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**
4260-075-BCP-2026-GB	3960010

Budget Request Title
Managed Care Final Rule: Implementation and Operations

Budget Request Summary
The Department of Health Care Services (DHCS), requests 6 one-year limited-term (LT) positions, four-year LT resources equivalent to 33 positions, and expenditure authority of $12,310,000 ($6,023,000 General Fund (GF); $6,287,000 Federal Fund (FF)) in Fiscal Year (FY) 2026-27 and $10,456,000 ($5,228,000 GF; $5,228,000 FF) in FY 2027-28 through FY 2029-30 to support the implementation and operations of the Managed Care Final Rule (Final Rule) requirements. In addition, DHCS requests four-year LT resources for 25 positions included in the 4260-303-BCP-2025-MR "Medicaid Managed Care, Access, and Eligibility Final Rules."

Requires Legislation (submit required legislation with the BCP)	**Code Section(s) to be Added/Amended/Repealed**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

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. 4260-255, 4260-256 **Project Approval Document:** S1BA
Approval Date: 9/2/2025 **Total Project Cost:** $2,500,000

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**
Nick Mills	1/10/2026

A. Problem Statement

The Department of Health Care Services (DHCS), requests 6 one-year limited-term (LT) positions, four-year LT resources equivalent to 33 positions, and expenditure authority of $12,310,000 ($6,023,000 General Fund (GF); $6,287,000 Federal Fund (FF)) in Fiscal Year (FY) 2026-27 and $10,456,000 ($5,228,000 GF; $5,228,000 FF) in FY 2027-28 through FY 2029-30 to support the implementation and operations of the Managed Care Final Rule (Final Rule) requirements. In addition, DHCS requests four-year LT resources for 25 positions included in the 4260-303-BCP-2025-MR "Medicaid Managed Care, Access, and Eligibility Final Rules."

Division Staffing Request Summary	Final Rule Component
Behavioral Health Oversight and Monitoring Division (BHOMD): Four-year LT resource equivalent to 1 Position Effective 7/1/2026 • 1 Analyst II	• Appointment Wait Time Standards (AWTS) and Exceptions
Business Operations Technology Services Division (BOTSD): One-year LT resource equivalent to 1 Position Effective 7/1/2026 • 1 Information Technology Specialist (ITS) II	• Enrolled Experience Surveys
Capitated Rates Development Division (CRDD): Four-year LT resources equivalent to 3 Positions Effective 7/1/2026 • 3 Analyst II	• Medical Loss Ratio (MLR)
Data Analytics Division (DAD): Four-year LT resource equivalent to 1 Position Effective 7/1/2026 • 1 Research Scientist (RS) III	• Website Transparency • Quality Strategy and External Quality Review (EQR) • Quality Rating System (QRS)
Health Information Management Division (HIMD): Four-year LT resource equivalent to 1 Position Effective 7/1/2026 • 1 Research Data Specialist (RDS) I	• Appointment Wait Time Standards • In Lieu of Service (ILOS)
Information Technology Strategy Services Division (ITSSD): One-year LT resources equivalent to 2 Positions Effective 7/1/2026 • 2 ITS II	• Appointment Wait Time Compliance • Enrolled Experience Surveys • Provider Payment Analysis • Website Transparency
Local Governmental Financing Division (LGFD): Four-year LT resource equivalent to 1 Position Effective 7/1/2026 • 1 RDS I	• Provider Payment Analysis
Managed Care Quality and Monitoring Division (MCQMD): Four-year LT resources equivalent to 5 Positions Effective 7/1/2026 • 3 Analyst II • 1 RDS III • 1 Supervisor I	• AWTS and Exceptions • ILOS
Medi-Cal Dental Services Division (MDSD): Four-year LT resource equivalent to 1 Position Effective 7/1/2026 • 1 Supervisor II	• AWTS and Exceptions
Medi-Cal Enterprise Systems Modernization Division (MESMD): One-year LT resources equivalent to 3 Positions Effective 7/1/2026 • 1 IT Manager (ITM) I • 2 ITS II	• Appointment Wait Time Compliance • Enrollee Experience Surveys • Provider Payment Analysis • Website Transparency

Division Staffing Request Summary	Final Rule Component
	• MLR • ILOS and Setting • Quality Strategy and EQR • QRS
Office of Communications (OC): Four-year LT resource equivalent to 1 Position Effective 7/1/2026 • 1 Analyst II	• Website Transparency
Program Data Reporting Division (PDRD): Four-year LT resources equivalent to 10 Positions Effective 7/1/2026 • 2 RDS I • 5 RDS II • 3 RS II	• AWTS • Enrolled Experience Survey • Provider Payment Analysis • ILOS
Quality and Health Equity Division (QHED): Four-year LT resource equivalent to 9 Positions Effective 7/1/2026 • 1 Analyst II • 1 Health Program Manager (HPM) I • 1 HPM II • 1 Health Program Specialist (HPS) II • 2 HPS I • 1 Manager II • 1 Medical Consultant (MC) Sup II • 1 Medical Consultant (MC) I	• Enrolled Experience Surveys • QRS

Contracts				
Division	**Description**	**Effective Start Date**	**Duration**	**Total Contract Amount**
ITSSD	Project Management (PM) Support Services	7/1/2026	1-Year	$600,000
ITSSD	California Department of Technology (CDT) Project Oversight Services (POS)	7/1/2026	1-Year	$131,000
Total				**$731,000**

On April 22, 2024, the federal Centers for Medicare & Medicaid Services (CMS) released the Managed Care Access, Finance, and Quality Final Rule ("Final Rule"). The Final Rule reshapes the federal regulatory landscape for Medicaid managed care programs with respect to ensuring access to care, transparency, quality measurement, and oversight of provider payment rates.

The Final Rule adopts new standards for access to care through managed care delivery systems and introduces enhanced requirements related to quality and finance, with varying effective dates beginning July 9, 2024. The Final Rule strengthens standards for timely access to care, enhances quality and fiscal standards for Self-Determination Programs, specifies ILOSs and settings to address health-related social needs, further specifies Medical Loss Ratio (MLR) requirements, and establishes a Quality Rating System (QRS) for Medi-Cal managed care plans (MCPs), Medi-Cal Dental managed care plans and Behavioral Health Plans (BHPs).

While DHCS is in compliance with many of these provisions, there are new or more stringent requirements in the regulations that necessitate additional resources beginning in FY 2026-27 for planning and implementation of the Final Rule.

