

STATE OF CALIFORNIA

**Budget Change Proposal - Cover Sheet**

DF-46 (REV 08/15)

Fiscal Year FY 2016-17	Business Unit 4260	Department Health Care Services	Priority No.
Budget Request Name 4260-301-SFL-DP-2016-A1		Program 3960010/9900100	Subprogram

Budget Request Description

1115 Waiver Renewal - "Medi-Cal 2020"

Budget Request Summary

The Department of Health Care Services (DHCS) requests a combination of two-year and five-year limited-term resources to support the implementation of California's 1115 waiver renewal, "Medi-Cal 2020". A renewal of the Medicaid Waiver is a fundamental component to California's ability to continue to successfully implement the Affordable Care Act (ACA) beyond the primary step of coverage expansion. Within the expenditure authority requested, \$14,200,000 will be used for contractual services over the span of 5 years.

Requires Legislation <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Code Section(s) to be Added/Amended/Repealed
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Does this BCP contain information technology (IT) components? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, departmental Chief Information Officer must sign.</i>	Department CIO <i>Barnes</i>	Date <i>3/28/16</i>
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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 <i>Andy Lovington</i>	Date <i>3/28/2016</i>	Reviewed By <i>[Signature]</i>	Date <i>3/29/16</i>
Department Director <i>John Kent</i>	Date <i>3/28/16</i>	Agency Secretary <i>[Signature]</i>	Date <i>3/29/16</i>

**Department of Finance Use Only**

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 <b>APR 01 2016</b>
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## BCP Fiscal Detail Sheet

BCP Title: 1115 Waiver Renewal - Medi-Cal 2020

DP Name: 4260-301-BCP-DP-2016-A1

### Budget Request Summary

	CY	BY	FY16			
			BY+1	BY+2	BY+3	BY+4
Salaries and Wages						
Earnings - Temporary Help	0	2,264	2,264	2,127	2,127	2,127
<b>Total Salaries and Wages</b>	<b>\$0</b>	<b>\$2,264</b>	<b>\$2,264</b>	<b>\$2,127</b>	<b>\$2,127</b>	<b>\$2,127</b>
Total Staff Benefits	0	1,094	1,094	1,028	1,028	1,028
<b>Total Personal Services</b>	<b>\$0</b>	<b>\$3,358</b>	<b>\$3,358</b>	<b>\$3,155</b>	<b>\$3,155</b>	<b>\$3,155</b>
Operating Expenses and Equipment						
5301 - General Expense	0	186	124	116	116	116
5302 - Printing	0	62	62	58	58	58
5304 - Communications	0	62	62	58	58	58
5320 - Travel: In-State	0	52	52	52	52	52
5322 - Training	0	31	31	29	29	29
5324 - Facilities Operation	0	279	279	261	261	261
5340 - Consulting and Professional Services -	0	6,540	2,540	2,040	1,540	1,540
5344 - Consolidated Data Centers	0	31	31	29	29	29
539X - Other	0	217	0	0	0	0
<b>Total Operating Expenses and Equipment</b>	<b>\$0</b>	<b>\$7,460</b>	<b>\$3,181</b>	<b>\$2,643</b>	<b>\$2,143</b>	<b>\$2,143</b>
<b>Total Budget Request</b>	<b>\$0</b>	<b>\$10,818</b>	<b>\$6,539</b>	<b>\$5,798</b>	<b>\$5,298</b>	<b>\$5,298</b>
<b>Fund Summary</b>						
Fund Source - State Operations						
0001 - General Fund	0	5,409	3,270	2,899	2,649	2,649
0890 - Federal Trust Fund	0	5,409	3,269	2,899	2,649	2,649
<b>Total State Operations Expenditures</b>	<b>\$0</b>	<b>\$10,818</b>	<b>\$6,539</b>	<b>\$5,798</b>	<b>\$5,298</b>	<b>\$5,298</b>
<b>Total All Funds</b>	<b>\$0</b>	<b>\$10,818</b>	<b>\$6,539</b>	<b>\$5,798</b>	<b>\$5,298</b>	<b>\$5,298</b>
<b>Program Summary</b>						
Program Funding						
3960010 - Medical Care Services (Medi-Cal)	0	10,818	6,539	5,798	5,298	5,298
9900100 - Administration	0	1,733	1,188	1,188	1,188	1,188
9900200 - Administration - Distributed	0	-1,733	-1,188	-1,188	-1,188	-1,188
<b>Total All Programs</b>	<b>\$0</b>	<b>\$10,818</b>	<b>\$6,539</b>	<b>\$5,798</b>	<b>\$5,298</b>	<b>\$5,298</b>

**Personal Services Details**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
VR00 - Various (Eff. 07-01-2016)(LT 06-30-2018)	0	137	137	0	0	0
VR00 - Various (Eff. 07-01-2016)(LT 06-30-2021)	0	2,127	2,127	2,127	2,127	2,127
<b>Total Salaries and Wages</b>	<b>\$0</b>	<b>\$2,264</b>	<b>\$2,264</b>	<b>\$2,127</b>	<b>\$2,127</b>	<b>\$2,127</b>
<b>Staff Benefits</b>						
5150350 - Health Insurance	0	544	544	512	512	512
5150600 - Retirement - General	0	550	550	516	516	516
<b>Total Staff Benefits</b>	<b>\$0</b>	<b>\$1,094</b>	<b>\$1,094</b>	<b>\$1,028</b>	<b>\$1,028</b>	<b>\$1,028</b>
<b>Total Personal Services</b>	<b>\$0</b>	<b>\$3,358</b>	<b>\$3,358</b>	<b>\$3,155</b>	<b>\$3,155</b>	<b>\$3,155</b>

## Analysis of Problem

### A. Budget Request Summary

The Department of Health Care Services (DHCS), requests a combination of two-year and five-year limited-term resources of \$10,818,000 (\$5,409,000 General Fund /\$5,409,000 Federal Fund) to support the implementation of California's new 1115 waiver, "Medi-Cal 2020". Within the expenditure authority requested, \$14,200,000 will be used for contractual services over the span of 5 years.

As California continues to be a leader in implementing the Affordable Care Act (ACA), operating the nation's largest Medicaid program, Medi-Cal 2020 will build on the efforts of California's previous 1115 waiver, "Bridge to Reform (BTR)," expanding and sustaining the delivery of high quality, cost effective care over time. The renewal of the Medicaid Waiver is a fundamental component to California's ability to continue to successfully implement the ACA beyond the primary step of coverage expansion.

Because of the successes of the last 1115 waiver, California is in a position to focus its efforts on other critical components of health care reform such as expanding access, improving health quality, equity and outcomes, and controlling the cost of care through a shift toward paying for value and outcomes instead of volume. The Medi-Cal 2020 waiver partners with the Centers for Medicare and Medicaid Services (CMS) in continuing to test innovative strategies that better coordinate care and align incentives around Medi-Cal members taking a whole-person approach to care.

With the renewal of the 1115 waiver, the efforts of the Medi-Cal program will be a transformation of the current health care delivery system and payment structure for the continued success and viability of the Medi-Cal program. The positions requested, which span over multiple divisions, will be utilized to help implement and administrate the several proposed programs of Medi-Cal 2020:

- Dental Transformation Initiative Program
- Public Hospital Redesign & Incentives in Medi-Cal Program (PRIME)
  - Alternative Payment Methodology (APM) Benchmark for PRIME Entities
- Whole Person Care Pilots
- Global Payment Program for the Remaining Uninsured
- Other requirements as set forth in the Special Terms and Conditions (STCs)

These programs, as well as the resources allocated to them, are entirely new concepts that were not included in the BTR waiver and therefore have no existing DHCS employees assigned to them. By granting these positions, DHCS will be able to perform the necessary monitoring and oversight of these new programs (and the populations affected by them) as outlined in the 1115 Waiver Special Terms and Conditions (STCs). Without these resources, the Department will be unable to perform the calculations, administration, and oversight needed to meet the STCs and significant losses in federal funding will be sustained.

Along with these programs, Medi-Cal 2020 also requires several assessments, evaluations, and achievement of benchmarks which will require significant tracking and workload. These administrative requirements include:

- Independent Hospital Assessments (2016 and 2017)
- Independent Assessment of Access

**Analysis of Problem**

- Global Payment Program Evaluations
- Hospital Redesign and Incentives in Medi-Cal Program (PRIME) Program Evaluations
- Other Waiver component evaluations

The following chart identifies organizationally where the resources are located within DHCS, the equivalent of staffing and classifications requested, and the area of Medi-Cal 2020 they will be focusing on:

<b>Organization</b>	<b>Resources Requested Equivalent to 31.0 Staffing (7/1/2016 – 6/30/2021)</b>	<b>Medi-Cal 2020 Program Activity</b>
OMD	3.0 Limited Term Positions <ul style="list-style-type: none"> <li>• 1.0 MC I</li> <li>• 2.0 AGPA</li> </ul>	<ul style="list-style-type: none"> <li>• Hospital Redesign and Incentives in Medi-Cal Program(PRIME) Program</li> </ul>
OLS	2.0 Limited Term Positions <ul style="list-style-type: none"> <li>• 2.0 Attorney IV</li> </ul>	<ul style="list-style-type: none"> <li>• Overall legal support for any waiver related activities and intersections with the program at large, which including but is not limited to:               <ul style="list-style-type: none"> <li>○ Federal/State and State/local and state negotiations</li> <li>○ Draft/review/analyze of legislation, policy, guidance, contracts, etc.</li> <li>○ Statutory and regulatory interpretation</li> </ul> </li> </ul>
MDS	12.0 Limited Term Positions <ul style="list-style-type: none"> <li>• 2.0 RA II</li> <li>• 7.0 AGPA</li> <li>• 1.0 DHC</li> <li>• 2.0 SISA</li> </ul>	<ul style="list-style-type: none"> <li>• Dental Transformation Initiative Program</li> </ul>
MCQMD	9.0 Limited Term Positions <ul style="list-style-type: none"> <li>• 1.0 SSM I</li> <li>• 2.0 RPS II (1.0 – 2yr LT)</li> <li>• 4.0 AGPA (1.0 – 2yr LT)</li> <li>• 1.0 RA II</li> <li>• 1.0 HPS I</li> </ul>	<ul style="list-style-type: none"> <li>• Whole Person Care Pilots               <ul style="list-style-type: none"> <li>○ Increased Access to Housing and Supportive Services</li> </ul> </li> <li>• Independent Assessment of Access</li> <li>• Integration and Care Coordination</li> <li>• Community-Based Adult Services (CBAS) fraud</li> <li>• Alternative Payment Methodologies</li> </ul>
SNFD	2.0 Limited Term Positions <ul style="list-style-type: none"> <li>• 1.0 RA II</li> <li>• 1.0 RPS I</li> </ul>	<ul style="list-style-type: none"> <li>• Global Payment Program</li> <li>• Public Hospital Redesign and Incentives in Medi-Cal Program (PRIME) payments</li> </ul>

**Analysis of Problem**

<b>Organization</b>	<b>Resources Requested Equivalent to 31.0 Staffing (7/1/2016 – 6/30/2021)</b>	<b>Medi-Cal 2020 Program Activity</b>
ADM	2.0 Limited Term Positions <ul style="list-style-type: none"> <li>• 1.0 APA</li> <li>• 1.0 AAA</li> </ul>	<ul style="list-style-type: none"> <li>• Administration – all programs</li> </ul>
RASD	1.0 Limited Term Position <ul style="list-style-type: none"> <li>• 1.0 RS III</li> </ul>	<ul style="list-style-type: none"> <li>• Statistical reporting</li> <li>• Analytic data file creation and hierarchical risk modeling</li> <li>• Institutional knowledge and context for all projects</li> <li>• Study design and analyses of health care outcomes, expenditures, and utilization</li> </ul>

**B. Background/History**

Pursuant to Section 1115 of the Social Security Act, the US Secretary of Health and Human Services has broad authority to allow experimental, pilot, or demonstration projects “likely to assist in promoting the objectives of the Medicaid statutes.” DHCS is the single State agency authorized to administer California’s Medicaid program, known as Medi-Cal. The BTR 1115 Waiver enabled California to implement an early expansion of Medicaid under the Affordable Care Act, as well as provide funding for health care delivery system reform and uncompensated care in designated public hospital systems. California’s entire Medi-Cal managed care program, Community-Based Adults Services (CBAS) program, and Coordinated Care Initiative are also operated under the 1115 Waiver.

The BTR 1115 Waiver expired on October 31, 2015; however, CMS authorized an extension through December 31, 2015. California received approval for a renewal to be effective January 1, 2016 for 5 more years, resulting in \$6.2 billion dollars of initial federal funding, through December 31, 2020.

