STATE OF CALIFORNIA
Budget Change Proposal - Cover Sheet
DF-46 (REV 03/25)

Fiscal Year	Business Unit Number	Department
FY 2026-27	4260	Health Care Services

Hyperion Budget Request Name	Relevant Program or Subprogram
4260-089-BCP-2026-GB	3960010

Budget Request Title
Value Strategy for Hospital Payments in Medi-Cal Managed Care

Budget Request Summary
The Department of Health Care Services requests 23 permanent positions, one-year limited term resources equivalent to 3 positions, and expenditure authority of $10,664,000 ($5,332,000 Reimbursements; $5,332,000 Federal Fund (FF)) in fiscal year (FY) 2026-27, $9,809,000 ($4,905,000 Reimbursements; $4,904,000 FF) in FY 2027-28 and FY 2028-29, and $6,809,000 ($3,405,000 Reimbursements; $3,404,000 FF) in FY 2029-30 and ongoing. The resources are needed to develop, implement, and sustain a comprehensive value strategy for payments for hospital services in the Medi-Cal program's managed care delivery system.

Requires Legislation (submit required legislation with the BCP)	Code Section(s) to be Added/Amended/Repealed
☐ Trailer Bill Language ☒ Budget Bill Language ☐ N/A	BBL contract and regulatory exemption

Does this BCP contain information technology (IT) components? ☒ Yes ☐ No *If yes, departmental Chief Information Officer must sign.*	Department CIO Crystal Taylor	Date 1/10/2026

For IT requests, specify the project number, the most recent project approval document (FSR, SPR, S1BA, S2AA, S3SD, S4PRA), the approval date, and the total project cost.

Project No. Project Approval Document:

Approval Date: Total Project Cost:

If proposal affects another department, does other department concur with proposal? ☐ Yes ☐ No
Attach comments of affected department, signed and dated by the department director or designee.

Prepared By	Date	Reviewed By	Date
Raheem Muhammad-Terrell	1/10/2026	Erika Sperbeck	1/10/2026
Department Director	**Date**	**Agency Secretary**	**Date**
Michelle Baass	1/10/2026	Brent Houser for Kim Johnson, CalHHS Secretary	1/10/2026

Department of Finance Use Only

Additional Review: ☐ Capital Outlay ☒ ITCU ☐ FSCU ☐ OSAE ☒ Dept. of Technology

Principal Program Budget Analyst	Date submitted to the Legislature
Megan Sabbah	1/10/2026

A. Problem Statement

The Department of Health Care Services (DHCS) requests 23 permanent positions, one-year limited term (LT) resources equivalent to 3 positions, and expenditure authority of $10,664,000 ($5,332,000 Reimbursements; $5,332,000 Federal Fund (FF)) in fiscal year (FY) 2026-27, $9,809,000 ($4,905,000 Reimbursements; $4,904,000 FF) in FY 2027-28 and FY 2028-29, and $6,809,000 ($3,405,000 Reimbursements; $3,404,000 FF) in FY 2029-30 and ongoing. The resources are needed to develop, implement, and sustain a comprehensive value strategy for payments for hospital services in the Medi-Cal program's managed care delivery system.

Requested Positions

Division	Position
Capitated Rates Development Division (CRDD): 12 Permanent Positions Effective 7/1/2026	• 1 Manager II • 1 Supervisor II • 2 Supervisor I • 2 Research Data Specialist (RDS) II • 2 RDS I • 4 Analyst II
Quality and Health Equity Division (QHED): 8 Permanent Positions Effective 7/1/2026	• 2 Medical Consultant (MC) II • 1 Health Program Manager (HPM) II • 1 Supervisor I • 4 Analyst II
Health Information Management Division (HIMD): One-year LT resources equivalent to 3 Positions Effective 7/1/2026 through 6/30/2027	• 3 Information Technology Specialist (ITS) II
Office of Legal Services (OLS): 2 Permanent Positions Effective 7/1/2026	• 2 Attorney IV
Health Care Financing (HCF): 1 Permanent Position Effective 7/1/2026	• 1 Research Scientist (RS) V (Social/Behavioral Sciences)

In the Medi-Cal Managed Care (MCMC) delivery system, covered hospital services are reimbursed through a combination of base payments that are typically negotiated between each hospital and Medi-Cal managed care plan (MCP) and supplemental payments that are established by DHCS pursuant to state law.

Federal regulations broadly prohibit the state from directing the amount, frequency, and mode of payments made by Medi-Cal MCPs to providers.[1] Pass-through payments (PTP) and state-directed payments (SDP) are financial mechanisms that enable DHCS to secure exemptions from this prohibition in limited circumstances and, therefore, to direct payments made by MCPs to providers in ways that advance Medi-Cal program goals and objectives and help to improve Medi-Cal members' health. PTPs are time-limited arrangements that are subject to federal phasedown and sunset timeframes.[2] SDPs are generally approved for one-year terms and must satisfy a robust list of requirements relating to factors such as, but not limited to, the appropriateness of payment levels, alignment with and achievement of the goals and objectives of Medi-Cal's comprehensive quality strategy, monitoring and evaluation, and documentation and reporting.

[1] Section 438.6(c) of Title 42 of the Code of Federal Regulations (42 C.F.R. 438.6(c)).
[2] 42 C.F.R. 438.6(d).

The federal Centers for Medicare & Medicaid Services (CMS) expects states to be judicious in their use of SDPs and, thus, subjects SDPs to intensive policy, regulatory, and actuarial review and scrutiny. These expectations were further heightened in the *Medicaid and Children's Health Insurance Program Managed Care Access, Finance and Quality Final Rule* (hereafter, "Final Rule") that was published in April 2024. All SDPs and PTPs must be accounted for in MCMC rate certifications and MCP contracts and, therefore, are subject to federal review and approval.

As of calendar year 2025 (CY 2025), DHCS operates seven SDPs and four PTPs specific to hospitals totaling more than $23.3 billion total funds (TF) annually, subject to federal approval. In most of these programs, the non-federal share is "self-financed" by the hospitals, or their affiliated governmental entities, rather than relying on state General Funds (SGF). In these self-financed programs, private hospitals fund the non-federal share through a Hospital Quality Assurance Fee (HQAF) while designated public hospitals (DPHs) and district and municipal public hospitals (DMPHs) utilize Intergovernmental transfers (IGTs). All PTPs will be sunset or transitioned to SDPs on or before January 1, 2027, to comply with federal rules.