Workload History

Except for the following existing workload, the workload history for newly proposed positions and the workload in this proposal has not been measured previously:

- Data De-Identification Reviews for Public Reporting and Publication (DAD)

B. Justification

DHCS previously received one-time funding to begin implementing requirements of the Final Rule effective in 2026. At the time, it was uncertain whether the federal rule would remain in place. However, in the most recent version of the federal Consolidated Budget, known as House Resolution 1, Congress did not include a moratorium on the Final Rule. As a result, additional resources are required to retain the initially approved positions and to address workload related to compliance, monitoring, and stakeholder engagement beyond FY 2025-26.

The LT resources requested will support DHCS in meeting increasing workload demands related to requirements of the Final Rule that go into effect in FY 2026-27 and beyond, for the following areas:

- Access
  - Appointment Wait Time Standards (AWTS) and Exceptions
  - Enrollee Experience Surveys
  - Provider Payment Analysis
  - Website Transparency
- Financing and Payment
  - MLR
  - ILOS and Setting
- Quality
  - Quality Strategy and External Quality Review (EQR)
  - Medicaid Advisory Committee and QRS

The development, implementation, and monitoring of the various Final Rule requirements require support from external contractors who serve functions that are not typical of state civil service classifications. These functions include, but are not limited to, highly complex project management, technical assistance (TA), and outreach support. To successfully implement the system changes the Final Rule requires, DHCS needs dedicated contract resource funding.

1. Access

Key provisions of the Final Rule related to ensuring access to care include federal AWTS for certain services, new state remedy plan submissions to the CMS, surveys to collect and report member experience, use of independent secret shoppers, provider directory accuracy, provider payment analysis, website transparency, and parameters for ILOS.

AWTS and Exceptions (Effective January 1, 2028)

CMS defines compliance as achieving a rate of appointment availability that meets the standards at least 90 percent of the time. For MCPs, the existing compliance threshold is 70 percent, which currently aligns with the Department of Managed Health Care. DHCS will need to establish standards and a compliance approach to implement policies and processes for MCPs to meet 90 percent compliance rates by 2028. DHCS will also need to develop a Timely Access standards exception process, for example for geographic areas with persistent health care professional shortages. DHCS currently provides the results of the Timely Access Survey to each MCP quarterly and requires MCPs to identify their rectifying actions to improve wait times.

Staff positions will be needed for our Compliance Program. Specifically, the resources will be used to establish standards, develop and issue policy guidance, conduct extensive stakeholder engagement and communication of new standards and policies, update or develop internal standard operating procedures for monitoring and oversight, implement procedures to monitor MCPs' compliance, update the retrospective audit programs under the Annual Audit Program (AAP), and update or develop policies for enforcement actions.

For Behavioral Health (BH), DHCS currently holds BHPs and Drug Medi-Cal (DMC) State Plan counties to an AWTS compliance threshold of 80 percent. Through the Mental Health Parity and Addiction Equity Act (Parity), DHCS requires DMC State Plan counties to meet the same AWTS as BHPs, therefore, any changes to these requirements and the workload associated with the increased compliance threshold will apply to DMC State Plan counties as well. The shift to the 90 percent compliance threshold will present an additional workload and potentially increase the likelihood of BHPs and DMC State Plan counties being out of compliance. Additionally, the Final Rule allows for exceptions to any network standards developed under the rule. BH does not currently consider or grant exceptions to appointment wait time standards. When DHCS approves an exception to a network standard, the Final Rule will require DHCS to conduct enhanced monitoring to verify member access to provider types or services and include the findings in the MCP assessment report submitted to CMS. The enhanced exceptions monitoring process will present a new workload that requires the support of data processes and systems. The requested positions for BH will support the development and implementation of an exception process as well as specialized monitoring of BHPs and DMC State Plan counties, and member access.

Dental will need to establish standards and a compliance approach to implement policies and processes for MCPs to meet the 90 percent compliance rate by 2028. Dental will also need to develop a Timely Access standards exception process, for example for geographic areas with persistent health care professional shortages. Dental currently conducts provider surveys and requires plans to identify action plans in order to improve wait times. The positions requested will be used to establish standards, develop and issue policy guidance, conduct extensive stakeholder engagement and communication of new standards and policies, update or develop internal standard operating procedures for monitoring and oversight, implement procedures to monitor dental MCPs' compliance, update the retrospective audit programs under the AAP, and update or develop policies for enforcement actions.

HIMD (Four-year LT resources equivalent to 1 Position)
1 RDS I

This resource will maintain and/or enhance network adequacy dashboards.

1 RDS I
The RDS I will lead the data quality effort to review plan data to confirm that the data is complete, accurate, and otherwise fit for use to determine if MCPs are meeting required network adequacy thresholds. The specialist will identify data quality issues, develop remediation plans, and work with program MCPs to fix their data quality issues. The RDS I will create and review reports to identify trends and notify MCQMD, BHOMD, and other program owners of potential issues. The RDS I will also support any identified enforcement actions with reports or other data visualizations as requested.

PDRD (Four-year LT resources equivalent to 4 Positions)
2 RS II
2 RDS II

As part of PDRD's role in supporting the implementation of the Final Rule, a dedicated team of data scientists and analysts will be engaged to support the development and validation of the methodologies necessary to verify compliance with AWTS and exception criteria. These experts will support the creation and refinement of the measures and metrics required to monitor managed care network data files for both quality and completeness. Their work will focus on establishing robust, evidence-based analytical approaches that verify network adequacy standards are not only met but are measurable and actionable across plans, populations, and regions. This process will include detailed statistical validation, documentation of assumptions, and testing for consistency with CMS's regulatory framework.

These resources will assume responsibilities to verify the integrity and usability of appointment wait time data for internal and external reporting. This includes the design and deployment of dashboards that have surface disparities, highlight patterns in compliance or exception use, and enable data-informed decision-making by state leaders and external stakeholders. Analysts will lead the creation of prototype visualizations, develop workflows for data ingestion and transformation, and verify that dashboards are adaptable to evolving policy needs and programmatic requirements. They will also collaborate closely with IT teams and policy experts to verify that system functionality aligns with regulatory expectations while maintaining accessibility and interpretability for end users.

MCQMD (Four-year LT resources equivalent to 4 Positions)
1 RDS III
3 Analyst II

MCQMD is requesting 1 RDS III and 3 Analyst II's to plan, implement, and monitor the AWTS and Exceptions process, including the MCP's process for overseeing their subcontractors. The 90 percent compliance rate requirement for MCPs is significantly greater than current DHCS and other California state department thresholds and will present an additional workload to certify MCPs are meeting 90 percent by the effective date. DHCS will need to research and develop exception policies to the access standards, allowable under the Final Rule, in order to address provider shortages and challenging geographies across the state.