**Resource History**

Director’s Office/Office of the Medical Director  
(Dollars in thousands)

Program Budget	2010-11	2011-12	2012-13	2013-14	2014-15
Authorized Expenditures	2,629	4,013	5,089	6,522	6,868
Actual Expenditures	2,629	4,013	5,089	6,522	6,868
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	19.0	18.0	20.0	33.5	32.5
Filled Positions	14.5	13.2	18.2	25.0	31.5
Vacancies	4.5	4.8	1.8	8.5	1.0

**Analysis of Problem**

Office of Legal Services  
(Dollars in thousands)

Program Budget	2010-11	2011-12	2012-13	2013-14	2014-15
Authorized Expenditures	15,710	10,307	10,307	12,214	13,579
Actual Expenditures	12,031	8,653	9,311	11,576	13,579
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	131.1	99.6	92.5	99.0	107.5
Filled Positions	116.6	77.2	74.6	85.1	106.2
Vacancies	14.5	22.4	17.9	13.9	1.3

Medi-Cal Dental Services Division  
(Dollars in thousands)

Program Budget	2010-11	2011-12	2012-13	2013-14	2014-15
Authorized Expenditures	2,597	2,597	2,859	3,176	3,470
Actual Expenditures	2,478	2,465	2,665	3,176	3,470
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	32.0	32.0	32.0	35.0	35.0
Filled Positions	27.2	26.4	29.2	29.1	30.0
Vacancies	4.8	5.6	2.8	5.9	5.0

Medi-Cal Managed Care Quality and Monitoring Division\*  
(Dollars in thousands)

Program Budget	2010-11	2011-12	2012-13	2013-14	2014-15
Authorized Expenditures	21,376	21,376	16,932	20,278	22,336
Actual Expenditures	15,139	15,622	14,647	20,278	22,336
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	166.9	186.5	156.5	163.0	177.0
Filled Positions	127.6	153.8	135.4	142.4	177.0
Vacancies	39.3	32.7	21.1	20.6	0.0

\*Effective FY 2015-16, Medi-Cal Managed Care Division split into Medi-Cal Managed Care Quality and Monitoring Division and Medi-Cal Managed Care Operations Division. Combined figures shown.

Safety Net Financing Division  
(Dollars in thousands)

Program Budget	2010-11	2011-12	2012-13	2013-14	2014-15
Authorized Expenditures	12,071	12,071	11,905	15,222	15,743
Actual Expenditures	9,935	9,469	8,566	15,222	15,743
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	81.0	126.0	87.5	86.5	94.0
Filled Positions	66.5	67.0	68.1	72.3	82.0
Vacancies	14.5	59	19.4	14.2	12.0

**Analysis of Problem**

Administration Division  
(Dollars in thousands)

Program Budget	2010-11	2011-12	2012-13	2013-14	2014-15
Authorized Expenditures	17,649	17,649	22,818	27,061	25,220
Actual Expenditures	17,012	17,560	21,637	20,317	22,238
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	231.5	233.5	258.5	273.0	256.0
Filled Positions	206.3	202.7	224.4	215.8	237.0
Vacancies	25.2	30.8	34.1	57.2	19.0

Research and Analytic Studies Division\*  
(Dollars in thousands)

Program Budget	2010-11	2011-12	2012-13	2013-14	2014-15
Authorized Expenditures	N/A	N/A	N/A	3,174	3,416
Actual Expenditures	N/A	N/A	N/A	2,793	3,416
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	N/A	N/A	N/A	25.0	25.0
Filled Positions	N/A	N/A	N/A	20.7	24.0
Vacancies	N/A	N/A	N/A	4.3	1.0

\*Effective FY 2013-14, RASD split from Administration Division. RASD figures only.

**Workload History**

Office of the Medical Director

Workload Measure	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Delivery System Reform Incentive Payments (DSRIP) Program, now called the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program						
Approved performance plans	N/A	21	21	21	21	21
Approved performance plan modifications	N/A	35	50	35	35	35
Approved performance reports (1 <sup>st</sup> semi-annual, 2 <sup>nd</sup> semi-annual, and annual reports)	N/A	63	63	63	63	63
Approved aggregate reports	N/A	1	1	1	1	1
Approved evaluation reports	N/A	N/A	N/A	1	N/A	1

**Analysis of Problem**

Office of Legal Services

Workload Measure	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
N/A	N/A	N/A	N/A	N/A	N/A	N/A

Managed Care Quality and Monitoring Division

Workload Measure	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
N/A	N/A	N/A	N/A	N/A	N/A	N/A

Medi-Cal Dental Services Division

Workload Measure	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
N/A	N/A	N/A	N/A	N/A	N/A	N/A

Safety Net Financing Division

Workload Measure	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Research laws, STCs, and payment history or current practice and provide recommendations - 6 major projects a year	6	6	6	6	6	6
Analyze legislation – 4 to 6 bills a year	4	4	4	4	4	4
Update STCs – 3 to 6 updates a year	3	3	3	3	3	3
Develop SPA - 0 to 1 update a year	1	0	0	0	0	0
Calculate and process DSH & SNCP payments for 21 hospitals – 10 calculations a year	10	10	10	10	10	10
Calculate and process DSRIP payments – 1 calculation for 17 systems 3 times a year	51	51	51	51	51	51
Calculate and process DSHP payments (including workforce dev) - calculations for 14 programs 4 times a year	56	56	56	56	56	56
Calculate and process IHS payments – 1 calculation 4 times a year	4	4	4	4	4	4
Complete interim and final reconciliations	0	0	0	1	1	1
Create estimates for budget – 16 policy changes completed	32	32	32	32	32	32

**Analysis of Problem**

<b>Workload Measure</b>	<b>2010-11</b>	<b>2011-12</b>	<b>2012-13</b>	<b>2013-14</b>	<b>2014-15</b>	<b>2015-16</b>
twice a year						
Collaborate with stakeholders - 15 meetings a year, 15 phone calls, and 30 emails.	60	60	60	60	60	60

Administration Division

<b>Workload Measure</b>	<b>2010-11</b>	<b>2011-12</b>	<b>2012-13</b>	<b>2013-14</b>	<b>2014-15</b>	<b>2015-16</b>
N/A	N/A	N/A	N/A	N/A	N/A	N/A

Research and Analytic Studies Division

<b>Workload Measure</b>	<b>2010-11</b>	<b>2011-12</b>	<b>2012-13</b>	<b>2013-14</b>	<b>2014-15</b>	<b>2015-16</b>
N/A	N/A	N/A	N/A	N/A	N/A	N/A

**C. State Level Considerations**

California’s 1115 Waiver embodies the shared commitment between the State and the federal government to support the successful realization of some of the ACA’s most critical objectives such as the Triple Aim. The Triple Aim drives to improve access and experience to health insurance, improve overall population health, and reduce health care costs. A Medicaid Waiver Renewal is a fundamental component to California’s ability to continue to successfully implement the ACA beyond the primary step of coverage expansion.

BTR 1115 Waiver authorities and programs that would continue under the Medi-Cal 2020 waiver include California’s Coordinated Care Initiative, the Community Based Adult Services (CBAS) waiver, managed care program, Indian Health Services (IHS) uncompensated care, Designated State Health Programs (DSHPs), and the amendments to implement a county-based Drug Medi-Cal Organized Delivery System program and to provide full scope benefits for pregnant women with incomes between 109% to 138% of the federal poverty level.

The focus of Medi-Cal 2020 is on continuing to drive the transformation of our Medi-Cal program, providing ongoing support for the safety net in California, and maintaining the long-term viability of the program and the Medicaid expansion. Medi-Cal 2020 will continue to facilitate financing innovation in developing sources of the non-federal share of Medicaid matching funds as California has done in prior years through partnerships with the federal government and with other public entity partners throughout the state.

The waiver fully supports DHCS’s mission to provide Californians with access to affordable, high-quality health care, including medical, dental, mental health, substance use treatment services, and long-term care. The resources requested in this proposal are necessary to implement the state’s renewed Medicaid Section 1115 waiver. California’s Waiver embodies the shared commitment between the state and the Federal government to support the successful realization of some of the most critical objectives for improving our health care delivery system.

## Analysis of Problem

Medi-Cal 2020 and its associated programs are also consistent with the DHCS Quality Strategy to find innovative ways to better coordinate care and align incentives around Medi-Cal beneficiaries to improve health outcomes while also containing health care costs. DHCS is also tasked with ensuring sufficient access and capacity in the broader delivery system, and maintaining the health care safety net. Specific to the Quality Strategy, the requested positions will perform duties that directly align with the following DHCS Strategic Plan goals:

- Improve the consumer experience so individuals can easily access high quality health care when they need it, where they need it, and at all stages of life.
- Treat the whole person by coordinating and integrating medical, dental, mental health, substance use treatment services, and long-term care.
- Improve and maintain health and well-being through effective prevention and intervention. Develop effective, efficient, and sustainable health care delivery systems.

### D. Justification

Concepts included in Medi-Cal 2020 will complement other delivery system and payment transformation efforts California is undertaking, such as initiatives and building blocks under the State Health Care Innovation Plan, including a planned implementation of ACA Section 2703 Health Home Option, leveraging frontline workers, and advancing Accountable Communities for Health.

Although the requested resources have a start date of July 1, 2016, the current waiver ended on December 31, 2015. As Medi-Cal 2020 started on January 1, 2016, there will be a 6 month gap where there will be no new positions available to assist in this new workload. Although all divisions will struggle with absorbing this workload, the format of the waiver will allow for a lesser burden in the earlier years. As these programs are new, there will be an implementation period, with later years having programs fully in effect. Implementation and planning periods often require less state side work than the later years, which will require program administration, evaluation, and other intensive activities.

The information below identifies the resource request per Division/Office and a brief description of why they are needed to implement the Medi-Cal 2020-specific activities. These include:

- *Dental Transformation Initiative Program*

DHCS will provide incentives to dental providers for increasing access and for meeting quality thresholds in core measures.

- *Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program*

Building on Delivery System Reform Incentive Payments (DSRIP), this program would establish three core domains (Outpatient Delivery System Transformation and Prevention, Targeted High-Risk or High-Cost Populations, and Resource Utilization Efficiency). The Department would need to analyze, evaluate, and oversee the approximate potential 60 program sites; provide technical assistance and oversight to hospital health system participants; conduct evaluations; design, track, measure,

## Analysis of Problem

assess, and modify (as needed) a broad range of clinical interventions; prepare reports for the Centers for Medicare and Medicaid Services (CMS); support learning collaboratives; and analyze and report on averted costs, etc.

- *Whole Person Care Pilots*

Pilots would create a comprehensive care plan for the highest risk individuals that goes beyond services provided in the Medi-Cal program. DHCS will have an intensive workload that crosses the spectrum of delivery system alignment and transformation; the department would need to request county proposals and work with plans, providers, and various county and community based organizations, as well as conduct an evaluation at the end of the pilot. The pilots provide the department flexibility to work with managed care plans and regional housing partnerships to provide care to individuals experiencing homelessness, particularly those with multiple chronic conditions. Department duties would include creating incentives for housing-based supports and other non-traditional Medicaid services, as well as working with aforementioned entities to develop and implement housing proposals for varying regions.

- *Global Payment Program*

Establish a county-specific global payment structure that integrates DSH and SNCP funding to serve as a lever for whole-person coordinated care. DHCS would create, implement and monitor service thresholds, create a new point methodology, establish metric, and track uninsured services in public hospital systems. The Global Payment Program will focus on value of care provided, rather than on volume of services provided.

### **Office of the Medical Director (OMD) – Limited-Term Resources Equivalent to 3.0 Positions**

1.0 Medical Consultant I (MC I)

2.0 Associate Governmental Program Analyst (AGPA)

#### *Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program*

OMD is responsible for the ongoing program monitoring, evaluation, technical assistance and operation for the public safety net transformation and program implementation of the Medi-Cal 2020 in approximately 60 hospitals/health systems. This includes developing policy and related processes, documenting program policy needs, and acting as liaison with all divisions, facilities and organizations involved in the PRIME Program. The liaison function includes extensive and ongoing work with CMS, the California Association of Public Hospitals (CAPH)/Safety Net Institute (SNI), the Public Hospital Leadership Forum, and individual public hospitals and health systems.

In addition, OMD is responsible for monitoring and oversight of hospital semi-annual interim, mid-year and final year-end annual reports submissions as well as the annual aggregate reports. Each hospital/health system submits two reports per year on their progress on up to 18 unique projects with nearly 100 metrics. The monitoring and review of these reports are an integral part of program operations and evaluating the success of hospital system improvement and transformation. OMD is also charged with identifying, guiding, and managing a large, external evaluation contract.

## Analysis of Problem

With the PRIME Program, the number of participating hospitals could be tripling in size. With the original Delivery System Transformation and Improvement Payment (DSRIP) program spanning California's 21 Public Hospital Systems the new demonstration seeks to include the approximately 39 non-designated public hospitals (NDPHs) and District/Municipal Public Hospitals (DMPHs) in California that are expected to participate and which have little to no experience with system transformation and quality improvement work of the magnitude required by the PRIME Program. This would require increased program management and oversight as well as on-going technical assistance for the NDPHs and DMPHs who will be participating in this demonstration for the first time.

Additionally, CMS has established more rigorous program requirements in the execution of this demonstration including, quarterly progress reports, monthly CMS/DHCS program monitoring calls, the development of rapid cycle assessment guidelines for participating PRIME entities, hospital learning collaboratives and annual CMS onsite meetings to report on progress of the demonstration. The state is also required to conduct several stakeholder engagement efforts for program transparency in addition to maintaining a program database complete with each hospital's five-year performance plans, plan modifications, interim mid-year and final year-end reports, program evaluation design and reports, and shared learning reports.

Based on shared learning with other DSRIP states, adequate staffing has been integral to the effectiveness and overall success of program monitoring. As an example, states such as Texas have over 60 individuals working on their DSRIP program and New York has a team of over 100. The Texas DSRIP program supports 20 Regional Healthcare Partnerships each of which contains a variable number of public and private hospitals. New York is supporting 25 Performing Provider System networks containing a variable number of medical practices and hospitals.