Type	Payment Arrangement	Non-Federal Share	CY 2025 Total *(in millions)*
SDP	Private Hospital Directed Payment (PHDP)	HQAF	$13,187.30
SDP	DPH Enhanced Payment Program (EPP)	IGT	$3,865.00
SDP	DPH Quality Incentive Pool (DPH-QIP)	IGT	$3,463.70
PTP	Private Hospital PTP	HQAF	$1,200.00
SDP	DMPH Directed Payment (DHDP)	IGT	$842.40
SDP	Children's Hospital Supplemental Payment	SGF	$230.00
SDP	DMPH Quality Incentive Pool (DMPH-QIP)	IGT	$178.50
SDP	Major Organ Transplants	SGF	$152.10
PTP	Public Distinct-Part Nursing Facility PTP	SGF	$110.9
PTP	Martin Luther King, Jr. Community Hospital PTP	SGF	$46.90
PTP	Benioff Children's Hospital Oakland PTP	IGT	$25.80

A portion of revenues generated from the HQAF are used to reimburse the state's costs of administering the program. Currently, this amount is capped at $500,000 per quarter, or $2 million per year.[3] Beginning in 2025, state law authorizes DHCS to assess an administrative fee, not to exceed 5 percent, on IGTs associated with the DHDP, DMPH-QIP, EPP, and DPH-QIP.[4]

Current State and Near-Term

California stands at a pivotal moment with respect to reimbursement of hospital services in the MCMC delivery system. With more than one in three Californians receiving coverage for physical health care from MCPs, and with MCMC spending for hospital services reaching tens of billions dollars each year, it is more important than ever to confirm that MCMC reimbursement for hospital services aligns with the changing demands and needs of the Medi-Cal program, and California's health sector more generally, and continues to support the delivery of appropriate, timely, and high-quality care to Medi-Cal members.

Over the past several years, California has seen multiple hospitals close, nearly close, or scale back services (such as labor and delivery centers) due to financial challenges or constraints. The drivers of these challenges, and the right solutions to them, are complex, multi-faceted, and often unique to each hospital. They may include inadequate reimbursement, ineffective cost controls, workforce shortages, rising labor and supply costs, unfunded capital costs, and other factors. To

[3] Section (§) 14169.53(b)(1)(A)(ii) of the Welfare and Institutions Code (WIC).
[4] WIC § 14197.4(f)(1)(B).

understand a hospital's financial position, all these factors must be considered. Although Medi-Cal reimbursement is not a "silver bullet" to these challenges—some hospitals that have experienced financial distress in recent years have served a predominantly Medi-Cal patient population, while others have served comparatively few Medi-Cal members—it is part of the equation that must be considered.

On average, statewide, MCMC reimburses significantly higher than Medicare for hospital inpatient services and near Medicare for hospital outpatient and emergency department services. Informed by extensive financial analysis and engagement with hospital stakeholders, DHCS implemented, subject to CMS approval, multi-billion-dollar increases to hospital SDPs commencing with the CY 2025 program year with no new SGF cost.

These unprecedented investments create many opportunities and certain challenges and obligations. As MCMC supplemental reimbursement grows in CY 2025, DHCS must reevaluate how SDPs affect financial incentives for care delivery to Medi-Cal members. For example, significantly lower reimbursement for hospital outpatient services than for hospital inpatient services, after accounting for relative cost differences between these services, may perversely incentivize hospitals to prioritize care in inpatient settings over outpatient settings. This would be neither economic and efficient nor support the core goal and objectives of improving Medi-Cal members' health and quality of care. Similarly, many existing SDPs provide a uniform level of supplemental reimbursement that varies only based on the volume of services provided. More thoughtful approaches are needed that consider differences due to geography, the quality of care or value provided to a Medi-Cal member, and other factors. The Legislature has acknowledged the importance of accounting for these types of factors in recent legislative actions that authorized geographically varied reimbursement for professional services (Senate Bill (SB) 159; Committee on Budget and Fiscal Review; Ch. 40, Stats. 2024) and consideration of value in hospital reimbursement (SB 177; Committee on Budget and Fiscal Review; Ch. 491, Stats. 2024).

DHCS will have to tackle these challenges and obligations against the backdrop of a changing federal regulatory landscape due to the Final Rule and House Resolution (H.R.) 1, enacted on July 4, 2025 (Public Law No: 119-21). California's hospital SDPs are under increased federal scrutiny and the significant increases for CY 2025 heighten the scrutiny. To secure the continued approvability of SDPs and the investments they represent in the MCMC delivery system, DHCS must comprehensively review and revise existing hospital SDPs to explore, identify, adopt, and maintain new approaches that will certify continued alignment with the changing needs of the Medi-Cal program, the changing requirements of the federal Medicaid landscape and the goals and objectives of Medi-Cal's comprehensive quality strategy, result in the achievement of those stated goals and objectives, and enable DHCS to confirm and demonstrate the ongoing value of these SDPs.

Comprehensive Value Strategy

To meet these challenges and obligations, DHCS proposes to use this unique opportunity to develop, publish, implement, and sustain a comprehensive value strategy for payments for hospital services that is designed to sustainably advance access to high-quality inpatient and outpatient hospital services, financially incentivize appropriate care delivery, and improve health outcomes for Medi-Cal members. This value strategy will enable DHCS to protect, as much as possible, MCMC reimbursement for hospital services using SDPs while exercising prudent fiscal stewardship with respect to these programs and implementing long-lasting, balanced solutions in alignment with Medi-Cal's comprehensive quality strategy, federal Medicaid requirements and guidance, and the economic and efficient provisioning of services in the Medi-Cal program.

The value strategy will focus on:

- Achieving sustainable levels of Medi-Cal reimbursement for hospital (and health system) services relative to other payers.

- Advancing appropriate incentives for care delivery that support the economic and efficient provisioning of services, Medi-Cal members' access to care, and improved member health outcomes. This may include approaches such as, but not limited to:

    - Incentivizing care in appropriate and lower-cost outpatient and community-based settings.