When DHCS deploys an exception to the standards, CMS requires enhanced monitoring processes to certify that members are not adversely impacted. Existing CMS requirements include network adequacy reviews for subcontractors and reporting to CMS using the Network Adequacy and Access Assurances Report (NAAAR) template. This requirement is imposed on DHCS via special terms and conditions requirements that reference Code of Federal Regulations (CFR) 438.207. The Timely Access compliance and exception monitoring for the new AWTS and existing network adequacy standards must be submitted to CMS using the NAAAR, and DHCS must conduct the new activities for subcontractors. The enhanced exceptions monitoring process will present a new workload that requires the support of data processes and systems.

The requested positions for MCQMD will support the development and implementation of an exception process as well as specialized monitoring of MCPs and their delegated subcontractors.

This workload will include but not be limited to:

- Planning and developing the exception processes to CMS network and access standards.
- Coordinating with stakeholders on the development of network and access standard exceptions.
- Developing program requirements to comply with state and federal law, the MCP contract, and implementation guidelines.
- Coordinating with internal data teams to develop enhanced monitoring processes.

- Developing and maintaining compliance tools and activities to review and monitor AWTS and network adequacy exceptions for both MCPs and delegated subcontractors.
- Conducting reviews of MCPs and delegated subcontractors' compliance results and associated exceptions.
- Facilitating follow up and TA with MCPs.

The RDS III will work with internal and external stakeholders to support development of reporting templates and provide consultation related to data sources and coding for enhanced exceptions monitoring. The RDS III will perform the most complex data analysis and calculations utilizing multiple different domains of structured and unstructured data across enrollment, utilization, provider network, grievance, and appeals data sets. The RDS III will collaborate with division partners in Enterprise Data and Information Management (EDIM) and Enterprise Technology Services and support reporting processes that will enable DHCS to comply with Final Rule changes. This includes data support related to identifying and obtaining data from external sources needed to support program goals and objectives, performing data linkages, and developing data sets and other data resources to support program monitoring and reporting.

BHOMD (Four-year LT resources equivalent to 1 Position)
1 Analyst II

BHOMD is requesting the above resource to plan, implement, and monitor the AWTS and Exceptions process. The shift to the 90 percent compliance threshold will present an additional workload and potentially lead to a greater increase of BHPs and DMC State Plans being out of compliance; in certain geographic areas of the state, 90 percent compliance may be challenging to achieve. DHCS will need to research and develop exception policies to the access standards, allowable under the Final Rule, in order to address provider shortages and challenging geographies across the state. Further, according to CMS requirements, when DHCS deploys an exception to the standards, BHOMD will need to conduct an enhanced monitoring process to certify members are not adversely impacted. The enhanced exceptions monitoring process will present a new workload that requires the support of data processes and systems.

1 Analyst II
The Analyst II will participate in planning and developing the processes for exceptions to network standards and coordinating with stakeholders on the development of network standards exceptions. These activities will include developing program requirements to comply with state and federal law, the BHP/State/County contract, and implementation guidelines. The Analyst II will be responsible for conducting reviews of BHPs network certification compliance results, DMC State Plan counties' AWTS compliance, and associated exceptions, and facilitate TA. The Analyst II will also conduct enhanced monitoring of enrollee access to services as part of network standard exceptions.

MDSD (Four-year LT resources equivalent to 1 Position)
1 Supervisor II

MDSD is requesting 1 Supervisor II to plan, implement, and monitor the AWTS and Exceptions process, including the Dental MCP's process for overseeing their subcontractors. The 90 percent compliance requirement for Dental MCPs to meet AWTS is significantly greater than current DHCS and other California state department thresholds and will present an additional workload to certify Dental MCPs are meeting 90 percent by the effective date in the Final Rule. In certain geographic areas of the state, 90 percent compliance rate will not be feasible. DHCS will need to research and develop exception policies to the access standards, allowable under the Final Rule, in order to address provider shortages and challenging geographies across the state.

When DHCS deploys an exception to the standards, CMS requires enhanced monitoring processes to certify members are not adversely impacted. Existing CMS requirements require DHCS to conduct network adequacy reviews for subcontractors that are delegated risk and report to CMS using the NAAAR template. This requirement is imposed on DHCS via special terms and conditions requirements that reference CFR 438.207. The Timely Access compliance and exception monitoring for the new AWTS and existing network adequacy standards must be submitted to CMS using the NAAAR, and thus by reference, DHCS must conduct the new activities for subcontractors. The enhanced exceptions monitoring process will present a new workload that requires the support of data processes and systems.

The requested position for MDSD will oversee and direct the development and implementation of an exception process as well as specialized monitoring of Dental MCPs and their delegated subcontractors.

This workload will include but not be limited to:

- Planning and developing and directing staff to implement the exception processes to CMS network and access standards.
- Coordinating with stakeholders on the development of network and access standard exceptions.
- Developing and directing staff on program requirements to comply with state and federal law, the Dental MCP contract, and implementation guidelines.
- Coordinating with internal data teams to develop enhanced monitoring processes.
- Developing, maintaining, and teaching staff how to use compliance tools and activities to review and monitor AWTS and network adequacy exceptions for both MCPs and delegated subcontractors.
- Conducting reviews of Dental MCPs and delegated subcontractors' compliance results and associated exceptions.
- Facilitating follow up and TA with Dental MCPs.

Enrollee Experience Surveys (Effective June 20, 2026)

To better capture and use member experience data to inform network adequacy analyses, the Final Rule requires states to 1) conduct an enrollee experience survey of their choosing annually for each of their MCPs, Dental managed care plans, and BHPs; and 2) use existing enrollee experience data in Children's Health Insurance Program (CHIP) in evaluation of network adequacy. DHCS is already in compliance with the first requirement through its annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, Consumer Perception Survey (Mental Health Plans, MHPs) and Treatment Perception Survey (DMC-ODS Plans). For Dental, DHCS is in compliance with the Child Dental Satisfaction Survey Report. The enrollee experience survey requirement does not apply in CHIP; the Final Rule instead requires states to use CHIP CAHPS survey data, which states are already required to collect under current regulations, to evaluate network adequacy. Moreover, to promote transparency, CMS requires states to annually post comparative summary results of CHIP CAHPS surveys by plan on their website. The workload to leverage CAHPS survey data to evaluate network adequacy is new. DHCS will also be required to annually post comparative summary results on CAHPS surveys by MCP on its website.

PDRD (Four-year LT resources equivalent to 2 Positions)
1 RS II
1 RDS II

PDRD requests dedicated analytic resources to lead and sustain data analysis and reporting efforts related to the Enrollee Experience Survey across the Medi-Cal managed care delivery system.