To support these workload requirements, the Department is requesting 1.0 limited term Medical Consultant I (MC I) and 2.0 limited term Associate Governmental Program Analysts (AGPA). Although PRIME is similar to and builds upon the successes of the current DSRIP program, no staffing was allocated for DSRIP in 2010; as PRIME will be a more administratively intensive program, the Office of the Medical Director is requesting three staff for this area.

The administrative program operations activities will include; 1) program analysis of 21 DPH sites and up to an additional 40 DMPH sites with regards to complex quality improvement and system transformation projects; 2) program integrity for accurate reporting on hospital and health system data and; 3) hospital health system technical assistance, oversight and compliance specified in the of the demonstrations Standard Terms and Conditions (STCs). Staff must also serve as the liaison to the Center for Medicare and Medicaid Services (CMS) and have active program management through collaboration with both the participating hospitals and our partners at the California Association of Public Hospitals (CAPH) and Safety Net Institute (SNI).

**Office of Legal Services (OLS) – Limited-Term Resources Equivalent to 2.0 Positions**  
*2.0 Attorney IV*

## Analysis of Problem

The legal work associated with the 1115 Waiver is among the most difficult and specialized at the Department. It requires experience and expertise across the entire spectrum of legal contexts, including legislative, regulatory, contractual, and litigation support work. In addition, this need for multifaceted legal counsel is specific to highly specialized and specific subject matters and sub-topics, such as Medi-Cal reimbursement, State-local financing and programmatic arrangements, or Medi-Cal dental program improvement, which carry a heightened level of legal and political sensitivity. Moreover, the legal work associated with the 1115 Waiver involves novel and still-developing theories and practice. Given the wide ranging State and Federal legal ramifications involved with these initiatives and the centrality of the 1115 Waiver to the Medi-Cal program, these proposed Attorney positions are integral for Medi-Cal 2020 because of their high level of experience and specialization in the various affected areas.

Although the OLS attorney positions are being requested during the initial Waiver renewal implementation, the need for expert, waiver-focused legal work will be an of on-going nature throughout the term of the waiver. As stated above, the complexity of the legal work associated with the Medi-Cal program warrants high-level Attorney positions. Current 1115 Waiver issues are being performed at an Assistant Chief Counsel level and above. Highly specialized experts are needed to perform the complex legal work related to the 1115 Waiver issues, which will continue to arise, and it is essential that this work is performed at the Attorney IV level.

The staff will perform the following activities:

- Support the Director's Office and various DHCS programs, especially the Medi-Cal Dental Services Division and Capitated Rates Development Division, in all Waiver deliberations with the Centers for Medicare and Medicaid Services (CMS), including the negotiation, drafting, review, and interpretation of the formal Waiver Special Terms and Conditions, and any amendments thereto.
- Draft, review, and analyze complex State Plan Amendments, 1115 Waiver Special Terms and Conditions (STCs), federal and state legislation and regulations for the development, implementation, and ongoing administration of each fiscal year of the 1115 Waiver, and those waiver-initiated activities intended to extend beyond the expiration of Medi-Cal 2020 (including implementation of alternative payment methodologies in Medi-Cal managed care). Respond to Requests for Additional Information and inquiries from the federal government.
- Research and prepare extensive legal opinions related to statutory and regulatory interpretation, contract interpretation, program administration, and related disputes as required for compliance with relevant federal and state laws, and the ongoing receipt of optimal federal financial participation.
- Draft, review, and analyze Waiver-related legislation, regulations, policy, procedures, and other departmental guidance throughout the course of Waiver implementation.
- Provide legal support for all 1115 waiver related contracts and other agreements, including managed care plan contracts and county-State agreements. Legal support also includes drafting, reviewing and amending managed care and prepaid health plan contracts, as well as change orders and letters between the State and the contractor(s), and various State-local agreements executing participation in Medi-Cal 2020 initiatives and pilots.

## Analysis of Problem

- Provide pre-litigation and litigation support, such as assessing potential legal issues, strategic planning to avoid litigation, and responding to demand letters and advocate concerns having large fiscal implications.
- Identify and address any legal issues arising from Waiver implementation that impact the Medi-Cal program.
- Research, analyze, and advise staff on responding to stakeholder questions and concerns to avoid potential litigation and waiver-related claiming or compliance matters with CMS.
- Advise on privacy, confidentiality, security and other legal issues that may arise from system changes necessary to develop, implement, and administer the 1115 Waiver.
- Coordinate with the Department of Finance (DOF) and Agency; respond to correspondence and other inquiries from the public, legislators, and other interested stakeholders.

### **Medi-Cal Dental Services Division (MDS) – Limited-Term Resources Equivalent to 12.0 Positions**

*2.0 Research Analyst II (RA II)*

*7.0 Associate Governmental Program Analyst (AGPA)*

*1.0 Dental Hygienist Consultant (DHC)*

*2.0 Staff Information Systems Analyst (SISA) Specialist*

12.0 limited-term staff are necessary for the planning, implementation, evaluation, and monitoring of the Medi-Cal Dental Transformation Initiative. Under the Medi-Cal program, dental services are provided to approximately 5.5 million Medi-Cal beneficiaries ages twenty (20) and under. Services are provided via two delivery systems – Fee for Service (FFS) and Dental Managed Care (DMC).

The initiative seeks to improve the access and delivery of care to this population. The incentive program will provide incentive payments to dental or entities that meet the qualifying program criteria within the four project domains:

- Increase Preventative Services Utilization for Children,
- Caries Risk Assessment and Disease Management Pilot,
- Increase Continuity of Care, and
- the Local Dental Pilot Program (LDPP).

Quintessential to the initiative, MDS is responsible for the development, data collection, quality improvement strategies, integration with other entities, and enhanced monitoring and oversight for all four of the domains and their corresponding delineated metrics. All units across the Division are integral to support the critical functions of the initiative.

MDS will work closely with the dental fiscal intermediary, dental plans, pilot applicants and participants to provide technical assistance to implement the various targeted incentives and interventions.

### ***Beneficiary Services Unit***

MDS will utilize 1.0 limited-term AGPA in the Beneficiary Services Unit (BSU), which is responsible for the development and monitoring of outreach plans that will generate awareness of the availability and importance of preventive dental services for children. In addition, an important role of this unit will be to develop a plan on how to access preventive

## **Analysis of Problem**

dental services for children. The BSU will be responsible for working with dental and children's health stakeholders to develop an adequate approach in developing an awareness plan. The AGPA will be responsible for analyzing the success of the awareness plan on utilization and addressing any identified deficiencies. As a result of the increased monitoring, care coordination, and efforts to improve utilization, it is expected that the BSU will experience a significant increase in the number of beneficiaries who need assistance through general correspondences, the Beneficiary Dental Exception (BDE) Phone Line, State Hearings and the beneficiary reimbursement process. Additionally, the AGPA will also share in the workload of the screening and selection of an anticipated large volume of applications to the LDPP, and monitoring of the new 15 local pilot projects.

### ***Contract Management and Policy Unit***

4.0 limited-term AGPAs will support the expansion of roles within the Contract Management and Policy Unit (CMPU), which is responsible for monitoring dental contractors by ensuring that program policies and procedures are being adhered to, and that they are in compliance with all relative Federal and State regulatory requirements. CMPU will be responsible for analyzing the fiscal impacts of any and all contract amendments, change orders, and policy changes that result from the necessary changes in policy or internal processes due to the implementation of the Dental Transformation Initiative. As a result, the four AGPAs will provide CMPU with the additional resources required to perform these duties. These specific duties include: compiling and analyzing statewide utilization data; screening and selection of an anticipated large volume of applications to the LDPP, and monitoring of the new 15 local pilot projects; developing recommendations to upper management on pilot interventions and expansion; drafting and submitting a regulations package to incorporate new dental procedures which are currently not covered benefits; reviewing and approving certified dental training programs; implementing and maintaining an opt-in system for eligible providers that wish to participate in the pilot; developing and submitting to dental contractors correspondence to initiate policy and systems changes; and reporting on utilization and pilot participation to CMS as required by the Waiver.

### ***Provider Services Unit***

2.0 limited-term AGPAs will support the expansion of roles within the (PSU), which is responsible for monitoring the provider network, including outreach, utilization review, monitoring of the Surveillance and Utilization Review Subsystem (S/URS), program integrity operations, provider enrollment functions, provider referral list operations, and provider support and training. The PSU is responsible for the development, implementation, and consistent monitoring of provider performance and would be determining eligibility with the criteria set forth by the Department through the 1115 Waiver on an annual basis. Moreover, the PSU is responsible for capturing information about provider capacity and implementing modifications to the referral database according to its results to provide more robust services to the beneficiary population. Furthermore, the monitoring and reporting of participating providers in the network would need to be further developed and increased. The AGPAs will be responsible for a portion of the workload of the screening and selection of an anticipated large volume of applications to the LDPP, and monitoring of the new 15 local pilot projects. The incentive program for providers is anticipated to impact increased enrollment and increasing workload by way of enhanced contractor oversight so that the referral list provider information is maintained and updated to reflect growth in the provider population. In addition, an important responsibility of this unit is the ability to effectively counteract fraud within the provider network and the timely enrollment of prospective providers, including the ability to immediately suspend and/or dis-enroll suspected

## **Analysis of Problem**

fraudulent providers, and the option to re-enroll such providers after suspension. Program integrity will be increased so care rendered to the beneficiary is provided appropriately as defined by the standard of care, and State and Federal law. Additional measures for continuous monitoring of the provider network and policies to address underserved areas will be implemented in 2016 so the success of the 1115 Waiver efforts are measurable and effective.

### ***Analytics Group***

2.0 limited-term Research Analyst II (RA) staff will support the MDSD Analytics Group which currently consists of two existing Research Analysts IIs. The RAs are the sole resource for MDSD data driven reporting through DHCS' Management Information System Decision Support System (MIS/DSS) and other dental specific data software applications. Due to the heightened importance and critical nature of ongoing monitoring of the provider network strength, including trends in beneficiary utilization to early identification of indicators of network inadequacy and barriers to access, the additional two RAs will play an essential role in the program's ability to develop informed analyses about the impact and success of the 1115 Waiver. The Analytics Group will be responsible for performing Tableau software system revisions to facilitate ongoing reporting, monitoring, and evaluation of beneficiary utilization data based on the newly developed criteria for assessing utilization (including modifications/additions to data stratification e.g. age/ethnicity/etc.) resulting from the provider incentive payments developed through the 1115 Waiver. The Analytics Group will be responsible for pulling data required for assessment of provider participation and regional deficiencies in the Denti-Cal network in addition to supporting stakeholder engagement efforts. Such efforts will include, but not be limited to, claims data extractions and geographic access analyses in order to further develop strategies to encourage increased provision of dental services that do not compromise program integrity.

### ***Dental Consultants***

1.0 limited-term Dental Hygienist Consultant (DHC) will provide consultation related to clinical assistance in the overall development and implementation of preventive programs within the FFS System Transformation & Improvement Program Dental Incentives program activity. The DHC will specifically serve in the following areas: serve as an advisor and consultant in planning and development of area-wide dental disease prevention programs; assist with the administration of dental hygiene activities in assigned areas; assist in developing, explaining, interpreting dental health initiatives at seminars for interested persons and groups; evaluate dental health initiatives and proposals from a clinical perspective; assist counties to establish programs for prevention of dental disease; give consultation on dental hygiene practices; and keep informed on advancements in dental health.

### ***Enterprise innovation Technology Services***

2.0 Staff Information Systems Analyst (SISA) Specialist staff will be used to provide support to all Dental Transformation Initiative projects from an information technology (IT) perspective. The SISAs will provide the technical systems expertise so business processes are defined as high level requirements, and that these are described in much greater detail in the technical requirements, which establish processes in information systems. The SISAs provide oversight so the principles of the Software Development Life Cycle (SDLC) are applied to enhancements of California Dental-Medical Management Information System (CD-MMIS) related to Denti-Cal. The SISAs will provide integration and liaison support for other DHCS information systems.

## Analysis of Problem

DTI efforts will require the creation, maintenance, and programming of systems and programs to support the program projects and milestones from a technical perspective. The SISAs will provide logical application over claims processing so sound automated adjudication processes are in all phases. The SISAs will coordinate integration of departmental systems with other information systems at the state and federal level. Additionally, as there are up to 15 LDPPs that will require varying business requirements for the delivery of care and adjudication of claims, the SISAs will be quintessential so that updated business and technical requirements are defined and met.

The SISA will also play a role in applying security standards to system requirements essential in meeting state and federal mandates. The SISAs will undertake technical improvement projects so the current reporting measures are in the technical infrastructure to assess the statistical significance of preventive services given to increased numbers of the target population. The SISAs will also update and make improvements to the technical infrastructure and architecture. The SISAs will collect data and develop regular and ad hoc reporting mechanisms to determine the impact of incentive payments on dental health outcomes. Similar databases must be developed and maintained to facilitate the tracking of dental procedures identified within the DTI. The SISAs will be involved in the development and implementation of system changes necessary to incorporate the new billing codes for adjudication. The SISAs will complete special reporting to track incidents of invasive dental care.

