

STATE OF CALIFORNIA
Budget Change Proposal - Cover Sheet
 DF-46 (REV 08/15)

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|--|-----------------------|---|-------------------|
| Fiscal Year 2016-17 | Business Unit 4150 | Department Department of Managed Health Care | Priority No. 5 |
| Budget Request Name 4150-104-BCP-BR-2016-GB | | Program 3870-Health Plan Program | Subprogram |

Budget Request Description
 Provider Directories (SB 137)

Budget Request Summary

The Department of Managed Health Care (DMHC) requests 8.0 permanent positions and \$1,436,000 for FY 2016-17; \$1,366,000 for FY 2017-18; and \$1,181,000 for FY 2018-19 and ongoing to address the increased workload resulting from the implementation of SB 137 (Chapter 649, Statutes of 2015).

This request includes \$153,000 for FY 2016-17; \$153,000 for FY 2017-18; and \$77,000 for FY 2018-19 and ongoing for the Office of Enforcement's (OE) expert witness and deposition costs for enforcement trials.

This request also includes limited-term expenditure authority of \$89,000 for FY 2016-17 and FY 2017-18, enabling DMHC's Office of Technology and Innovation (OTI) to address short-term IT-related setup activities.

| | |
|---|--|
| Requires Legislation <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Code Section(s) to be Added/Amended/Repealed |
|---|--|

| | | |
|--|----------------|------|
| Does this BCP contain information technology (IT) components? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>If yes, departmental Chief Information Officer must sign.</i> | Department CIO | Date |
|--|----------------|------|

For IT requests, specify the date a Special Project Report (SPR) or Feasibility Study Report (FSR) was approved by the Department of Technology, or previously by the Department of Finance.
 FSR SPR Project No. Date:

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 Jennifer Clark, CFO | Date January 4, 2016 | Reviewed By <i>Amber McSargent</i> | Date 1-4-2016 |
| <i>21: [Signature]</i> Department Director | Date 1/4/2016 | Agency Secretary <i>[Signature]</i> | Date 1-6-16 |

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

BCP Type: Policy Workload Budget per Government Code 13308.05

| | |
|----------------------------|-----------------------------------|
| PPBA <i>[Signature]</i> | Date submitted to the Legislature |
|----------------------------|-----------------------------------|

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Analysis of Problem

A. Budget Request Summary

The DMHC requests 8.0 permanent positions and \$1,436,000 for FY 2016-17; \$1,366,000 for FY 2017-18; and \$1,181,000 for FY 2018-19 and ongoing to address the increased workload resulting from the implementation of SB 137 (Chapter 649, Statutes of 2015). The requested positions are as follows:

| Program/Classification | FY 2016-17 & ongoing |
|--|-------------------------|
| Office of Legal Services (OLS) | |
| Attorney I | 1.0 |
| Office of Plan Licensing (OPL) | |
| Attorney I | 1.0 |
| Associate Governmental Program Analyst | 1.0 |
| Division of Plan Surveys (DPS) | |
| Attorney I | 1.0 |
| Associate HCPSA | 1.0 |
| Office of Enforcement (OE) | |
| Attorney III | 1.0 |
| Office of Financial Review (OFR) | |
| Corporations Examiner | 1.0 |
| Office of Administrative Services (OAS) | |
| Associate Governmental Program Analyst | 1.0 |
| TOTAL | 8.0 |

This request includes \$153,000 for FY 2016-17; \$153,000 for FY 2017-18 and \$77,000 for FY 2018-19 and ongoing for the OE's expert witness and deposition costs for enforcement trials.

This request also includes limited-term expenditure authority of \$89,000 for FY 2016-17 and FY 2017-18, enabling OTI to address short-term IT-related setup activities.

B. Background/History

Resource History (Dollars in thousands)

| Program Budget | FY 10-11 | FY 11-12 | FY 12-13 | FY 13-14 | FY 14-15 |
|-------------------------|--|----------|----------|----------|----------|
| Authorized Expenditures | There are no SB 137 authorized expenditures to date. | | | | |
| Actual Expenditures | | | | | |
| Revenues | | | | | |
| Authorized Positions | | | | | |
| Filled Positions | | | | | |
| Vacancies | | | | | |

Workload History

| Workload Measure | FY 10-11 | FY 11-12 | FY 12-13 | FY 13-14 | FY 14-15 | FY 15-16 |
|------------------|----------|----------|----------|----------|----------|----------|
| N/A | | | | | | |