    - Evaluating reimbursement levels across all service lines and provider types.

    - Streamlining program design and operational processes, where feasible, to clarify financial incentives, accelerate receipt of payment by hospitals, and minimize avoidable administrative burdens for hospitals, MCPs, and DHCS.

- Aligning with Medi-Cal's comprehensive quality strategy and leveraging SDPs to advance population health, quality of care, and health equity for Medi-Cal members. This may include approaches such as, but not limited to:

    - Considering the broader impacts of hospital SDPs on the Medi-Cal program beyond the narrower impact on the hospital industry and hospital services.

    - Prioritizing support for hospitals and/or lines of service that, were they to close or be discontinued, respectively, would most directly affect Medi-Cal members' health.

    - Adhering to a multi-year strategy that draws more value from SDPs and increasingly links payments directly to population health, quality of care, and health equity goals and objectives.

- Certifying the continued federal approvability of SDPs.

DHCS obtained one-time funding, including support from the California Health Data and Planning Fund (HDPF), equivalent to 29 positions and applicable contract resources for FY 2025-26, which is being used to begin the requisite work. This request aims to secure the ongoing, permanent position authority and funding that is needed to complete and implement the value strategy, and to sustain the new or modified reimbursement methodologies on an ongoing basis. This request maintains all core elements of the original resource request, and substitutes HDPF with Reimbursements starting in FY 2026-27.

B. Justification

At a high level, the staff and contract resources will:

- Develop, in consultation with stakeholders, and publish a comprehensive value strategy that includes recommendations for changes to hospital reimbursement methodologies and considerations for obtaining the necessary federal approvals for, and any conforming state law changes necessary to effectuate, recommended changes to reimbursement methodologies.

- Implement the value strategy through, as applicable, new or modified reimbursement methodologies, including seeking any necessary federal approvals and conforming state law changes.

- Sustain the new or modified reimbursement methodologies on an ongoing basis including, but not limited to, associated recurring policy and guidance development, analyses and calculations, data exchange or management, quality or performance measurement, payment processing, oversight and monitoring, stakeholder education and technical assistance, and ad-hoc solutioning.

CRDD (12 Permanent Positions)
1 Manager II
1 Supervisor II
2 Supervisor I
2 RDS II
2 RDS I
4 Analyst II

The Manager II will have full management and supervisory responsibility for the branch overseeing all hospital SDPs. This branch will be composed of one section that currently exists, and one new section with two new units. The Manager II will directly supervise two Supervisor II. The Manager II will be the senior manager responsible for formulating and administering reimbursement methodologies, policies, and programs related to hospital SDPs under the comprehensive value strategy.

The Supervisor II will have supervisory responsibility for a new section overseeing the implementation of the comprehensive value strategy for public hospitals. The Supervisor II will directly supervise an RDS II and a Supervisor I.

Two Supervisor Is will be responsible for the oversight, supervision of staff, and alignment of the new SDP workloads associated with the comprehensive value strategy.

Two RDS IIs will independently perform the most complex data analysis, respond to the most urgent ad-hoc research requests, act in a lead capacity to perform technical quality review of research data work produced by line units, develop new standardized research data methodologies and guidelines for use by line units, and train and mentor line unit research data staff.

Two RDS Is will develop and maintain tools and methodologies used to analyze and evaluate reimbursement rates, costs, and utilization across counties, regions, hospitals, and MCPs to support development and review of hospital reimbursement methodologies under the comprehensive value strategy, design and maintain tools and methodologies to comply with CMS monitoring requirements, and respond to complex ad-hoc research and data requests.

Four Analyst IIs will review, analyze, and draft responses to MCP and hospital inquiries, develop technical program guidance and documentation, coordinate with cross-divisional partners in QHED, HIMD, and the Data Analytics Division, and coordinate the development and implementation of SDPs with other affected HCF teams. CRDD may initially cross-advertise these positions at the Staff Services Analyst level to develop new staff, but ongoing workload will be at the AGPA journey level.

QHED (8 Permanent Positions)
2 MC II

1 HPM II
1 Supervisor I
4 Analyst II

2 MC II
QHED is requesting two MC IIs to oversee day-to-day programmatic decision making, annual program development, and long-term strategy across private and DPH/DMPH directed payment programs. One MC II will work with the PHDP program while the other will work with the DPH/DMPH directed payment program. Hospital directed payment programs must be run taking into context what happens at the frontline in hospitals; otherwise, the programs will not properly incentivize changes in behavior that improve care delivery to Medi-Cal members. Physicians are uniquely positioned to understand the nuances of frontline healthcare delivery.

Day-to-day work will include interpreting measure specifications, clinical review of hospitals' and MCPs' data (to certify reporting integrity), and clinical oversight of the teams running each directed payment program.

Annual program development will include the following: (1) developing and updating measure specifications for the directed payment programs, including measures for which DHCS is the measure steward (which requires clinician input to confirm specifications are rational); (2) determining which quality measures are included in the programs; and (3) determining how many measures a hospital can report on.

Long-term strategic planning will include being lead on the following: (1) developing and implementing a long-term road map to move to MCP reporting (and possibly DHCS reporting beyond that) of quality measures on behalf of hospital; (2) determining how and when hospitals can choose which measures are tied to funding; (3) determining the structure for hospitals to earn funds; (4) evaluating and choosing benchmarks for performance; (5) evaluating and implementing strategies to address health equity; and (6) evaluating and implementing strategies to simplify hospital directed payment programs.

1 HPM II
QHED is requesting one HPM II to manage all hospital directed payment programs. The HPM II will be responsible for supervising staff and providing guidance in day-to-day program oversight and making policy decisions.

Currently, the QIP program for DPHs and DMPHs are managed via a unit which consists of a Supervisor I and Analyst IIs. As the size and scope of hospital directed payment programs expand, creating a section with a section chief will verify the programs are effectively managed and aligned. The new section under this position will include two units (each managed by its own Supervisor I); one unit will be the current Program Accountability Unit which manages the QIP program, and the second will be the newly formed unit to oversee the PHDP program.

This new role and section will engage and coordinate with internal and external stakeholders to develop and implement the department's quality and equity strategy related to hospital directed payments, and coordinate efforts across the department and with other California payers, hospital entities, and partners to align quality and equity measures.