### **Managed Care Quality and Monitoring Division (MCQMD) – Limited-Term Resources Equivalent to 9.0 Positions**

- 1.0 Staff Services Manager I (SSM I)
- 2.0 Research Program Specialist II (RPS II) (1.0 – 2yr LT)
- 4.0 Associate Governmental Program Analyst (AGPA) (1.0 – 2yr LT)
- 1.0 Research Analyst II (RA II)
- 1.0 Health Program Specialist I (HPS I)

The 9.0 limited term staff are needed for the planning, implementation, and evaluation of the Medi-Cal 2020. Since the Medi-Cal managed care plans are conduits to many of the core strategies in the Waiver, MCQMD is included in much of the work in the areas of data collection, quality improvement strategies, integration with other entities, and enhanced monitoring and oversight. Various levels of staff across the Division are needed to support the critical functions of the Waiver. MCQMD will play a crucial role in identifying, collecting, and analyzing the data that will be used to assess the effectiveness and value of the programs. Further, DHCS is working towards integration with behavioral health entities, such as mental health and substance use disorder programs, to enable the whole-person care approach. MCQMD will play a pivotal role in partnering with the behavioral health entities and assessing how these efforts contribute toward the DHCS Quality Strategy and three-linked goals. The Division will work closely with the plans and provide technical assistance.

### **Independent Review of Access**

- 1.0 Associate Governmental Program Analyst (AGPA) (1.0 – 2yr LT)
- 1.0 Research Program Specialist (RPS II) (1.0 – 2yr LT)

The Associate Governmental Program Analyst will be responsible for EQRO contract amendments and internal procedures required to meet the goals of the CMS independent review of access. This position will work with the EQRO to develop an Access assessment that evaluates primary, core specialty, and facility access to care for managed care

## **Analysis of Problem**

beneficiaries based on the current health plan network adequacy requirements set forth in the state's Knox-Keene Health Care Service Plan Act of 1975 (KKA) and Medicaid managed care contracts. Staff will assist in data collection and analysis, provide technical assistance to the EQRO, organize meetings of program staff and EQRO representatives to plan and execute the Access assessment and report, conduct ongoing network access monitoring and participate in interdepartmental forums, workgroups, advisory committees, and task forces related to the requirements of the Section 1115 Waiver.

The Research Program Specialist II (RPS II) will be responsible for the most complex data mining, analysis and exchange from DHCS' data warehouse necessary to support the EQRO's Access Assessment. The data sets that will be accessed within the warehouse may include, Medi-Cal managed care encounter data, Medi-Cal managed care provider data, Medi-Cal FFS claims data and Medi-Cal FFS provider data.

MCQMD is also requesting \$3,000,000 in authority to support the federally mandated, independent assessment of access that will be administered by the External Quality Review Organization (EQRO) to meet STC requirements of measuring Medi-Cal members' access to needed health care services in the managed care delivery system. This additional authority will allow the EQRO to conduct the independent assessment.

### ***Integration and Care Coordination***

#### ***1.0 Health Program Specialist I (HPS I)***

Effective integration and coordination of care leads to better health outcomes and reductions in overall health care costs. Effective care coordination and integration allows beneficiaries to receive health services, medication and referrals at the right time and in the right place. Additionally, effective care coordination increases a health system's ability to monitor the utilization of services and that unnecessary health care spending in the form of prescribing the same services (x-rays, lab work up, etc.) by the various providers treating the same individual, does not occur.

The HPS I will work as the Department lead in overseeing the implementation of care integration and coordination efforts through the pilots across the 22 managed care plans. Dedicating a specific resource to oversee the ongoing efforts made by the managed care plans is critical so plans are held accountable in the provision of effective coordination and integration of services, and gains achieved during the demonstration period are sustained. The Department will be required to provide a state-level infrastructure to achieve care coordination, which includes establishing data and information sharing guidelines and/or mechanisms to provide for timely sharing of beneficiary data for treatment purposes.

### ***Whole Person Care Pilot***

#### ***1.0 Staff Services Manager I (SSM I)***

#### ***3.0 Associate Governmental Analyst (AGPA)***

#### ***1.0 Research Program Specialist II (RPS II)***

The workload activities associated with the Whole-Person Care Pilot (WPC) include program design, development, implementation and management at the state level. The five (5.0) staff will be responsible for the ongoing development and review of operational decisions including program model research, design, implementation; contract development, management and amendments; managing sensitive external relationships with federal and

## Analysis of Problem

local government agencies, other state agencies, health care providers, advocates, contracted entities, and other key stakeholder groups. The proposed resources will be utilized so the program evaluation is designed and conducted in compliance with federal and State requirements. Staff will also manage related waiver amendments, project management, consultant management, and stakeholder work.

The Staff Services Manager (SSM I) will maintain compliance with project deadlines and oversee and direct all activities associated with: project management, contract management, consultant management, and stakeholder engagement; oversee and direct program model research design, development, and program evaluation; coordinate ongoing consultation with internal and external partners; monitor and develop program processes; oversees and directs all activities associated with CMS periodic report requirements; review and interpret State and federal documents; assist in drafting program policy recommendations and memoranda; review staff interpretation and implementation of changes to controlling documents; present major program issues/recommendations to management for discussion and decision; consult with and advise other program and management staff on HHP policy and oversee the development of policies and procedures of the Waiver. The SSM I will hire, train, and provide the necessary supervision and support of the AGPAs.

The three (3) limited-term AGPAs will conduct program model research and design, draft waiver and contract amendments, draft requirements, policies, and procedures to develop, implement and monitor the Pilot. These may include provider bulletins, policy letters, manuals, and other instructions and communications to stakeholders; monitor Pilot programs for compliance with applicable State and federal requirements; review reports generated by Pilot programs to determine compliance; write quarterly progress reports; act as the liaison with evaluator; communicate with, and provide ongoing technical assistance and support to stakeholders. The staff will also provide technical assistance to counties, managed care plans (MCPs), and providers and are responsible for ongoing monitoring and analyses of all operational requirements of the Waiver renewal.

The 1.0 limited-term Research Program Specialist II (RPS II) will be responsible for the most complex data mining, analysis and exchange from DHCS' data warehouse necessary to support the Whole Person Care Pilot. These data may be used to identify target populations, coordinate care across participating entities and ongoing monitoring and evaluation of the pilot. The data sets that will be accessed within the warehouse may include, Medi-Cal managed care encounter data, Medi-Cal managed care provider data, Medi-Cal FFS claims data and Medi-Cal FFS provider data.

### **Alternate Payment Methodology**

#### *1.0 Research Analyst II (RA II)*

Alternative Payment Methodologies (APMs) will be used to move towards value-based payments. Under PRIME, four tiers of capitated or alternative payment would exist. To provide support for sustainability beyond the demonstration DPHs must demonstrate, in the aggregate, a shift from a fee for service to value-based managed care payments by 2020. Generally this will be in the form of capitation, though other APMs may be acceptable. APMs must provide payment at the provider level that is tied to value and quality which provides incentives to clinicians to provide the right care, at the right time, at the right place.

## Analysis of Problem

The Research Analyst II will be responsible for research, design and implementation of an ongoing monitoring and reporting process for Medi-Cal managed care health plan compliance with Alternate Payment Methodology program requirements. This will include coordination with Medi-Cal managed care health plans and participating hospital entities for data submission, analysis and reporting. Staff will also be responsible for the conceptualization and development of methodologies using statistical and other quantitative estimating techniques. In addition, the RA II will provide continued oversight and monitoring of the Community-Based Adult Services (CBAS) program so that CBAS provider standards of participation requirements as set forth in the STCs are being met. Due to new requirements imposed by the STC 51, MCQMD has also expanded its work efforts around fraudulent providers significantly increasing work relating to notifying MCPs of credible allegations of fraud for CBAS providers, collecting payment information after notification and reporting it to CMS, and offsetting payments when credible allegations of fraud are proved.

### **Safety Net Financing Division – Limited-Term Resources Equivalent to 2.0 Positions**

*1.0 Research Analyst II (RA II)*

*1.0 Research Program Specialist I (RPS I)*

The Safety Net Financing Division (SNFD) administers fee-for-service Medi-Cal and supplemental payments for uncompensated care. The requested resources will reside in the Hospital Uninsured Demonstration and Subacute Section (HUDSS) which is responsible for calculating the redirection of county health realignment funding, monitoring subacute facilities, and administering some of the financing for the State's 1115 waivers. Staff will develop, administer and monitor the Global Payment Program financing model for public hospitals and develop and administer other Medi-Cal 2020 waiver payments.

Currently, HUDSS staff calculate and administer the following payments under the Medi-Cal Hospital Uninsured Care Demonstration (MH/UCD) 1115 waiver (2005-2010) and the Bridge to Reform 1115 waiver (2010-2015):

- Safety Net Care Pool (SNCP)
- Disproportionate Share Hospital (DSH)
- Delivery System Reform Incentive Pool (DSRIP)
- Designated State Health Programs –including Workforce Development Programs
- Medicaid Coverage Expansion
- Health Care Coverage Initiative
- Indian Health Services

For the Medi-Cal 2020 waiver, the new resources will be needed to calculate and administer payments for 1115 waiver programs such as:

- Public Hospital Redesign and Incentives in Medi-Cal (PRIME)
- Global Payment Program
- Dental Transformation Initiative
- Whole Person Care Pilots
- State Only Medical Programs
- Budget Neutrality
- Assessments and Evaluations

The requested staff resources will become the subject matter experts for many of the Medi-Cal 2020 programs in the areas of fiscal policy and finance. In the area of fiscal policy, the

## **Analysis of Problem**

staff will analyze legislation, develop statute, serve as a liaison with CMS and amend the Special Terms and Conditions of the waiver as needed. The RA II and RPS I will meet regularly with Department staff and external stakeholders to answer questions and identify and resolve issues. Staff will develop, implement and monitor payment processes and procedures and will assist in the development of waiver reports to CMS and other entities.

In the area of finance, the RA II and RPS I will assist in developing models necessary to calculate payments. Staff will calculate and process payments on a quarterly or semi-annual basis. The RA II and RPS I will complete interim and final reconciliations as necessary. Staff will be data experts and will gather data from various systems to complete research, calculate payments, and complete final reconciliations. The RPS I will handle the more complicated and technical workload.

The new waiver will also include 39 healthcare district/municipality systems, known as non-designated public hospitals (NDPHs) District/Municipal Public Hospitals (DMPHs) that are also critical public safety net systems. Two-thirds of these systems are rural, and nearly half are designated as critical access hospitals. In addition, many of these facilities operate rural health clinics. These systems are located in 28 counties across the state. These 39 NDPH/DMPH systems did not participate in previous 1115 waivers, and their participation in the Medi-Cal 2020 waiver will increase staff workload.

The Medi-Cal 2020 waiver is the third five year waiver implemented by the Department, and the majority of DPH funding is authorized under the 1115 waiver. Since the implementation of the Affordable Care Act, there has continued to be a residual uninsured population resulting in uncompensated care costs. Existing staff are already working at capacity and cannot address new workload from the Medi-Cal 2020 waiver without adversely impacting existing workload. If the RPS I and the RA II are not approved, it will impact the ability of the department to claim federal funds and implement Medi-Cal 2020 financing in a timely manner.

### **Administration Division – Limited-Term Resources Equivalent to 2.0 Positions**

*1.0 Associate Personnel Analyst (APA)*

*1.0 Associate Accounting Analyst (AAA)*

### ***Human Resources Branch***

The waiver's scope is department-wide and its proposed programs will cause a significant increase in DHCS workload. This workload will be completed by 30.0 new staff resources, which in turn creates significant administrative work. The Human Resources Branch (HRB) will need to provide administrative support by helping the department hire and retain the most capable waiver workforce, as well as handle position employment, performance management, payroll and benefits, injured worker compensation, and labor relations. HRB is requesting an APA to oversee the hiring and administration of Medi-Cal 2020 waiver staff. The APA handles all classification, performance management, and management consultant issues with the Divisions. This position is needed to administer the appropriate laws, rules, regulations, and contract language pertaining to personnel transactions, employee relations, and performance management. Without this position, HRB will be unable to timely complete its current workload, along with the new workload related to waiver renewal personnel.

### ***Financial Management Branch***

## Analysis of Problem

One (1.0) limited-term Associate Accounting Analyst (AAA) in the Financial Management Branch's Accounting Section to prepare the complex managed care reconciliation, analyze, research and resolve complex discrepancies; analyze and interpret complex financial data for federal reporting (the adopted waiver requires the accounting federal reporting unit to produce 1,700 additional CMS reports annually to report and draw federal funding); respond to requests from program management and CMS auditors quarterly, process invoices for payment, issue and process difference checks, review and record contracts to determine appropriate accounting transactions for payment tracking, update fiscal worksheets and prepare quarterly summary information; supply supportive detail to program staff and federal and state auditors.

### **Research and Analytic Studies Division (RASD) – Limited-Term Resources Equivalent to 1.0 Position**

#### *1.0 Research Scientist III (RS III)*

RASD compiles official statistics and develops analytic resources that inform policy and assist the California Department of Health Care Services (DHCS) in achieving its mission and goals. Medi-Cal 2020 will require multiple programs within DHCS to implement projects of complex analytic and statistical design. The various projects will also require advanced outcome analyses through data collection, linkage, summarization, and risk adjustment. As DHCS' official research and statistical bureau, RASD will interface with five divisions in support of study designs, metrics, contractors, institutional knowledge transfer, and outcome analyses. Given that Medi-Cal 2020 objectives are outside the scope of current workload, an additional limited-term RS III is needed in order for RASD to fulfill its objectives.

