

STATE OF CALIFORNIA

Budget Change Proposal - Cover Sheet

DF-46 (REV 02/15)

Fiscal Year FY 2016-17	Business Unit 4260	Department Health Care Services	Priority No.
Budget Request Name 4260-402-BCP-BR-2016-MR		Program 3960010	Subprogram

Budget Request Description

Federal Managed Care Regulations Staffing Resources

Budget Request Summary

The Department of Health Care Services (DHCS), requests resources for the implementation of Medicaid and CHIP Managed Care Final Rule CMS-2390-P and Fee-for-Service Final Rule CMS-2328-NC.

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 No	Code Section(s) to be Added/Amended/Repealed	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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Department CIO	Date
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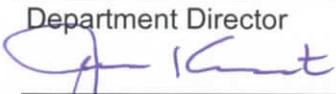
If yes, departmental Chief Information Officer must sign.

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

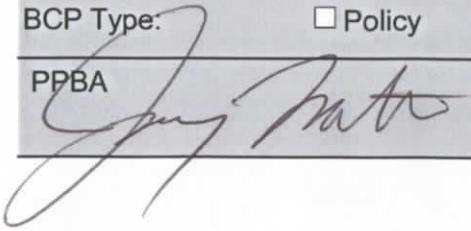
Attach comments of affected department, signed and dated by the department director or designee.

Prepared By	Date	Reviewed By	Date
Department Director 	Date 5/12/16	Agency Secretary 	Date 5/12/16

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 	Date submitted to the Legislature 5-13-16
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BCP Fiscal Detail Sheet

BCP Title: Federal Managed Care Regulations Staffing Resources

DP Name: 4260-402-BCP-DP-2016-M

Budget Request Summary

	FY16					
	CY	BY	BY+1	BY+2	BY+3	BY+4
Positions - Permanent	0.0	38.0	38.0	38.0	38.0	38.0
Total Positions	0.0	38.0	38.0	38.0	38.0	38.0
Salaries and Wages						
Earnings - Permanent	0	2,664	2,664	2,664	2,664	2,664
Earnings - Temporary Help	0	1,335	1,335	0	0	0
Total Salaries and Wages	\$0	\$3,999	\$3,999	\$2,664	\$2,664	\$2,664
Total Staff Benefits	0	1,930	1,930	1,285	1,285	1,285
Total Personal Services	\$0	\$5,929	\$5,929	\$3,949	\$3,949	\$3,949
Operating Expenses and Equipment						
5301 - General Expense	0	342	228	152	152	152
5302 - Printing	0	114	114	76	76	76
5304 - Communications	0	114	114	76	76	76
5322 - Training	0	57	57	38	38	38
5324 - Facilities Operation	0	513	513	342	342	342
5340 - Consulting and Professional Services - External	0	3,000	3,000	0	0	0
5344 - Consolidated Data Centers	0	57	57	38	38	38
539X - Other	0	285	0	0	0	0
Total Operating Expenses and Equipment	\$0	\$4,482	\$4,083	\$722	\$722	\$722
Total Budget Request	\$0	\$10,411	\$10,012	\$4,671	\$4,671	\$4,671

Fund Summary

Fund Source - State Operations						
0001 - General Fund	0	4,984	4,795	2,124	2,124	2,124
0890 - Federal Trust Fund	0	5,427	5,217	2,547	2,547	2,547
Total State Operations Expenditures	\$0	\$10,411	\$10,012	\$4,671	\$4,671	\$4,671
Total All Funds	\$0	\$10,411	\$10,012	\$4,671	\$4,671	\$4,671

Program Summary

Program Funding						
3960010 - Medical Care Services (Medi-Cal)	0	10,411	10,012	4,671	4,671	4,671
9900100 - Administration	0	326	305	305	305	305

9900200 - Administration - Distributed
Total All Programs

0	\$0	-326	\$10,411	-305	\$10,012	-305	\$4,671	-305	\$4,671	-305	\$4,671
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Personal Services Details

Positions	Salary Information								
	Min	Mid	Max	<u>CY</u>	<u>BY</u>	<u>BY+1</u>	<u>BY+2</u>	<u>BY+3</u>	<u>BY+4</u>
1139 - Office Techn (Typing) (Eff. 07-01-2016)				0.0	1.0	1.0	1.0	1.0	1.0
1303 - Personnel Spec (Eff. 07-01-2016)				0.0	1.0	1.0	1.0	1.0	1.0
4249 - Hlth Program Auditor IV (Eff. 07-01-2016)				0.0	2.0	2.0	2.0	2.0	2.0
4252 - Hlth Program Auditor III (Eff. 07-01-2016)				0.0	1.0	1.0	1.0	1.0	1.0
4800 - Staff Svcs Mgr I (Eff. 07-01-2016)				0.0	1.0	1.0	1.0	1.0	1.0
5142 - Assoc Pers Analyst (Eff. 07-01-2016)				0.0	1.0	1.0	1.0	1.0	1.0
5393 - Assoc Govtl Program Analyst (Eff. 07-01-2016)				0.0	11.0	11.0	11.0	11.0	11.0
5731 - Research Analyst II (Eff. 07-01-2016)				0.0	3.0	3.0	3.0	3.0	3.0
5734 - Research Mgr I (Eff. 07-01-2016)				0.0	1.0	1.0	1.0	1.0	1.0
5742 - Research Program Spec I (Eff. 07-01-2016)				0.0	4.0	4.0	4.0	4.0	4.0
5758 - Research Program Spec II (Eff. 07-01-2016)				0.0	3.0	3.0	3.0	3.0	3.0
5778 - Atty (Eff. 07-01-2016)				0.0	1.0	1.0	1.0	1.0	1.0
5795 - Atty III (Eff. 07-01-2016)				0.0	2.0	2.0	2.0	2.0	2.0
7787 - Med Consultant I (Eff. 07-01-2016)				0.0	1.0	1.0	1.0	1.0	1.0
8144 - Nurse Evaluator II (Eff. 07-01-2016)				0.0	5.0	5.0	5.0	5.0	5.0
VR00 - Various (Eff. 07-01-2016)(LT 06-30-2018)				0.0	0.0	0.0	0.0	0.0	0.0
Total Positions				0.0	38.0	38.0	38.0	38.0	38.0

Salaries and Wages	<u>CY</u>	<u>BY</u>	<u>BY+1</u>	<u>BY+2</u>	<u>BY+3</u>	<u>BY+4</u>
1139 - Office Techn (Typing) (Eff. 07-01-2016)	0	38	38	38	38	38
1303 - Personnel Spec (Eff. 07-01-2016)	0	43	43	43	43	43
4249 - Hlth Program Auditor IV (Eff. 07-01-2016)	0	140	140	140	140	140
4252 - Hlth Program Auditor III (Eff. 07-01-2016)	0	67	67	67	67	67
4800 - Staff Svcs Mgr I (Eff. 07-01-2016)	0	71	71	71	71	71

5142 - Assoc Pers Analyst (Eff. 07-01-2016)	0	62	62	62	62	62
5393 - Assoc Govtl Program Analyst (Eff. 07-01-2016)	0	684	684	684	684	684
5731 - Research Analyst II (Eff. 07-01-2016)	0	196	196	196	196	196
5734 - Research Mgr I (Eff. 07-01-2016)	0	72	72	72	72	72
5742 - Research Program Spec I (Eff. 07-01-2016)	0	273	273	273	273	273
5758 - Research Program Spec II (Eff. 07-01-2016)	0	225	225	225	225	225
5778 - Atty (Eff. 07-01-2016)	0	80	80	80	80	80
5795 - Atty III (Eff. 07-01-2016)	0	220	220	220	220	220
7787 - Med Consultant I (Eff. 07-01-2016)	0	136	136	136	136	136
8144 - Nurse Evaluator II (Eff. 07-01-2016)	0	357	357	357	357	357
VR00 - Various (Eff. 07-01-2016)(LT 06-30-2018)	0	1,335	1,335	0	0	0
Total Salaries and Wages	\$0	\$3,999	\$3,999	\$2,664	\$2,664	\$2,664
Staff Benefits						
5150350 - Health Insurance	0	959	959	638	638	638
5150600 - Retirement - General	0	971	971	647	647	647
Total Staff Benefits	\$0	\$1,930	\$1,930	\$1,285	\$1,285	\$1,285
Total Personal Services	\$0	\$5,929	\$5,929	\$3,949	\$3,949	\$3,949

Analysis of Problem

A. Budget Request Summary

The Department of Health Care Services (DHCS) requests the establishment of 38.0 permanent positions and expenditure authority, and 2-year limited-term funding for staff resources and contractual services. The request supports the implementation of Medicaid and CHIP Managed Care Final Rule CMS-2390-P and Fee-for-Service Final Rule CMS-2328-NC.

Total funding request: \$10,411,000 (\$4,984,000 GF/\$5,427,000 FF)

Final Rule 2390-P changes the Medicaid managed care regulations to reflect the increased utilization of managed care as a delivery system. It aligns the rules governing Medicaid managed care with those of other major sources of coverage, including Qualified Health Plans and Medicare Advantage Plans; implements statutory provisions; changes actuarial payment provisions ; and promotes the quality of care and strengthen efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. It also strengthens beneficiary protections and policies related to program integrity. This rule also requires states to establish comprehensive quality strategies for their Medicaid and CHIP programs regardless of how services are provided to beneficiaries.

Final Rule 2328-NC requires states to develop and implement a transparent, data-driven process to evaluate provider payments, in regards to covered care and services consistent with section 1902(a)(30)(A) of the Social Security Act.

The following chart identifies the positions/resources requested and organizationally where they are located within DHCS (see below detail for main areas of the final regulations where resources are being requested):

Analysis of Problem

Division	Request	Activity
MCQMD	<p>11.0 Perm Positions</p> <ul style="list-style-type: none"> • 1.0 RM I • 1.0 RPS II • 2.0 RPS I • 4.0 AGPA • 1.0 RA II • 1.0 MC I • 1.0 OT <p>2-Year LT Funding Equivalent to</p> <ul style="list-style-type: none"> • 1.0 RPS II • 5.0 AGPA • 1.0 HPS II <p>2-Year LT Contract Funding (EQRO)</p>	<p>42 CFR 438.310 (Quality Measurement) 438.66 (Performance Monitoring) 438.68 (Network Adequacy) 438.242 (Data Quality) 438.340 (Quality Strategy) 438.602 (Program Reporting) 438 (Promulgate Regulations) 438.608 (Program Standards) 438.320 (Quality Measurement) 438.330 (Quality Assessment) 438.334 (Quality Rating System) 438.402 (Grievance System)</p>
MCOD	<p>2.0 Perm Positions</p> <ul style="list-style-type: none"> • 2.0 AGPA <p>2-Year LT Funding Equivalent to</p> <ul style="list-style-type: none"> • 1.0 AGPA • 1.0 AISA 	<p>438.602 (Program Integrity) 438.66 (State Monitoring Standards) 438.68 (Network Adequacy Standards) 438.71 (Beneficiary Protections – Beneficiary Support System) 438.10 (Modernize Regulatory Requirements – Information)</p>
CRDD	<p>8.0 Perm Positions</p> <ul style="list-style-type: none"> • 2.0 RPS I • 2.0 RA II • 1.0 SSM I • 2.0 AGPA <p>2-Year LT Funding Equivalent to</p> <ul style="list-style-type: none"> • 1.0 AGPA 	<p>438.4, 438.5, 438.8, 438.74 (Medical Loss Ratio) 438.2 (Definitions) 438.4 (Actuarial Soundness) 438.5 (Rate Development Standards) 438.6 (Special Contract Provisions Related to Payment) 438.7 (Rate Certification Submission)</p>

Analysis of Problem

Division	Request	Activity
LTCD	2-Year LT Funding Equivalent to <ul style="list-style-type: none"> • 1.0 RPS I • 2.0 RA II • 1.0 AGPA 	438.208 (Long-Term Services and Supports) 438.2, 438.3, 438.70, 438.71, 438.214, 438.816 (Managed Long-Term Services and Supports) 438.68 (Criteria for Developing Network Adequacy Standards for MLTSS Programs)
OLS	3.0 Perm Positions <ul style="list-style-type: none"> • 2.0 Attorney III • 1.0 Attorney 2-Year LT Funding Equivalent to <ul style="list-style-type: none"> • 1.0 Attorney III • 2.0 Attorney 	All of 42 CFR 438
MHSD	2.0 Perm Positions <ul style="list-style-type: none"> • 2.0 AGPA 	438.604 (Program Integrity) 438.602 (Program Integrity) 438, Subparts D & E (Quality of Care) 438.4 & 431.2 (Appeals and Grievances) 438.3 & 438.6 (Standard Contract Provisions)
A&I	8.0 Perm Positions <ul style="list-style-type: none"> • 1.0 HPA III • 2.0 HPA IV • 5.0 NE II 	438.66 (State Monitoring Requirements) 438.230 (Subcontractual Relationships and Delegation) 438.604 (Program Integrity) 438.818 (Encounter Data and Health Information Systems)
RASD	2.0 Perm Position <ul style="list-style-type: none"> • 2.0 RPS II 2-Year LT Funding Equivalent to <ul style="list-style-type: none"> • 1.0 RPS I • 1.0 RS II 	447.203(b)
ADM	3.0 Perm Positions <ul style="list-style-type: none"> • 1.0 PS • 1.0 APA • 1.0 AGPA 	Administration – all programs

Analysis of Problem

B. Background/History

Managed Care Regulations

Since 1965, Medicaid has financed health care coverage for certain categories of low income individuals. States administer the program within broad federal guidelines and have considerable flexibility in designing certain aspects of the program, including eligibility, covered services, and provider payment rates. States generally cover Medicaid services for beneficiaries through two major financing approaches: traditional fee-for-service (FFS), in which the Medicaid program directly reimburses providers for care provided to beneficiaries, and capitated managed care, in which the state pays Managed Care Organizations (MCOs) a fixed monthly per member per month (capitation) payment for covered health care services. Managed care is a health care delivery system organized to manage cost, utilization, and quality.