Existing state law requires health care service plans (health plans) to provide a list of contracting providers within a requesting enrollee's or prospective enrollee's general geographic area. Since 2001, when AB 938 (Cohn, Chapter 817, Statutes of 2001) was enacted, state law has also included requirements related to health plans' provider directories. With the enactment of the Patient Protection and Affordable Care Act (ACA), the accuracy of provider directories has never been more important as

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the ACA has enabled hundreds of thousands of individuals who formerly lacked health coverage to obtain health coverage for the first time. Since the ACA requires health plans to cover individuals who formerly could not obtain coverage due to their health problems, health plans have focused on other ways to control costs. One way health plans have attempted to control costs is to develop products with 'narrow networks,' which have fewer provider options, but still achieve network adequacy. Consequently, there may be even greater variation in a health plan's provider networks than in the past, with some networks having more limited provider options than others.

Understandable and accurate provider networks enable consumers to make important decisions and are fundamental components to allow enrollees timely access to health care services. SB 137, effective July 1, 2016, amends the Health and Safety Code to expand upon existing provider directory requirements by establishing clear and specific requirements for publishing and maintaining health plans' provider directories, including content, updating and reporting standards. To achieve this, SB 137 includes the applicable controls and requirements, and provides the DMHC and California Department of Insurance (CDI) with the responsibility to develop uniform provider directory standards that health plans and providers must follow. SB 137 also gives the DMHC the authority to enforce the law and take action if a health plan or provider is found to be non-compliant.

The requirements of SB 137 apply to all full service and specialty health plans including Medi-Cal managed care plans and includes the following provisions:

- Health plans must require their contracting providers, when they are no longer accepting patients, to direct potential enrollees to the health plan for additional assistance in finding a different provider and to inform the DMHC of the possible inaccurate information in the directory.
- Health plans must publish and maintain provider directories on their public website, with information on contracting providers that deliver health care services to the health plan's enrollees.
- Health plans must reimburse enrollees for any amount beyond what the enrollee would have paid for in-network services, if the enrollee reasonably relied on the provider directory.
- Mandates specific requirements and timelines for health plans to actively investigate reports of inaccuracies in their directories and sets forth triggers for when a provider must be removed from the directory. The specific requirements and timeframes include:
 - Health plans must update their provider directories throughout the year based on specified criteria.
 - Health plans must, at least annually, review and update all of their provider directories in their entirety. As part of the annual update, health plans are required to send notices to providers at least annually, or once every six months for individual health professionals who are not affiliated with a physician group. The notice must include all of the products the provider is contracted to provide services for as well as a warning that failure to respond may result in a payment delay.
 - Providers must respond within 30 days to notices from health plans confirming the information the health plan has for that provider is correct or with updated information.
 - If the provider does not respond to the health plans request for information within 30-days, the health plan has 15 business days to verify the provider's information in writing, electronically or by telephone.
 - If the health plan cannot verify the provider's information, they must notify the provider 10 days in advance that the health plan will be removing the provider from their directory. This 10-day notice will also contain a second warning to the provider that failure to verify their information may result in a payment delay.

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- Based on the providers' responses as well as upon receipt and verification of information indicating that updates are necessary, health plans must revise provider information as part of their weekly online directory update and their quarterly updates for printed directories. Other triggers identified in SB 137 for such updates include:
 - Reports from enrollees or potential enrollees that the provider directory contains inaccurate information.
 - Changes from providers outside of the annual or semi-annual affirmation process discussed above, such as address changes.
- In addition to health plans removing providers from directories when they cannot verify the providers information, they must also remove providers when:
 - The provider has retired or has ceased to practice.
 - The provider or provider group is no longer contracted with the health plan.
 - The contracting provider group has informed the health plan that the provider is no longer associated with the provider group and is no longer under contract with the health plan.
- Instead of requiring a health plan to file its entire provider directory annually with the DMHC to review, it now requires health plans to annually submit their policies and procedures explaining how they will comply with the law and develop an accurate provider directory. This approach is consistent with how the DMHC currently reviews health plan requirements.

These provisions enable providers to receive information from the health plans to identify under which plan products they are contracted to provide services – an issue that providers have consistently raised with respect to their inability to ensure their information is accurate.

SB 137 requires the DMHC to create uniform standards for provider directories on or before December 31, 2016. Because these standards are expected to require health plans to make significant system changes, the provisions requiring regulatory guidance will go into effect by July 31, 2017, or 12 months after the provider directory standards are developed, whichever occurs later. One of the significant standards will include the process for referring a patient to hospitals and other providers and the way information is presented in the directories.