The RS III will be required to plan, organize, and direct scientific research projects of a highly developed scope and level of complexity to evaluate health care outcomes, expenditures, and utilization related to demonstration projects implemented through Medi-Cal 2020. The RS III will make decisions of a highly technical and scientific nature related to study design, access metrics, risk adjustment, and statistical methods. For analytic support in the development of historical baseline statistics, evaluation of policy proposals and literature studies and meta analyses, in-depth written studies designed to identify the "at is" state. This work will be performed in support of the incentive programs for increased access to dental services, whole-person care pilots, alternative payment methodology for managed care plans, and the five core domains of the public hospital redesign and incentive program.

The RS III will create complex analytic analyses utilizing hierarchical risk models (such as the Chronic Illness and Disability Payment System and CMS' hierarchical condition category (HCC) risk adjustment). The RS III will perform probabilistic linking, summarization of Medi-Cal administrative data and identifiable patient-level utilization data in order to create clinical profiles of the population. In order to develop linked or summarized analytic files, the RS III will identify appropriate internal data sources, as well as external data sources such as the Hospital acute care inpatient and emergency department datasets compiled by the Office of Statewide Health Planning and Development, and the California Department of Public Health Vital Statistics Death Statistical Master File and Birth Statistics Master File. The RS III will collaborate with university researchers, research consultants, and research contractors on Medi-Cal/Medicare datasets, knowledge transfer, and peer review of study outcomes.

**Analysis of Problem**

**E. Outcomes and Accountability**

Medi-Cal 2020 is designed to improve the quality of care and ultimately the health of Medi-Cal members by driving quality and health outcomes improvement across settings of care, promote system integration, and align incentives. This effort will bring together multiple divisions of DHCS, CMS, other state and local agencies, plans, providers, and safety net programs to share accountability for Medi-Cal members' health outcomes, which will result in high-quality, integrated care and increase the value of California's health care dollar, promoting the long-term viability of the program.

The requested resources will help achieve the main goals of Medi-Cal 2020:

- Improve health care quality and outcomes for the Medi-Cal population
- Strengthen primary care delivery and access
- Build a foundation for an integrated health care delivery system that incentivizes quality and efficiency
- Address social determinants of health and improve health care equity
- Use California's sophisticated Medicaid Program as an incubator to test innovative approaches to whole person care

With the approval of the resources, DHCS will have the capacity and necessary resources to achieve these goals and both manage the existing program expansions across multiple domains, and develop program improvements and adjustments. The department will also retain oversight responsibilities including contract management and monitoring of all programs, as well as provide greater assurance that the workload volume can be managed accordingly and that federal and state mandates will be addressed promptly. Specific projected outcomes are below:

**Projected Outcomes**

Office of the Medical Director

<b>Workload Measure</b>	<b>2015-16</b>	<b>2016-17</b>	<b>2017-18</b>	<b>2018-19</b>	<b>2019-20</b>	<b>2020-21</b>
<b>Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program</b>						
Approved performance plans	60	0	0	0	0	0
Approved performance plan modifications	0	60	60	60	60	60
Approved performance reports (Interim Mid-Year Report and Final Year-End Report)	N/A	120	120	120	120	60
PRIME Quarterly Progress Reports	2	4	4	4	4	4
Documents to post on public website (and comply with Section 508)	61	180	180	180	181	121
Hospital and health system technical assistance calls (2/month per entity)	1440	1440	1440	1440	1440	1440

Analysis of Problem

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Monthly program monitoring calls with CMS (waiver and PRIME)	24	24	24	24	24	24
Approved evaluation design, interim and summative reports (draft and final)	2	0	0	0	2	2
Approved guidance for rapid cycle hospital and health system assessments	2	0	0	0	0	0
Number of new entities submitting clinical data	0	39	39	39	39	39
Review hospital and health system data submissions for data integrity and compliance	21	60	60	60	60	60
Conduct and facilitate hospital and health system learning collaboratives	18	12	12	12	12	12
Secure and manage evaluation and technical assistance contacts	2	2	2	2	2	2
State presentations for CMS	2	1	1	1	1	1
Stakeholder engagement meetings to develop 5-year performance plans	3	0	0	0	0	0

Office of Legal Services

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Provide Dental with legal opinions related to governing federal and state law	5	50	50	50	45	45
Provide Dental with legal analyses related to State Plan Amendments, policy letters and instructional information	5	50	50	50	40	40
Draft and amendment Dental's Geographic Managed Care and Prepaid Health Plan contracts including change orders and fiscal	5	75	75	75	75	45

Analysis of Problem

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
intermediary letters						
Dental litigation and pre-litigation cases and notices of dispute	25	25	25	25	25	25
Dental stakeholder meetings, inquiries and correspondence	10	20	20	20	20	20
Dental privacy, confidentiality and security issues including PRAs and data requests	100	100	100	100	100	100
Provide Dental legal advice regarding CMS inquiries, audits and responding to legislative inquiries	50	50	50	50	50	50
Provide legal opinions related to governing federal and state law.	25	50	50	50	50	50
Draft and review Waiver and State Plan Amendments	5	50	50	50	50	50
Draft, analyze, review, advise, and provide legal opinions related to contracts.	5	75	75	75	75	75
Litigation and pre-litigation support	15	30	30	30	30	30
Participate in and support for ongoing communication and meetings with CMS	50	80	80	80	100	100
Coordinate, draft, review, analyze, and respond to stakeholder and legislative correspondence and inquiries	50	100	100	100	100	100
Draft, analyze, and review waiver related legislation, regulations, and policy guidance.	50	75	75	75	75	75

Medi-Cal Dental Services Division

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Provider Publications	12	24	24	24	24	24

Analysis of Problem

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Beneficiary Informing Materials	20	30	30	30	30	30
Stakeholder Committees	18	24	24	24	24	24
Audits	24	40	40	40	40	40
Performance Metrics Development	15	15	15	15	15	15
Data Collection and Reporting	256	256	256	256	256	256
BDE Calls/ Correspondence	930	1200	1200	1200	1200	1200
State Hearings	1,900	2,090	2,090	2,090	2,090	2,090
Beneficiary Reimbursements	88	97	97	97	97	97
Awareness Plan (includes beneficiaries, PCPs, and Dentists)	5	5	5	5	5	5
CMS Reporting	2	2	2	2	2	2
Provider Payments	12,500	12,500	18,300	18,300	18,300	18,300
Develop research methodologies required to provide the collection and analysis of data related to the 1115 Waiver	4	4	4	4	4	4
Develop comprehensive quarterly reports of quality of care, management briefs, and benchmark reports	16	16	16	16	16	16
Provider Correspondence	280	280	280	280	280	280
Beneficiary Correspondence	4920	4920	4920	4920	4920	4920
Develop criteria for local pilot applications	1	1	1	1	1	1
Review local pilot applications	40	40	15	15	15	15
Monthly assessment and monitoring of data and progress	48	48	48	48	48	48
Regulation Package(s)	1	1	1	1	1	1
Provider Training	4	8	8	8	8	8
Clinic Training	10	20	20	20	20	20
SPA	1	1	1	1	1	1

**Analysis of Problem**

<b>Workload Measure</b>	<b>2015-16</b>	<b>2016-17</b>	<b>2017-18</b>	<b>2018-19</b>	<b>2019-20</b>	<b>2020-21</b>
Provide updated Instructions to Contractors	4	4	4	4	4	4
Develop and implement policy related to the new Section 1115 Waiver	10	10	10	10	10	10
Information system change support and security	2400	2400	2400	2400	2400	2400
Business and technical process review	1200	1200	1200	1200	1200	1200

**Managed Care Quality and Monitoring Division**

<b>Workload Measure</b>	<b>2015-16</b>	<b>2016-17</b>	<b>2017-18</b>	<b>2018-19</b>	<b>2019-20</b>	<b>2020-21</b>
Develop and implement policy related to the implementation of the new Section 1115 Waiver	500	500	600	600	700	700
Develop and refine Quality Improvement Programs	100	100	200	200	250	250
Research state and federal laws and regulations; develop and execute contract amendments	75	75	100	100	125	125
Provide technical assistance to Medi-Cal managed care plans in complying with data recording and submission	100	100	200	200	250	250
Develop research methodologies required to ensure the collection and analysis of data related to the new Section 1115 Waiver	500	500	600	600	700	700
Participate in health care committees and work groups to develop and implement health care programs as a result of the new Section 1115 Waiver	150	150	200	200	250	250

Analysis of Problem

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Develop statistical reports and publications of scientific findings, comprehensive annual reports of quality of care Medi-Cal Managed Care program, management briefs, benchmark reports and dashboards	100	100	200	200	250	250
Assist Medi-Cal MCPs in understanding and executing enhanced standards and processes related to the new Section 1115 Waiver	22	22	22	22	22	22
Track and trend audit findings discovered during the independent audit or survey process. Advise MCPs on acceptable practices	29	29	29	0	0	0
Assists in data collection and analysis for audits of MCPs.	264	264	264	0	0	0
Investigates concerns identified through the Access Advisory Committee	15	15	15	0	0	0
Works with MCPs to ameliorate identified issues with executing enhanced access standards and processes under the new Section 1115 Waiver	44	44	44	0	0	0

Safety Net Financing

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Research laws, STCs, and payment history or current practice and provide recommendations - 9 major projects a year	6	9	9	9	9	9
Analyze legislation – 4 to 6 bills a year	4	6	6	6	6	6
Update STCs – 6 updates a year	3	6	6	6	6	6

**Analysis of Problem**

<b>Workload Measure</b>	<b>2015-16</b>	<b>2016-17</b>	<b>2017-18</b>	<b>2018-19</b>	<b>2019-20</b>	<b>2020-21</b>
Develop SPA - 0 to 2 update a year	0	2	2	2	2	2
Calculate and process global payment for uninsured for 21 hospitals – 10 calculations a year	10	10	10	10	10	10
Calculate and process DSHP payments – 1 calculation for 10 programs 4 times a year	20	40	40	40	40	40
Calculate and process PRIME payments – 1 calculation for approximately 50 providers 2 times a year	50	100	100	100	100	100
Complete interim and final reconciliations	1	11	11	11	11	11
Create estimates for budget – 20 policy changes completed twice a year	32	40	40	40	40	40
Collaborate with stakeholders - 24 meetings a year, 20 phone calls, and 40 emails.	60	84	84	84	84	84

**Administration Division**

<b>Workload Measure</b>	<b>2015-16</b>	<b>2016-17</b>	<b>2017-18</b>	<b>2018-19</b>	<b>2019-20</b>	<b>2020-21</b>
Hire/oversee waiver positions	31	31	31	31	31	31
Process Request for Personnel Action (RPA)	31	31	31	31	31	31
Respond to telephone and email inquiries from departmental employees and management regarding payroll and benefit issues; respond to reorganization, classification, and pay proposals	1100	1100	1100	1100	1100	1100

Analysis of Problem

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Process Personnel Action Requests (PARS) and determine appropriate personnel transactions and salary rates.	360	360	360	360	360	360
Prepare accounts receivable & payroll adjustment documents for Accounting	145	145	145	145	145	145
Process State Disability Insurance, Non-Industrial Disability Insurance, FMLA and Catastrophic Leave benefit requests.	24	24	24	24	24	24
Provide employees with benefit administration and process all enrollment, cancellation, and change documents.	120	120	120	120	120	120
Timekeeping and leave balance – audit timesheets, maintain leave records, process changes, corrections, etc.	120	120	120	120	120	120
Dock Cutoff and master payroll release activities	12	12	12	12	12	12
Formal response for signature for out of class assignments/grievances, merit issue appeals, requests for alternate compensation and miscellaneous complaints.	25	25	25	25	25	25
Complete probationary reports, individual development plans, counseling memorandums, probation rejections, adverse actions, AWOL separations, non-punitive medical actions, etc.	26	26	26	26	26	26

Analysis of Problem

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Process invoices for payment	720	720	720	720	720	720
Record contracts, update budget worksheets and prepare quarterly summary information	720	720	720	720	720	720
Supply supportive detail to Departmental program staff and Federal and State auditors	110	110	110	110	110	110
Oversee contract procurement processes; Review and contract approval of contracts for waiver renewal	8	8	8	8	8	8
Develop contract training to line programs	10	10	10	10	10	10

Research and Analytic Studies Division

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Research and plan metrics for access outcomes	300	200	50	25	25	25
Develop baseline analytic files (linked and non-linked)	300	300	150	100	100	100
Provide institutional knowledge and context for the specific projects and analyses of Medi-Cal 2020 health care outcomes, expenditures, and utilization through legislative, literature, and program research.	400	400	400	400	400	400
Perform probabilistic linking, summarization of Medi-Cal administrative data and identifiable patient-level utilization data in order to create clinical profiles of the population	200	300	300	300	300	300
Develops hierarchical models that estimate health expenditures and	100	200	200	200	200	200

**Analysis of Problem**

<b>Workload Measure</b>	<b>2015-16</b>	<b>2016-17</b>	<b>2017-18</b>	<b>2018-19</b>	<b>2019-20</b>	<b>2020-21</b>
utilization						
Create statistical briefs, white papers, and presentations	100	100	200	275	275	275
Create analytic datasets requested by Medi-Cal programs that will be charged with designing and implementing incentive programs pursuant to the Medi-Cal 2020 1115 waiver.	300	200	200	200	200	200
Plan, organize, and direct scientific research projects	100	100	300	300	300	300

**F. Analysis of All Feasible Alternatives**

**Alternative 1:** Approve a combination of two-year and five-year limited-term resources of \$10,818,000 (\$5,409,000 General Fund /\$5,409,000 Federal Fund), including contract funding of \$14,200,000 over the span of 5 years to complete/implement the requirements of the Medi-Cal 2020.