States design, administer, and oversee their own Medicaid managed care programs within the requirements set forth in federal Medicaid law and further elaborated in regulation. These federal regulations, last updated in 2002, set forth state responsibilities and requirements in areas including enrollee rights and protections, quality assessment and performance improvement (including provider access standards), external quality review, grievances and appeals, program integrity, and sanctions. The 2002 regulations (67 Fed. Reg. 40989, June 14), were a response to the Balanced Budget Act of 1997 (Pub. L. 105-33).

The Centers for Medicare and Medicaid Services (CMS) released its Medicaid managed care proposed revision to the 2002 rule on May 26, 2015; it was published in the Federal Register on June 1, 2015. CMS issued Final Rule CMS-2390-P on May 6, 2016. The final rule primarily amends and expands the requirements of Title 42, Code of Federal Regulations, Part 438, pertaining to managed care.

Noting that the health care delivery landscape has changed substantially both within the Medicaid program and outside of it, CMS proposes changes to the Medicaid managed care regulatory structure to facilitate and support delivery system reform initiatives resulting in improved health outcomes and the beneficiary experience, while effectively managing costs. The agency additionally seeks to align managed care with other sources of coverage such as Medicare Advantage and Exchange plans.

The rules have multiple, direct purposes: to improve accountability in the Medicaid managed care program; to ensure beneficiary protections in the areas of provider networks, coverage standards, and treatment of appeals; and to strengthen program integrity safeguards. In so doing, the rule effectively seeks to balance greater regulatory oversight and accountability of both state and industry practices with wider deference to states in how they choose to design managed care and utilize contractors.

Most fundamentally, the new rule extends a more rigorous regulatory structure to all forms of capitated managed care, whether full-risk managed care organizations or partially capitated plans. The reforms themselves sweep across a broad landscape.

Analysis of Problem

Fee-For-Service Regulations

In November 2015, CMS amended the requirements for states' documentation of access to care for fee-for-service beneficiaries found in 42 CFR Part 447¹. These new requirements necessitate the design and development of a new access monitoring plan, and list specific measures for separate analyses. CMS requires that both the monitoring plan and analyses be revised and updated periodically as new information is evaluated. These new requirements represent a dramatic increase in a highly technical politically sensitive workload beyond DHCS' current monitoring efforts. For example, whereas DHCS now monitors eight physician specialty types, related only to primary care, new requirements call for the inclusion of *all* physician specialty types. Since the Medi-Cal program has over 50 physician specialty types, this change exponentially increases the scope and complexity of current reporting. Such changes increase the number of datasets relied upon, data linkages that must occur, development of analytic files, calculation of statistics, overall analyses, and research writing. These efforts can only be completed through the addition of skilled research staff.

Finally, pursuant to 42 CFR Part 447, CMS requires states to incorporate provider rate reviews into their access monitoring plans and analyses. These reviews examine Medi-Cal services and providers, and must include a comparison of Medi-Cal payment rates to those of other public and private payers. The new requirement to include such analyses will increase the complexity of DHCS' reports.

Resource History
(Dollars in thousands)

Medi-Cal Managed Care Quality and Monitoring / Managed Care Operations Division

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

Capitated Rates Development Division

Program Budget	2010-11	2011-12	2012-13	2013-14	2014-15
Authorized Expenditures	N/A	N/A	6,571	8,005	7,871
Actual Expenditures	N/A	2,807	6,571	8,005	6,652
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	N/A	N/A	37.5	37.5	45.0
Filled Positions	N/A	N/A	29.1	31.6	30.0
Vacancies	N/A	N/A	8.4	5.9	15.0

¹ Federal Register/Vol. 80, No. 2011/Monday, November 2, 2015/Rules and Regulations

**Federal Managed Care Regulations Staffing Resources
4260-402-BCP-BR-2016-MR**

Analysis of Problem

Long-Term Care Division

Program Budget	2010-11	2011-12	2012-13	2013-14	2014-15
Authorized Expenditures	10,478	13,312	12,627	13,021	14,370
Actual Expenditures	9,905	12,594	12,627	12,074	13,332
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	101.0	120.0	118.5	124.0	122.0
Filled Positions	95.8	103.6	104.0	102.5	106.0
Vacancies	5.2	16.4	14.5	21.5	16.0

Office of Legal Services

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

Mental Health Services Division

Program Budget	2010-11	2011-12	2012-13	2013-14	2014-15
Authorized Expenditures	N/A	N/A	23,898	23,295	25,284
Actual Expenditures	N/A	N/A	19,579	21,696	23,736
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	N/A	N/A	95.0	125.0	138.0
Filled Positions	N/A	N/A	73.3	105.6	138.0
Vacancies	N/A	N/A	21.7	19.4	0.0

*Mental Health Services Division transitioned to DHCS in FY 2011-12.

Audits and Investigations

Program Budget	2010-11	2011-12	2012-13	2013-14	2014-15
Authorized Expenditures	69,925	69,925	72,811	80,125	89,431
Actual Expenditures	63,854	68,940	71,112	78,592	85,242
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	767.8	765.8	716.5	715.5	726.5
Filled Positions	625.2	651.2	667.0	670.9	699.5
Vacancies	142.6	114.6	49.5	44.6	27.0

Analysis of Problem

Research and Analytic Studies

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
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.

Administration

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	23,110	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

For Workload History Tables, See Attachment B

C. State Level Considerations

As stated in the DHCS Strategic Plan, DHCS is committed to ensuring timely access to care as well as to be cost efficient and promote a positive beneficiary experience, more efficient with limited state resources by transitioning many of our members to a more organized system of managed care, where services will be coordinated to serve the whole person with the right care at the right time, all combining to help secure better health outcomes. With managed care, we are working towards patient-centered, coordinated care and to allow Medi-Cal members to be aware of their choices. This proposal reflects DHCS' priority to eliminate fraud, waste and abuse in the State's Medicaid program.

The 2013-17 DHCS Strategic Plan Introduction states "The Commitments in our Strategic Plan support our dedication to consumer experience...adhering to our core values of integrity, service, accountability and innovation." This proposal supports the DHCS Strategic Plan by implementing strategies identified in two of the eight Commitments stated in the Strategic Plan.

Commitment 4: Develop effective, efficient, and sustainable health care delivery systems through effective oversight, ensuring program integrity and compliance.

Commitment 7: Hold ourselves and our providers, plans and partners accountable for performance.

Analysis of Problem

This proposal is also consistent with the DHCS Quality Strategy and goals of the Centers for Medicare and Medicaid (CMS) 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.

This proposal aligns with the Governor's Executive Order B-19-12, which states that California lacks a statewide strategy for collecting, prioritizing, and sharing this information to help beneficiaries make informed decisions about their own health and health care. Moreover, it is consistent with the Office of Inspector General's 2010 report, which recommended that CMS collaborate with States to develop effective strategies to bolster beneficiary participation in preventive care and initiate education and incentives for providers to encourage complete preventive screenings.

DHCS entered into an interagency agreement (IA) with the Department of Managed Health Care beginning June 1, 2011 to conduct financial audits including medical loss ratio (MLR) and administrative expense examinations of each health plan participating in the duals demonstration, the Seniors and Persons with Disabilities (SPDs), and Healthy Families Program (HFP) transition into managed care. The proposed regulations will likely affect the Department of Managed Health Care, Department of Social Services, Department of Aging, among others.

D. Justification

Managed Care Quality and Monitoring Division – 18.0 Staff Resources

1.0 Research Manager I (RM I)

2.0 Research Program Specialist II (RPS II) – 1.0 2-year LT equivalent

2.0 Research Program Specialist I (RPS I)

9.0 Associate Governmental Program Analyst (AGPA) – 5.0 2-year LT equivalent

1.0 Health Program Specialist II (HPS II) – 2-year LT equivalent

1.0 Research Analyst II (RA II)

1.0 Medical Consultant I (MC I)

1.0 Office Technician (OT)

Within the Department's Medi-Cal Managed Care program, the Managed Care Quality & Monitoring Division (MCQMD) is responsible for gathering and analyzing MCP data to ensure that program expenditures are based on complete, accurate, reasonable, and timely encounter data and that each beneficiary has timely access to high quality health care services provided by an appropriate provider type in the right location. MCQMD monitors the quality, timeliness, and access of services provided by 22 Medi-Cal managed care health plans (MCPs) each operating in one or more of all of the state's 58 counties and serving over 9 million Medi-Cal beneficiaries.

MCQMD includes two Branches: Policy & Medical Monitoring Branch (PMMB) and Program Monitoring & Compliance Branch (PMCB). PMMB analyzes proposed policy changes; promulgates regulations; analyzes legislation; publishes policy statements; analyzes data related to quality improvement and performance measures; and conducts desk and site reviews of clinical performance and policy issues, such as medical exemption requests, facility accessibility, equipment adequacy, provider accessibility, and quality improvement

Analysis of Problem

and performance measures. PMCB gathers, analyzes, and reports on data related to health care encounters and performance measures.

MCQMD requests 18.0 staff resources to implement the federal regulations. MCQMD is at the center of the work in the areas of promulgating necessary state regulations, 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 these new federal regulations; existing staffing levels and workload are unable to adequately address these federal requirements.

MCQMD is also requesting \$3 million in contract authority to support data auditing and validation by an external quality review organization (EQRO) which will be critical to ensuring the department has appropriate resources to evaluate and publicly report MCP health outcomes and utilization factors experienced by Medi-Cal members accessing services in the managed care delivery system. The EQRO funding is available for 50% Federal Reimbursement and 50% General Fund. This additional funding will allow the EQRO contractor to expand its quality review activities as defined in the contract's scope of work and in compliance with the requirements of the new federal rulemaking (42 CFR 438.310, et seq. [Quality Measurement]).

The new rulemaking expands the detail and scope of existing oversight activities and requires states to substantially expand oversight of MCP activities by requiring greater detail in oversight activities and verification of information reported by MCPs, including data on provider networks according to a specified range of provider types, cultural and language standards, and quality improvement projects. The new rules also require states to demonstrate their will to issue sanctions to MCPs that repeatedly fail to comply with program requirements. As stated in Part I, Section A:

“This proposed rule would revise the Medicaid managed care regulations to align with other statutory and regulatory provisions that pertain to other sources of coverage, strengthen actuarial soundness and other payment regulations to improve accountability of rates paid in the Medicaid managed care program, ensure beneficiary protections, and incorporate statutory provisions affecting Medicaid managed care passed since 2002. In addition, the rule promotes beneficiary access to care by strengthening provider networks. This proposed rule also recognizes that through managed care plans, state and federal taxpayer dollars are used to purchase covered services from providers on behalf of Medicaid enrollees, thus ensuring accountability and strengthening program integrity safeguards necessary to ensure the appropriate stewardship of those funds.”

MCQMD plays a crucial role in collecting, and analyzing the data that will be used to assess the Department's effectiveness in complying with these regulations. Approval of these resources will allow MCQMD to work more closely with the MCPs and provide technical assistance to implement a variety of targeted incentives and interventions.

MCQMD's current monitoring activities do not extend to all populations or components of the Medi-Cal Managed Care program. For example, MCQMD assures that its MCPs maintain provider networks that include adequate numbers of primary care physicians; this rulemaking requires MCQMD to also assure adequate numbers of seven other provider types and to report these findings separately for adults and children. MCQMD Research Program Specialists develop highly complex queries of Department data to gather, validate,

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analyze, and report the status of these categories. The additional research staff listed below will substantially help alleviate this gap in required monitoring activities.

Another example concerns MCQMD's Nurse Evaluators who receive reports from MCPs on MCP reviews of each of their providers' facilities, equipment, and records; however, the shortage of Nurse Evaluator positions results in their inability to analyze each of these reports or follow up on each negative finding. The Nurse Evaluators also perform site reviews of a sample of provider facilities on an unscheduled basis. The additional Associate Government Program Analysts listed below will substantially help alleviate this gap in required monitoring activities pairing clinical and non-clinical staff together to complete the work.

Additionally, the new staff resources will address complex policy issues, such as promulgating the corresponding state regulations to align with the federal regulations, establishing and publishing provider network adequacy standards for beneficiaries and stakeholders, establishing and publishing cultural sensitivity standards for all populations of beneficiaries, and ensuring full participation in State Fair Hearing procedures and follow-up.

The 1.0 Research Manager (RM) I (PMCB) will lead a team of RPS I's and Associate Governmental Program Analysts (AGPAs) in researching and monitoring plan performance issues and annual network certifications, expanded time and distance standard requirements, and the analysis of encounter data for completeness and quality, as defined by 42 CFR 438.66 (Performance Monitoring), 438.68 (Network Adequacy), 438.242 (Data Quality), and 438.340 (Quality Strategy). Reviews staff projects, monitors staff time and evaluates staff performance, and collaborates with other research managers in identifying topics and projects for research, reviewing and evaluating technical reports and analyses generated in support of the new monitoring and performance requirements of the new federal rulemaking, and communicating with management on current trends and goals to ensure MCP and Department compliance.

The 2.0 Research Program Specialists (RPS) II (PMCB) will independently design, implement, and report on findings of research projects, and prepare and present technical reports to management and stakeholder groups related to the new monitoring and performance requirements of the federal rulemaking, as defined at 42 CFR 438.66 (Performance Monitoring), 438.68 (Network Adequacy), 438.242 (Data Quality), and 438.340 (Quality Strategy). These RPS II's construct the most complex data queries and perform the most technically difficult analyses to specifically address the monitoring issues, including the use of GIS Mapping software to evaluate network adequacy.