1 Supervisor I
QHED is requesting one Supervisor I to manage the PHDP program. The Supervisor I will be tasked to oversee incentive claims and payment for the PHDP program as well as manage day-to-day program activities, complete more complex policy analysis and priority projects associated with PHDPs, convene and engage with other DHCS divisions including CRDD and Managed Care

Quality and Monitoring Division on payment and program activities. In addition, the Supervisor I will provide direct supervision of the four Analyst II positions.

The Supervisor I and four Analyst II positions will make up a new unit that solely focuses on policy and responsibilities centered around PHDPs. This unit will sit in a new section within the Value-Based Payment Branch, that will have focal management and oversight of all hospital directed payment programs.

4 Analyst IIs
QHED is requesting four Analyst II to assist in day-to-day programmatic support of private hospitals/entities, conduct completeness and comprehensive reviews on semi-annual and annual reports, monitor and assess the implementation of program policy and protocols, and propose recommendations and solutions based on report analyses. Additionally, the Analyst IIs will be tasked to annually review, update, and incorporate performance measures into a specification manual for participating private hospital systems/entities to use. They will also assist in developing policy documents and to review, analyze, and approve annual hospital performance reports to determine hospital payment amounts on reported metrics per hospital. Specifically, the Analyst IIs will perform monitoring and review of these performance reports which are an integral part of program operations and evaluating the success of hospital system improvement and transformation.

The Analyst IIs will also provide continuous support and technical assistance to participating private hospital systems/entities, which would include tasks such as but not limited to participating in regular calls with key external partners who represent participating hospitals, working with hospital appointed staff on web portal/reporting issues and resolutions, and collaborating with other DHCS divisions and external partners to align performance and incentive payment.

HIMD (One-Year LT resources equivalent to 3 Positions)
3 ITS II

HIMD is requesting three ITS IIs that will maintain and demonstrate leadership and expertise in data related to state directed payments and act as the liaison to DHCS programs in data management and strategy. The three ITS IIs will provide data support and consultation related to methodical development and limitations, data collection and improvement, data reporting and querying, and data linkage and integration. The three ITS IIs will also work with program to develop long-term data strategy to support current and future requirements. The ITS IIs will also design the appropriate exchanges to help SDP payment data move between the necessary systems and to enable efficient access to SDP data. The ITS IIs will provide consultation in support of data management activities with knowledge and skills in data management principles, services, components, trends, interfaces, protocols, and data architectures. The ITS IIs will also perform quality checks on data to provide confidence to program in the monitoring of data to determine levels of performance and compliance with the Final Rule. The ITS IIs will also support the T-MSIS mandated reporting to CMS as SDP data is required in T-MSIS reporting. The ITS IIs will enable the capturing and reporting of data in the Management Information System and Decision Support System that aligns with T-MSIS reporting requirements and will participate in Standard Operating Procedure testing with CMS.

OLS (2 Permanent Positions)
2 Attorney IV

OLS requests two Attorney IV positions to support new workload related to the implementation and maintenance of the SDPs. OLS will advise on the implementation of the SDPs and draft and revise documentation needed to secure federal approvals necessary to effectuate these

programs. The Attorney IVs will be responsible for researching and advising on the several state plan amendments (SPA) and SDP preprints that must be prepared and submitted to CMS, which will include complex reimbursement methodology changes due to the new CMS Final Rule and H.R. 1. This will also include responding to CMS questions and negotiating with CMS to secure federal approval. After initial implementation, directed payment programs will require regular updates and adjustments based on federal rule changes. In addition to regular policy updates, these payment programs will produce regular requests for legal advice about novel factual scenarios requiring interpretation. Furthermore, monitoring compliance of providers and plans with the newly created obligations will require legal advice and may require potential legal action. Together, this will produce a long-term ongoing workload.

HCF (1 Permanent Position)
1 RS V (Social/Behavioral Sciences)

The RS V will advise the Deputy Director, HCF, and Assistant Deputy Director, Financing, on economic and demographic matters; plan, organize, and direct complex economic and demographic studies that inform the development of reimbursement methodologies; and perform the most complex statistical and econometric analyses. The RS V will support making evidence-based decisions that advance health care access, quality, and equity through scientific cost and benefit analyses of alternative reimbursement methodologies and policies. The RS V will examine factors including, but not limited to, social and economic trends and inequality; economic impacts and cost factors of policies; individual and organizational performance; community dynamics and structure; and community and statewide decision making and policy development.

Contracts

Hospital Comprehensive Value Strategy Design & Implementation Contract (Three-Year LT)
$3,000,000 ($1,500,000 Reimbursements; $1,500,000 FF) FY 2026-27 through FY 2028-29

Contractor support for development and implementation of a comprehensive value strategy for hospital SDPs including:

- Support for stakeholder engagement on the design of the strategy, including facilitating internal and external workgroups, developing discussion and presentation materials, and reviewing and analyzing stakeholder feedback.

- Designing appropriate population health, quality of care, health equity, and cost accountability metrics, and associated reimbursement mechanisms to support sustainable reimbursement of hospitals in the Medi-Cal program.

- Analyzing and leveraging data regarding hospitals' Medi-Cal revenues, costs, and cost drivers, reimbursement levels relative to other payers, and considerations applicable to specific subsets of hospitals, geographies, lines of service (such as labor-and-delivery), and other stratifications.

- Analyzing existing PTPs and SDPs to identify opportunities to align with overarching goals in the comprehensive value strategy. Supporting DHCS to obtain federal approvals and implement operational changes necessary to effectuate the comprehensive value strategy.

Hospital Directed Payment Ongoing Support Contract
$2,400,000 ($1,200,000 Reimbursements; $1,200,000 FF) in FY 2026-27 and ongoing

Contractor support for ongoing operations of hospital SDPs:

- Contractor support to audit quality measure submissions that are expected in the future for the PHDP. Some quality measures may be External Quality Review Organization audited Managed Care Accountability Set measures reported by MCPs on behalf of the private hospitals. However, many measures for private hospitals are expected to be inpatient measures. Due to data availability, MCPs cannot report on most inpatient measures. Private hospitals will have to report performance on these measures directly to DHCS, and auditing of these data are necessary to confirm data accuracy and programmatic integrity.