This work supports the Department's broader goal of integrating enrollee feedback into network adequacy standards and supporting equitable access to care. PDRD plays a central coordinating role in this process and is responsible for collaboration with key internal stakeholders, including the MCQMD, MDSD, QHED, and EDIM units. To support this effort, PDRD requests one RS II and one RDS II to lead the development and refinement of analytic methodologies and performance measures used to monitor, interpret, and evolve the Enrollee Experience Survey across all major Medi-Cal delivery systems.

These resources will assume stewardship responsibilities needed to effectively use enrollee experience data in policy and program decision-making. Their work will include designing and maintaining dashboards, creating proof-of-concept visualizations, and implementing data quality validation protocols that enhance both the accuracy and usability of reported results. The RS II will be responsible for guiding the scientific approach to metric development and confirming methodological consistency across programs, while the RDS II will focus on operationalizing these methodologies and maintaining the technical infrastructure to support regular reporting and visualization. Together, they will develop tools to surface patterns, track changes over time, and identify disparities in enrollee experiences. By embedding these analyses into the Department's broader network adequacy framework, these positions will support the inclusion of enrollee input in performance metrics and the evolution of access and quality standards across Medi-Cal.

QHED (Four-year LT resources equivalent to 2 Positions)
1 MC II Sup
1 HPM I

These resources will be required to create a system for developing an annual QI plan for each MCP, Dental managed care plan, and BHP-based on the findings from enrollee experience surveys for continuous QI. QHED is responsible for MCP, Dental managed care plan, and BHP quality and performance improvement system design and implementation and will require the following additional resources to accommodate the new workload: one MC II Sup and one HPM I.

The MC II Sup will provide clinical leadership for the professional and technical staff in the section and will support the team responsible for evaluating the results of the enrollee experience surveys and working with MCPs to develop performance improvement plans to improve quality of care and address disparities. The MC II Sup will also be responsible for drafting clinical recommendations to the director, or the director's designee, based on the results of the enrollee experience survey results to help inform revisions to DHCS' comprehensive quality strategy, health equity framework, and other strategic QI efforts. The MC II Sup will be responsible for leading engagement with DHCS partners to address state-level findings from the enrollee experience surveys to guide the development of goals and strategies. The MC II Sup will review the annual CAHPS survey to determine if additional state-specific measures need to be included to assess network adequacy to continue to meet the diverse needs of California's Medi-Cal population. The MC II Sup will also be responsible for all aspects of supervision of the professional and technical staff in the section, including recruitment, retention, training, and management for effective policy implementation.

The HPM I will supervise staff and provide guidance on day-to-day program and policy decisions related to the implementation of the annual enrollee experience surveys and subsequent MCP enrollee experience improvement plans. The HPM I will also collaborate with internal partners to identify opportunities for strategic alignment to improve quality of care and enrollee experience, while sustaining or reducing the administrative burden of MCPs through standardization, integration, and process improvement. The HPM I will support collaboration with, and provide consultation to, the MC II Sup and DHCS leadership on QI health equity efforts.

The HPM I will be responsible for all aspects of supervision of the staff in this unit, including recruitment, retention, training, and management for effective policy implementation.

Provider Payment Analysis (Effective January 1, 2027)

MCPs and BHPs are required to submit an annual payment analysis to DHCS that compares MCP and BHP payment rates, respectively for certain services as a proportion of Medicare's payment rate, and for certain home and community-based services (HCBS), the state's Medicaid state plan payment rate. The payment analysis pertains to primary care, Obstetrics and Gynecology (OB/GYN), outpatient mental health, and Substance Use Disorder (SUD) services, as well as specified HCBS, covered under the MCP and BHP contracts. DHCS will be required to collect payment data as required by CMS and submit to CMS through the NAAAR.

LGFD (Four-year LT resources equivalent to 1 Position)
1 RDS I

Annually, county BHPs will be required to submit an annual payment analysis that compares county BHPs' payment rates for certain services as a proportion of Medicare's payment rate. LGFD will be required to establish new reporting workflows and templates for this new requirement. LGFD staff will also be required to analyze submitted data and report out to BHOMD.

The RDS I will provide analytical support and analysis of BH services rates related to network adequacy. LGFD will report its findings to BHOMD for further oversight and monitoring. The RDS I will also provide support and TA to BHPs regarding the payment analysis reporting process and requirements.

PDRD (Four-year LT resources equivalent to 1 Position)
1 RDS II

PDRD requests additional analytic resources to support programmatic efforts in confirming the accuracy of payment analysis and maintaining compliance with state and federal requirements. This work will focus on validating payment data related to certain service categories, including primary care, OB/GYN, outpatient mental health, and SUD services. These services represent key access points for Medi-Cal enrollees, and accurate payment data are essential to monitoring network adequacy, provider participation, and member access. PDRD will play a central role in coordinating across divisions to establish consistent standards for payment data validation and to verify that discrepancies are identified, addressed, and resolved in a timely and transparent manner.

To lead this work, PDRD requests one RDS II to evaluate and monitor the accuracy of managed care plan-submitted payment files. The RDS II will be responsible for designing and implementing analytic methodologies that allow for the identification of anomalies or inconsistencies in reported payment amounts, frequency, and provider attribution. This will include establishing a repeatable workflow to determine whether prior inaccuracies have been corrected in subsequent submissions, documenting trends over time, and developing internal tools to improve both efficiency and interpretability of the data. By establishing a robust validation process, this resource will help verify that payment data are reliable and actionable, ultimately contributing to more effective oversight, rate-setting processes, and equitable access to services within the Medi-Cal program.

Website Transparency (Effective January 1, 2027)

While states are already required to have websites with prominent and readily accessible information, users frequently encounter challenges navigating state websites. To make information more accessible and improve the user experience, the Final Rule requires the DHCS website to: include required content (or links to required content) on a single website; directly link to the specific information requested on a plan website, rather than linking to a general website; and explain the availability of assistance for accessing the information at no cost, including information on the availability of oral interpretation and written translation, alternate formats, auxiliary aids and services, and a toll-free teletype/temporary duty telephone number. CMS provided a list of content that states must feature on their websites. Further, DHCS will be required to check the website at least quarterly to make sure information is up-to-date and that it is functioning as required.

OC (Four-year LT resources equivalent to 1 Position)
1 Analyst II

The Analyst II will assist program staff in maintaining compliance with CMS Website Transparency requirements by coordinating with web contributors and program teams. This role will provide guidance on content updates, and support programs in meeting usability and accessibility standards. The Analyst II will collaborate with IT and program staff to improve site navigation, verify direct links to required materials, and oversee compliance with language accessibility requirements. By monitoring website analytics and assisting in the development of interactive tools, this position will help maintain a user-friendly, transparent platform that meets CMS regulations and improves member access to health information.