The 2.0 Research Program Specialists (RPS) I (PMCB) will carry out research projects, prepare and present technical reports related to annual network certifications, expanded time and distance standard requirements, and engage in taking, monitoring and conducting quality checks with an expanded provider file, and working with encounter data, as defined at 42 CFR 438.66 (Performance Monitoring), 438.68 (Network Adequacy), 438.242 (Data Quality), and 438.340 (Quality Strategy). These RPS I's construct the less complex data queries and perform technical analyses to specifically address the monitoring issues related to the new rulemaking to support regulatory emphasis on transparency around network adequacy and availability of services to beneficiaries.

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The 9.0 Associate Governmental Program Analyst (AGPA) (PMCB and PMMB) are responsible for independently completing assignments related to monitoring MCP performance related to the operational requirements of the new federal rulemaking, including the less technical or clinical components of the rulemaking to ensure complete and valid data, and to ensure full MCP readiness and ongoing quality, as required at 42 CFR 438.66 (Performance Monitoring), 438.68 (Network Adequacy), 438.320 (Quality Measurement), 438.602 (Program Reporting), and 438.608 (Program Standards).

- Support Research Staff: 3.0 AGPAs (1.0 permanent and 2.0 2-year LT equivalent)
- Support Clinical Staff: 5.0 AGPAs (2.0 permanent and 3.0 2-year LT equivalent)
- Regulatory Changes: 1.0 permanent AGPA will be responsible for developing and effectuating the necessary regulatory changes to four chapters of regulations in Title 22, which is approximately 341 existing sections of state code in order to align them with the new federal requirements. The AGPA activities facilitate increased flexibility among the research and clinical staffs to focus on their technical and clinical duties while program procedures, policies and regulations are researched and developed by the AGPAs.

The 1.0 Health Program Specialist (HPS) II (PMMB) will independently develop and implement policies and strategies associated with statewide goals for health care quality improvement activities, and participate as a leader or subject matter expert in stakeholder and advisory workgroups. This level of leadership addresses the higher level of quality monitoring and program integration required under the new federal rulemaking at 42 CFR 438.330 (Quality Assessment). The HPS II will also develop methods for ensuring MCP compliance with corrective actions and improvement projects under both State and federal authorities, as required at 42 CFR 438.66 (Program Monitoring), 438.68 (Network Adequacy), 438.320 (Quality Measurement), 438.602 (Program Reporting), and 438.608 (Program Standards).

The 1.0 Research Analyst (RA) II (PMMB) will analyze data related to quality improvement and performance standards and make recommendations to management regarding corrective actions and improvement projects. The RA II will collaborate with the HPS II in developing data analysis in support of statewide quality improvement projects, as required at 42 CFR 438.66 (Program Monitoring) 438.330 (Quality Assessment) and alignment with efforts stated in 438.334 (Quality Rating System).

The 1.0 Medical Consultant (MC) I (PMMB) will support monitoring efforts through clarifying clinical policy, providing technical assistance, and working with health plans on corrective action, when needed. The MC I renders clinical determinations related to grievances and exemptions, as defined at 42 CFR 438.402, et seq. (Grievance System), and oversees and maintains the integrity of the program's quality strategy, as defined at 42 CFR 438.340 (Quality Strategy) and provided medical expertise related to the development of section 438.334 (Quality Rating System).

The 1.0 Office Technician (OT) will support the increased clerical support needs of the Division both related to the growth in staff and increased need for publishing and sharing of information.

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Managed Care Operations Division – 4.0 Staff Resources

3.0 Associate Governmental Program Analyst (AGPA) – 1.0 2-year LT equivalent

1.0 Associate Information System Analyst (AISA) – 2-year LT equivalent

The Managed Care Operations Division (MCOD) within the Department of Health Care Services (DHCS) oversees 22 MCPs that operate in all 58 California counties. These MCPs emphasize primary and preventive care and most health care plans contracting with the Medi-Cal Managed Care program are licensed under the Knox-Keene Health Care Service Plan Act of 1975. Under Medi-Cal Managed Care, DHCS contracts with the health plans that are paid on a capitated basis, assuming all financial risk. Any changes to the federal regulations would have an overarching effect on all areas of managed care and would significantly increase the workload of MCOD and DHCS. MCOD is responsible for all operational issues related to MCPs including enrollment and disenrollment. The Division also oversees and operates the Beneficiary Support System. The proposed rule makes significant changes to these areas and as such additional resources are needed.

The addition of these MCOD resources is necessary to address the new workload created by the federal regulations for Medi-Cal managed care and for ongoing efforts to address the items in the regulations outlined below. This workload increase will continue through the foreseeable future.

MCOD MCSSB Waiver & Cal MediConnect Section MCOD MCSSB Operations Section

Two AGPA staff (1.0 LT), in the Waiver & Cal MediConnect Section (located in the 1115 Waiver Unit), and one AGPA in the Operations Section will be utilized to mitigate any possible negative impact on MCOD by having the appropriate positions to directly address these requirements.

The regulation included in *I.B.5.c Beneficiary Protections – Beneficiary Support System §438.71* will add the requirement for plan and provider training as this is not a current function of MCOD which would have a major impact on our Operations Section. This would also create additional workload that would not be able to be met with current positions available. For example, all 35 managed care primary contracts would need to be reviewed and amended to meet the new requirements outlined in the regulation, in addition to address any language clarification or new terminology outlined in the proposed regulations. Also, MCOD does not currently have a formal complaint process to track and resolve beneficiary issues through our enrollment broker. As a requirement, it would have a major impact on the functions and operations of these entities. Currently, health plans and other regulatory agencies handle beneficiary complaints and concerns regarding health plan organizations. MCOD provides general education on managed care and Long Term Services and Support (LTSS), but the requirement involves more extensive education functions and operations, which would be a substantial increase in terms of workload.

The regulation included in *I.B.6.d Modernize Regulatory Requirements – Information §438.10(h)(1) (i)-(viii)* will add the requirement for updating provider directories on a monthly basis instead of the current standard of every six months per the DHCS contract with the managed care plans. A frequency change from twice a year to twelve times a year would cause a dramatic workload increase with our contractor who prints, stores and mails the provider directories as well as MCOD who reviews and approves them. With regard to the

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formatting standards in the regulations, there are currently no formatting standards required of plans for the provider directories beyond the contractually required data elements. This would require plans to completely change their current directories, including possibly changing the programming used. MCO would in turn need to develop, review, and approve the new format initially and on an ongoing basis to ensure the plans comply with this regulation. This would be a substantial increase in workload over what is currently in place. The requested positions will be tasked with taking on this increased workload.

MCO MCSSB SSU – 2-Year LT Funding Equivalent to an AISA

As a result of new regulation 438.71 placed on DHCS, staff is needed to provide technical assistance support and to effectively oversee current practices and implement several new ones. The system is a multi-user software system with a full complement of data collection, data management, data analysis and reporting tools. Existing staff cannot absorb this workload, as the enhanced requirements require additional support due to the significant increase in new activities and workload. DHCS policies, procedures and/or systems to ensure quality control on the current contract requires a significant amount of staff time, including:

- Provide advice, consultation, and make recommendation to management on issues related to HCO enrollment broker contract
- Monitor and visit call center locations to ensure informing materials are in compliance with regulations previously identified.
- Ensure timely and accurate submissions of mandatory reports including but not limited to beneficiary complaint data.
- Coordinate efforts necessary to develop and implement system changes needed.
- Make changes or updates to the Health Care Options System

Approving this request will ensure that all implementation deadlines required are met in a timely manner.

Capitated Rates Development Division – 8.0 Positions

2.0 Research Program Specialist I (RPS I)

2.0 Research Analyst II

1.0 Staff Services Manager I (SSM I)

3.0 Associate Governmental Program Analyst (AGPA) – 1.0 2-year LT equivalent

The DHCS Capitated Rates Development Division (CRDD) is responsible for the development of rate methodologies and actuarially sound capitation rates for Medi-Cal managed care plans, and for ensuring Medi-Cal managed care capitation rates are in compliance with the State's health care policies and federal regulations and receive the necessary federal approvals from the Centers for Medicare and Medicaid Services (CMS) for payment of capitation rates. In addition, CRDD reviews and monitors Medi-Cal managed care plan contractors' financial statements and reports to ensure plans meet and maintain contractually required financial viability standards as well as statutory and regulatory requirements.

CMS has recently issued new rules regarding setting of capitation rates for managed care plans. The new federal rules fundamentally overhaul key requirements, practices, and procedures related to capitation rate setting by introducing new requirements which require

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the Department to change existing rate practices and procedures. The new rules significantly affect immediate and ongoing workload requirements, increasing necessary communications between Departmental staff, CMS, actuaries, managed care plans, and key stakeholders, and further require the Department to provide additional rate documentation, analyses, structured education, and clarification regarding rate setting issues that are critical to the delivery of appropriate and quality health care to Medi-Cal beneficiaries.

The new federal rules provide that actuarial certification must be at the individual rate cell level, rather than certifying to a rate range. Therefore, any changes to rates require an entire certification package to be developed and submitted for CMS approval. Past and current practice allowed the Department to make reasonable and financially sound adjustments within the certified rate range without the need to develop and submit a new certification. The rate certification package must now include a further level of detail and documentation sufficient for CMS to conduct a rigorous actuarial evaluation of the rate standards in accordance with generally accepted actuarial principles and practices and the new federal requirements. These new requirements add to the rate processing workload by increasing the standards of actuarial documentation required at the time of submission, and therefore increase non-actuarial staff workload such as communicating with health plans and stakeholders, and collecting and analyzing complex data that will be used during the development of actuarially sound rates. These new requirements will intensify existing pressures for staff to meet rate and contract submission requirements for timely approval.

The new federal rules reinforce a more stringent federal focus on developing rates on a prospective rather than retrospective basis, defining actuarial soundness as “a prospective process that anticipates the reasonable, appropriate, and attainable costs under the managed care contract for the rating period”. This change will require all rates components to be calculated based on projected enrollment rather than actual enrollment as current practices allow. Use of projected enrollment will require the Department to reconcile amounts related to Intergovernmental Transfers (IGTs) (Rate Range IGTs and Base IGTs) and other health care policies, such as Senate Bill 208 (Chapter 714, Statutes of 2010), Assembly Bill 85 (Chapter, 24, Statutes of 2013), SB 239 (Chapter 657, Statutes of 2013) Hospital Quality Assurance Fee (HQAF), and SB 857 (Chapter 31, Statutes 2014) (MLK), all of which are important and necessary financing mechanism of the Medi-Cal delivery system. The new federal rules limit the states’ ability to direct provider reimbursement through managed care contracts to instances involving the implementation of value-based purchasing approaches, delivery system reform or performance improvement initiatives, or minimum and maximum provider fee schedules. This restriction represents a significant departure from past and current standards and requires the Department to fundamentally reevaluate current capitation-based strategies to safeguard the health and viability of Medi-Cal’s provider system. The Department will be required to assume the workload of developing, proposing, and implementing compliant strategies, and evaluating the fiscal and program impacts of such strategies and their alternatives.

The new federal rules provide for a nationally determined uniform medical loss ratio (MLR) standard no less than 85 percent as well as minimum standards for the MLR calculation methodology. The new federal rules require the development of the MLR calculation for all rate categories; implementation of this requirement involves extensive stakeholder engagement with the health plans, providers, and requires CMS approval prior to implementation. Once a baseline methodology is approved, the components of the numerator and denominator will need to be re-evaluated on an annual basis. This includes

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verification of the proper categorization of healthcare premiums and expenditures submitted by managed care plans. The results of the MLR calculations must be considered in the development of prospective capitation rates and the actuaries must be able to certify that the capitation rates allow for plans to reasonably achieve the minimum MLR standard. The rules also require that the results of the MLR calculations be reported to CMS with the rate certification, and that the methodology for calculating the federal share be presented to CMS. These new requirements create new and significant staff workload involving collection and review of financial data and statements, financial analysis and reporting, and intensive communication with health plans, actuaries, CMS, and other stakeholders. DHCS currently has interagency agreements with DMHC for the purpose of assessing plan provider network adequacy through medical surveys, reviews of plan provider networks and financial audits. However, the MLR exams currently performed by DMHC do not encompass the work which would be required under the new CMS rules as the MLR calculations will be Medicaid specific and have different denominators and numerators. The DMHC MLR exams are performed approximately once every three years for a defined state fiscal year. CRDD will assume the responsibility and workload of the new annual MLR calculations for Medicaid.

CMS requires that capitated rates must be certified as actuarially sound and comply with all federal regulations. In addition, for rates developed for rate years beginning on or after January 1, 2015, CMS added another layer to the approval process through the Office of the Actuary (OACT) and is performing a more extensive analysis of capitation rate packages sent to them for approval. OACT approvals are required prior to rates being formalized in contracts and actual payments made to plans. These new requirements will increase workload for both internal actuaries and consulting actuaries and increase the amount of technical assistance the actuarial services contractor will be required to provide CMS. In turn, the requirements will increase workload for analytical and research staff who collect, review, maintain, and perform analyses of data that will be used by the actuaries to inform the development of actuarially sound capitation rates.

The new federal rules also provide for additional health care quality and network access and adequacy standards, and require that the certification of actuarially sound rates include consideration of these standards. This is an increased workload for staff who will be required to coordinate with other divisions to collect, review, and structure the necessary data for use by the actuaries.