Pros:

- DHCS would continue to meet state and federal mandates for the 1115 Waiver and ACA.
- Lower personnel costs to DHCS.
- Would provide limited-term assistance to existing workload demands.

Con:

- Loss of knowledge from staff after the limited-term basis has expired.
- Difficulty in recruiting and maintaining staff in limited-term appointments.

**Alternative 2:** Approve 31.0 limited-term positions and permanent contract funding, but stagger selected position start dates.

Pros:

- DHCS would continue to meet state and federal mandates for the 1115 Waiver and ACA.
- Lower personnel costs to DHCS.

Cons:

- This approach does not provide continuity of program operations and maintenance
- Current workforce will have to absorb Medi-Cal 2020 workload even longer than 8 months.
- Restricts Department's ability to oversee and administer program; possible loss of federal funding.

### Analysis of Problem

**Alternative 3:** Do not approve new State resources or expenditure authority (including contract funding).

Pro:

- No growth in state government and no long-term effect on the State General Fund.

Cons:

- Current workloads may be abandoned or the federally mandated services will not be implemented.
- The state will not be in compliance with federal requirements.
- Severely restricts Department's ability to oversee and administer program; probable loss of federal funding.

### G. Implementation Plan

Medi-Cal 2020 commenced January 1, 2016 and DHCS must act quickly and efficiently to implement the Medi-Cal 2020. The requested resources will be utilized to perform the calculations, administration, and oversight of the new programs, as well as finalize and revise the Special Terms and Conditions of the Waiver. Since requested staffing resources will not be effective until July 1, 2016, there will be a 6-month period where existing DHCS staff will have to assume the additional workload. However, the timing of many waiver renewal implementation activities within DHCS is largely contingent upon the activities and negotiations between CMS, internal partners, and stakeholders.

Analysis of Problem

H. Supplemental Information

*Total Contractual Services: \$14,200,000 TF (\$7,100,000 Genera Fund) over five State Fiscal Years*

Division	Fund Split	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	Total
MCQMD (EQRO – Fed Req)	50/50	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000	\$5,000,000
MCQMD (EQRO – Eval)	50/50	\$3,000,000	\$0	\$0	\$0	\$0	\$3,000,000
MCQMD (SPD/CCS)	50/50	\$1,000,000	\$0	\$0	\$0	\$0	\$1,000,000
OMD (learning collabs)	50/50	\$500,000	\$0	\$0	\$0	\$0	\$500,000
OMD (external eval)	50/50	\$500,000	\$500,000	\$500,000	\$500,000	\$500,000	\$2,500,000
RASD (datasets)	50/50	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000	\$100,000
RASD (eval risk)	50/50	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000	\$100,000
SNFD (Uncomp Care)	50/50	\$500,000	\$500,000	\$0	\$0	\$0	\$1,000,000
SNFD (GPP)	50/50	\$0	\$500,000	\$500,000	\$0	\$0	\$1,000,000
Total Funding:		\$6,540,000	\$2,540,000	\$2,040,000	\$1,540,000	\$1,540,000	\$14,200,000
<i>General Fund:</i>		<i>\$3,270,000</i>	<i>\$1,270,000</i>	<i>\$1,020,000</i>	<i>\$770,000</i>	<i>\$770,000</i>	<i>\$7,100,000</i>

## Analysis of Problem

### Managed Care Quality and Monitoring Division – \$9,000,000

EQRO contract for \$5,000,000, for five years; \$1,000,000 (\$500,000 GF/\$500,000 FF) per year. An EQRO contractor is needed to satisfy federal requirements to conduct quality and oversight including the collecting, auditing and analysis of data to support each of the six plan models.

EQRO contract for \$3,000,000 (\$1,500,000 GF/\$1,500,000 FF), one-time FY 2016-17. Contract to complete the independent evaluation of access as required by CMS.

Evaluation contract for \$1,000,000 (\$500,000 GF/\$500,000 FF), one-time FY 2016-17. Contract to continue evaluation of the Seniors and Persons with Disabilities (SPD) population and the California Children's Services (CCS) pilots.

### Office of the Medical Director – \$3,000,000

PRIME external evaluation contract for \$2,500,000, for five years; \$500,000 (\$250,000 GF/\$250,000 FF) per year. Contract for a rigorous, external evaluation capable of demonstrating causality as specified by CMS.

PRIME metric development and learning collaborative contract for \$500,000 (\$250,000 GF/\$250,000), one-time FY 2016-17. Contract to meet the provision of specialized clinical and quality improvement-related, and evaluation technical assistance, including, as mandated by CMS, the development of metrics to measure the success of the program, creation and management of learning collaboratives, and the building of data collection and analytic systems to support the external evaluation.

### Research and Analytic Studies Division – \$200,000

\$100,000 for five years; \$40,000 (\$20,000 GF/\$20,000 FF) per year, to build Medicare and Medi-Cal datasets.

\$100,000 for five years; \$40,000 (\$20,000 GF/\$20,000 FF) per year, for Evaluating Risk adjustment models using combined Medicare and Medi-Cal datasets and evaluating various LTC populations.

### Safety Net Financing Division (SNFD) – \$2,000,000

Uncompensated Care Assessments contract for \$1,000,000 over two years; \$500,000 (\$250,000 GF/\$250,000 FF) for FY 2016-17 and FY 2017-18 to complete the uncompensated care assessments for California hospitals required by CMS for 2016 and 2017.

Global Payment Program evaluation contract for \$1,000,000 over two years; \$500,000 (\$250,000 GF/\$250,000 FF) for FY 2017-18 and FY 2018-19. CMS required evaluation of the GPP.

## I. Recommendation

DHCS recommends approval of Alternative #1. The combination of two-year and five-year limited-term resources, including the contract funding, is necessary to implement the waiver and assist in the transformation of the health care delivery system and payment reform. Resources will monitor for the continued success and viability of the Medi-Cal program. The resources are critical to the timely and orderly implementation and administration of all Medi-Cal 2020 activities.

**WORKLOAD STANDARDS**  
**Director's Office - Office of the Medical Director**  
**5-year Limited-Term Resources (7/1/16-6/30/21)**

<b>Activities</b>	<b>Number of Items Weekly, Monthly, Etc.</b>	<b>Hours per Item</b>	<b>Total Hours</b>
Provide senior clinical leadership and advanced technical assistance to other DHCS divisions, hospital systems, counties, stakeholders, and the Centers for Medicare and Medicaid Services (CMS) in the development, implementation, and evaluation of the Fee for Service Maternity Incentive Program.	4/week	1	208
Review and design clinical performance measures for development of the Fee for Service Maternity Incentive Program	1/week	3	156
Provide clinical technical assistance with participating hospitals and CMS on the development of hospital maternity performance programs	2/week	1	104
Provide training and consultation to individual hospitals and hospital systems on clinical quality improvement techniques and principles	5/month	5	300
Make recommendations for system change related to performance measures and payments	4/year	10	40
Evaluate hospital reports to analyze and verify clinical performance	460/year	1.5	920
Analyze and develop ad hoc reports on hospital clinical performance and outcomes	2/year	65	92
<b>Total hours worked</b>			<b>1,800</b>

**WORKLOAD STANDARDS**  
**Director's Office, Office of the Medical Director**  
**5-year Limited-Term Resources (7/1/16-6/30/21)**

Activities	Number of Items per Position	Hours per Item	Total Hours
Assist with the coordination and facilitation of internal meetings for the development of the PRIME Program to establish and negotiate the program Standard Terms and Conditions (STCs) including performance deliverables and reporting requirements.	3/week	2	624
Receive, review and approve hospital performance plans and liaison with CMS for federal approval / respond to feedback.	20/total	8	320
Receive, review and approve hospital performance reports (interim mid-year and final year-end) and liaison with CMS for federal approval / respond to feedback.	40/year	6	480
Receive, review and approve hospital performance plan modifications on an as needed basis and liaison with CMS for federal approval / respond to feedback	20/year	4	160
Develop and provide technical assistance and training to participating PRIME entities on the 1115 Waiver STCs and individual hospital performance plan development; respond to calls and emails from participating entities.	40/month	0.75	720
Plan, receive, review and approve evaluation design and reports (interim and summative) and liaison with CMS for federal approval / respond to feedback	6/total	8	96
Assist in the development and submission of PRIME quarterly reports to CMS	4/year	4	32
Prepare and participate in monthly program calls with CMS and participate in monthly 1115 Waiver monitoring calls	2/month	2	96
Develop and maintain PRIME webspace with all required PRIME elements, Section 508 compliant	54/year	1.5	162
Assist in the development and preparation of DHCS leadership for annual onsite state presentation to CMS	1/year	11	22
Assist in the planning and coordination of hospital and health system learning collaboratives	12/year	24	576
Assist in the organization of stakeholder engagement meetings and review of public comments	3/total	20	120
Manage PRIME contracts and amendments, track budgets and expenditures, and process payments	2/month	4	192
<b>Total hours worked</b>			<b>3,600</b>

**WORKLOAD STANDARDS**  
**Office of Legal Services**  
**5-year Limited-Term Resources (7/1/16-6/30/21)**

<b>Activity</b>	<b>Number of Items</b>	<b>Hours Per Item</b>	<b>Total Hours</b>
Research and analyze federal and state laws to advise program, executive management, and Agency/GO in developing state policies and procedures related to development, implementation, and ongoing administration of the 1115 Waiver.	40	6	240
Draft and review complex State Plan Amendments, 1115 Waiver Special Terms and Conditions (STCs), federal and state legislation and regulations for the development, implementation, and ongoing administration of each fiscal year of the 1115 Waiver.	20	6	120
Review policy letters and instructional materials	20	6	120
Negotiate, draft, and review County-State contracts, managed care plan contracts, inter-agency agreements and other difficult contracts, amendments and change orders, and coordinate with DGS and the FI contractor.	30	4	120
Draft, review and revise necessary State Plan Amendments, and 1115 Waiver STCs.	24	25	600
Provide pre-litigation support, such as assessing potential legal issues, strategic planning to avoid litigation, and responding to demand letters and advocate concerns having large fiscal implications	30	20	600
Participate in discussions with CMS, intra- and inter-departmental workgroup efforts, including researching, analyzing, and advising staff in policy development	30	20	600
Research, analyze, and advise staff on responding to stakeholder questions and concerns to avoid potential litigation	40	10	400
Advise on privacy, confidentiality, security and other legal issues that may arise from systems changes necessary to develop, implement, and administer the 1115 Waiver.	20	20	400
Coordinate with DOF and Agency; respond to correspondence and other inquiries from the public, legislators, and other interested stakeholders within tight timeframes	20	20	400
<b>Total hours worked</b>			<b>3,600</b>

**WORKLOAD STANDARDS**  
**Medi-Cal Dental Services Division**  
**Beneficiary Services Unit**  
**5-year Limited-Term Resources (7/1/16-6/30/21)**

<b>Activity</b>	<b>Number of Items</b>	<b>Hours Per Item</b>	<b>Total Hours</b>
Develop an awareness plan that describes how the Department has generated awareness among enrollees of the availability of, the importance of, and how to access preventive dental services for children. Specific approaches will break out for example, age groupings, rural and urban residents, or primary language.	1	160	160
Convene workgroups with interested dental and children's health stakeholders to solicit input and approval on proposed awareness plan.	9	5	45
Participates in intra- and inter-departmental workgroup efforts, health providers, advocates, and other key stakeholders.	18	5	90
Development of beneficiary informing materials	20	8	160
Conduct an annual analysis of whether the awareness plan has succeeded in generating the necessary utilization, by subgrouping, to meet the goals of this domain, and a description of changes to the awareness plan to address any identified deficiencies.	12	24	288
Assess data describing the use of preventive dental services and, separately, other dental services, and expenditures on preventive dental services and, separately, other dental services.	12	24	288
Analyze and evaluate departmental State Hearing position statements, rehearing cases, conditional waivers, remands, proposed decisions, and/or invoices as they relate to State hearings	170	2	340
Process invoices associated with Conlan vs. Shrewry case reimbursements, monitoring that all payment conditions are met prior to invoice approval	8	1	8
Beneficiary Communication and Customer Service: Provide quality customer service to beneficiaries seeking dental treatment, address complaints grievances received within both the FFS and DMC delivery. Assess and respond to beneficiaries' general inquiries received telephone and mail.	120	1	120
Prepare and participate in monthly program calls with CMS and participate in monthly 1115 Waiver monitoring calls	36	2	72
Staff training (of self and others)	5	2	10
Participate in the review of local pilot applications and ongoing monitoring reports.	30	8	240
Miscellaneous: Miscellaneous office duties including email correspondence, meeting attendance, etc.	24	1	24
<b>Total hours worked</b>			<b>1,821</b>

**WORKLOAD STANDARDS**  
**Medi-Cal Dental Services Division**  
**Contract Management and Policy Unit**  
**5-year Limited-Term Resources (7/1/16-6/30/21)**