SB 137 also places a direct obligation on providers to report their information to the health plans and allows health plans to delay payment to incentivize provider responses when requested for the provider directory.

SB 137 allows health plans to delay payment for one month in the event the provider does not respond to the required request for directory information verification. For providers reimbursed by capitation, the health plan cannot delay more than 50 percent of the total capitation rate for the next scheduled capitation payment. For providers reimbursed via claims, the health plan can delay claims payments for up to one calendar month beginning on the first day of the following month.

In order to address the concern of compliance with the new authority to delay payment, SB 137 requires the DMHC to include a review of the health plan's compliance with this provision in its routine financial examinations of the health plans, which occur every three to five years.

The DMHC has authority to work with provider groups to enable them to report any concerns regarding non-compliance. If the DMHC receives such reports, it can take action immediately by requiring the health plan to demonstrate its compliance with the law. The DMHC can also initiate non-routine

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examinations of health plans with respect to payment delays at any time it appears a plan is delaying payments without just cause.

Further, the DMHC has a number of mechanisms under existing law to enforce health plan compliance with all of the provisions of SB 137, including the payment delay provision. Such mechanisms include: injunctive relief; issuing Cease and Desist Orders; assessing civil penalties up to \$2,500 per violation; and assessing administrative fines (for which there is no statutory dollar cap).

While the workload associated with SB 137 may seem similar to that of SB 964 (Chapter 573, Statutes of 2014), SB 137 has an entirely separate focus. SB 964 addresses health plan network adequacy and requires the DMHC to consider the geographic distribution of all providers in a health plan network, the capacity of the providers, and the scope of specialties covered by those providers. This review is to ensure the provider network can meet the network adequacy requirements set forth in the Knox-Keene Act so all enrollees have appropriate access to care. SB 137 addresses health plan operations, rather than network changes, with a distinct focus on directory standards. The workload associated with SB 137 entails developing directory standards, reviewing new and focused online directory filings, and ongoing compliance review of policies and procedures and online processes implemented by health plans.

C. State Level Considerations

This request provides the additional resources necessary to enable the DMHC to address the additional ongoing workload resulting from the implementation of SB 137.

SB 137 requires the DMHC to work with the CDI in developing uniform directory data standards.

D. Justification

The DMHC licenses and regulates health plans that provide full-service and specialty services to more than 25 million Californians. The DMHC regulates health plans under the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (Knox Keen Act), as amended. To meet its mission of protecting consumer health care rights and ensuring a stable health care delivery system, the DMHC resolves grievances; conducts onsite medical surveys and financial exams; and reviews and approves plan contracts, disclosures, and vendor arrangements.

Currently, the DMHC regulates a total of 74 full service and 49 specialized health plans that contract with providers to deliver services to enrollees and that maintain provider directories in accordance with current law. Implementation of SB 137 creates additional workload for all DMHC offices as its provisions require changes to existing departmental processes, such as routine medical surveys, financial reviews, and licensure. In addition to process changes, the DMHC anticipates additional workload resulting from SB 137 due to an increased number of requests for information and enforcement case referrals, additional staff, and the necessary completion of legal memoranda and regulation packages.

Office of Legal Services (OLS)

OLS conducts legislative and legal analyses for the DMHC; leads rulemaking activities, including pre-notice stakeholder engagement, research and analysis, drafts regulatory language, conducts public hearings, responding to comments, and files regulation package(s) with the Office of Administrative Law; and responds to Public Records Act and Information Practices Act requests. To perform the additional workload required by SB 137, OLS requests the following permanent positions:

1.0 Attorney I

This position will be responsible for the promulgation of regulations and completion of legal memoranda and review of legal questions related to SB 137. The review of legal questions encompasses all tasks necessary to compose the final determination, including gathering data, researching applicable law,

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conducting staff meetings, crafting a position, briefing management, and presenting to impacted or requesting divisions.

Office of Plan Licensing (OPL)

OPL is responsible for assuring regulatory compliance of health plans with the Knox Keene Act and the Final Rule, which includes licensing health plans and approving changes to the licensee and its operations such as provider, vendor, and subscriber contracts; provider networks; utilization management processes; quality assurance systems; and financial viability. In order to facilitate ongoing review of SB 137 compliance for each of the 74 full service and 49 specialized health plans, OPL is requesting the following permanent positions to perform the additional ongoing workload:

1.0 Attorney I

This position will be responsible for conducting legal research to determine criteria and requirements for implementation of the provider directory process requirements; leading interdepartmental meetings related to implementation of the review process; developing and maintaining a structure for review of compliance of each health care service plan, including checklists, spreadsheets, and templates for use during filing reviews; designing and updating filing review guidelines for internal review; performing comprehensive review of submitted filings, including a summary of the filing, coordinating with other divisions (e.g., the OFR) to review submitted documents, preparation of appropriate comments, legal analysis of the filing for compliance, and compiling documentation support referrals to the OE.