CRDD staff will be required to develop rate methodologies for each of the above mentioned policy areas. The overhaul of our entire rate setting process creates extensive analytical and research workload which exceeds the capacity of current rate setting staff resources. To meet the requirement of the proposed rule, CRDD requires the following:

1.0 permanent RPS I will use the plan financial statements as well as the MLR calculation reviews to support and assist the actuaries setting the capitation rates. The incumbent will track and update the rate development templates, conduct complex research and data analyses in support of rate development under the new guidelines and develop reports and recommendations in support of data-based policy development. The new rule imposes significant operational challenges that will require consultation with the stakeholder community, health plans, and Departmental staff for the development of new internal and external timelines, processes and payment mechanisms. This includes and is not limited to extensive stakeholder workgroups, the identification of data sources, the development of assumptions, trends, factors, and thresholds, and the determination of current and future

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data baselines. This position will also develop analyses and reports on actual capitation payments and enrollment by examining financial reports, extracting and analyzing enrollment and payment data, analyzing plan submitted fiscal information and IGT transactions, and reviewing applicable financial and utilization ratios and forecasts. The results of the findings will be used for reconciliations and informing policy development.

1.0 permanent RA II will perform statistical studies and perform and review MLR calculations, including verification of proper categorization of healthcare premiums and expenditures submitted by managed care plans. The incumbent will prepare summary descriptions of the outcome of each MLR calculation for each MLR reporting year for all managed care plans, and report the results of the calculations to assist in the rate setting process. This position will develop the methodology to calculate the federal share, and assist in drafting contract language related to MLR requirements to be included in the managed care contracts.

1.0 2-year LT equivalent AGPA will conduct the required studies and reviews of MLR calculations, review financial statements, analyze and verify the proper categorization of healthcare premiums and expenditures submitted by plans, prepare summary descriptions of the outcome of each MLR evaluation. The AGPA will identify and resolve issues related to the financial information provided by plans, identify significant financial trends and provide financial analyses on the plan reported financial information. The AGPA will assist in drafting and implementing contract language related to MLR requirements to be included in managed care contracts.

1.0 permanent RPS I will provide CRDD with ongoing expert technical program consultation related to compliance with the new CMS rules related to rate setting. The RPS I will evaluate and interpret the applicability of the new rules to specific circumstances, evaluate the compliance of existing processes and practices with the new rules and recommend changes as needed, monitor the compliance of proposed legislation with the federal guidelines, and participate in health-related advisory committees and work groups focused on the impacts of the new rules and related compliance strategies. The new rule imposes significant operational challenges that will require consultation with the stakeholder community, health plans, and Departmental staff for the development of new internal and external timelines, processes and payment mechanisms. This includes and is not limited to extensive stakeholder workgroups, the identification of data sources, the development of assumptions, trends, factors, and thresholds, and the determination of current and future data baselines. This position will also develop analyses and reports on actual capitation by examining financial reports, extracting and analyzing enrollment and payment data, analyzing plan submitted fiscal information and IGT transactions, and reviewing applicable financial and utilization ratios and forecasts. The results of the findings will be used for reconciliations and informing policy development.

2.0 permanent AGPAs and 1.0 permanent RA II will assist the corresponding policy area leads (2.0 RPS I and 2.0 RPS II) in the developmental and oversight of stakeholder communications and workgroups; assist in the development of internal and external timeliness, processes, and payment mechanism; and assist in data collection and data analytics. The AGPAs will also provide additional workload assistance associated with the increase in reconciliation activity resulting from the move to prospectively including IGT funded increases in capitation rates. The AGPA positions will work to ensure IGTs are in compliance with the federal rule change. In addition, the AGPA positions will perform

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complex and sensitive research and financial analysis functions, including researching, analyzing, monitoring and documenting the flow of funds for each of the above policy areas. The AGPAs will assist other professional staff in examining financial reports, analyzing fiscal information and IGT transactions, and reviewing applicable financial and utilization ratios and forecasts. The AGPAs will be responsible for maintaining ongoing records and financial historical summaries of the various documents, contract amendments, and incoming and outgoing funds, and will be responsible for reconciliation of funds paid through the IGT to actual payments to plans. In addition, the AGPAs will assist with interactions between funding entities, health plans, counties, CMS, and other interested parties.

1.0 permanent SSM I will plan, organize, and direct the activities of the staff responsible for managing compliance with the new CMS rules related to rate processing. The incumbent will be responsible for overseeing the standard and consistency of work, setting and monitoring goals and priorities, evaluating and documenting performance for direct reports, and communicating with other managers, staff, and stakeholders about program implementation, and policy issues. This position will function as a project lead to ensure that rate processing timelines are met, correspondence with plans and CMS are properly managed, while maintaining rate deliverable schedules as outline in the new federal rules. The incumbent will also be responsible for all aspects of supervision, including recruitment, retention and training, evaluating and documenting performance, and communicating with staff.

Additionally, the 2.0 existing RPS II positions are required to complete the new workload generated by the new federal rules associated with disallowance of the certification of a rate range. In recognition of the importance of adjusting quickly to the new federal requirements and sustaining ongoing workload necessary to comply with the requirements, 2.0 RPS II positions will be shifted from their current assignments and dedicated to performing work related to the new CMS rules. The 2.0 RPS II will assist in complying and analyzing the new required documentation to allow CMS to conduct a sufficient review of rate packages. The new rule imposes significant operational challenges that will require consultation with the stakeholder community, health plans, and Departmental staff for the development of new internal and external timelines, processes and payment mechanisms. This includes and is not limited to extensive stakeholder workgroups, the identification of data sources, the development of assumptions, trends, factors, and thresholds, and the determination of current and future data baselines. This position will also develop analyses and reports on actual capitation payments and enrollment by examining financial reports, extracting and analyzing enrollment and payment data, analyzing plan submitted fiscal information and IGT transactions, and reviewing applicable financial and utilization ratios and forecasts. The results of the findings will be used for reconciliations and informing policy development. The 2.0 RPS II will also assist the RPS I expert technical program consultant and will evaluate and interpret the applicability of the new rules to specific circumstances, evaluate the compliance of existing processes and practices with the new rules and recommend changes as needed, monitor the compliance of proposed legislation with the federal guidelines, and participate in health-related advisory committees and work groups focused on the impacts of the new rules and related compliance strategies.

Other than outlined above, further workload necessary to achieve and sustain ongoing compliance with the new federal requirements cannot be absorbed with existing staffing levels without significantly compromising existing work outcomes and deliverables, which

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include rate development resulting in approximately \$40 billion in annual payments to managed care plans.

Long Term Care Division – 4.0 Staff Resources (2-year LT equivalent)

1.0 Research Program Specialist II (RPS II)

2.0 Research Analyst II (RA II)

1.0 Associate Government Program Analyst (AGPA)

In accordance with Final Rule 2390-P, DHCS is required to update its MLTSS managed care delivery system to include metrics for evaluating the soundness of actuarial payment provisions, promote accountability of Medicaid managed care plans, promote enhanced quality of care provisions, and strengthen delivery systems that serve Medicaid beneficiaries. The requested 2-year LT funding will provide resources necessary for successful implementation of the changes.

The 1.0 AGPA will play a vital role in developing communication strategies and messaging, reviewing current MLTSS managed care plan contracts and MLTSS provider contracts, providing technical assistance to MLTSS managed care plans, MLTSS providers, community stakeholders, and subcontracted vendors to ensure initial compliance with statutory requirements and regulations; preparing and planning for State MLTSS stakeholder committee, managing independent consumer services and supports contracts and monitoring and oversight of MLTSS managed care plans networks, access and provider capacity, stakeholder engagements and independent consumer services and supports contracts to ensure ongoing compliance. Staff will also be responsible for the development, review, and amending of current State approved contracts and development of new policies and procedures applicable to State approved contracts. The staff will serve as a liaison between the department, MLTSS managed care plans and MLTSS providers, providing technical assistance to ensure MLTSS managed care plans and providers adhere to and understand the guidelines stipulated in new MLTSS policies and procedures. Staff will research, design, and develop protocols to initiate outreach and facilitate the formation of an MLTSS Stakeholder Committee. The MLTSS Stakeholder Committee will develop a forum to share and recommend best practices and successful delivery of services to MLTSS beneficiaries. Staff will also be responsible for researching, designing, and implementing guidelines for appropriate coordination of care practices. In conjunction with the development of these guidelines, these resources will also be responsible for researching, developing, and implementing methods for monitoring and oversight of managed care plans and providers. Staff will also work in partnership with the research analysts and research program specialist to develop methodologies and design metrics for extracting quantitative data representative of MLTSS measures and outcomes.

The 2.0 RA II staff will monitor, evaluate and report the expenditures and activities of independent consumer services and supports; as well as assist with other various activities requiring the extraction and analysis of data to ensure successful implementation, administration and operation of changes pursuant to the Final Rule. In addition, they will play a vital role in assisting stakeholders with understanding quantitative data provided by MLTSS programs as the needs of the stakeholders and system evolve. These staff will also have additional workload requirements associated with contributing to the success of the MLTSS program. They will also be responsible for researching, designing, developing, implementing and tracking network adequacy standards for MLTSS. In addition, they will be responsible for researching, designing, developing, implementing and tracking quality

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assurance measures for determining if the data received from MLTSS managed care plans and providers meets federal and state requirements. The staff will be responsible for extracting and analyzing data representative of network adequacy, capacity in MLTSS MCO's, and the quality and level of performance for an MLTSS program. Staff will also be expected to develop metrics for monitoring the effective implementation of care coordination practices as well as develop metrics for assessing MCO compliance with State expectations for facilitation of care coordination practices. Staff will also work in partnership with EITS and management to ensure the appropriate variables or components are included in the development of metrics and data queries. Staff will also be required to prepare and submit ad hoc reports, executive summaries, and departmental memorandums as deemed appropriate.

The 1.0 RPS I staff will be responsible for researching, designing, and implementing metrics and data queries for evaluating expenditures and activities for independent consumer services and supports received by MLTSS beneficiaries. Staff will also extract data representative of variables such as program efficiency, program effectiveness, and quality of program performance. In addition, staff will be responsible for researching, designing, and implementing internal quality assurance measures to ensure the data extracted in conjunction with the projects above have internal validity and reliability. Staff will act as the subject matter expert and will work in collaboration with MLTSS MCO's, providers, and stakeholders to resolve discrepancies with data related to program networks, capacity, efficiency, effectiveness, and/or performance. Staff will also be responsible for reviewing the data metrics and methodologies of MLTSS MCO's and providers to ensure the data provided to the State is in compliance with the federal and state level requirements.

Due to the new workload tasks and deliverables, the demands associated with meeting the needs of community stakeholders and proposed MLTSS program requirements, and the high level of technical expertise required to provide management and oversight of quantitative data collection, the staff in this business plan are vital to the success of implementing and overseeing new MLTSS regulations. The RPS I will work in conjunction with the RA II and its associated workload, assisting in more complex issues associated with the Final Rule.

Office of Legal Services – 6.0 Staff Resources

3.0 Attorney III – 1.0 2-year LT equivalent

3.0 Attorney – 2.0 2-year LT equivalent

Health Care Financing Team (OLS-HCF)

1.0 Attorney III

1.0 Attorney I (2-year LT equivalent)

The legal work associated with managed care finance in California is among the most complex and specialized at the Department, in large part because it requires a high working familiarity with the intricacies of Medi-Cal coverage and State-local fiscal matters, in addition to the primary subject matter expertise regarding Medicaid finance. The need for expert counsel in this area becomes more imperative when considering the heightened requirements and scrutiny that will come to the managed care rate setting realm, and the new initiatives and prohibitions that have been finalized into federal regulation. The final rule has wide legal implications and many sections will require ongoing OLS-HCF support and assistance to ensure successful implementation, compliance and oversight. OLS-HCF

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will assist in the legal component of each division's workload, as well as any litigation of any other legal issues that arise as a result of the final rule. Not only is the legal work in this area complex and far reaching, but it also presents a need for experienced counsel across the spectrum of legal contexts and tasks, including litigation avoidance and support, legislative, regulatory, and contractual work.

The Attorney III and Attorney resources will perform the following activities related to implementation of and ongoing compliance with the various financing components of the final regulations:

- Support the Director's Office and various DHCS programs in all managed care rate development deliberations with CMS and contracted entities, in light of the significant increase in scrutiny the final rule brings to managed care rate setting.
- Support the Director's Office and various DHCS programs in the development and ongoing oversight of financing arrangement
- Research and prepare extensive legal opinions related to statutory and regulatory interpretation, contract interpretation, program administration, and related disputes as required to ensure compliance with relevant federal and state laws, to ensure the ongoing receipt of optimal federal financial participation.
- Draft, review, and analyze finance-related legislation, regulations, policy, procedures, and other departmental guidance, with respect to restructuring programs in line with the rules and on an ongoing basis.
- Provide legal support for all finance-related components of managed care contracts and other associated agreements, including contracts with managed care entities and State-local financing agreements.
- Provide pre-litigation and litigation support.
- Identify, analyze and address any legal issues impacting the financing or payment policies of Medi-Cal programs that arising from implementation of and ongoing compliance with the final rule.

*Health Care Delivery Systems (HCDS) Team
2.0 Attorney III (1.0 2-year LT equivalent)
2.0 Attorney (1.0 2-year LT equivalent)*

Managed Care and Long-Term Care Program Support

The OLS/HCDS team provides legal support to the Managed Care Quality and Monitoring Division (MCQMD), the Managed Care Project Management and Operations Division (MCPMO) and Long term Care Division (LTCD). With MCQMD's MCPMO and LTCD's anticipated increased workload under the proposed regulations, OLS will need two attorney positions (one Attorney III and one Attorney position) to timely and accurately provide the necessary legal support for this additional program workload.

The Attorney III and Attorney resources will perform the following activities:

- Support the Director's Office and various Department programs in meetings with CMS, DOF, Agency and/or the Governor's Office regarding the Department's expanded oversight and monitoring of MCPs, including the legal sufficiency of quality reviews, imposition of sanctions of MCPs, data collection and analytics relating to MCPs, beneficiary protections, provider network adequacy, and increased program integrity measures.