Information Technology Supporting Final Rule Requirements

These information technology and project support positions will support DHCS programs responsible for implementing the Final Rule in achieving compliance.

MESMD (3 One-Year LT Positions)
1 ITM I
2 ITS II

1 ITM I
The ITM I will serve as lead product manager (PM) and provide product strategy leadership and guidance to multiple Final Rules PMs, product owners (PO), and technical leads. This role will work with DHCS program managers and workstream leads to manage and monitor the strategic alignment of the portfolio of digital services. Further, the position will define objectives and key results (OKR) to demonstrate alignment with the strategic outcomes expressed by the Final Rule and report progress. Additionally, the technical PM will manage and track a product roadmap to achieve OKR.

2 ITS II
The ITS IIs will serve as PM/PO to manage internal and external stakeholders' satisfaction with the digital services solution's objectives. The PM/PO will work closely with the affected programs and product development scrum teams to articulate and prioritize the product level user stories that must be delivered to demonstrate key results. These positions would then work closely with the vendor and DHCS technical architect to deliver the required objectives.

ITSSD (2 One-Year LT Positions)
2 ITS II

Under ITSSD, the requested positions will help provide oversight into the new standards for access to care through the managed care delivery system. The ITS IIs will establish maximum appointment wait time standards, conduct annual secret shopper surveys to validate MCPs' compliance with appointment wait time standards, and conduct an annual enrollee experience survey for each MCP. Further, the positions will submit an annual payment analysis that compares MCPs' payment rates for certain services, implement a remedy plan for any MCP, and maintain a single web page that is readily identifiable to the public, easy to use and contains required information for public transparency.

The ITS II, state project manager, will be responsible for providing project manager activities to provide seamless coordination, timely execution, and alignment with project goals. The project manager will manage and facilitate communication, resolve conflicts, identify risks, and inform and engage all stakeholders. The ITS II will provide project manager support and guidance by minimizing risks and delivering efficient, high-quality services to the department.

Additionally, this role will involve serving as a liaison and Subject Matter Expert (SME), coordinating projects, providing status reports, and facilitating meetings with DHCS programs, governance committees, stakeholders, and oversight agencies.

The ITS II, business analyst, will provide guidance, business analysis, and improved documentation for CDT and California Health and Human Services (CalHHS) oversight reporting coordination and support. The business analyst will be responsible for developing, reviewing, and submitting documents that meet CDT and CalHHS reporting standards for internal and external approval. This position will perform key duties that support and improve documentation and reporting quality: technical writing, editing, and review; story, case, and diagram development; and incorporating feedback from managers and other sources. The business analyst will partner with PMs to lead meetings and facilitate communication between project teams and DHCS program stakeholders relating to oversight reporting documentation. Other duties include providing status updates on oversight reporting timelines and submittals, responding to internal/external feedback, performing reviews, and submitting finalized documents.

ITSSD Contract (PM Support Services One-Year LT)
$600,000 ($90,000 GF; $510,000 FF) FY 2026-27

The PM Support Services will provide DHCS with the project oversight, project advisory, and PM support necessary to execute, monitor, and support the Final Rule Efforts to maintain compliance with federal requirements. DHCS will need to secure the resources required to manage, communicate, monitor, and report on the numerous areas and systems that this change will impact. Resources are required to work with internal and external stakeholders, technical personnel, and system sponsors to provide leadership for all project management and for system updates necessary to support the Final Rules requirements; develop project artifacts and documentation throughout the work effort; establish and implement effective communication strategies; generate executive-level status reports and facilitate sponsor/steering committee meetings; manage risks and issues cross-functionally and establish mitigation plans; manage the initiative project schedule, milestones, timelines, and cost; utilize PM best practices, processes, and procedures to consistently apply to IT projects.

ITSSD Contract (CDT POS One-Year LT)
$131,000 ($20,000 GF; $111,000 FF) FY 2026-27

The ITSSD requests funding for the CDT Project Approval Lifecycle (PAL), PAL Oversight, and the Statewide Technology Procurement Division's IT consulting services specifically for IT Project Approvals and Oversight (PAO), should leverage existing systems and platforms to be determined a PAL project.

These services are necessary for any PAL related projects. For managed care projects, the PAO will fulfill the following essential functions, as required by state departments for medium- and high-reportable IT projects:

- Review and Analysis: Conduct reviews and analyses of all IT-related BCPs and their supporting documentation.
- Independent Project Oversight: Deliver independent oversight on medium and high-reportable IT projects, confirming that these projects adhere to established timelines, scope, and budgets.
- Project Health Monitoring: Review and monitor the overall health of the work effort.

BOTSD (1 One-Year LT Position)
1 ITS II

Within BOTSD, the one IT position will support changes to impacted systems and associated downstream systems processes, including but not limited to, potentially Medi-Cal Eligibility Data System (MEDS) and the Capitation Payment Management System. Furthermore, strict data security standards and regulations must be adhered to in implementing the solution, including impact to systems and any associated downstream systems processes.

1 ITS II
The MEDS business analyst will collaborate with programming, testing, and production support teams to define and document a detailed project schedule plan for changes to MEDS or ancillary systems related to CMS-required changes. The position will participate in technical system operations meetings and create a requirements traceability matrix to foster system development understanding, confirm the technical solution, and the testing scenarios sufficiently represent the expected outcome of the identified business requirements for the CMS changes.

MLR (Effective July 9, 2024)

MCPs are required to submit actual and verifiable expenditures and revenues for additional payment types as part of their MLR reports to states; MCPs and Dental managed care plans are also required to report any identified or recovered overpayments to states annually. DHCS is required to report MLRs for each MCP and Dental managed care plan which DHCS currently does via the Medicaid Data Collection Tool for Managed Care Reporting portal. CMS requires additional detailed reporting for QI expenditures, provider incentive payments, and expense allocation reporting to align with recent regulatory changes for marketplace plans, and other specified contractual requirements for provider incentive payments.

CRDD (Four-year LT resources equivalent to 3 Positions)
3 Analyst II

These new requirements significantly increase federal expectations for DHCS' oversight of MLR in the context of the expanded reporting requirements relating to MCPs, Dental managed care plans, subcontractors, and downstream subcontractors' incentive programs to confirm they are tied to clearly defined, objectively measurable, and well-documented clinical or QI standards. Relating to QI activities, CMS modified the regulations and provided clarity on the type of expenditures that will be disallowed moving forward. Additionally, MCPs, subcontractors, and downstream subcontractors must include detailed descriptions of methods used to allocate expenses to include claims incurred, QI expenses, federal and state taxes and licensing or regulator fees, and other non-claims costs. Filling these positions is essential to successfully implementing the increased federal expectations for DHCS' oversight and to comply with the new requirements.