1.0 Associate Governmental Program Analyst

This position will be responsible for assisting with the analysis and implementation of provider directory process requirements, including developing and maintaining a structure for compliance implementation; creating and maintaining a weekly tracking report to document health plan compliance issues and status of completion of annual filings; coordinating the initial review of each health plan's initial filing and subsequent amendments for any administrative issues and deficiencies; assisting with compiling documentation in preparation for drafting referrals to the OE; and participating in trainings outlining compliance review processes and updates reflecting changes in the law.

Division of Plan Surveys (DPS)

DPS, part of DMHC's Help Center, is responsible for conducting routine medical surveys of each licensed full service and specialty health plan on a triennial basis as required by the Knox Keene Act, as well as non-routine investigative medical surveys as deemed necessary by DMHC's Director. As part of that survey, DPS conducts a review to assess if health plan processes ensure access and availability of health care services. Presently, DPS reviews health plan provider directories for compliance with existing laws as a part of this review. DPS anticipates the scope of this review will expand with the implementation of SB 137 and is requesting the following permanent positions to perform the additional ongoing workload:

1.0 Attorney I

This position will be responsible for assisting with the survey process, including survey preparation, developing the survey strategy, and providing legal review of deficiencies; providing legal review of corrective actions during follow-up surveys; and reviewing revisions to the applicable audit tool or Technical Assistance Guide (TAG).

1.0 Associate HCSPA

This position will be responsible for analyzing each of the health plan's processes and informational flows to facilitate compliance with SB 137 during the survey, monitoring corrective actions and conducting follow-up surveys, and drafting revisions to the applicable audit tool or TAG.

Office of Enforcement (OE)

OE handles the litigation needs of the DMHC, representing the Department in actions to enforce the managed health care laws and in actions that are brought against the Department. Cases may be

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referred to OE by other DMHC programs that review the activities of health plans for compliance with the Knox Keen Act.

OE has historically received individual complaint referrals for an inadequate network from the Help Center and has treated these referrals as a "track and trend" opportunity, unless substantial harm was identified. DPS has also referred a small number of matters, which are more complex in nature. OE anticipates an increase of approximately 15 annual referrals in FY 2016-17 and FY 2017-18 from other DMHC programs as SB 137 provides specific provisions to compare a health plan's actions against to determine if a violation has occurred resulting in a more concise remedy, with one referral going to trial. Based on two provider network inadequacy cases OE is currently prosecuting and its experience prosecuting similarly large-scale cases, it is expected SB 137-related referrals will be complex as each case involves a review of each provider contract, database change process, and the protocols and procedures to change databases. These prosecutions can be extremely time and document-intensive. This workload cannot be absorbed by current staffing and will require the following permanent position and contract resources to perform the additional ongoing workload:

1.0 Attorney III

This position will be responsible for evaluating enforcement referrals, drafting/sending investigative discovery, recommending a course of action based on evidence received and violations found, and all activities associated with trials/hearings. Trial/hearing activities include preparing course of resolution; preparing law and motion prosecution and defense; pre-trial preparation; researching applicable law, potential violations, and potential defenses to prosecute action; trial/hearing attendance; post-trial briefing; and enforcement of verdict/order.

Expert Witness/Consultant and Trial Costs

OE anticipates at least three expert consultants will be needed to address the issues raised by these referrals at a cost of approximately \$45,000 per contract for a total of \$135,000 per fiscal year. These expert consultant contracts are not necessarily related to trial needs, but will be necessary to provide OE with expert opinions on new issues SB 137 raises. In addition to expert consultants, associated trial costs include payment of witnesses travel to and from court, trial resources (discovery expenses, court reporters, copying costs, exhibit preparation), and travel expenses. OE estimates the following associated trial costs: exhibit preparation at approximately \$1,000; six administrative discovery depositions per year at approximately \$2,000 per deposition (for a total of \$12,000); and trial-related travel expenses of approximately \$5,000. Total cost is \$153,000 per year for FY 2016-17 and FY 2017-18.