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- Research and prepare extensive legal opinions related to statutory and regulatory interpretation, contract interpretation, program administration, and related disputes as required to ensure compliance with relevant federal and state laws, and to ensure that the new standards being imposed by the regulations are met including but not limited to the following areas: expanded oversight and monitoring of MCPs, imposition of sanctions of MCPs, data collection and analytics relating to MCPs, beneficiary protections, provider network adequacy, and increased program integrity measures.
- On an ongoing basis, draft, review, and analyze managed care-related legislation, regulations, policy, procedures, and other departmental guidance, with respect to modernizing programs in line with the rules.
- On an ongoing basis, provide legal support for all managed care contracts and other agreements, including managed care plan contracts and county-State agreements including determining the legal requirements for and limitation of sub-contract and delegation arrangements.
- On an ongoing basis, provide pre-litigation and litigation support.
- Identify and address any legal issues arising from implementation that impacts Medi-Cal managed care programs.
- Provide the legal support for the auto disenrollment of LTSS members from Plans to ensure regulatory and due process protections.
- Research and prepare extensive legal opinions related to network adequacy compliance standards, the promulgation of Home and Community Based Services regulations and the credentialing of providers.
- Assist in drafting, reviewing, and analyzing managed care-related legislation, regulations, policy, procedures, and other departmental guidance, with respect to on-going modernization of programs in line with the rules.
- Assist in providing pre-litigation and litigation support.
- Identify and address any legal issues arising from implementation that impacts Medi-Cal managed care programs.
- Confirming the legal adequacy of notices to LTSS participants, reviewing and approving MLTSS managed care plan contracts and MLTSS provider contracts, providing technical assistance to MLTSS managed care plans.

Audits & Investigation Program Support

The OLS/HCDS team provides legal support to the Audits and Investigation Division (A&I), which is responsible for ensuring program integrity and the elimination of all source of fraud and abuse in the Med-Cal program. A&I anticipates a substantial workload increase to comply with CMS' new rules. Not only will there be new standards to implement through statutory and regulatory actions, there will also be a significant increase in the number and complexity of the provider enrollment onsite visits and investigations, suspension, and payment withhold actions. OLS will need two attorney positions (one Attorney III and one Attorney staff) to timely and accurately provide the necessary legal support for the additional A&I program workload. An Attorney III is required to provide the experienced legal advice on the stringent provider disclosure for large business entities and providers with numerous investment and professional interests, investigations of complex provider relationships and contracts, as well as the sophisticated rate and performance auditing requirements. The Attorney is required to provide legal assistance with the less complicated but more voluminous investigation, auditing, and general integrity work required by the new regulations.

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The Attorney III and attorney resources will perform the following activities:

- Perform the legal review of periodic and recurrent audits on encounter and financial data submitted by Managed Care Organizations (MCO).
- Provide the legal support for validation of encounter data for rate setting;
- Provide the legal support for the annual auditing of PACE plans, including the setting of audit criteria consistent with the CMS' regulatory mandates.
- Assist in drafting, reviewing, and analyzing managed care-related legislation, regulations, policy, procedures, and other departmental guidance, with respect to on-going modernization of the Department's program integrity efforts in line with the CMS' rules.
- Research and prepare legal opinions related to provider enrollment disclosure verifications and site visits for managed care providers.
- Research and prepare legal opinions related to statutory and regulatory requirements and standards for auditing contracted and subcontracted managed care providers and medical groups.
- Research and prepare legal opinions related to statutory and regulatory requirements for auditing of plan performance data as required by section 438.66.
- Research and prepare legal opinions related to statutory and regulatory requirements for auditing of standards as applied to managed care providers under new regulations.
- Coordination with state and federal efforts to improve program integrity and implement CMS's new standards and regulations for Medi-Cal and Medicare-Medi-Cal plans.
- Assist in drafting, reviewing, and analyzing program integrity related legislation, regulations, policy, procedures, and other departmental guidance, with respect to on-going modernization of the Department's program integrity efforts in line with CMS' new rules.
- Provide legal support and due process analysis for program investigations, suspensions and implementation of payment withholds for managed care providers suspected of engaging in fraudulent activities.

Mental Health Services Division – 2.0 Staff Resources

2.0 Associate Governmental Program Analyst (AGPA)

The Medi-Cal Specialty Mental Health Services (SMHS) program is “carved-out” of the broader Medi-Cal program and operates under the authority of a waiver approved by the Centers for Medicare and Medicaid Services (CMS) under Section 1915(b) of the Social Security Act. DHCS' current 1915(b) waiver was renewed for a five-year period, July 1, 2015 through June 30, 2020.

The comprehensive array of SMHS is provided to Medi-Cal beneficiaries of each county through a Mental Health Plan (MHP). The MHPs are required to provide or arrange for the provision of SMHS to beneficiaries that meet SMHS medical necessity criteria, in a manner that is consistent with the beneficiaries' mental health treatment needs and goals as documented in their treatment plans.

Pursuant to the 1915(b) waiver, MHPs are considered Pre-paid Inpatient Health Plans (PIHPs) and as such, are subject to Medicaid Managed Care (MMC) rules that govern or apply to PIHPs. The new federal regulations will result in a substantial increase in workload in program monitoring and oversight, compliance, and quality assurance areas, which primarily affect the Program Oversight and Compliance Branch (POCB) and the Program

Analysis of Problem

Policy and Quality Assurance Branch (PPQAB), within the Mental Health Services Division (MHSD). Such an increase in DHCS MHSD workload is not feasible with the current staff levels.

To comply with the new federal regulations, DHCS MHSD staff workload will increase in the following areas, requiring the new positions identified above.

Program Policy and Quality Assurance Branch (PPQAB)

PPQAB conducts work in the areas of promulgating necessary state regulations, data collection, and quality improvement strategies. The new position will address complex policy issues, such as promulgating the corresponding state regulations to align with the federal regulations, establishing and publishing provider network adequacy standards for beneficiaries and stakeholders, establishing and publishing cultural sensitivity standards for all populations of beneficiaries, and ensuring full participation in State Fair Hearing procedures and follow-up.

The AGPA will conduct continued review and analysis of the final federal rules; implementation activities related to the new rules including promulgating new, and/or amending existing State regulations to conform to final federal MMC rules, amending the DHCS/MHP contract to conform to the new rules, engaging stakeholders in the process of adopting State regulation and DHCS/MHP contract changes, developing and issuing DHCS MHSUDS Information Notices and other policy guidance related to programmatic changes related to the new rules, and providing technical assistance and training to MHPs to assist with MHP implementation of the new rules.

Program Oversight and Compliance Branch (POCB)

POCB plays a crucial role in collecting, and analyzing the data that will be used to assess the Department's effectiveness in complying with these regulations for SMHS. Approval of this position is necessary to enable POCB to work closely with the MHPs and provide technical assistance to implement a variety of targeted incentives and interventions. The new rules expand the detail and scope of existing oversight activities, by requiring greater detail in oversight activities and verification of information reported by MHPs, including data on provider networks according to a specified range of provider types, cultural and language standards, and quality improvement projects.

The AGPA will perform the new workload in the area of program integrity and related oversight functions. The new rules include new provisions and requirements related to program integrity, particularly related to onsite reviews of MHP providers, which are not currently conducted by POCB. The AGPA will perform regular and ongoing monitoring and oversight of MHPs to ensure compliance with program integrity requirements as well as MHP providers. Specific tasks include, but will not be limited to: developing reporting templates to collect necessary data and information from MHPs, verifying beneficiaries received services, analyzing data collected and developing reports for DHCS management on provider program integrity, and developing findings reports and plans of correction for MHPs and their network providers. In addition, the AGPAs will provide technical assistance and respond to inquiries from the counties of their assigned regions related to this work and the relevant requirements.

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Audits & Investigations Division – 8.0 Staff Resources

1.0 Health Program Auditor III (HPA III)

2.0 Health Program Auditor IV (HPA IV)

5.0 Nurse Evaluator II (NE II)

State Monitoring Requirements (Paragraph 438.66)

The state's monitoring system must address all aspects of the managed care program, including the performance of (1) Administration and management, (2) Appeal and grievance systems, (3) Claims management, (4) Enrollee materials and customer services, (5) Finance, including medical loss ratio reporting, (6) Information systems, including encounter data reporting, (7) Marketing, (8) Medical management, including utilization management and case management, (9) Program integrity, (10) Provider network management, (11) Availability and accessibility of services, (12) Quality improvement, and (13) Areas related to the delivery of long term services.

The State must submit to CMS no later than 150 days after each contract year, a report providing information on and an assessment of the operations of each plan.

To meet these requirements, the Medical Review Branch (MRB) requests:

- 5.0 permanent Nurse Evaluator II, and 1.0 permanent Health Program Auditor III positions to comply with proposed regulations that will require the State to validate encounter data.

The NE II's are needed to validate (on a sample basis) encounter data that managed care plans have submitted for accuracy and completeness.

- Accuracy will be evaluated by comparing reported encounter data against the medical records that should contain evidence of those medical services.
- Completeness will be evaluated by determining whether medical services documented in a random sample of medical records were reported accurately by the plan as encounters.

The HPA III will perform audit related functions pertaining to the encounter data validation, including:

- Determining the audit sample.
 - Utilizing medical determinations to complete tests for accuracy and completeness.
 - Develop audit findings.
 - Prepare a report of findings.
- 2.0 permanent Health Program Auditor IV positions to perform the required audits of the providers contracted and subcontracted to the managed care plans to monitor compliance with the new standards required under 42 CFR section 438.230, which require states to monitor any subcontracts and any sub-contractor that has been delegated one of the contract requirements of the primary managed care plan. For example, Kaiser Permanente has 22 such delegation arrangements in California. A&I estimates 135 hours per delegation arrangement, which equates to two positions. A Health Program Auditor IV position is required because the work involved is of such complexity that it requires a staff specialist to handle the new proposed rule auditing, compliance, implementation, monitoring, and evaluation.

Analysis of Problem

The 2.0 HPA IVs will perform the following functions:

- Develops audit plan/program for delegated entities who function as subcontractors to primary Medi-Cal managed care plans
- Independently performs audit procedures to determine compliance with contract requirements delegated from the primary Medi-Cal managed care plan
- Collects adequate audit evidence, prepares working papers, develops audit findings, and conducts an exit conference with Medi-Cal managed care plan executives
- Prepares audit report and correspondence related to the audit.
- Provide technical audit support to MRB in the evaluation of complex delegation audit issues

In order to fulfill program integrity requirements in Subpart H, § 438.604 requires states to ensure that managed care plans submit encounter data in a manner consistent with § 438.818(a)(2) which requires encounter data to be validated for completeness and accuracy. A&I requires new positions to perform audits of encounter data to ensure completeness and accuracy. This data is then useful for program integrity and its accurate data, which provides insight as to the performance of the managed care plan providers.

Research and Analytic Studies Division – 4.0 Staff Resources

1.0 Research Program Specialist I (RPS I) – 2-year LT equivalent

2.0 Research Program Specialist II (RPS II)

1.0 Research Scientist II (RS II) – 2-year LT equivalent

1.0 Research Program Specialist I (RPS I): The RPS I will perform technical research and statistical work necessary to accomplish the objectives and tasks of DHCS' FFS access monitoring activities. The RPS I will accomplish these objectives through the use of various computer programs to obtain and analyze Medi-Cal data. The RPS I will interpret research study findings and communicate them to Department management. The RPS I will be responsible for research functions related to access monitoring for subpopulations within Medi-Cal, and will work closely with the analytical staff to achieve this objective.

The RPS I will research current literature relating to patient access to care, and identify national benchmarks for health outcomes, health care utilization, and health system capacity measurement. These benchmarks will be incorporated into numerous reports to evaluate Medi-Cal program policies and initiatives with specific goals aimed at beneficiary subgroups. The RPS I will create healthcare metrics such as beneficiary enrollment trends, healthcare provider distribution, and health services utilization trends using multiple sources of data, and compare research findings to national benchmarks.

The RPS I will prepare written materials tailored for various audiences, allowing dissemination of information in the broadest manner possible. To complement narrative text, the RPS I will create charts, tables, and other visuals in order to more effectively convey program information, and develop narrative text to describe the findings of the research and data analysis. The RPS I will verify that deliverables are formatted correctly, and proofread and edit written materials to ensure accuracy and clarity.

2.0 Research Program Specialist II (RPS II): The RPS II will perform technical research and statistical work necessary to accomplish the objectives and tasks of DHCS' FFS access monitoring activities. The RPS II will accomplish these objectives through the use of various computer programs to obtain and analyze Medi-Cal data. The RPS II will interpret, document, and present these findings to Department management, and create a

Analysis of Problem

comprehensive document describing what is needed to satisfy new access monitoring requirements.

The RPS II will provide lead assistance in developing analytic datasets and complex models to evaluate health programs and services. Using a variety of sources, the RPS II will develop and evaluate health care metrics; monitor release dates/update schedules for source data files; and request files from OSHPD, CHIS, and CDPH.

The RPS II will serve as an expert on the use of a variety of technical computer applications, such as SAS, ArcGIS, and Microsoft Office suite, designed to process/format data and to conduct complex data display and statistical analysis. The RPS II will instruct other staff in procedures for developing file extracts and the more complex use of statistical software.

The RPS II will develop innovative methods to analyze and present data, and build quarterly analytic datasets using Medi-Cal administrative data, external linked files, and state surveys. The RPS II will perform exploratory data analysis and specify criteria for extracting information from multiple sources of data. The RPS II will assist senior-level research staff with complex linkage projects that join Medi-Cal administrative data to external datasets such as the OSHPD Patient Discharge Data and the CDPH Birth and Death Statistical Master Files, performing quality checks on linked results.