- Contractor support to audit quality measure submissions in the existing DPH-QIP and DMPH-QIP programs. Current resources are insufficient to audit all hospitals with a satisfactory level of assurance. Without auditing of hospital-produced data, the risk of inaccurate quality data increases which could impact the integrity of the program and of program payments, and the future federal approvability of the program and availability of federal financial participation. Similar to the PHDP, while some measures will transition to being reported by MCPs in the future, there are many measures only hospitals can report and auditing of these is essential.

- Contractor support to organize and facilitate an annual conference to share best practices among hospitals, MCPs, and other stakeholders to identify strategies to improve patient care quality on the ground and continuously leverages lessons learned to iterate and improve hospital SDPs.

C. Departmentwide and Statewide Considerations

This proposal is consistent with the Department's purpose and goals to increase meaningful access and achieve excellence in health outcomes. DHCS is the single state agency responsible for financing and administering the Medi-Cal program. DHCS' requested resources will be used to implement changes in SDPs in compliance with federal regulations. Non-compliance with federal regulations, or failure to secure approval of SDPs, will jeopardize federal funding.

D. Outcomes and Accountability

Approval of these resources will certify that DHCS has the capacity and resources to successfully develop and operationalize the new program-related responsibilities associated with increased funding and changes related to DHCS-offered programs and benefits and the ongoing monitoring of hospital SDPs.

Resources will be used to support the development of processes and procedures, stand up workflows, and other planning activities, associated with implementing, operationalizing, and sustaining the new procedures related to hospital SDPs.

If approved, the following outcomes will ultimately be achieved:

- Increase value generated from the significant volume of MCMC supplemental reimbursement for hospital services.
- Improve oversight and monitoring of the respective programs, and alignment to broader Medi-Cal goals and objectives related to population health, quality of care, and health equity for Medi-Cal members.
- Increase member access to care and improve health outcomes.

- Strengthen relationships and communication with stakeholders and the public.
- Enhanced compliance with regulatory requirements.

Projected Outcomes

Workload Measures	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31
Facilitate with internal stakeholders to update DHCS systems to create infrastructure to support new workstreams.	26	26	26	26	26	26
Analyze data, generate reports, and provide insights to verify program integrity and to inform policy decisions and program enhancements.	6,000	6,000	6,000	6,000	6,000	6,000
Establish and document operational procedures, policies, review tools, and various tracking systems.	1,000	1,000	1,000	1,000	1,000	1,000
Evaluate, development, and implement measures for directed payment programs.	1,000	1,000	1,000	1,000	1,000	1,000
Develop a long-term strategy for implementation of hospital directed payment programs.	1,000	1,000	1,000	1,000	1,000	1,000
Facilitate regular and structured engagement with all stakeholders through small work groups, Chief Financial Officer meetings, and technical assistance webinars.	104	104	104	104	104	104
Develop, review, and maintain all policies and procedures related to federal regulation compliance.	500	500	500	500	500	500

E. Implementation Plan

Upon approval of this proposal, the impacted divisions will initiate the necessary steps to continue the previously-approved positions as of July 1, 2026. All positions are being recruited and filled according to DHCS' standard recruitment processes, which are outlined in both internal DHCS-produced and external California Human Resources-produced policies, procedures, and requirements for hiring qualified state staff.

F. Supplemental Information

- Attachment A: Workload Standards
- Attachment B: Fiscal Detail Sheet

Proposed Provisional Language for Item 4260-001-0001/0890

4260-001-0001
(a) Of the funds appropriated in this item, $5,332,000 is available to support the State Department of Health Care Services in development of a comprehensive hospital value strategy to advance access to high-quality inpatient and outpatient hospital services, financially incentivize appropriate care delivery, and improve health outcomes for Medi- Cal beneficiaries.

(b) The State Department of Health Care Services may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid, nonbid, or negotiated basis to support the design, implementation, and ongoing support of the hospital value strategy and state directed payments for hospitals. Contracts entered into or amended pursuant to this provision, through June 30, 2027, shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, the State Contracting Manual and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement, interpret, or make specific this provision, in whole or in part, by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions without taking any further regulatory action.

4260-001-0890
(a) Of the funds appropriated in this item, $5,332,000 is available to support the State Department of Health Care Services in development of a comprehensive hospital value strategy to advance access to high-quality inpatient and outpatient hospital services, financially incentivize appropriate care delivery, and improve health outcomes for Medi-Cal beneficiaries.

(b) The State Department of Health Care Services may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid, nonbid, or negotiated basis to support the design, implementation, and ongoing support of the hospital value strategy and state directed payments for hospitals. Contracts entered into or amended pursuant to this provision, through June 30, 2027, shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, the State Contracting Manual and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement, interpret, or make specific this provision, in whole or in part, by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions without taking any further regulatory action.

G. Workload Standards

WORKLOAD STANDARDS
Capitated Rates Development Division
1 Manager II
805-760-4802-XXX
Permanent

Activities	Number of Items	Hours per Item	Total Hours
Oversee hospital SDP comprehensive value strategy implementation and operation.	45	10	450
Supervise and lead Branch activities including administration and directing workload.	45	10	450
Formulate and administer reimbursement methodologies, policies, and programs related to hospital SDPs.	45	10	450
Advise Division Chief and DHCS Executive Staff on Branch projects, activities, recommendations, and cross-cutting impacts.	45	10	450
Total hours worked			**1,800**
1,800 hours = 1 Position			
Actual number of Positions requested			**1**

WORKLOAD STANDARDS
Capitated Rates Development Division
1 Supervisor II
805-760-4801-XXX
Permanent

Activities	Number of Items	Hours per Item	Total Hours
Supervise and lead section activities related including administration and directing workload.	20	15	300
Advise Branch Chief on section projects and activities.	50	3	150
Review and edit section-generated work products and deliverables.	125	4	500
Establish and maintain section project priorities.	20	15	300
Recruit, train, and supervise section staff.	5	20	100
Review and approve reimbursement methodologies, policies, and programs.	15	30	450
Total hours worked			**1,800**
1,800 hours = 1 Position			
Actual number of Positions requested			**1**