The Analyst IIs will conduct continuous and comprehensive monitoring of the expanded requirements within the updated Final Rule to certify compliance by MCPs, Dental managed care plans, subcontractors, and downstream subcontractors. The Analyst IIs will analyze data, generate reports, and present analyses and recommendations to project leads, management, external contractors, and health plans concerning the MLR expanded requirements. They will certify compliance of expanded requirement related to MCPs incentive programs, expanded Health Care Quality Improvement requirements, and other regulations. They will monitor and evaluate MCPs' appropriate use, review, and oversight of subcontractor generated MLR reports. They will facilitate regular and structured engagement with MCPs, subcontractors, and stakeholders fostering collaboration, feedback, and improvements in implementation of the expanded requirements. The Analyst IIs verify that data is accurately collected and analyzed and adequately monitored, which is vital to certify compliance in support of the expanded MLR requirements within the updated Final Rule. CRDD may cross advertise this role at the Analyst I level to develop new staff, but workload will be at the Analyst II journey level.

ILOS and Setting (Effective January 1, 2025)

CMS has specified that, in risk-based, capitated managed care delivery systems, ILOS can be used as immediate or longer-term substitutes for a covered service or setting under the state plan, or when the ILOS can be expected to reduce or prevent the future need for such service or setting to better support health related social needs (e.g., certain allowable housing and nutritional supports that are medically appropriate and cost effective). CMS requires that an ILOS be considered approvable as a service or setting through the Medicaid state plan or a Medicaid section 1915I waiver; and that specific information to be documented in MCP contracts for each ILOS. DHCS will be required to provide additional documentation on its processes to determine an ILOS medically appropriate and cost effective if the ILOS costs (as a percentage of total capitation payments) exceed 1.5 percent. CMS has imposed a limit of 5 percent on total ILOS costs as a percentage of total capitation payments for each program. DHCS will be required to conduct monitoring of each ILOS and an evaluation after five years if the ILOS costs (as a percentage of total capitation payments) exceed 1.5 percent; and settings to be provided timely if an ILOS will be terminated.

MCQMD (Four-year LT resources equivalent to 1 Position)
1 Supervisor I

MCQMD requests one Supervisor I to meet expanded CMS reporting requirements as part of the Final Rule and support enhanced monitoring and stakeholder engagement of Community Supports services. MCPs continue to expand Community Supports across the state, including the mandatory Transitional Rent benefit, effective January 1, 2026. MCQMD must monitor and report to CMS, this includes responsibilities for: collecting data, analyzing data, generating the Managed Care Program Assessment Reports, and providing insights to inform policy decisions and program enhancements.

PDRD (Four-year LT resources equivalent to 3 Positions)
1 RDS II
2 RDS I

PDRD requests one RDS II and two RDS Is to continue current steward levels to a new dedicated unit for the monitoring and stakeholder engagement of Community Supports services within Medi-Cal MCPs as required. These resources will be integral in assisting in the requirement of monitoring of each individual Community Support and stewarding with internal department and evaluation partners. Each Community Support will need an individual check.

The RDS II is the point of contactfor the creation of the initial data quality checks. To support monitoring the RDS Is work directly with the program area to present findings, trends, visualizations, and possible remedies to low-quality or low outcomes. These requirements will need to be incorporated in visualizations for monthly, quarterly, and annual measures and metrics.

3. Quality

The Final Rule requires more administrative effort from states, and subsequently, from MCPs, Dental managed care plans, BHPs in these areas. Key provisions for quality impacting DHCS include the Quality Strategy and QRS.

This section provides the required information for the key provisions under Quality:

- Quality Strategy and EQR
- QRS

DAD (Four-year LT resources equivalent to 1 Position)
1 RS III

This resource will develop and implement data collection, data extraction, linkage, data transformation, and validation/verification strategies; provide subject matter expertise in operationalizing QRS requirements and rules on alternative QRS; develop measure specifications; generate analytics; and support contractors, internal program staff, and external stakeholders using the data. These resources will engage SMEs, systems experts, program staff, and technical staff across delivery systems to verify all quality requirements are met. Projected outcomes include enhanced quality of health care services, data driven decision-making, increased accountability and transparency, and improved member outcomes.

The RS III will provide scientific support for EQR reporting and the QRS Measure Set. The position will provide scientific consultation and TA in developing a data-driven approach to monitoring clinical quality and health equity outcomes related to the measure set. The position will apply scientific approaches to develop, compile, and analyze measures to be included in the QRS Quality Measure Set that are feasible, comply with DHCS data standards, and advance program goals. The position will act as a team lead for data extraction, linkage, research, and statistical analysis. The position will lead the development and production of publication-quality data products.

Quality Strategy and EQR (Effective December 31, 2028)

CMS will require states to provide more meaningful data and information to be included in the annual EQR reports; and establish consistent 12-month review periods for the annual EQR activities to confirm the reports contain the most recent data and information.

QHED (Four-year LT resources equivalent to 2 Positions)
1 Manager II
1 HPS I

These resources will be used to update and align data reporting requirements with the Final Rule, across delivery systems as related to annual EQR activities. The two positions will be a part of an analytical based unit assessing EQRO results, collaborating with program owners to update data standards, and provide meaningful action items based on EQRO results to update policy and better manage the managed care entities.

This unit will collaborate with EDIM on addressing updates to data periods, meticulously reviewing each EQRO activity, updating EQRO project scopes, updating department policy and guidance, and potentially updating plan contracts to uphold Final Rule requirements. These resources will liaise between the respective delivery system and the EQRO as well as all other collaborating divisions.

The Manager II will provide high-level leadership and strategic oversight for the planning, development, and implementation of departmental policies, guidance, and data systems to verify compliance with CMS' Final Rule and alignment with California's Comprehensive Quality Strategy. The Manager II will direct EQRO-related projects and QI activities across multiple delivery systems of care, with a focus on advancing health outcomes, equity, and accountability.

In this role, the Manager II will manage and guide a team of professional staff in carrying out complex analytical and operational tasks. These include the evaluation and modernization of data collection and reporting systems, the development of department-wide guidance and policy updates, and the coordination of external quality review activities in support of the department's broader quality goals.