Beginning in FY 2018-19, a decline in SB 137-related referrals of approximately 5-10 per year is anticipated as the health plans become more familiar with SB 137 requirements. Conversely, trial expenses will level off to approximately \$77,000 and remain steady at that rate thereafter. These estimates are based on actual costs incurred for similar trials OE has conducted.

Office of Financial Review (OFR)

Division of Financial Oversight (DFO), part of OFR, monitors and evaluates the financial viability of health plans to facilitate continued access to health care services for the enrollees/patients of California. This is accomplished by reviewing financial statements; analyzing financial arrangements and other information submitted as part of the licensing, material modification, and amendment process; and by performing routine and non-routine examinations.

In order to perform the additional ongoing workload involved with reviewing health plan compliance with SB 137, DFO is requesting the following permanent position to perform the additional ongoing workload:

1.0 Corporations Examiner

This position will be responsible for performing claims sampling analyses, reviewing claims for compliance with SB 137, writing a final report on findings, and performing the review of capitation

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withholds and including any exceptions in a report for each health care service plan every three years. On an annual basis this position will review health plan records submitted to the DMHC regarding delay of payment of provider claims/capitation, review and approve/deny plan policies and procedures regarding the withhold of payments of claims/capitation to providers, and review plan records submitted to the DMHC each time a health plan withholds the payment of claims/capitation to a provider.

Office of Administrative Services (OAS)

OAS encompasses all departmental support services functions with the exception of IT. These functions include accounting, budgeting, human resources, training and organizational effectiveness, and business management. While the program areas of the DMHC expand, resources to support the programs should also increase. Program expansion due to the passage of SB 137 results in additional hiring activities; the processing of employee-related transactions, such as personnel transactions, travel expense claims, and trainings; contracts and procurements, etc. In order to obtain sufficient resources to handle the workload resulting from SB 137 and to support the additional positions requested in this proposal, OAS is requesting the following permanent position to perform the additional ongoing workload:

1.0 Associate Governmental Program Analyst (AGPA)

This position will address the increased workload in the support services functions, such as processing contracts and procurements, preparing budget allotments, managing expenditures, processing accounting transactions and related documents, coordinating job-related training, conducting tasks associated with hiring and human resources issues, and coordinating facility-related accommodations and requests.

Office of Technology and Innovation (OTI)

The Division of Support Services (DSS), a division within the OTI, provides support services for and procurement of desktops, laptops, and the associated suite of productivity software. This division is also responsible for staffing the IT Help Desk to respond to both PC administrators and DMHC employees for problem resolution; providing administration for databases and the Exchange/Outlook email application; maintaining DMHC's network, file and printer servers, and application servers; and enabling the security of data through the implementation of virus detection software and intruder detection.

The implementation of SB 137 requires an increase in IT-related support services to address the needs of the additional positions requested in this proposal and related programmatic workload. DSS is requesting two-year limited-term resources to provide the DMHC with sufficient IT-related services to manage the increased workload resulting from SB 137. Resources will be used to support the IT Help Desk and respond to highly complex issues; prepare IT equipment for survey, refresh equipment, maintain the equipment storage room; support critical outages; maintain employee access; creating network accounts; and processing change requests, service requests, incidences and maintenance tasks.

E. Outcomes and Accountability

Projected Outcomes

| Workload Measure | FY 15-16 | FY 16-17 | FY 17-18 | FY 18-19 | FY 19-20 | FY 20-21 |
|--|----------|----------|----------|----------|----------|----------|
| Office of Legal Services (OLS) | | | | | | |
| Conduct legal research and policy analysis. Includes reviewing legal questions, gathering data and supporting documentation, staff coordination, reviewing applicable law, gathering legal references, crafting position, drafting memos, briefing management, and presenting final determination to impacted staff. | 0 | 5 | 5 | 5 | 5 | 5 |

