027.

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: No

Increased Revenue: No

Cost Savings: No

Cost Avoidance: No

Cost Recovery: No

Will the state incur a financial penalty or sanction if this proposal is not implemented? No

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

Click or tap here to enter text.

Improvement

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: 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:

The DMHC Office of Financial Review (OFR) monitors the financial status of health plans and capitated providers, which are providers such as hospitals, risk bearing organizations, or provider groups that contract with health plans, to ensure they can meet their financial obligations to purchasers and providers.

AB 3275 will significantly impact claim reimbursement timeframes for health plans and capitated providers. The timeframe to process and pay claims will be cut in half for full-service health plans and capitated providers, reducing from 45 working days to 30 calendar days. This will result in an increase in claims payment timeliness issues that will need to be monitored and addressed by the DMHC.

Under the current law, health plans are required to submit quarterly, and annual claims settlement practices reports to the DMHC, which includes claims and provider dispute resolution compliance information for the health plans and their capitated providers. The OFR currently uses an archaic application - Claims Settlement Practices and Dispute Resolution Report - to track claims payment and provider dispute resolution timeliness issues reported by health plans and capitated providers, as well as the associated corrective action plans. It is a manual process to develop reports and analyze trends for each health plan and capitated provider, which takes resources to compile. The AB 3275 updated timeframes would require the DMHC to update the quarterly and annual claims settlement practices reporting templates to capture new and updated data. The increased number of claims payment timeliness issues will add to this process and place an additional strain on resources.

This proposed application will streamline the DMHC's existing process and allow the OFR to 1) track and monitor claims payment timeliness issues and the associated corrective action plans effectively 2) generate relevant reports in a more timely and efficient manner, and 3) post health plan submissions in real time. This will allow the DMHC to better track claims payment and provider dispute compliance issues and address them with the health plans timely, which will ensure the financial stability of the healthcare delivery system.

While there is no financial benefit for the DMHC, there is benefit to providers and the overall health care delivery system. The increased penalty shall promote accurate payment of interest. Current law requires interest to accrue at a rate of 15% per annum if the applicable claim reimbursement deadline is not met, and establishes a fee of $10 if a health plan fails to automatically include interest owed on payment of a claim. This bill would change the current $10 penalty for failure to automatically include interest on a claim payment to a fee of the greater of $15 or 10% of the accrued interest. While adding a percentage-based penalty does add complexity to reimbursement calculations and will have more impact on high-dollar claims, the DMHC believes claims should be reimbursed timely and accurately and that the increase in penalty fee will encourage accurate payment of interest on claims.

Objective ID: 1

Objective: Reduce the time required to review claims payment timeliness data and corrective action plans submitted by health plans.

Metric: Time to review the data.

Baseline: Average of 16 hours per submission.

Target Result: Average of 8 hours per submission measured through automated reports / dashboard, 12 – 18 months after the completion of the implementation of the complete solution.

Objective ID: 2

Objective: Develop high quality reports identifying and categorizing claims payment timeliness issues experienced by health plans and capitated providers.

Metric: Time to generate reports.

Baseline: Average of 16 hours per report developed.

Target Result: Average of less than 4 hours per report generated and measured through automated mechanisms such as a dashboard, 12 -18 months after the completion of the implementation of the complete solution .

Objective ID: 3

Objective: Achieve high quality trend analyses of claims payment timeliness issues experienced by health plans and capitated providers.

Metric: Time to analyze the data related to claims payment timeliness issues experienced by health plans and capitated providers.

Baseline: Average of 24 hours per analysis.

Target Result: Average of 8 hours per analysis and measured through a business intelligence / analytics report / dashboard, 12 – 18 months after the implementation of the complete solution.

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

1. **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.

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: Yes

   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)**:** Both New and Existing Processes

1.9 Initial Complexity Assessment

1. **Complexity Assessment (Business Score):** 0.7

   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.

   Programmatic regulations: No

   HIPAA/CIIS/FTI/PII/PCI: No

   Security: No

   ADA: No

   Other: No

   Not Applicable: Yes

   Noncompliance Description: N/A

Click or tap here to enter text.

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: Three (3) – Sacramento, Rancho Cordova, and Los Angeles

   Estimated Number of Transactions/Business Events (per cycle): 1800 capitated provider filings per year

   Approximate number of internal end-users: 80

   Approximate number of external end-users: 500

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?

   10/7/2024

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

   Managed Care Fund: Budget Change Proposal, with funds available for planning on 7/1/2025

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:

   Managed Care Fund: Budget Change Proposal, with funds available for implementation on July 1, 2026 upon PAL approval

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

   If "Yes" is selected, specify when this BCP will be submitted: Fall 2025

2. Please provide a rough order of magnitude (ROM) estimate as to the total cost of the project: Less than $10 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: 10/17/2024

Form Received Date: 10/17/2024

Form Accepted Date: 10/17/2024

Form Status: Completed

Form Status Date: 10/17/2024

Form Disposition: Approved

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

Form Disposition Date: 10/17/2024

Department of Technology Project Number (0000-000): 4150-038