Activity	Number of Items	Hours Per Item	Total Hours
Compile and analyze statewide utilization rates; provide to upper management a recommendation of which counties should be selected to participate in Domain 2 of the DTI	12	25	300
Develop and implement an opt-in system for eligible providers that elect to participate in Domain 2 of the DTI; research acceptable accredited trainings that will be required as part of the opt-in process	10	20	200
Submit regulation package to add new CDT codes	20	30	600
Technical Assistance: Provide program policy interpretation/guidance, contract requirement clarification, and technical assistance to FI and DMC staff	15	20	300
Review submitted pilot proposals; write and submit response correspondence	10	20	200
Work with FI to collect CRA utilization rates; provide to upper management a recommendation if the pilot should be broadened	15	20	300
Develop and submit to CMS reports as required by 1115 Waiver	10	25	250
Assist in developing provider training materials on DTI incentives	10	15	150
Monitor performance metrics for utilization; determine if interventions are successful; develop alternatives as necessary	30	20	600
Assist in the oversight of local dental pilot projects	15	10	150
Collaborate with CMS in the development of evaluation criteria for the LDPPs	10	40	400
Monitor and evaluate each of the fifteen (15) LDPPs so the terms of the proposals are abided by on an ongoing and continuous basis	15	240	3,600
Staff training (of self and others)	10	15	150
Attend meetings	10	10	100
<b>Total hours worked</b>			<b>7,300</b>

**WORKLOAD STANDARDS**  
**Medi-Cal Dental Services Division**  
**Provider Services Unit**  
**5-year Limited-Term Resources (7/1/16-6/30/21)**

Activity	Number of Items	Hours Per Item	Total Hours
Monitor the provider network, including outreach, utilization review, monitoring of the Surveillance and Utilization Review Subsystem (S/URS), program integrity operations, provider enrollment functions, provider referral list operations, and provider support and training	20	30	600
Develop, implement, and consistently monitor provider performance	10	36	360
Determine provider eligibility using the criteria set forth by the Department through the 1115 Waiver on an annual basis	10	12	120
Capture information regarding provider capacity and implement modifications to the referral database based on results	10	12	120
Develop and increase monitoring and reporting of participating providers in the network	10	40	400
Technical Assistance: Provide program policy interpretation/guidance, contract requirement clarification, and technical assistance to FI and DMC staff	20	21	420
S/URS: Monitor FI contractor's S/URS operations for contract compliance; monitor S/URS system to flag suspected fraudulent behavior	20	21	420
Forward indicators of fraud to the appropriate organization for action and process requests from OLS and A&I	10	12	120
Contractor oversight so the referral list provider information is maintained and updated	40	10	400
Monitor timely enrollment of prospective providers, including the ability to immediately suspend and/or dis-enroll suspected fraudulent providers, and the option to re-enroll such providers after suspension	10	20	200
Develop additional measures so the success of the 1115 Waiver efforts are measurable and effective	10	12	120
Monitor and evaluate the LDPPs so the terms of the proposals are abided by as requested which fall within the purview of the Provider Services Unit	10	16	160
Staff training (of self and others)	10	20	200
Attend meetings	60	2	120
<b>Total hours worked</b>			<b>3,760</b>

**WORKLOAD STANDARDS**  
**Medi-Cal Dental Services Division**  
**5-year Limited-Term Resources (7/1/16-6/30/21)**

Activity	Number of Items	Hours Per Item	Total Hours
Data Monitoring - Work independently or collaboratively to research, analyze, and report on any issues or declining trends that may impact Dental Transformation Initiative. This includes analyzing claims data to track network adequacy, tracking progress of each domain's performance metrics and benchmarks, and any additional data-related issues that can impact the domains. Provide executive staff with data driven analysis and program analysts with data reports for day to day business needs and monthly monitoring of each of the incentive programs. Make recommendations for monitoring data components of each domain in an effective and efficient manner throughout the Waiver period.	48	16	768
Program Integrity – Determine any dental data challenges with reports from the front and back-end. Assists and facilitates remediation of dental data challenges that has been identified. Investigate accuracy of dental data which includes, but is not limited to, claims, provider, and beneficiary data.	48	10	480
Reporting - Contribute to research and data analytic reporting for mid-year and annual reporting of each domain.	24	20	480
MIS/DSS Reports - Simple: Generate Adhoc reports and analyzes data results in Business Objects based on < 3 parameters.	72	5	360
MIS/DSS Reports - Complex: Generate Adhoc reports and analyze data results in Business Objects based on > 3 parameters. Includes extensive research on issue topics and reporting on the analysis of the data.	50	16	800
Presentations - Present to executive staff with program analysts data and visuals for the evaluation phase of each domain annually before reporting to Centers for Medicare and Medicaid Services.	24	1	24
Presentation Prep - Prepare for presentations with executive staff by compiling data and visuals that would allow simple understanding of complex performance metrics and benchmarks of each domain	24	4	96
Webinars/User Meetings - Attend Webinars and User Meetings in order to remain up to date with recent system changes to any software used and various research methodologies shared throughout the Department on data analytics.	144	2	288
Staff Meetings - Participate and update management with projects and timeframes.	144	1	144
Stakeholder Meetings – Participate in stakeholder meetings to provide data-related updates	48	1	48

<b>Activity</b>	<b>Number of Items</b>	<b>Hours Per Item</b>	<b>Total Hours</b>
Miscellaneous (emails, admin, etc.) - Miscellaneous office duties requested by management. Includes email correspondence.	192	1	192
<b>Total hours worked</b>			<b>3,680</b>

**WORKLOAD STANDARDS**  
**Medi-Cal Dental Services Division**  
**5-year Limited-Term Resources (7/1/16-6/30/21)**

Activity	Number of Items	Hours Per Item	Total Hours
Provide clinical leadership and technical assistance to MDSD, contractors, counties, stakeholders, and the Centers for Medicare and Medicaid Services (CMS) in the program development, implementation, and evaluation	400	1.5	600
Review and design clinical performance measures for development. Evaluate rendering provider reports to analyze and verify clinical performance	180	2	360
Prepare/ provide training and consultation to individual dental providers on clinical quality improvement techniques and principles related to preventative care and hygiene with the designated dental consultant. Participate in stakeholder meetings to provide data-related updates	24	5	120
Make recommendations for system changes related to performance measures and payments.	16	15	240
Stakeholder Meetings – Participate in stakeholder meetings to provide data-related updates	48	1	48
Staff Meetings - Participate and update management with projects and timeframes.	104	1	104
Miscellaneous (emails, admin, etc.) - Miscellaneous office duties requested by management. Includes email correspondence.	500	1	500
<b>Total hours worked</b>			<b>1,972</b>

**WORKLOAD STANDARDS**  
**Medi-Cal Dental Services Division**  
**5-year Limited-Term Resources (7/1/16-6/30/21)**

Activity	Number of Items	Hours Per Item	Total Hours
Assist in the development of the technical and business requirements for system changes in the furtherance of the objectives of the dental transformation initiative projects from a technical perspective.	240	2	480
Analysis of deliverables for the Software Development Life Cycle (SDLC); specific functional design, technical system design, test plan, security impact assessment and post implementation report.	500	2	1,000
Examine test results of the system changes and review documentation of implementation for assigned work requests.	40	10	400
Facilitate and assist with the creation of the ad hoc reporting elements that will allow enable additional ad hoc reporting measures.	180	2	360
Involvement in the creation and maintenance of new databases or changes to existing databases.	30	4	120
Represent MDSD in systems-technical work load planning meetings with the fiscal intermediary and administrative service organization and report back to the division.	30	4	120
Review and approve business and system documentation related to CD-MMIS.	70	2	140
Facilitate the transition from testing environment to the actual environment in CD-MMIS mainframe and other systems to support policy changes which affect system infrastructure and edits.	20	1	20
Respond to correspondence and issues addressed to MDSD related to technical issues.	400	2	800
Reviewing work plans and evaluating proposed functional and technical requirements for security.	40	4	160
<b>Total hours worked</b>			<b>3,600</b>

**WORKLOAD STANDARDS**  
**Managed Care Quality and Monitoring Division**  
**(Whole Person Care Pilots)**  
**5-year Limited-Term Resources (7/1/16-6/30/21)**

Activities	Number of Items per Year (per position)	Hours per Item	Total Hours
Assists in developing policy letters related to the implementation of enhanced standards and processes under the new Section 1115 Waiver. This includes, but is not limited to, researching state and federal laws and regulations, writing contract language, working with other internal/external entities such as county participants in whole person care pilots, attending meetings.	40	15	1,800
Researches and makes recommendations to management on program implementation, monitoring and evaluation methods related to the new Section 1115 Waiver; develops these methods as directed by management. Activities could include establishing and documenting operational procedures, policies, review tools, and tracking systems, conduct monitoring activities.	20	20	1,200
Provides ongoing technical assistance and communication on program and contract issues related to implementation of the new Section 1115 Waiver to managed care plans, other departmental programs, stakeholders, and State and federal agencies. Resolves programmatic and technical questions.	20	20	1,200
Serves as lead in the analysis of nonclinical aspects of managed care plan policies, procedures, and other deliverables for compliance with specific requirements of the Section 1115 Waiver. This will include training other staff, documenting processes, establishing tracking systems, reviewing plan documents.	20	10	600
Assists in data collection and analysis relating to managed care plan provider networks, beneficiary populations, enrollment levels, utilization, and other data-related tasks as necessary to identify emerging issues and trends; alerts other team members and management with recommended actions or alternatives, draft quarterly progress reports, liaise with program evaluator.	20	10	600
<b>Total hours worked</b>			<b>5,400</b>

**WORKLOAD STANDARDS**  
**Managed Care Quality and Monitoring Division**  
**(Whole Person Care Pilots)**  
**5-year Limited-Term Resources (7/1/16-6/30/21)**

<b>Activities</b>	<b>Number of Items per Year</b>	<b>Hours per Item</b>	<b>Total Hours</b>
Coordinates, supervises, and monitors workload performed by a staff of analysts in the development, implementation, and ongoing monitoring of Section 1115 Waiver Whole Person Care Pilot projects, including those related to data quality and completeness. Serves as liaison to other Department programs, sister agencies, and federal partners to coordinate services, implement programs, and monitor effectiveness. Presents major program issues/recommendations to management for discussion and decision.	100	10	1,000
Provides consultation and technical assistance to Medi-Cal managed care health plans, Medi-Cal beneficiaries, local health agencies, and stakeholder organizations regarding administrative requirements in complying with data recording and submission. Assists in development and implementation of stakeholders/advocates process for gathering input on the program implementation activities.	40	10	400
Oversees development of regulations, policies, and procedures and other control documents; dissemination of program letters, memos, and other correspondence relating to policy issues. Oversees and directs all activities associated with CMS periodic reporting requirements.	15	10	150
Analyzes pending and proposed legislation; provides consultation to legislative staff; prepares special reports, letters, memos, and various other correspondence.	15	10	150
Provides training for new staff in all aspects of program and job responsibilities; resolves personnel problems/grievances; promotes staff education and development.	10	10	100
<b>Total hours worked</b>			<b>1,800</b>

**WORKLOAD STANDARDS**  
**Managed Care Quality and Monitoring Division**  
**(Whole Person Care Pilots)**  
**5-year Limited-Term Resources (7/1/16-6/30/21)**

Activities	Number of Items per Year	Hours per Item	Total Hours
Independently design and develop highly complex analytic queries used to extract data from the DHCS MIS/DSS as necessary to support design, implementation, monitoring and evaluation of the Whole Person Care Pilot. Independently design and develop research methodologies required of the collection and analysis of appropriate, meaningful, and unbiased data. Identify required data, information, materials, and resources needed to complete/perform a project. Conduct and interpret descriptive and/or inferential statistical analyses using appropriate software (Business Objects, SAS, EXCEL) to test research hypotheses and to formulate conclusions and recommendations.	86	100	600
Using sound research methods and principles, analyze Whole Person Care Pilot statistical data to reach sound conclusions and/or make recommendations to MCQMD management regarding policy and other related issues. Prepare detailed reports that clearly and concisely identify the problem, potential solutions, and a proposed course of action. Write reports, policies, and procedures using proper grammar, punctuation, and sentence structure.	6	100	600
Review legislation for the impact to the MCQMD and make operational the impact of any new legislation that will impact waivers. Drafts and presents proposed legislation and regulations. Assists actuaries in testifying at public hearings, legislative meetings, and judicial proceedings as necessary.	12	20	240
Act as a lead to facilitate meetings and discussions regarding pilot MCQMD-related topics in a manner that participants remain focused on the intended topic and encourages active participation.	12	15	160
Attend meetings, conference calls, etc. related to expert subject areas, and act as a liaison for the MCQMD.	6050	4	200
<b>Total hours worked</b>			<b>1,800</b>

**WORKLOAD STANDARDS**  
**Managed Care Quality and Monitoring Division**  
**(Independent Review of Access)**  
**2-year Limited-Term Resources (7/1/16-6/30/18)**

<b>Activities</b>	<b>Number of Items per Year</b>	<b>Hours per Item</b>	<b>Total Hours</b>
Assists in developing policy letters related to the implementation of enhanced standards and processes under the new Section 1115 Waiver. This includes, but is not limited to, researching state and federal laws and regulations, writing contract language, working with other internal/external entities, attending meetings. Organizes meetings of program staff and EQRO representatives to plan and execute the Access assessment and reports. Participates in interdepartmental forums, workgroups, advisory committees, and task forces related to the requirements of the Section 1115 Waiver.	40	15	600
Researches and makes recommendations to management on program monitoring and evaluation methods related to the new Section 1115 Waiver; develops these methods as directed by management. Activities could include establishing and documenting operational procedures, policies, review tools, and tracking systems.	20	20	400
Provides ongoing technical assistance and communication on program and contract issues related to implementation of the new Section 1115 Waiver to managed care plans, other departmental programs, and State and federal agencies. Resolves programmatic and technical questions.	20	20	400
Serves as lead in the analysis independently reviewing contract deliverables from the EQRO and applying requirements of the Section 1115 Waiver to deliverables. This will include training other staff, documenting processes, establishing tracking systems, reviewing plan documents.	20	10	200
Assists in data collection and analysis relating to managed care plan provider networks, beneficiary populations, enrollment levels, utilization, and other data-related tasks as necessary to identify emerging issues and trends; alerts other team members and management with recommended actions or alternatives. Provides input into the structure of the Access assessment.	20	10	200
<b>Total hours worked</b>			<b>1,800</b>