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| Promulgation of one regulation package. Includes conducting stakeholder meetings, capturing feedback, research and analyze policy concerns, draft proposed regulation, draft APA documents, hold public hearings, summarize comments, analyze and respond to comments, and process regulation through formal rulemaking process. | 0 | 0 | 1 | 0 | 0 | 0 |
| Office of Plan Licensing (OPL) | | | | | | |
| Legal Compliance Analysis and Implementation: | | | | | | |
| Conduct legal research to determine criteria and requirements for implementation. (Attorney only) | 0 | 1 | 1 | 1 | 1 | 1 |
| Conduct interdepartmental meetings to gather additional information necessary for implementation. | 0 | 12 | 6 | 6 | 6 | 6 |
| Participate in stakeholder meetings held throughout the process of developing standards. (Attorney only) | 0 | 12 | 4 | 4 | 4 | 4 |
| Develop structure of compliance implementation plan annually by November 1 (including external checklists and spreadsheets and templates to be utilized during filing review) (Health and Safety Code Section 1367.27. (m)(1)). | 0 | 3 | 1 | 1 | 1 | 1 |
| Design filing review guidelines for internal review (including internal checklists and spreadsheets for filing tracking). (Attorney only) | 0 | 3 | 1 | 1 | 1 | 1 |
| Create and maintain weekly tracking report and documentation of each health plan compliance issues and completion of status. (AGPA only) | 0 | 123 | 123 | 123 | 123 | 123 |
| Conduct initial filing review of plan submission and subsequent filing amendments to identify administrative issues and deficiencies. (AGPA only) | 0 | 123 | 123 | 123 | 123 | 123 |
| Participate in training of compliance review processes and updates to anticipate compliance laws. (AGPA only) | 0 | 1 | 1 | 1 | 1 | 1 |
| Review of Current Licensee Filings: | | | | | | |
| Provide summary of the filing. (Attorney only) | 0 | 123 | 123 | 123 | 123 | 123 |
| Review plan documents (plan policies, Evidence of Coverages (EOC), provider contracts, administrative service plan agreements, and grievances/complaints associated with plan directory navigation and/or accuracy) for legal compliance. Prepare responsive comments for plan filings and subsequent filing amendments. (Attorney only) | 0 | 123 | 123 | 123 | 123 | 123 |
| Coordinate with OFR to review Delayed Payment Reports (Health and Safety Code Section 1367.27. (p)(4)). (Attorney only) | 0 | 123 | 123 | 123 | 123 | 123 |
| Legal consultation with senior attorneys and/or Assistant Chief Counsel to discuss issues as they arise. (Attorney only) | 0 | 123 | 61 | 61 | 61 | 61 |
| New License Application Review: | | | | | | |
| Conduct pre-filing and filing conferences with | 0 | 5 | 5 | 5 | 5 | 5 |

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| applicant. (Attorney only) | | | | | | |
| Provide summary of the filing/Briefing Memorandum. (Attorney only) | 0 | 5 | 5 | 5 | 5 | 5 |
| Review plan documents (plan policies, EOCs, provider contracts, administrative service plan agreements, and grievances/complaints associated with plan directory navigation and/or accuracy) for legal compliance. | 0 | 5 | 5 | 5 | 5 | 5 |
| Division of Plan Surveys (DPS) | | | | | | |
| Participate in routine surveys. Includes preparing survey, developing survey strategy, providing legal review of deficiencies, and analyzing each plan's processes and informational flows to facilitate compliance with Health and Safety Code Section 1367.27. | 0 | 35 | 35 | 35 | 35 | 35 |
| Participate in follow-up surveys. Includes preparing follow-up survey, developing survey strategy, providing legal review of corrective actions, conducting follow-up surveys, monitoring corrective action plans, and issuing follow-up reports. | 0 | 17 | 17 | 17 | 17 | 17 |
| Draft and review revisions to the applicable audit tools or TAG, and develop and conduct training. | 0 | 1 | 0 | 0 | 0 | 0 |
| Office of Enforcement (OE) | | | | | | |
| Evaluate case, draft and send investigative discovery, evaluate responses, analyze need for further information and follow up. | 0 | 15 | 15 | 10 | 10 | 10 |
| Locate, evaluate, retain and consult with expert for purposes of evaluation and trial/hearing preparation. | 0 | 3 | 3 | 3 | 3 | 3 |
| Evaluate and recommend course of action based upon evidence received and violations found. | 0 | 15 | 15 | 10 | 10 | 10 |
| Prepare appropriate course of resolution using accusation/pleadings, including appropriate location for prosecution. | 0 | 15 | 15 | 10 | 10 | 10 |
| Prepare law and motion prosecution and defense. | 0 | 3 | 3 | 3 | 3 | 3 |
| Pre-trial preparation, including penalty justification memos, court ordered status conference briefs, settlement conference statements, and trial briefs. | 0 | 15 | 15 | 10 | 10 | 10 |
| Research applicable law, potential violations, and potential defenses to prosecute action. | 0 | 15 | 15 | 10 | 10 | 10 |
| Trial/Hearing activities. Includes attendance and preparation; post-trial briefing, including post-trial briefs and motions, and written argument of case; and enforcement of verdict/order through court hearing and contact with opposing parties. | 0 | 1 | 1 | 1 | 1 | 1 |
| Office of Financial Review (OFR) | | | | | | |
| Perform claims review (3-year cycle). Includes claims sampling analyses, review of claims for compliance with SB 137, preparation of a final report that includes all exceptions, and review of | 0 | 40 | 40 | 40 | 40 | 40 |