Attachment A

WORKLOAD STANDARDS
Capitated Rates Development Division
2 Supervisor I
805-760-4800-XXX
Permanent

Activities	Number of Items	Hours per Item	Total Hours
Lead unit activities and staff related to directed payments.	25	20	500
Review and edit unit-generated work products and deliverables.	220	7.5	1,650
Utilize staff effectively in the conduct of program and policy development for directed payments.	25	20	500
Establish and maintain project priorities.	25	20	500
Recruit and train lower-level staff.	5	30	150
Make programmatic recommendations to section chief.	20	15	300
Total hours worked			**3,600**
1,800 hours = 1 Position			
Actual number of Positions requested			**2**

WORKLOAD STANDARDS
Capitated Rates Development Division
2 Research Data Specialist II
805-760-5758-XXX
Permanent

Activities	Number of Items	Hours per Item	Total Hours
Perform complex data analysis related to directed payments.	30	20	600
Perform ad-hoc research requests related to hospital SDPs.	20	40	800
Act in a lead capacity for all section data requests.	20	20	400
Train and mentor unit staff in data techniques and development.	20	20	400
Develop new standardized research data methodologies and guidelines for use by line units.	30	20	600
Provide technical assistance to internal and external stakeholders related to data needs.	80	10	800
Total hours worked			**3,600**
1,800 hours = 1 Position			
Actual number of Positions requested			**2**

Attachment A

WORKLOAD STANDARDS
Capitated Rates Development Division
2 Research Data Specialist I
805-760-5742-XXX
Permanent

Activities	Number of Items	Hours per Item	Total Hours
Develop and maintain tools and methodologies used to analyze and evaluate reimbursement rates and utilization related to hospital SDPs.	60	20	1,200
Research, gather, compile, and analyze structured and unstructured data.	60	10	600
Analyze reimbursement costs and utilization trends across regions, counties, and health care delivery systems to support directed payment development and review.	60	10	600
Design and maintain tools and methodologies to comply with CMS monitoring requirements.	60	10	600
Respond to complex ad hoc research data requests.	60	10	600
Total hours worked			**3,600**
1,800 hours = 1 Position			
Actual number of Positions requested			**2**

WORKLOAD STANDARDS
Capitated Rates Development Division
4 Analyst II
805-760-5393-XXX
Permanent

Activities	Number of Items	Hours per Item	Total Hours
Coordinate the work of others, act as a team or conference leader.	104	10	1,040
Review, analyze, and draft responses to provider and MCP inquiries, develop technical program guidance and documentation.	1,550	2	3,100
Document control, development, tracking, and maintenance of rate setting documents and communications.	100	10	1,000
Coordinate the development and implementation of directed payment programs.	72	10	720
Review MCP submitted data, reports, procedures, and other documentation.	134	10	1,340
Total hours worked			**7,200**
1,800 hours = 1 Position			
Actual number of Positions requested			**4**

WORKLOAD STANDARDS
Quality and Health Equity Division
2 Medical Consultant II
803-097-7788-XXX
Permanent

Activities	Number of Items	Hours per Item	Total Hours
Clinical review of performance data submitted by hospitals and MCPs to certify the integrity of data. This will involve verifying reported data appear clinically reasonable.	520	1	520
Provide clinical consultation to hospital directed payment program staff on auditing tasks, measure specification interpretation, and other issues that require clinical consultation.	520	1	520
Stakeholder engagement, auditor, and internal meetings to develop, interpret, and update measure specifications. Will involve detailed clinical analysis to verify measure specifications are appropriate and measure what is intended, especially for measure that are developed and maintained by DHCS ("homegrown measures").	130	4	520
Stakeholder engagement, auditor, and internal meetings to choose quality measures and number of measures for hospital directed payment programs. Will involve detailed analysis to determine clinical appropriateness of measures, consistent with DHCS strategic priorities (which includes attending internal meetings to keep abreast of), and review of best practices for incentive programs.	260	2	520
Develop and implement long-term strategies for hospital directed payment programs. This will involve regular internal and external meeting, including with both stakeholders and contractors. Clinical input is essential to verify the long-term strategy helps achieve DHCS' goals and is a realistic approach given how healthcare is delivered.	4	260	1,040
Develop and implement health equity strategies for hospital directed payment programs. This will involve regular internal and external meetings, including engaging with stakeholders and to determine best practices for implementing health equity programming.	4	120	480
Total hours worked			**3,600**
1,800 hours = 1 Position			
Actual number of Positions requested			**2**

WORKLOAD STANDARDS
Quality and Health Equity Division
1 Health Program Manager II
803-097-8428-XXX
Permanent

Activities	Number of Items	Hours per Item	Total Hours
Engage with internal DHCS divisions and external stakeholders to coordinate the alignment of the Department's financial quality incentive programs with the department's Comprehensive Quality Strategy. Work in partnership with contractor to plan, organize, and facilitate an annual stakeholder conference.	1	480	480
Supervise staff and provide guidance in day-to-day program and policy decisions and other management functions such as attending to personnel matters.	1	480	480
Lead the development of measure specifications and benchmarks for quality incentive programs.	1	360	360
Review and approve legislative bill analyses, legislative concepts, legislative proposals, and analysis of federal statutory and regulatory changes related to quality incentive programs.	1	180	180
Develop processes and timelines for reviewing provider and plan reports on quality measures submitted to DHCS. Work with other departmental divisions to coordinate quality payments based on improvements in quality demonstrated by these reports.	1	180	180
Coordinate efforts across the Department and with other California payers to align quality measures	1	120	120
Total hours worked			**1,800**
1,800 hours = 1 Position			
Actual number of Positions requested			**1**

WORKLOAD STANDARDS
Quality and Health Equity Division
1 Supervisor I
803-097-4800-XXX
Permanent