**WORKLOAD STANDARDS**  
**Managed Care Quality and Monitoring Division**  
**(Independent Review of Access)**  
**2-year Limited-Term Resources (7/1/16-6/30/18)**

<b>Activities</b>	<b>Number of Items per Year</b>	<b>Hours per Item</b>	<b>Total Hours</b>
Independently design and develop highly complex analytic queries used to extract data from the DHCS MIS/DSS as necessary to support the EQRO Independent Access Assessment. Independently design and develop research methodologies required so the collection and analysis of appropriate, meaningful, and unbiased data. Coordinate with the EQRO as necessary so that all data required by the assessment is provided. Design and develop research methodologies and data submission requirements to support the ongoing monitoring of network access following completion of the EQRO Independent Access Assessment.	8	100	800
Using sound research methods and principles, analyze EQRO Access Assessment data to reach sound conclusions and/or make recommendations to MCQMD regarding policy and other related issues. Review and approve detailed assessment reports so they clearly and concisely identify the problem, potential solutions, and a proposed course of action.	6	100	600
Act as a lead to facilitate meetings and discussions regarding assessment-related topics in a manner that participants remain focused on the intended topic and encourages active participation.	12	15	160
Attend meetings, conference calls, etc. related to expert subject areas, and act as a liaison for the MCQMD.	60	4	240
<b>Total hours worked</b>			<b>1,800</b>

**WORKLOAD STANDARDS**  
**Managed Care Quality and Monitoring Division**  
**(Alternate Payment Methodology)**  
**5-year Limited-Term Resources (7/1/16-6/30/21)**

<b>Activities</b>	<b>Number of Items per Year</b>	<b>Hours per Item</b>	<b>Total Hours</b>
Monitor and extract data using Structured Query Language (SQL) in SQL Server Management Studio, Business Objects and SAS software. Perform highly technical research and analysis focused on the Alternate Payment Methodology data from Medi-Cal managed care health plans to measure compliance with program requirements. Prepare comparative reports of the data submitted by contracted health plans and other sources. Prepare technical reports describing methodology and findings; make recommendations to management relating to further specific analyses of health plans, Division quality improvement projects, and healthcare quality improvement.	40	15	600
Develop and maintain a Microsoft Access database to monitor activities as directed by management. Program monitoring activities could include establishing and documenting data submission requirements, operational procedures, policies, review tools, and tracking systems. Develop quality measures to assess different dimensions of data quality.	30	20	600
Provide ongoing technical assistance and communication on program and contract issues related to implementation of the Alternate Payment Methodology program to managed care plans, other departmental programs, stakeholders, and State and federal agencies. Resolves programmatic and technical questions. Prepare written correspondence, proposals, issue papers, and reports.	20	20	400
Design standardized reports for ongoing tracking. Design and program computer tabulations, graphics and other display tools, using appropriate computer applications.	20	10	200
<b>Total hours worked</b>			<b>1,800</b>

**WORKLOAD STANDARDS**  
**Managed Care Quality and Monitoring Division**  
**Policy and Medical Monitoring Branch**  
**(Integration and Care Coordination)**  
**5-year Limited-Term Resources (7/1/16-6/30/21)**

<b>Activities</b>	<b>Number of Items per Year</b>	<b>Hours per Item</b>	<b>Total Hours</b>
Act as a liaison and lead consultant to prepare, coordinate, and monitor MCQMD efforts around the development of integration and care coordination guidelines and best practices; provide direction and assistance to management and other staff regarding policy issues, health program activities, and facilitate work groups involving staff of various levels, advise the Deputy Director on sensitive personnel, risk management, budgetary and litigation management concerns, develop MCQMD program plans and strategies, compile, analyze, format and disseminate data reports related to MCQMD operations, and provide well-reasoned recommendations.	6	100	600
Independently assist in the development of care coordination and best practices of integration of services; be knowledgeable in the application of health care regulations, policies and procedures; participate in monitoring and evaluating health programs and projects; gather, analyze and organize data related to health programs, and analyze administrative problems and recommend effective action.	6	100	600
Act as a subject-matter expert to revise, monitor, and help finalize various MCQMD issues or projects on care coordination and integration efforts, including participate in health care committees and work groups providing oversight, input and direction as it pertains to health care program evaluations and improvements in the MCQMD's multiple priority areas.	12	20	240
Function as a liaison for MCQMD with other program areas within the DHCS, serve as a technical program consultant in areas of care coordination and integration of services.	12	15	160
Represent the MCQMD in meetings and other forums on issues related to the Medi-Cal.	50	4	200
<b>Total hours worked</b>			<b>1,800</b>

**WORKLOAD STANDARDS**  
**Safety Net Financing Division**  
**5-year Limited-Term Resources (7/1/16-6/30/21)**

Activities	Number of Items Weekly, Monthly, Etc.	Hours per Item	Total Hours
Assist in the development, implementation and monitoring of new waiver funding mechanisms for the DPHs. Research reimbursement methodologies, analyze data, create Excel documents, and present findings.	6	22	132
Analyze and compile data capturing the impact of changes in the waiver on the total reimbursement to hospitals.	3	20	60
Analyze current waiver legislation and work with legal to draft legislation related to Medi-Cal 2020.	6	22	132
Assist in the development of Special Terms and Conditions for Medi-Cal 2020, and in State Plan Amendment updates.	12	20	240
Develop and use calculation models as necessary to calculate Medi-Cal inpatient payments, and global payments for the uninsured under Medi-Cal 2020.	5	20	100
Review provider data and supporting documentation as necessary.	8	10	80
Develop and use calculation models to calculate State Only Medical Programs, and Workforce Development Program payments under Medi-Cal 2020.	40	5	200
Develop and use calculation models to calculate PRIME payments under the Medi-Cal 2020.	2	40	80
Work with stakeholders and auditors to address any necessary changes in provider reporting under Medi-Cal 2020.	3	20	60
Work with auditors and other SNFD staff to revise final reconciliation procedures as needed for new waiver years and to develop evaluation or reporting tools as necessary.	3	12	36
Assist in the development of the annual Medi-Cal interim inpatient rate for DPHs.	1	10	10
Act as the subject matter expert on the fee-for-service hospital financing aspects of Medi-Cal 2020, including a thorough knowledge of the STCs, legislation, Medi-Cal inpatient payments, and other waiver payments.	12	30	360
Assist in the calculation and processing of quarterly and semi-annual payments to DPHs.	4	15	60
Conduct research, compile findings, and present data and recommendations to management regarding reimbursement under Medi-Cal 2020.	12	10	120
Research and answer questions from stakeholders, executive management, and control agencies related to the reimbursement under Medi-Cal 2020.	12	10	120
<b>Total hours worked</b>			<b>1,790</b>

**WORKLOAD STANDARDS**  
**Safety Net Financing Division**  
**5-year Limited-Term Resources (7/1/16-6/30/21)**

Activities	Number of Items Weekly, Monthly, Etc.	Hours per Item	Total Hours
SNFD lead in the development and implementation of new waiver funding concepts for the DPHs. This includes researching current and proposed reimbursement methodologies, attending meetings, analyzing data, and presenting findings and proposed methodologies to management.	6	25	150
Perform peer reviews of work performed by other staff in the unit.	46	1	46
Research complex funding questions related to Medi-Cal 2020.	12	20	240
Develop policy or procedure documents related to data gathering and calculating payments.	12	20	240
Develop funding methodologies and solutions to funding issues that arise in the area of hospital reimbursement.	4	20	80
Develop one or more databases for tracking of systems development for waiver control and implementation.	12	30	360
Develop implementation and analysis reports that cover Medi-Cal 2020.	4	15	60
Prepare files and online reports for the internet.	12	3	36
Act as the subject matter expert on the fee-for-service hospital financing aspects of Medi-Cal 2020, including a thorough knowledge of the STCs, legislation, Medi-Cal inpatient payments, and other waiver payments.	12	21	252
Conduct research, compile findings, and present data and recommendations to management regarding reimbursement under Medi-Cal 2020.	12	21	252
Work with auditors and other SNFD staff to revise final reconciliation procedures as needed for new waiver years and to develop evaluation or reporting tools as necessary.	12	3	36
Research and answer questions from stakeholders, executive management, and control agencies related to the reimbursement under Medi-Cal 2020.	12	8	96
<b>Total hours worked</b>			1,848

**WORKLOAD STANDARDS**  
**Administration Division**  
**Human Resources Branch**  
**5-year Limited-Term Resources (7/1/16-6/30/21)**

<b>Activities</b>	<b>Number of Items Weekly</b>	<b>Hours per Item</b>	<b>Total Hours</b>
Provides guidance, through research, via email, phone, or in person, to division supervisors and managers, relative to personnel-related policies, standards, rules, procedures, labor contract issues, and employee issues.	20	.5	520
Conducts research and analysis and prepares formal response for signature for out of class assignments/grievances, merit issue appeals, requests for alternate compensation and miscellaneous complaints.	5/monthly	3	180
Performs analysis and responds to reorganization proposals, researches feasibility and practicality of various types of classification and pay proposals and prepares responses	2/monthly	4	96
Reviewing, editing, and finalizing all personnel related documents and personnel actions, i.e. probationary reports, individual development plans, counseling memorandums.	1	2	104
Rejections on probation, adverse actions, AWOL separations, non-punitive medical actions, etc.	5/yr	135	675
Consulting with attorneys, preparing for, and attending various settlement negotiations and appeal hearings, on behalf of the Department, regarding personnel issues.	1/monthly	5	60
Evaluate and approve position and organizational structure, through the Request for Personnel Action (RPA). Provide alternative classification and organizational structure, as appropriate. Documenting changes within the RPA system.	5	.5	130
Consults with OCR and Health and Safety regarding reasonable accommodations, fair hiring practices, allegations of harassment, discrimination, workplace violence, etc.	1	1	52
<b>Total hours worked</b>			<b>1,817</b>

**WORKLOAD STANDARDS**  
**Administration Division**  
**Accounting Program**  
**5-year Limited-Term Resources (7/1/16-6/30/21)**

<b>Activities</b>	<b>Number of Items Weekly, Monthly, Etc.</b>	<b>Hours per Item</b>	<b>Total Hours</b>
Prepare complex Managed Care reconciliation, analyze and research complex discrepancies and resolve.	75	4	300
Analyze and interpret complex financial data for federal reporting on the quarterly CMS64 reports	75	4	300
Respond to requests from Managed Care, management and CMS auditors of supportive detail.	94.5	4	378
Process invoices for payment, this includes auditing invoices for accuracy and completeness, scheduling invoices to SCO for payment, posting invoices into the integrated system (CMS64). Issue and process difference checks.	720	4	180
Review and record contracts to determine the appropriate accounting transactions for payment tracking, update budget worksheets and prepare quarterly summary information.	720	4	180
Supply supportive detail to Departmental program staff and Federal and State auditors to enable them to meet their Medi-Cal program related responsibilities.	110	4	338
<b>Total hours worked</b>			<b>1,778</b>

**WORKLOAD STANDARDS**  
**Research and Analytic Studies Division**  
**5-year Limited-Term Resources (7/1/16-6/30/21)**

Activities	Number of Items	Hours per Item	Total Hours
Creates analytic datasets using probabilistic linking to summarize Medi-Cal administrative data in support of Waiver initiatives within DHCS. These initiatives include demonstration projects in the Medi-Cal Dental Division, Safety Net Financing Division, and the Managed Care Quality and Monitoring Division. Dataset linkage may include Hospital and Emergency Department datasets compiled by the Office of Statewide Health Planning and Development, as well as the Vital Statistics Death Statistical Master File. Collaborates with research contractors on Medicare- Medi-Cal matched datasets for dual eligibles.	10	60	600
Provide institutional knowledge and context for the specific projects and analyses of Medi-Cal 2020 health care outcomes, expenditures, and utilization through legislative, literature, and program research.	25	20	500
Uses linked datasets and other administrative program data, and plans and organizes research projects to evaluate health care expenditures, health services utilization, and health outcomes within the Medi-Cal program. Such outcome metrics may include emergency department visit rates, avoidable hospitalizations, birth outcomes, and subpopulation risk assessments.	4	75	300
Develops hierarchical models that estimate health expenditures/utilization, taking into account various administrative and demographic variables and clinical risk factors of enrollees (e.g. CMS-HCC/CDPS). Makes decisions of a highly technical and scientific nature related to study design, as well as the selection of sophisticated analytic methodologies and statistical methods for evaluation as well as policy design and development.	2	100	200
Create statistical briefs, white papers, and presentations that inform both internal and external stakeholders and policymakers of Medi-Cal 2020 progress and outcomes.	5	28	140
Other administrative duties as assigned.	1	60	60
<b>Total hours worked</b>			1,800