1.0 Research Scientist II (RS II): The RS II will design, organize, and direct highly complex scientific research projects in order to evaluate access to care in the FFS health care delivery system. The RS II will make decisions of a highly technical and scientific nature related to study design, evaluation techniques, access metrics, and statistical methods. This will ensure analytic support in the development of historical baseline statistics, and evaluation of literature studies. The RS II will develop major scientific studies that determine the current and future health care needs of program beneficiaries; assess and evaluate individual barriers to health care services; assess capacity of the Medi-Cal health care delivery system; evaluate the geographic dispersion of service providers; measure and evaluate health care access disparities among groups, evaluate and explain the impact of social economic status on access to health care services, and explain Medi-Cal's unique role in providing health care services to complex populations with multiple co-morbidities and social economic challenges..

The RS II will use both qualitative and quantitative methodologies, and apply novel techniques where no methodologies have previously been established. The RS II will enhance or expand upon Departmental data sources, and will function as the lead scientific advisor for the Department's health care access monitoring system.

The RS II will plan, develop, and evaluate probabilistic linking and summarization of Medi-Cal administrative data and identifiable patient-level utilization data created by research staff. In order to design linked, summarized, or qualitative analytic files, the RS II 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 (OSHPD), the California Department of Public Health (CDPH) Vital Statistics Death Statistical Master File and Birth Statistics Master File, the California Health Interview Survey (CHIS), U.S. Census data, Department of Finance demographic and economic data, and DHCS' Provider Master File.

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Administration Division – 3.0 Positions

1.0 Personnel Specialist (PS)

1.0 Associate Personnel Analyst (APA)

1.0 Associate Governmental Program Analyst (AGPA)

Human Resources Branch

CMS' Final Rule 2390-P has department-wide impact; ensuring compliance with its proposed regulations will require a significant increase in DHCS workload. This workload will be completed by newly proposed positions and resources (excluding the three Administration Division positions), 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 workforce, as well as handle position employment, performance management, payroll and benefits, injured worker, and labor relations. HRB is requesting a PS and APA to oversee the hiring and administration of the new staff. The PS positions will handle all personnel transactions in the areas of personnel record keeping, certification, payroll, and personnel documents processing and related personnel transactions functions. The APA handles all classification, performance management, and management consultant issues with the Divisions. These positions are needed to administer the appropriate laws, rules, regulations, and contract language pertaining to personnel transactions, employee relations, and performance management. Without these positions, HRB is unable to timely complete its current workload, along with the new workload.

Program Support Branch

The Contract Management Unit (CMU) within the Program Support Branch is requesting an AGPA position to provide CMU with the necessary resources to assist in its efforts in streamlining and strengthening the overall contracting process. The AGPA will provide necessary oversight, evaluation and technical support for the implementation of the Medicaid and CHIP Managed Care Final Rule CMS-2390-P while ensuring compliance with State Contracting Manual (SCM), Public Contract Code (PCC), Government Code (GC) and Federal guidelines.

CMU provides a critical role for the Department by providing management and oversight of the contract procurement processes, review, contract development and approval for the Department which consists of approximately 40 Divisions. Currently, CMU processes approximately 1,000 contracts per Fiscal Year totaling over \$1 billion which include general and federal funds. CMU ensures that all contracts meet SCM, PCC, GC and Federal guidelines. To ensure that all guidelines are followed, CMU is in the process of updating and implementing new policies and procedures which are aimed at streamlining the overall contract flow. This process will improve any outstanding deficiencies and allow CMU to manage current workload within existing resources. Due to the additional funding, size, volume and complexity of the contracts that will be forthcoming with the Proposed Rule, CMU's workload will increase significantly and will therefore require additional staff.

Analysis of Problem

E. Outcomes and Accountability

The approval of the requested positions will create the following outcomes, among others as described below in the projected outcomes charts:

Managed Care Operations Division

MCOD MCSSB Waiver & Cal MediConnect Section

MCOD MCSSB Operations

Without these resources, DHCS would be at risk of not meeting the new requirements included in the proposed federal regulations (§438.71, §438.10 - § 438.14, § 438.207) and potentially face fines from CMS. DHCS has all oversight responsibilities for the contract management and the monitoring of 35 managed care contracts with health plans providing Medi-Cal services to an estimated 9.6 million Medi-Cal Managed Care enrollees in all 58 California Counties. DHCS will continue to utilize the staff for the ongoing required elements referenced in the proposed federal regulations to ensure the oversight, contract management, and monitoring; including that all required reporting to CMS is completed accurately and timely.

If the requested resources are granted, the following outcomes will be achieved:

- All required documentation for provider directory review and approval timely.
- Standardization of provider directories to establish comprehensive quality strategies for all managed care programs regardless where in the state beneficiaries obtain these informing materials.
- Provider network review and certification which includes reporting, tracking and monitoring will be conducted on a timely basis.
- Tracking systems for managing the increased volume of provider directory reviews and approval, document control for standardization of provider directories.
- Strategic planning for future provider network expansions will be instituted with periodic measuring for performance of goals.
- Beneficiary protection and beneficiary support systems by developing and implementing a beneficiary enrollment complaint process that offers an internal appeals process with specified time frames, with external appeal to the state fair hearing process in the event of an adverse determination.
- New communication channels will continue to be developed to enhance all aspects of ongoing activities, including the utilization of new technologies whenever possible.
- Feedback loops for issue resolution for stakeholders and DHCS staff.
- Timely response to questions from stakeholders and other outside entities.
- Ensure compliance of medical LTSS criteria by managed care plans through regular reviews and to identify and resolve issues.
- Development, implementation and ongoing review/monitoring of model template handbook for managed care enrollees.

MCOD MCSSB SSU

In addition to the current workload, new efforts include: daily/weekly communication with call center & contract staff, conducting site visits, secret caller activities, call monitoring and providing assistance as required; compiling mandated statistics for reports; developing a new system to track complaints; and compiling documents for requests for information from the legislature and/or other entities.

Analysis of Problem

Capitated Rates Development Division

With the requested funding, the Department will be able to provide necessary additional funding for a contract for actuarial consulting services and those actuaries will be able to comply with the new CMS rules to calculate and certify managed care capitation rates and complete rate packages for annually redetermined rates and all associated revisions to the capitation rates. Rate packages include rate calculation worksheets, summary files, actuarial certifications in compliance with new federal requirements, methodology documents, program change charts, and data files documenting managed care efficiency adjustments and risk adjustment data. The Department will then have the appropriate rates and supporting documentation available to satisfy CMS requirements and thereby obtain federal matching funds.

Mental Health Services Division

Expected MHSD outcomes of the approval of these positions would include the following:

- Continued approval and retention of the five-year Medi-Cal SMHS Waiver by providing the staff resources needed to implement and comply with the new federal rules;
- Compliment compliance with and implementation of the 1915(b) waiver Special Terms and Conditions (STCs) that are consistent with new federal rules;
- Promote improved quality of care;
- Strengthen efforts to improve the MHP delivery systems that serve Medi-Cal beneficiaries;
- Promote appropriate beneficiary protections;
- Enhance MHP policies related to program integrity;
- Enhance the state's ability to identify and investigate fraud, waste, and abuse; and,
- Establishment of comprehensive quality strategies for the SMHS Program.

Audits and Investigations Division

The resources requested for encounter data validation will allow Audits & Investigations to perform the important aspects of encounter data validation, including determining the completeness and accuracy of the submitted data.

Staff Accountability: The DHCS management staff will review the actions of the staff requested by this proposal to ensure program goals are achieved. In addition, the federal Office of the Inspector General conducts regular periodic program integrity reviews to ensure compliance with federal standards of participation in the Medicaid program.

For Projected Outcomes Tables, See Attachment C

F. Analysis of All Feasible Alternatives

Alternative 1: Approve the establishment of 38.0 permanent positions and expenditure authority, and 2-year limited-term funding for staff resources and contractual services to support the implementation of Medicaid and CHIP Managed Care Final Rule CMS-2390-P and Final Rule CMS-2328-NC. \$10,411,000 (\$4,984,000 General Fund/\$5,427,000 Federal Fund)

Analysis of Problem

Pros:

- Workload associated with implementing the final rules need to be processed and completed in a timely manner.
- Allows DHCS to research, administer, and communicate the new standards and criteria of the new federal rulemaking.
- Allows DHCS to monitor and evaluate the programs, the new standards and criteria of the new federal rulemaking.
- DHCS will be able to comply with all federal regulations.

Cons:

- Increase in General Fund costs.
- Expands state government

Alternative 2: Approve two-year limited term expenditure authority of \$10,411,000 (\$4,984,000 General Fund/\$5,427,000 Federal Fund) for workload associated with implementation of CMS Final Rules 2390-P and 2328-NC.

Pros:

- Less impact to the General Fund if positions are not renewed/extended after 2 years.
- DHCS would continue to meet state and federal regulations in the Managed Care Final Rules.
- Allows DHCS to research, administer, and communicate the new standards and criteria of the new federal rulemaking.
- Allows DHCS to monitor and evaluate new standards and criteria of the new federal rulemaking.
- Would provide temporary assistance to new workload demands.

Cons:

- This approach does not ensure continuity of program operations and maintenance.
- Loss of knowledge from staff after the 2-year, limited-term basis has expired.
- Limits opportunities for program growth and development.
- Difficulty in recruiting and maintaining staff in limited-term positions.

Alternative 3: Approve two-year limited term expenditure authority of \$10,411,000 (\$4,984,000 General Fund/\$5,427,000 Federal Fund), with staggered implementation dates for ongoing workload associated with implementation of CMS Final Rules 2390-P and 2328-NC.

Pros:

- Less impact to the General Fund as positions would not all start effective 7/1/16.
- DHCS would be meet state and federal regulations, in most areas, of the CMS Final Rule 2390-P.
- Would provide temporary assistance to new workload demands.

Analysis of Problem

Cons:

- This approach does not ensure continuity of program operations and maintenance.
- Current workforce will have to absorb the new workload for a significant period of time, jeopardizing the Department's ability to comply with all regulations.
- Restricts the Department's ability to oversee, administer, and audit properly.

Alternative 4: Redirect existing staff and do not approve contract, no cost.

Pros:

- No additional funding or staffing is required.
- Does not expand state government.

Cons:

- Current workloads may be abandoned or the federally mandated regulations will not be implemented.
- Burdens existing staff with additional workload and may require payment of overtime.
- May burden other Divisions.
-
- May lose the ability to successfully implement the initiatives outlined in the new federal rulemaking.
- May be unable to perform the administration and oversight of the programs outlined in the new federal rulemaking.

G. Implementation Plan

CMS finalized proposed rules 2390-P and 2328-NC. Due to the wide scope and sheer amount of changes the regulation proposes, once these resources are approved, detailed duty statements will be developed and recruitment efforts will begin with a plan for the positions to be filled as soon as possible. As all requested resources will become effective July 1, 2016, there is the possibility of a period where existing DHCS staff will have to assume the additional workload.

CMS published an implementation schedule for provisions of the final rule.

The following key areas affect Capitated Rates Development Division (CRDD) current rate setting process and fundamentally overhaul key requirements, practices, and procedures related to capitation rate setting by introducing new requirements which require the Department to change existing rate practices and procedures.

Implementation required 60 days after final publication:

- 438.2 Rate related definition changes

Analysis of Problem

Implementation no later than July 1, 2017:

- 438.5 Rate development standards
 - 438.5 (b) Annual Medical Loss Ratio (MLR) calculations must be calculated, reported, and used in developing rates for future years.
 - 438.59 (c) – (f) Base data, trend, non-benefit component of the rate, and rate adjustment changes.
- 438.6 Pass-through payments under managed care organization contracts and special contract provisions related to payment changes
- 438.7 Rate certification submission changes
- 438.74 State oversight of the minimum MLR requirement.
- 438.8 MLR standards changes

Implementation no later than July 1, 2018:

- 438.4 Actuarial Certification to a rate per rate cell (elimination of rate range)
- 438.4 Actuarial soundness, capitation rates must be adequate to meet Section 438.206, 438.207, and 438.208
- 438.7 Ability to increase or decrease certified capitation rate

Implementation no later than July 1, 2019:

- 438.4 (b) (9) Actuarial Soundness – rates must be developed and certified so that a plan can reasonably achieve an MLR of at least 85 percent

H. Supplemental Information

DHCS is currently at capacity and will need cubicle buildouts including cabling at a one-time cost of \$285,000.

MCQMD is also requesting \$3 million in 2-year LT expenditure authority to support data auditing and validation by an external quality review organization (EQRO) which will be critical to ensuring the department has appropriate resources to evaluate and publicly report MCP health outcomes and utilization factors experienced by Medi-Cal members accessing services in the managed care delivery system. The EQRO funding is available for 50% Federal Reimbursement and 50% General Fund. This additional funding will allow the EQRO contractor to expand its quality review activities as defined in the contract's scope of work and in compliance with the requirements of the new federal rulemaking (42 CFR 438.310, et seq. [Quality Measurement]).