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| capitation withholds. | | | | | | |
| Perform annual review of plan documentation. Includes review of plan records submitted to DMHC regarding delay of payment of provider claims/capitation, review and approval/denial of plan policies and procedures regarding withhold of payments of claims/capitation to providers, and review of plan records submitted to DMHC each time a plan withholds the payment of claims/capitation to a provider. | 0 | 123 | 123 | 123 | 123 | 123 |
| Office of Administrative Services (OAS) | | | | | | |
| Review and approve procurements and contracts. | 0 | 54 | 54 | 54 | 54 | 54 |
| Prepare budget allotments and adjustments to program budgets. | 0 | 10 | 10 | 10 | 10 | 10 |
| Manage program expenditures and projections on a monthly basis. | 0 | 12 | 12 | 12 | 12 | 12 |
| Review and approve program staff expenditures on a monthly basis (e.g., travel expense claims, training, etc.) | 0 | 12 | 12 | 12 | 12 | 12 |
| Review and approve vendor invoices. | 0 | 112 | 112 | 112 | 112 | 112 |
| Validate and enter employee timesheets into accounting system. | 0 | 156 | 156 | 156 | 156 | 156 |
| Review, approve, and release warrants to staff. | 0 | 156 | 156 | 156 | 156 | 156 |
| Monthly coordination of job-related training. | 0 | 12 | 12 | 12 | 12 | 12 |
| Perform new hire activities (includes recruitment and retention tasks, hiring process, verification of employment eligibility, etc.). | 0 | 13 | 13 | 13 | 13 | 13 |
| Quarterly review of employee grievances, discipline issues and adverse actions. | 0 | 4 | 4 | 4 | 4 | 4 |
| Monthly support dealing with general Human Resources issues (e.g., staff personnel-related questions, EAP, EEO, etc.). | 0 | 12 | 12 | 12 | 12 | 12 |
| Monthly coordination of facility-related accommodations and requests. | 0 | 12 | 12 | 12 | 12 | 12 |
| Office of Technology and Innovation (OTI) | | | | | | |
| New user setup. Includes setup of equipment, applications, security and access, and initial desktop imaging. | 0 | 13 | 1 | 0 | 0 | 0 |
| Ongoing maintenance of desktops and laptops, software upgrades, including testing and deployment. | 0 | 13 | 13 | 0 | 0 | 0 |
| Procurements/annual renewals for IT equipment and software (includes annual renewal of six licenses/staff). | 0 | 78 | 78 | 0 | 0 | 0 |
| Change requests requiring technical application expertise. | 0 | 13 | 13 | 0 | 0 | 0 |
| Service requests. Includes changes to access rights, remote and e-mail access, user profile changes, moves, and resolution of security-related issues. | 0 | 13 | 13 | 0 | 0 | 0 |
| Processing of Help Desk tickets. | 0 | 65 | 65 | 0 | 0 | 0 |
| Quarterly asset management of IT equipment. | 0 | 4 | 4 | 0 | 0 | 0 |

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| Perform IT equipment refresh every two years. Includes desktops, laptops, monitors, and remote access tools. | 0 | 0 | 13 | 0 | 0 | 0 |
| Monthly security patch management/updates of security and malware protection applications. | 0 | 156 | 156 | 0 | 0 | 0 |

F. Analysis of All Feasible Alternatives

Alternative 1: Approve the DMHC's request for 8.0 permanent positions and \$1,436,000 for FY 2016-17; \$1,366,000 for FY 2017-18; and \$1,181,000 for FY 2018-19 and ongoing to address the increased workload resulting from the implementation of SB 137 (Chapter 649, Statutes of 2015).

This request includes \$153,000 for FY 2016-17; \$153,000 for FY 2017-18; and \$77,000 for FY 2018-19 and ongoing for the OE's expert witness and deposition costs for enforcement trials.

This request also includes two-year limited-term resources of \$89,000 to address IT-related setup activities.

Pros:

- DMHC will have the necessary resources to implement the provisions of SB 137.

Cons:

- Increases the size of State government and expenditures.

Alternative 2: Approve the request at a lower level.