The HPS I will serve as the lead project manager for EQRO data collection across activities and projects to fulfill EQRO protocols. The HPS will collaborate with internal and external stakeholders, make recommendations, provide reviews of deliverables, and serve as the liaison between program partners. The HPS I will coordinate updates of department guidance and will work with the EQRO contractor to consult on key areas.

QRS (Effective December 31, 2028)

The Final Rule will require DHCS to maintain a single QRS web page for each delivery system that is readily identifiable to the public, easy to use, and contains required information for public transparency. Establishes the state's QRS website as a state's "one-stop-shop" where members could access information about Medicaid and CHIP eligibility and managed care; compare MCPs, and Dental managed care plans, when choice applies, based on quality and other factors key to beneficiary decision making, such as the plan's drug formulary and provider network; and ultimately select a plan that meets their needs. CMS has established the CMS framework and state requirements for the QRS (including an initial set of mandatory measures for the quality ratings), and the process by which the mandatory measures would be updated in the future; as well as the methodology for calculating the quality ratings displayed on each state's QRS. CMS also has broadened flexibility for states to implement an alternative QRS.

QHED (Four-year LT resources equivalent to 5 Positions)

1 HPS I
1 MC I
1 HPM II
1 HPS II
1 Analyst II

These resources will be used to assess current data collection capacity, strategies, and responsibilities within DHCS as well as attain subject matter expertise in QRS requirements and rules on alternative QRS. Resources will also be used for internal and external stakeholder engagement during initial assessment period as well as planning and implementation. These resources will also be needed once public-facing QRS is up for updating and maintenance.

The HPS I will work within the EQRO review section and collaborate significantly with Quality & Health Equity Evaluation Monitoring on operationalizing the QRS. This resource will enable the EQRO to consult and assess the QRS as well as review performed quality ratings from the EQRO across the Medi-Cal landscape.

This collaboration will aid in achieving compliance with the Final Rule, and report results in the Annual Technical Report in accordance with federal and state guidance. The HPS I will engage with SMEs, systems experts, and technical staff across delivery systems to verify all necessary requirements are met. They will review deliverables for quality and accuracy from an EQR perspective, upholding EQR protocol requirements, particularly if the EQRO will be contracted to assist in the implementation of a QRS for DHCS. The resources will work with the EQRO and internal partners to provide contract oversight for this activity. Projected outcomes include enhanced quality of healthcare services, data driven decision-making, increased accountability and transparency, cost efficiency and improved member outcomes. The workload standards involve annual data collection and analysis, timely and accurate reporting, PM and continuous QI. The HPS I will verify that all tasks aligned with QRS goals and timelines, manage resources efficiently and seek feedback to improve QRS activities.

The MC I will act as a SME and be responsible for providing clinical support for analysis of the QRS Measure Set. The position will provide medical expertise, consultation, and TA in developing a data-driven approach to monitoring clinical quality and health equity outcomes related to the measure set. This position will review new proposed measures to be included in the QRS Quality Measure Set and provide feedback to CMS based on the most up-to-date clinical literature to certify measures that are clinically meaningful for California and advance program goals. The MC I will review, interpret, and communicate feedback internally and externally. In collaboration with the MC II, HPS II and involved stakeholders, the MC I will use subject matter expertise in reviewing available data, evaluating data quality, and reporting feasibility to meet data stratification requirements. This position will also collaborate on the design and development of the public reporting tool(s) to meet reporting requirements. Following implementation, the MC I will use subject matter expertise to continue the clinical research, evaluation, and analysis needed to maintain the program.

The HPM II will be responsible for collaborating across divisions as well as engaging with external stakeholders (primarily MCPs) to assess current DHCS data collection capacity and identify gaps in implementation of CMS requirements for QRS. This position will lead, guide, and support program analysts/specialists who will be responsible for needs assessment, planning, and implementation of QRS. The position will establish and maintain priorities with a broad view of the program plan to meet all QRS implementation deadlines. The position will be responsible for all aspects of supervision, including recruitment, retention, and training, certifying the standard of work, evaluating and documenting performance. The HPM II will also make high-level decisions and communicate to upper management and staff about program implementation, policy issues, and deadlines.

The HPS II will serve as the technical lead for the newly established CMS QRS program, proving key measure development, and data visualization expertise to QHED. This position will be responsible for developing an implementation plan, which will include identifying and engaging with relevant internal and external stakeholders. This position will be the primary liaison for cross-division and external stakeholder collaboration during the implementation phase. Such implementation work will include website development to meet CMS' expansive website requirements, communicating and collaborating with plans regarding data collection, and communicating and coordinating with plans and an EQRO to manage the assessment of plans' information systems capabilities. To meet website requirements, this position will serve as the QHED SME for a cross-divisional team to identify currently available DHCS websites that may already display required information, information that is not currently available, and methods for gathering and displaying newly required information.

To feed into the website data, this position will collaborate with stakeholders to pre-plan data gathering requirements and establish a process flow and guidelines.

The HPS II will lead the creation, review, and submission of documents to CMS, including requests for timeline extensions or measure/reporting modifications as needed and annual reports on plan performance related to the required measure set. This position will also collaborate with SMEs to analyze and evaluate published CMS measure requirements for feasibility for the state and provide feedback to DHCS regarding future potential measures. The HPS II will work with team members to certify communication of program updates and needs with leadership, and coordinate with analyst staff on PM.

In collaboration with the HPS II, the Analyst II will be responsible for independently completing assignments related to the development of a data collection and reporting strategy to meet the new requirements of the CMS QRS. During the implementation phase, the position will assist the HPS II with program planning and coordination with internal and external stakeholders, including providing administrative support for internal and external stakeholder meetings and communication, and the creation and review of reports and documents to CMS. The Analyst II will review and provide recommendations regarding the format of data collected to streamline reporting and will assist the HPS II in website development to meet CMS requirements, as well as provide support for data visualization best practices. Following implementation, the Analyst II will perform the day-to-day functions needed to maintain the program processes and reporting tools, such as organizing and analyzing collected data for reporting, analyzing new data requirements based on changes to the measure set, and communicating new measure specifications to plans.

Four-Year LT funding authority – (25 Permanent Positions)

The FY 2025-26 May Revision BCP (4260-303-BCP-2025-MR), "Medicaid Managed Care, Access, and Eligibility Final Rules," included 25 permanent positions with one-time resources. As part of the FY 2026-27 Governor's Budget BCP, DHCS is requesting four-year LT resources equivalent to 25 positions.

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 provisions of the Final Rule in order to be in compliance with the federal regulations. Non-compliance with federal regulations can adversely impact federal funding and other consequences for federal participation.