I. Recommendation

DHCS recommends approval of Alternative #1 which would authorize 38.0 permanent positions and expenditure authority, and 2-year limited-term funding for staff resources and contractual services to support the implementation of Medicaid and CHIP Managed Care Final Rule CMS-2390-P and Final Rule CMS-2328-NC. \$10,411,000 (\$4,984,000 General Fund/\$5,427,000 Federal Fund)

WORKLOAD STANDARDS
Managed Care Quality and Monitoring Division
Program Monitoring and Compliance Branch
Associate Governmental Program Analysts / 805-146-5393-xxx
1.0 Permanent and 2.0 2-Year Limited-Term Equivalent

Activities	Number of Items per Year	Hours per Item	Total Hours	Total Hours
Assists research staff in analyzing policy related to data gathering and validation, network adequacy, MCP readiness, and performance monitoring, as required at 42 CFR 438.66, 438.68, 438.302, 438.602, and 438.608.. 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.	40	15	600	1800
Researches and makes recommendations to management on program monitoring and evaluation methods related to the new federal rulemaking; develops these methods as directed by management. Activities could include establishing and documenting operational procedures, policies, review tools, and tracking systems.	20	20	400	1200
Provides ongoing technical assistance on program and contract issues related to implementation of the new federal rulemaking to managed care plans, other departmental programs, and State and federal agencies. Resolves programmatic and technical questions.	20	20	400	1200
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 new federal rulemaking. This will include training other staff, documenting processes, establishing tracking systems, reviewing plan documents.	20	10	200	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.	20	10	200	600
Total hours worked			1,800	5,400
1,800 hours = 1 Position				
Actual number of Positions requested			1.0	1.0

WORKLOAD STANDARDS
Managed Care Quality and Monitoring Division
Program Monitoring and Compliance Branch
Research Program Specialists II / 805-146-5758-xxx
1.0 Permanent and 1.0 2-year LT equivalent

Activities	Number of Items per Year	Hours per Item	Total Hours	Total Hours
Independently designs and develops statistical studies and research on the most complex issues of high value to the Department related to monitoring the performance of health plans, and network adequacy, as defined at 42 CFR 438.66, 438.68, 438.242, and 438.340. Prepares and presents technical reports to management and stakeholder groups. Identifies and applies research methods required to ensure the collection and analysis of appropriate, meaningful, and unbiased data. Identifies required data, information, materials, and resources needed to complete/perform a project. Conducts and interprets descriptive and/or inferential statistical analyses using appropriate software (GIS Mapping, SPSS, SAS, and Excel) to test research hypotheses and to formulate conclusions and recommendations.	6	100	600	1200
Uses sound research methods and principles; analyzes statistics to reach sound conclusions and/or make recommendations to MCQMD regarding policy and other related issues. Prepares detailed reports that clearly and concisely identify the problem, potential solutions, and a proposed course of action. Writes reports, policies, and procedures using proper grammar, punctuation, and sentence structure.	6	100	600	1200
Reviews legislation for its impact on MCQMD and makes 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	480
Acts as a lead to facilitate meetings and discussions regarding MCQMD-related topics in a manner that ensures participants remain focused on the intended topic and encourages active participation.	12	15	160	320
Participates in meetings and conference calls related to expert subject areas; acts as a liaison for the MCQMD, and performs other duties as required.	50	4	200	400
Total hours worked			1,800	3,600
1,800 hours = 1 Position				
Actual number of Positions requested			1.0	1.0

WORKLOAD STANDARDS
Managed Care Quality and Monitoring Division
Program Monitoring and Compliance Branch
(2.0) Research Program Specialists I / 805-146-5742-xxx
Permanent

Activities	Number of Items per Year	Hours per Item	Total Hours	Total Hours
Independently, and in collaboration with the Research Program Specialist II, designs and develops statistical studies and research related to annual network certifications, expanded time and distance standard requirements, and in taking, monitoring and conducting quality checks with an expanded provider file, and working with encounter data, as defined at 42 CFR 438.66, 438.68, 438.242, and 438.340. Identifies and applies research methods required to ensure the collection and analysis of appropriate, meaningful, and unbiased data. Identifies required data, information, materials, and resources needed to complete/perform a project. Conducts and interprets descriptive and/or inferential statistical analyses using appropriate software (SPSS, SAS, and Excel) to test research hypotheses and to formulate conclusions and recommendations.	6	100	600	1200
Uses sound research methods and principles; analyzes statistics to reach sound conclusions and/or make recommendations to MCQMD regarding policy and other related issues. Prepares detailed reports that clearly and concisely identify the problem, potential solutions, and a proposed course of action. Writes reports, policies, and procedures using proper grammar, punctuation, and sentence structure.	6	100	600	1200
Reviews legislation for its impact on MCQMD and makes 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	480
Acts as a lead to facilitate meetings and discussions regarding MCQMD-related topics in a manner that ensures participants remain focused on the intended topic and encourages active participation.	12	15	160	320
Participates in meetings and conference calls related to expert subject areas; acts as a liaison for the MCQMD, and performs other duties as required.	50	4	200	400
Total hours worked			1,800	3,600
1,800 hours = 1 Position				
Actual number of Positions requested			1.0	2.0

WORKLOAD STANDARDS
Managed Care Quality and Monitoring Division
Program Monitoring and Compliance Branch
(1.0) Research Manager I / 805-146-5734-xxx
Permanent

Activities	Number of Items per Year	Hours per Item	Total Hours
Directs the work of a team of research program specialists, research analysts, and other analytical staff in the planning, organization, and performance of research projects that involve designing large scale data collection processes; establishing goals, objectives, priorities, and procedures for evaluation of the Medi-Cal Managed Care program; and ensuring that the studies undertaken result in valid results.	100	10	1000
Collaborates department wide with researchers, epidemiologists, biostatisticians, and other research and healthcare professionals related to essential functions of the Medi-Cal Managed Care program.	50	4	200
Manages data management activities, including: providing expert guidance and direction on research design, statistical analysis, program logistics, and data collection and processing; develops strategies for the evaluation and validation of the completeness and accuracy of encounter data submitted by the health plans; and prepares and interprets complex statistical reports.	50	4	200
Communicates program development and evaluation strategies, findings, and recommendations both verbally and in writing to managed care contractors, all levels of Department management, the federal Centers for Medicare and Medicaid Services (CMS), the professional healthcare community, and other stakeholders.	20	10	200
Represents the Division and the Department at various meetings and/or hearings, including meetings with advocacy groups, health plans, CMS, and Department management.	40	5	200
Total hours worked			1,800
1800 hours = 1 Position			
Actual number of Positions requested			1.0

WORKLOAD STANDARDS
Managed Care Quality and Monitoring Division
Policy and Medical Monitoring Branch
Associate Governmental Program Analysts / 805-147-5393-XXX
2.0 Permanent and 3.0 2-Year Limited-Term Equivalent

Activities	Number of Items per Year	Hours per Item	Total Hours	Total Hours
Performs data collection and analysis related to managed care quality and performance measures; calculates and reports to management on quality trends among specified provider types; calculates other data trends as required; develops additional quality data measures as necessary to identify emerging issues and trends; alerts other team members and management with recommended actions or alternatives. In support of 42 CFR 438.66(c).	50	12	600	3000
Researches and makes recommendations to management on program monitoring and evaluation methods related to the new federal rulemaking, including developing a proposal for submission and analysis of Physical Accessibility Review data. Activities might also include establishing and documenting operational procedures, policies, review tools, and tracking systems. In support of 42 CFR 438.66(d).	25	16	400	2000
Provides ongoing technical assistance on program and contract issues related to implementation of the new federal rulemaking to managed care plans, other departmental programs, and State and federal agencies. Resolves programmatic and technical questions. Includes assisting managed care plans in use of SharePoint software to convey quality and performance data and to participate in training. In support of 42 CFR 438.66(b).	20	20	400	2000
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 new federal rulemaking. This will include training other staff, documenting processes, establishing tracking systems, reviewing plan documents. In support of 42 CFR 438.66(e), 438.68, 438.302, 438.602, and 438.608.	20	10	200	1000

Activities	Number of Items per Year	Hours per Item	Total Hours	Total Hours
Assists in developing policy letters related to the implementation of enhanced standards and processes required under new federal rulemaking (CMS-2390-P). 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. In support of 42 CFR 438.66(e), 438.68, 438.302, 438.602, and 438.608.	20	10	200	1000
Total hours worked			1800	9,000
1,800 hours = 1 Position				
Actual number of Positions requested			1.0	2.0

WORKLOAD STANDARDS
Managed Care Quality and Monitoring Division
Policy and Medical Monitoring Branch
(1.0) Associate Governmental Program Analysts / 805-147-5393-xxx
Permanent

Activities	Number of Items per Year	Hours per Item	Total Hours
Act as lead in the development and effectuation of regulations. Identify, develop, and amend regulations as necessary. Research and review past and present federal and state statutes, regulations, policy documents and contract language. Assist in testifying at public hearings. Respond to public comments. Coordinate with Department and Division program staff, OLS, OOR and OAL. Seek stakeholder input. Respond to inquiries from Agency, Department of Finance, and Fiscal Forecasting.	2	540	1080
Analyze state and federal legislation for impact on MCQMD, MCOD and DHCS. Develop legislative proposals and trailer bill language to implement changes to existing programs or to develop new programs. Coordinate and meet with inter and intra departmental agencies and legislative staff on bill related issues. Assist in testifying at legislative hearings. Respond to legislative and constituent related inquiries and questions. Coordinate legislative reports.	10	36	360
Provide policy support for MCQMD and MCOD. Identify, research, and assess policy related statutory, regulatory, program, procedural, contractual, and operational issues and questions.	120	1.5	180
Draft and coordinate all plan letters and duals plan letters for MCQMD, MCOD, other DHCS Divisions, and inter and intra departmental entities. Draft and review managed care plan contract language.	30	6	180
Total hours worked			1,800
1,800 hours = 1 Position			
Actual number of Positions requested			1.0

WORKLOAD STANDARDS
Managed Care Quality and Monitoring Division
Policy and Medical Monitoring Branch
2-Year Limited-Term Equivalent to (1.0) Health Program Specialist II

Activities	Number of Items per Year	Hours per Item	Total Hours
Act as a liaison and lead consultant to prepare, coordinate, and monitor MCQMD issues or projects addressing highly sensitive and complex healthcare issues; provide direction and assistance to management and other staff regarding policy issues, health program activities, and facilitate workgroups 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 public health and health care projects; 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. Provides higher level of program leadership required for quality monitoring under the new federal rulemaking (42 CFR 438.330).	6	100	600
Act as a subject-matter expert to revise, monitor, and help finalize various MCQMD issues or projects, including participate in health care committees and workgroups providing oversight, input and direction as it pertains to health care program evaluations and improvements in the MCQMD's multiple priority areas, as required at 42 CFR 438.66, 438.68, 438.302, 438.602, and 438.608.	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 high sensitivity regarding health care data monitoring and health care data collection processes.	12	15	160
Represent MCQMD in meetings and other forums on issues related to the Medi-Cal benefits and performs other duties as required.	50	4	200
Total hours worked			1,800
1,800 hours = 1 Position			
Actual number of Positions requested			1.0

WORKLOAD STANDARDS
Managed Care Quality and Monitoring Division
Policy and Medical Monitoring Branch
(1.0) Medical Consultant I / 805-147-7787-xxx
Permanent

Activity	Number of Items per Year	Hours per Item	Total Hours
As described at 42 CFR 438.402 et seq., renders clinical determinations of beneficiary requests for medical exemption from mandatory enrollment in managed care plans (MCPs). Analyzes requests in relation to beneficiary medical conditions, provider documentation, and State and federal law and policy. Provides expert testimony at related State Fair Hearings.	200	5	1000
Develops and updates MCQMD medical policy relevant to monitoring and quality-improvement activities specified in federal rulemaking CMS-2390. Provides expert technical assistance to MCQMD staff and management on clinical issues and medical procedure. Serves as liaison to other Department programs/offices, public health agencies, and other State agencies and staff to assure appropriate coordination of monitoring and quality improvement policy development, interpretation, and implementation.	80	5	400
Participates on committees and workgroups developed to discuss quality improvement and monitoring issues, such as maintaining the integrity of the quality rating system (42 CFR 438.334 and 438.340). Schedules and facilitates meetings with outside groups to discuss issues of mutual interest.	40	5	200
Participates in education/training efforts involving quality improvement and monitoring issues both within and outside the Department and performs other duties as necessary.	20	10	200
Total hours worked			1,800
1,800 hours = 1 Position			
Actual number of Positions requested			1.0

WORKLOAD STANDARDS
Managed Care Quality and Monitoring Division
Policy and Medical Monitoring Branch
(1.0) Research Analyst II / 805-147-5731-xxx
Permanent

Activity	Number of Items per Year	Hours per Item	Total Hours
Analyze data related to quality improvement and performance standards and make recommendations to management regarding corrective actions and improvement projects. Collaborate with the HPS II in developing data analysis in support of statewide quality improvement projects, as required at 42 CFR 438.66 and 438.330.	50	20	1000
Develop operational processes and procedures for tracking corrective actions, and calculate potential sanctions in the event of chronic underperformance.	10	20	200
Collaborate with AGPAs in quantification of policy assumptions related to budgets and legislative proposals.	10	10	100
Evaluate contract language in light of new monitoring requirements and propose updates to Branch procedures for ensuring compliance.	10	10	100
In consultation with clinical and research staff, research and collect data needed for quarterly and annual reports on quality improvement and performance measures.	15	20	300
Develop and perform research to respond to inquiries from oversight agencies such as CMS, Department of Finance, and the State Legislature. Conduct research specific to impact of enrollment and capitation rates.	10	10	100
Total hours worked			1,800
1,800 hours = 1 Position			
Actual number of Positions requested			1.0

WORKLOAD STANDARDS
Managed Care Quality and Monitoring Division
(1.0) Office Technician (Typing) / 805-145-1139-xxx
Permanent

Activity	Number of Items per Year	Hours per Item	Total Hours
Receive format, log, and route internal documents for Division staff.	150	4	600
Receive, log, and route delivery of deliverables and reports from external stakeholders.	400	1	400
Schedule and coordinate meetings for Division managers and staff.	250	2	500
Support activities of other Division clerical staff.	100	1	100
Assist staff in scheduling travel and onsite monitoring visits.	50	2	100
Take notes for meetings and phone conferences.	50	2	100
Total hours worked			1,800
1,800 hours = 1 Position			
Actual number of Positions requested			1.0