Activities	Number of Items	Hours per Item	Total Hours
Train staff to conduct performance analysis and monitoring alignment with program specifications and policies. Collaborate with DHCS partners and experts on program documents and develop guidance for staff training on all new protocols and procedures. Guide staff in providing technical assistance for the PHDP program, track deadlines and progress for policy documents and reports. Manage day-to-day activities and complex projects. Analyze issues, develop alternatives and recommendations based on research, legislation (state and federal), and policy briefs related to health care policy and administration.	1	720	720
Supervise staff and perform other management functions such as hiring, training, evaluating, and monitoring performance. Monitor, evaluate and complete employee performance appraisals on a timely basis. Develop and inform employee of job expectations for work evaluation. Evaluate work performed and identify training needs for improved job performance. Provide leadership and growth opportunities for staff, promoting staff development. Promptly identify and address/resolve employee performance issues. Confirm that program operations and hiring practices conform to bargaining unit contracts, state policies and equal employment opportunity objectives and guidelines.	1	720	720
Convene and engage with other DHCS divisions on payment and programmatic activities. Attend and convene meetings both within QPHM, other DHCS divisions, and with external contractors and stakeholders. Work in partnership with contractor to plan, organize, and facilitate an annual stakeholder conference.	1	180	180
Conduct other special projects requested by QPHM upper management and the Directorate. Provide research, analysis, and oversight of special or sensitive projects and assignments for the Directorate by effectively interacting with all levels of management within the Department.	1	180	180
Total hours worked			**1,800**
1,800 hours = 1 Position			
Actual number of Positions requested			**1**

WORKLOAD STANDARDS
Quality and Health Equity Division
4 Analyst II
803-097-5393-XXX
Permanent

Activities	Number of Items	Hours per Item	Total Hours
Provides project support for the hospital directed payment programs in identifying, adjudicating, and resolving complex policy issues. Independently reviews hospital system reports, analyzes the data, and evaluates system performance based on the reports. Provides complex technical assistance to hospital system staff to help systems achieve defined quality improvement performance targets. Independently develops, supports, evaluates, and improves learning networks consisting of several hospital systems. Collaboratively develops written and verbal communication content for learning collaborative and/or program webinars.	4	900	3,600
Provides project support for program evaluation and learning collaborative development. Assists external evaluators/auditors with preparing evaluation reports that accurately reflect the activities undertaken during the program year. Prepares reports for the CMS. Participates in project monitoring through regular conference calls and written guidance managed by CMS. Extracts data from program reporting portal and de-identifies data in accordance with DHCS standards. Communicates and problem solves with individual hospitals as well as hospital associations.	4	360	1,440
Conducts independent analytical research and develops complex policy analysis. Supports periodic updates to the Quality Strategy. Independently works on policies and programs related to quality improvement programs and broader system transformation. This work.	4	360	1,440
Serve as an analyst in special projects or other assignments, as required, including occasional bill analyses. Prepares and presents oral and written recommendations to management. Organizes and helps team facilitate meetings, trainings, seminars, and conferences on population health, clinical quality, and health care costs.	4	180	720
Total hours worked			**7,200**
1,800 hours = 1 Position			
Actual number of Positions requested			**4**

Attachment A

WORKLOAD STANDARDS
Health Information Management Division
Limited-Term Resources Equivalent to 3 Information Technology Specialist II
803-395-1414-XXX
(7/1/2026 – 6/30/2027)

Activities	Number of Items	Hours per Item	Total Hours
Analyze and develop data management requirements to support new or updated state directed payment data	80	10	800
Analyze data design and data exchange constraints of existing and proposed business applications and recommend solutions	80	10	800
Analyze challenging data integration problems across health care delivery systems and recommend solutions	80	10	800
Identify problem areas and develop action plans to mitigate data related problems across health care delivery systems to support directed payment development.	60	20	1,200
Identify the correct data architectural model to address the customer's business objectives and integrate new or updated strategy for SPDs with existing data services and projects in DHCS.	80	10	800
Facilitate and support business requirements and align with strategic planning for the enterprise projects and its customers, business partners, and vendors.	50	4	200
Collaborate with Enterprise Technology Services to implement required architecture and technology to support data services efforts.	4	10	400
Perform data quality checks and liaise with CMS on T-MSIS impacts related to SDP data	4	10	400
Total hours worked			**5,400**
1,800 hours = 1 Position			
Actual number of Positions requested			**3**

WORKLOAD STANDARDS
Office of Legal Services
2 Attorney IV
803-030-5780-XXX
Permanent

Activities	Number of Items	Hours per Item	Total Hours
Participate in CMS discussions, intra- and inter-departmental workgroup efforts, including researching, analyzing, and advising staff in healthcare issues affecting discreet populations.	80	10	800
Perform complex research and analyze federal and state laws to advise the department and Agency/Governor's Office (GO) and provide ongoing compliance advice to program staff.	6	10	600
Draft, review, and revise necessary federal Medicaid authorities, including waiver or SPAs.	88	10	880
Draft and review policy and procedure letters, program guides, and similar documents related to policy guidance.	40	10	400
Provide pre-litigation support, such as assessing potential legal issues, strategic planning to avoid litigation, and advocate concerns having large fiscal implications.	30	10	300
Draft and review federal and state legislation and regulations necessary to implement and administer Medi-Cal directed payment programs.	22	10	220
Coordinate with Department of Finance, Agency, GO; respond to correspondence and other inquiries from the public, legislators, and other interested stakeholders within tight timeframes.	20	10	200
Research, analyze, and advise staff for responding to external inquiries, plan negotiation and communications, and stakeholder questions and concerns to reach consensus avoid potential litigation.	20	10	200
Total hours worked			**3,600**
1,800 hours = 1 Position			
Actual number of Positions requested			**2**

Attachment A

WORKLOAD STANDARDS
Health Care Financing
1 Research Scientist V
805-790-5636-XXX
Permanent

Activities	Number of Items	Hours per Item	Total Hours
Perform economic and demographic research and examine factors related to social and economic trends and inequalities.	12	30	360
Plan, organize, and direct complex studies.	4	90	360
Inform the development of reimbursement methodologies.	6	60	360
Support evidence-based decisions making that advances health care access, quality, and equity through high-quality cost/benefit analyses of alternative reimbursement methodologies and policies.	24	15	360
Analyze reports and data sets relevant to community dynamics and structure, statewide decision making, and policy development.	24	15	360
Total hours worked			**1,800**
1,800 hours = 1 Position			
Actual number of Positions requested			**1**