D. Outcomes and Accountability

Approval of these resources support DHCS's capacity to successfully operationalize the new requirements related to Department-offered programs and benefits and the monitoring of Medi-Cal MCPs, BHPs, and DMC State Plan counties, and Dental managed care plans to verify timely access to quality care.

Resources will be used to support the development of processes and procedures, stand up systems, and other planning activities, associated with implementing and operationalizing the new requirements of the Final Rule.

If approved, the following outcomes will ultimately be achieved:

- Improved oversight and monitoring of the respective plans.
- Increased member access to care and improved health outcomes.
- Strengthened relationships and communication with members, stakeholders, and the public writ large.

- Enhanced compliance with regulatory requirements

Final Rule Section/Subsection	Projected Outcomes
Access	
AWTS and Exceptions	• The Final Rule requires DHCS to implement compliance rate thresholds for appointment wait times; DHCS has not previously issued compliance rate thresholds for MCPs, Dental managed care plans and BHPs for purposes of enforcement. • DHCS will utilize the resources to develop, implement, and monitor an exceptions process for MCPs and BHPs for failing to meet new compliance rate thresholds for appointment wait times, which would require DHCS to consider the payment rates offered by MCPs, Dental managed care plans, and BHPs to providers included in the provider group subject to the exception.
Enrollee Experience Surveys	• The Final Rule requires DHCS to conduct enrollee experience surveys annually for each MCP, Dental managed care plan, and BHP and use existing enrollee experience in CHIP in evaluation of network adequacy. While DHCS has existing compliance in some enrollee's experience survey requirements for which DHCS can leverage existing data gathered to fully meet Final Rule compliance, the workload is new. • DHCS will also be required to annually post comparative summary results on CAHPS surveys by MCP on its website.
Provider Payment Analysis	• Final Rule requirements include submission of payment data as identified by CMS and submit though the NAAAR. The information is provided to DHCS through the MCPs, Dental managed care plans, and BHPs. DHCS will need to conduct stakeholder workgroups to create reporting templates and work with DHCS entities responsible for storing and processing the data collected.
Website Transparency	• Final Rule updates to website content requirements, access, assistance, and review frequency require DHCS to revise existing processes, and develop new processes to meet Final Rule compliance.
Financing and Payment	
MLR	• Increased reporting for QI expenditures, provider incentive payments, and expense allocation reporting.
ILOS and Setting	• Enhanced reporting when ILOS is identified as medically appropriate and cost effective based on CMS-defined thresholds. • ILOS monitoring and recurring evaluations based on CMS-defined thresholds. • Timely transition planning in advance of an ILOS termination.
Quality	
Quality Strategy and EQR	• Additional data in annual EQR reporting. • Implementation of consistent review periods to certify current data and information. • Integrate accreditation review for EQR.

Final Rule Section/Subsection	Projected Outcomes
	• Increased public engagement around DHCS managed care, dental, and behavioral health quality strategies.
Medicaid and CHIP QRS	• Consolidate to a single, publicly available and easy to use QRS web page for improve public transparency based on CMS framework, requirements, and methodology.

E. Implementation Plan

Upon approval of this proposal, the impacted divisions/offices will initiate the necessary steps to secure the positions with start dates of July 1, 2026. All positions will be recruited and filled according to DHCS' standard recruitment processes, which are outlined in both internal DHCS-produced and external California Department of Human Resources-produced policies, procedures, and requirements for hiring qualified state staff.

F. Supplemental Information

Add provisions to the following appropriations:

4260-001-0001

(a) The Department of Finance may decrease this item by up to $6,929,000 if the Centers for Medi-care and Medicaid Services' Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F) or the Ensuring Access to Medicaid Ser-vices Final Rule (CMS-2442-F) is rescinded or repealed. Any adjustment of this item shall be reported in writing to the chairpersons of the fiscal committees in each house of the Legislature and the Chairperson of the Joint Legislative Budget Committee within 10 days of the date the adjustment is approved.

Attachment A: Fiscal Detail Sheet

G. BCP Fiscal Detail Sheet

BCP Title: Managed Care Final Rule: Implementation and Operations

BR Name: 4260-075-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
Salaries and Wages Earnings - Temporary Help	0	6,230	5,482	5,482	5,482	0
Total Salaries and Wages	**$0**	**$6,230**	**$5,482**	**$5,482**	**$5,482**	**$0**
Total Staff Benefits	0	3,136	2,760	2,760	2,760	0
Total Personal Services	**$0**	**$9,366**	**$8,242**	**$8,242**	**$8,242**	**$0**

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	805	1,344	1,344	1,344	0
5302 - Printing	0	128	116	116	116	0
5304 - Communications	0	128	116	116	116	0
5322 - Training	0	64	58	58	58	0
5324 - Facilities Operation	0	576	522	522	522	0
5340 - Consulting and Professional Services - External	0	731	0	0	0	0
5344 - Consolidated Data Centers	0	64	58	58	58	0
539X - Other	0	448	0	0	0	0
Total Operating Expenses and Equipment	**$0**	**$2,944**	**$2,214**	**$2,214**	**$2,214**	**$0**

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**	**$12,310**	**$10,456**	**$10,456**	**$10,456**	**$0**

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 - 0001 - General Fund	0	6,023	5,228	5,228	5,228	0
State Operations - 0890 - Federal Trust Fund	0	6,287	5,228	5,228	5,228	0
Total State Operations Expenditures	**$0**	**$12,310**	**$10,456**	**$10,456**	**$10,456**	**$0**
Total All Funds	**$0**	**$12,310**	**$10,456**	**$10,456**	**$10,456**	**$0**

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	12,310	10,456	10,456	10,456	0
Total All Programs	**$0**	**$12,310**	**$10,456**	**$10,456**	**$10,456**	**$0**

Personal Services Details
Salaries and Wages

Salaries and Wages	FY26 Current Year	FY26 Budget Year	FY26 BY+1	FY26 BY+2	FY26 BY+3	FY26 BY+4
TH00 - Temporary Help (LT Term Exp. 06-30-2027)	0	748	0	0	0	0
TH00 - Temporary Help (LT Term Exp. 06-30-2030)	0	5,482	5,482	5,482	5,482	0
Total Salaries and Wages	**$0**	**$6,230**	**$5,482**	**$5,482**	**$5,482**	**$0**

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	1,498	1,318	1,318	1,318	0
5150600 - Retirement - General	0	1,638	1,442	1,442	1,442	0
Total Staff Benefits	**$0**	**$3,136**	**$2,760**	**$2,760**	**$2,760**	**$0**

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**	**$9,366**	**$8,242**	**$8,242**	**$8,242**	**$0**