Pros:

- Provides minimal resources to meet all the provisions of SB 137.

Cons:

- Would cause delays in implementing the requirements of SB 137.
- Less positions and funding would result in the redirection of staff resources in order to accomplish the necessary tasks/activities associated with SB 137. However, DMHC staff is already at capacity and this would add to existing backlogs in other areas.

Alternative 3: Deny the request in which case DMHC will have to redirect existing resources in entirety.

Pros:

- Does not increase the size of State government or expenditures.

Cons:

- The Department may not fulfill all requirements mandated by SB 137.
- Will create a backlog in other areas of the Department's responsibilities.

G. Implementation Plan

The 8.0 positions requested will be effective July 1, 2016. DMHC will start recruitment in late FY 2015-16 to enable positions to be filled by that date and activities outlined in this BCP are performed to meet requirements set forth by SB 137.

H. Supplemental Information

This proposal will be funded through annual assessments of the health plans that are regulated by the DMHC. The fiscal impact of this request to full service health plans is less than \$0.04 per enrollee.

I. Recommendation

Alternative 1: Approve the DMHC's request for 8.0 permanent positions and \$1,436,000 for FY 2016-17; \$1,366,000 for FY 2017-18; and \$1,181,000 for FY 2018-19 and ongoing to address the increased workload resulting from the implementation of SB 137 (Chapter 649, Statutes of 2015).

This request includes \$153,000 for FY 2016-17; \$153,000 for FY 2017-18; and \$77,000 for FY 2018-19 and ongoing for the OE's expert witness and deposition costs for enforcement trials.

This request also includes two-year limited-term resources of \$89,000 for FY 2016-17 and FY 2017-18, enabling OTI to address IT-related setup activities.

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BCP Fiscal Detail Sheet

BCP Title: Provider Directories (SB 137)

DP Name: 4150-104-BCP-DP-2016-GB

Budget Request Summary

| | FY16 | | | | | |
|--|------------|----------------|----------------|----------------|----------------|----------------|
| | CY | BY | BY+1 | BY+2 | BY+3 | BY+4 |
| Positions - Permanent | 0.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 |
| Total Positions | 0.0 | 8.0 | 8.0 | 8.0 | 8.0 | 8.0 |
| Salaries and Wages | | | | | | |
| Earnings - Permanent | 0 | 601 | 601 | 601 | 601 | 601 |
| Earnings - Temporary Help | 0 | 67 | 67 | 0 | 0 | 0 |
| Total Salaries and Wages | \$0 | \$668 | \$668 | \$601 | \$601 | \$601 |
| Total Staff Benefits | 0 | 375 | 375 | 353 | 353 | 353 |
| Total Personal Services | \$0 | \$1,043 | \$1,043 | \$954 | \$954 | \$954 |
| Operating Expenses and Equipment | | | | | | |
| 5301 - General Expense | 0 | 88 | 18 | 16 | 16 | 16 |
| 5302 - Printing | 0 | 9 | 9 | 8 | 8 | 8 |
| 5304 - Communications | 0 | 9 | 9 | 8 | 8 | 8 |
| 5320 - Travel: In-State | 0 | 44 | 44 | 38 | 38 | 38 |
| 5322 - Training | 0 | 9 | 9 | 8 | 8 | 8 |
| 5324 - Facilities Operation | 0 | 81 | 81 | 72 | 72 | 72 |
| 5340 - Consulting and Professional Services - External | 0 | 153 | 153 | 77 | 77 | 77 |
| Total Operating Expenses and Equipment | \$0 | \$393 | \$323 | \$227 | \$227 | \$227 |
| Total Budget Request | \$0 | \$1,436 | \$1,366 | \$1,181 | \$1,181 | \$1,181 |
| Fund Summary | | | | | | |
| Fund Source - State Operations | | | | | | |
| 0933 - Managed Care Fund | 0 | 1,436 | 1,366 | 1,181 | 1,181 | 1,181 |
| Total State Operations Expenditures | \$0 | \$1,436 | \$1,366 | \$1,181 | \$1,181 | \$1,181 |
| Total All Funds | \$0 | \$1,436 | \$1,366 | \$1,181 | \$1,181 | \$1,181 |
| Program Summary | | | | | | |
| Program Funding | | | | | | |
| 3870 - Health Plan Program | 0 | 1,436 | 1,366 | 1,181 | 1,181 | 1,181 |
| Total All Programs | \$0 | \$1,436 | \$1,366 | \$1,181 | \$1,181 | \$1,181 |