H. BCP Fiscal Detail Sheet

BCP Title: Value Strategy for Hospital Payments in Medi-Cal Managed Care

BR Name: 4260-089-BCP-2026-GB

Budget Request Summary

Personal Services

Personal Services	FY26 Current Year	FY26 Budget Year	FY26 BY+1	FY26 BY+2	FY26 BY+3	FY26 BY+4
Positions - Permanent	0.0	23.0	23.0	23.0	23.0	23.0
Total Positions	**0.0**	**23.0**	**23.0**	**23.0**	**23.0**	**23.0**
Earnings - Permanent	0	2,575	2,575	2,575	2,575	2,575
Salaries and Wages Earnings - Temporary Help	0	369	0	0	0	0
Total Salaries and Wages	**$0**	**$2,944**	**$2,575**	**$2,575**	**$2,575**	**$2,575**
Total Staff Benefits	0	1,482	1,296	1,296	1,296	1,296
Total Personal Services	**$0**	**$4,426**	**$3,871**	**$3,871**	**$3,871**	**$3,871**

Operating Expenses and Equipment

Operating Expenses and Equipment	FY26 Current Year	FY26 Budget Year	FY26 BY+1	FY26 BY+2	FY26 BY+3	FY26 BY+4
5301 - General Expense	0	156	92	92	92	92
5302 - Printing	0	52	46	46	46	46
5304 - Communications	0	52	46	46	46	46
5320 - Travel: In-State	0	110	101	101	101	101
5322 - Training	0	26	23	23	23	23
5324 - Facilities Operation	0	234	207	207	207	207
5340 - Consulting and Professional Services - External	0	5,400	5,400	5,400	2,400	2,400
5344 - Consolidated Data Centers	0	26	23	23	23	23
539X - Other	0	182	0	0	0	0
Total Operating Expenses and Equipment	**$0**	**$6,238**	**$5,938**	**$5,938**	**$2,938**	**$2,938**

Total Budget Request

Total Budget Request	FY26 Current Year	FY26 Budget Year	FY26 BY+1	FY26 BY+2	FY26 BY+3	FY26 BY+4
Total Budget Request	**$0**	**$10,664**	**$9,809**	**$9,809**	**$6,809**	**$6,809**

Fund Summary

Fund Source

Fund Source	FY26 Current Year	FY26 Budget Year	FY26 BY+1	FY26 BY+2	FY26 BY+3	FY26 BY+4
State Operations - 0890 - Federal Trust Fund	0	5,332	4,904	4,904	3,404	3,404
0995 - Reimbursements	0	5,332	4,905	4,905	3,405	3,405
Total State Operations Expenditures	**$0**	**$10,664**	**$9,809**	**$9,809**	**$6,809**	**$6,809**
Total All Funds	**$0**	**$10,664**	**$9,809**	**$9,809**	**$6,809**	**$6,809**

Program Summary

Program Funding

Program Funding	FY26 Current Year	FY26 Budget Year	FY26 BY+1	FY26 BY+2	FY26 BY+3	FY26 BY+4
3960010 - Medical Care Services (Medi-Cal)	0	10,664	9,809	9,809	6,809	6,809
Total All Programs	**$0**	**$10,664**	**$9,809**	**$9,809**	**$6,809**	**$6,809**

Attachment B

Personal Services Details

Positions

Positions	FY26 Current Year	FY26 Budget Year	FY26 BY+1	FY26 BY+2	FY26 BY+3	FY26 BY+4
4800 - Supervisor I	0.0	3.0	3.0	3.0	3.0	3.0
4801 - Supervisor II	0.0	1.0	1.0	1.0	1.0	1.0
4802 - Manager II	0.0	1.0	1.0	1.0	1.0	1.0
5393 - Analyst II	0.0	8.0	8.0	8.0	8.0	8.0
5636 - Research Scientist V	0.0	1.0	1.0	1.0	1.0	1.0
5742 - Research Data Spec I	0.0	2.0	2.0	2.0	2.0	2.0
5758 - Research Data Spec II	0.0	2.0	2.0	2.0	2.0	2.0
5780 - Attorney IV	0.0	2.0	2.0	2.0	2.0	2.0
7788 - Med Consultant II	0.0	2.0	2.0	2.0	2.0	2.0
8428 - Hlth Program Mgr II	0.0	1.0	1.0	1.0	1.0	1.0
TH00 - Temporary Help (LT Term Exp. 06-30-2027)	0.0	0.0	0.0	0.0	0.0	0.0
Total Positions	**0.0**	**23.0**	**23.0**	**23.0**	**23.0**	**23.0**

Salaries and Wages

Salaries and Wages	FY26 Current Year	FY26 Budget Year	FY26 BY+1	FY26 BY+2	FY26 BY+3	FY26 BY+4
4800 - Supervisor I	0	289	289	289	289	289
4801 - Supervisor II	0	106	106	106	106	106
4802 - Manager II	0	123	123	123	123	123
5393 - Analyst II	0	663	663	663	663	663
5636 - Research Scientist V	0	140	140	140	140	140
5742 - Research Data Spec I	0	191	191	191	191	191
5758 - Research Data Spec II	0	210	210	210	210	210
5780 - Attorney IV	0	337	337	337	337	337
7788 - Med Consultant II	0	410	410	410	410	410
8428 - Hlth Program Mgr II	0	106	106	106	106	106
TH00 - Temporary Help (LT Term Exp. 06-30-2027)	0	369	0	0	0	0
Total Salaries and Wages	**$0**	**$2,944**	**$2,575**	**$2,575**	**$2,575**	**$2,575**

Staff Benefits

Staff Benefits	FY26 Current Year	FY26 Budget Year	FY26 BY+1	FY26 BY+2	FY26 BY+3	FY26 BY+4
5150350 - Health Insurance	0	708	618	618	618	618
5150600 - Retirement - General	0	774	678	678	678	678
Total Staff Benefits	**$0**	**$1,482**	**$1,296**	**$1,296**	**$1,296**	**$1,296**

Total Personal Services

Total Personal Services	FY26 Current Year	FY26 Budget Year	FY26 BY+1	FY26 BY+2	FY26 BY+3	FY26 BY+4
Total Personal Services	**$0**	**$4,426**	**$3,871**	**$3,871**	**$3,871**	**$3,871**