WORKLOAD STANDARDS
Managed Care Operations Division
Managed Care Systems and Support Branch
2-Year Limited-Term Equivalent to (1.0) Associate Information Systems Analyst

Activities	Number of Items per Year	Hours per Item	Total Hours
Works independently with program staff to identify business and system requirements and define project scopes. Based on project scopes, draft c-letters, change orders and system development notices.	125	2	250
Provides direct contractor oversight and monitoring and compiles mandated statistics for reports.	100	4	400
Monitors call center activities. This includes researching, reviewing, existing call material and scripts, and altering and/or developing and providing new Customer Service Representative scripts, performing site visits, conducting random call screening, and conducting undercover calling.	100	4	400
Maintains daily and weekly communication with call center and contract staff in the form of phone/conference calls, emails, webinars, in person meetings and training sessions. Monitor reports and test new system implementations.	275	2	550
Independently researches and develops a new system to track complaints. Researches, analyzes and compiles documents for requests for information from the Legislature and/or other entries. Ensures requests are in compliance with release guidelines.	100	2	200
Total hours worked			1,800
1,800 hours = 1 Position			
Actual number of Positions requested			1.0

WORKLOAD STANDARDS
Managed Care Operations Division
Managed Care Systems and Support Branch
(2.0) Associate Governmental Program Analyst / 805-156-5393-xxx
Permanent

Activities	Number of Items per Year	Hours per Item	Total Hours	Total Hours
Respond to the Plans' questions and concerns, verbally and/or in writing, be able to prioritize work, and be an effective communicator. Reviews and analyzes reports and performance data as well as all types of contractually required submissions, e.g. provider directories, marketing material/member material, newsletters, marketing plan, provider networks, subcontracts, retro-disenrollment requests; collect data for tracking and trending.	900	1.5	1350	2700
Maintains and develops statistical reports relating to contractors' performance; and make recommendations regarding contractors' performances. Collects data for tracking and trending; maintains and develops statistical reports relating to contractors' performance; and makes recommendations to upper management.	24	12	288	576
Resolves questions regarding the program and provides technical assistance to contractors and State/federal agencies; communicates via written correspondence, telephone, and e-mail on contract issues and problems in a timely manner; consults with financial auditors, nurses, and pharmacy consultants in the performance of medical and fiscal administrative reviews;	100	1	100	200
Represents the Medi-Cal Managed Care Program at meetings with community stakeholders, various task forces, county agencies, consumers, providers, and other governmental staff (i.e., Department of Managed Health Care, Center for Medicare & Medicaid Services, and Department of Finance).	6	2	12	24
Completes special assignments, including, but not limited to, Request for Applications and Requests for Proposals; transitioning new populations to managed care; and overseeing health plan implementation in a county or region.	3	20	60	120
Total hours worked			1810	3,620
1,800 hours = 1 Position				
Actual number of Positions requested				2.0

WORKLOAD STANDARDS
Managed Care Operations Division
Managed Care Systems and Support Branch
2-Year Limited-Term Equivalent - (1.0) Associate Governmental Program Analyst

Activities	Number of Items per Year	Hours per Item	Total Hours	Total Hours
Respond to the Plans' questions and concerns, verbally and/or in writing, be able to prioritize work, and be an effective communicator. Reviews and analyzes reports and performance data as well as all types of contractually required submissions, e.g. provider directories, marketing material/member material, newsletters, marketing plan, provider networks, subcontracts, retro-disenrollment requests; collect data for tracking and trending.	900	1.5	1350	1350
Maintains and develops statistical reports relating to contractors' performance; and make recommendations regarding contractors' performances. Collects data for tracking and trending; maintains and develops statistical reports relating to contractors' performance; and makes recommendations to upper management.	24	12	288	288
Resolves questions regarding the program and provides technical assistance to contractors and State/federal agencies; communicates via written correspondence, telephone, and e-mail on contract issues and problems in a timely manner; consults with financial auditors, nurses, and pharmacy consultants in the performance of medical and fiscal administrative reviews;	100	1	100	100
Represents the Medi-Cal Managed Care Program at meetings with community stakeholders, various task forces, county agencies, consumers, providers, and other governmental staff (i.e., Department of Managed Health Care, Center for Medicare & Medicaid Services, and Department of Finance).	6	2	12	12
Completes special assignments, including, but not limited to, Request for Applications and Requests for Proposals; transitioning new populations to managed care; and overseeing health plan implementation in a county or region.	3	20	60	60
Total hours worked			1810	1810
1,800 hours = 1 Position				
Actual number of Positions requested				1.0

WORKLOAD STANDARDS
Capitated Rates Development Division
(1.0) Research Program Specialist I / 805-760-5742-xxx
CMS Rule Change
Permanent

Activity	Number of Items	Avg. Hrs. per Item	Total Annual Hours
Lead operational activities, including stakeholder engagement and planning of timelines and processes, related to the development of a new rate setting methodology.	12	20	240
Conduct studies of complicated financial issues using plan financial statements and MLR calculation assessments to develop reports used in rate development and identify potential fiscal program impacts to plans not in compliance with MLR rules.	30	15	450
Work with DHCS and contracted actuaries to modify, maintain, disseminate and process Rate Development Templates (RDTs). Analyze RDTs and work with plans to ensure correct submission of RDT information.	40	9	360
Conduct complex research and data analyses in support of rate development under the new CMS rule. Develop reports and recommendations in support of policy decisions.	10	16	160
Participate in work groups and meetings with internal and external stakeholders, and support and assist the actuaries setting the capitation rates. Advise management as a subject-matter expert and make recommendations on proposals and alternatives related to the new CMS rule.	52	6	312
Extract, review, and analyze financial and utilization data, including financial statements and reports, managed care enrollment data, and IGT transactions. Develop related analyses and reports of capitation payments and enrollment.	20	15	300
Total hours worked			1822
1,800 hours = 1.0 Position			
Actual number of positions requested			1.0

WORKLOAD STANDARDS
Capitated Rates Development Division
(1.0) Research Analyst II (General), 805-760-5731-xxx
CMS Rule Change
Permanent

Activity	Number of Items	Avg. Hrs. per Item	Total Annual Hours
Perform statistical studies and perform and review MLR calculations, including verification of proper categorization of healthcare premiums and expenditures submitted by managed care plans as required by the MLR requirements imposed by CMS.	24	40	960
Prepare and report summary descriptions of the outcome of each MLR calculation for each MLR reporting year for all managed care plans and submit to CMS for review.	14	16	224
Perform additional analyses as necessary, in support of the rate setting process, of data from health plans that do not meet the minimum MLR requirements.	15	16	240
Report results of MLR calculation reviews to assist in the rate setting process for the next rate year and compile any other information necessary for completing the rate setting process.	13	18	234
Participate in work groups, stakeholder meetings, and discussions with internal and external actuaries.	12	15	180
Total hours worked			1,838
1,800 hours = 1.0 Position			
Actual number of positions requested			1.0

WORKLOAD STANDARDS
Capitated Rates Development Division
2-Year Limited-Term Equivalent - (1.0) Associate Governmental Program Analyst
CMS Rule Change

Activity	Number of Items	Avg. Hrs. per Item	Total Annual Hours
Conduct reviews of MLR calculations, including reviewing financial statements and analyzing and verifying the proper categorization of healthcare premiums and expenditures submitted by plans.	24	40	960
Assist the RA II to prepare summary descriptions of the outcome of each MLR calculation for each MLR reporting year for all managed care plans for submission to CMS for review.	14	16	224
Perform additional analyses as necessary, in support of the rate setting process, of data from health plans that do not meet the minimum MLR requirements.	15	16	240
Report the results of MLR calculation reviews to assist in the rate setting process for the next rate year and compile any other information necessary for completing the rate setting process.	20	18	360
Participate in work groups, stakeholder meetings, and discussions with internal and external actuaries.	12	6	48
Total hours worked			1,832
1,800 hours = 1.0 Position			
Actual number of positions requested			1.0

WORKLOAD STANDARDS
Capitated Rates Development Division
(1.0) Research Program Specialist I / 805-760-5742-xxx
CMS Rule Change
Permanent

Activity	Number of Items	Avg. Hrs. per Item	Total Annual Hours
Conduct studies of complicated financial issues using plan financial statements and MLR calculation assessments to develop reports used in rate development and identify potential fiscal program impacts to plans not in compliance with MLR rules.	50	15	750
Work with DHCS actuaries to modify, maintain, disseminate and process Rate Development Templates (RDT). Analyze RDTs and work with plans to ensure correct submission of RDT information. Extract RDT data and create maintain database to identify trends geographically and plans specific regarding healthcare/administration costs. Develop applicable financial and utilization ratios and forecasts.	40	9	360
Develop studies of fiscal issues, briefing papers, issue memos and policy letters in response to inquiries or requests from oversight agencies such as CMS, Department of Finance, and the State Legislature and health plans.	24	15	360
Advise management and make recommendations on proposals and alternatives related to CMS proposed rule/MLR and rate setting policy and procedures. Participate in stakeholder group meetings and act as subject matter expert.	8	22	176
Develop and implement capitated rates payment evaluation process used for IGT reconciliation. Extract data and develop financial reports, analyzing fiscal information, managed care enrollment and IGT transactions.	12	15	180
Draft and implement contract language related to MLR requirements to be included in managed care contracts.	12	2	24
Total hours worked			1850
1,800 hours = 1.0 Position			
Actual number of positions requested			1.0

WORKLOAD STANDARDS
Capitated Rates Development Division
(2.0) Associate Governmental Program Analyst, 805-760-5393-xxx
CMS Rule Change
Permanent

Activity	Number of Items	Avg. Hrs. per Item	Total Annual Hours
Assist policy leads to develop and oversee of stakeholder communications related to the new CMS rule. Assist in the development of internal and external timelines, processes, and payment mechanisms in response to the new CMS rule.	2	400	800
Perform work related to reconciliation activity resulting from the move to prospectively included IGT-funded increases in capitation rates.	2	200	400
Perform research and financial analyses, including monitoring, analyzing, and documenting the flow of funds for relevant policy areas.	20	30	600
Assist other staff to examine financial reports, analyze financial information and IGT transactions, and review applicable financial and utilization data.	40	16	640
Maintain ongoing records and financial history summaries of relevant documents, contract amendments, and fund movements. Reconcile funds paid through IGTs to actual payments to plans.	2	200	400
Advise management and provide recommendations on proposals and alternatives. Participate in workgroups with other Divisions and agencies outside the Department as needed.	24	24	576
Total hours worked			3,616
1,800 hours = 1.0 Position			
Actual number of positions requested			2.0

WORKLOAD STANDARDS
Capitated Rates Development Division
(1.0) Research Analyst II, Permanent / 805-760-4588-xxx
CMS Rule Change
Permanent

Activity	Number of Items	Avg. Hrs. per Item	Total Annual Hours
Assist policy leads to develop and oversee of stakeholder communications related to the new CMS rule. Assist in the development of internal and external timelines, processes, and payment mechanisms in response to the new CMS rule.	1	400	400
Perform statistical analysis and work related to reconciliation activity resulting from the move to prospectively included IGT-funded increases in capitation rates.	1	200	200
Perform complex research and financial analyses, including monitoring, analyzing, and documenting the flow of funds for relevant policy areas.	10	30	300
Assist other staff to examine financial reports, analyze financial information and IGT transactions, and review applicable financial and utilization data.	20	16	320
Maintain ongoing records and financial history summaries of relevant documents, contract amendments, and fund movements. Reconcile funds paid through IGTs to actual payments to plans.	1	200	200
Advise management and provide recommendations on proposals and alternatives. Participate in workgroups with other Divisions and agencies outside the Department as needed.	12	24	288
Total hours worked			1708
1,800 hours = 1.0 Position			
Actual number of positions requested			1.0

WORKLOAD STANDARDS
Capitated Rates Development Division
(1.0) Staff Services Manager I, Permanent / 805-760-4800-xxx
CMS Rule Change
Permanent

Activity	Number of Items	Avg. Hrs. per Item	Total Annual Hours
Plan, monitor and supervise the quality and timeliness of work performed by analytical and research staff related to the new CMS rule. Establish and monitor standards and consistency of work.	27	20	540
Hire, train, and directly manage staff responsible for achieving and maintaining compliance with the new CMS rule. Provide direction, guidance, and counseling as necessary. Review timesheets and personnel requests.	60	4	240
Directly supervise staff work on projects intended to facilitate financing innovation in developing sources of the non-federal share of Medicaid matching funds through partnerships with the federal government and other public entity partners.	12	20	240
Conduct high-level project management to facilitate financing innovation in developing sources of the non-federal share of Medicaid matching funds through partnerships with the federal government and with other public entity partners.	24	16	384
Provide ongoing communication with Division staff, various other DHCS divisions and other appropriate State agencies to resolve issues brought to the attention of the State and to assist in the development of policy where deficiencies are identified.	15	15	225
Research and develop reports and recommendations on financial policy and standards through consultation with other branches.	10	20	200
Total hours worked			1,829
1,800 hours = 1.0 Position			
Actual number of positions requested			1.0

WORKLOAD STANDARDS
Long-Term Care Division
2-Year Limited-Term Equivalent to (2.0) Research Analyst II

Activities	Number of Items (Weekly, Monthly, Etc.)	Hours per Item	Total Hours
Researches and evaluates MLTSS compliance with current contracts with promulgated regulations and ensures continued compliance with the contract	7	8	56
Researches, designs, remediates, and monitors the network adequacy of each MLTSS plan.	78	8	624
Researches, designs, implements, remediates, and monitors the access and provider capacity of each MLTSS plan.	78	10	780
Researches, develops, implements, remediates, and monitors the quality of MLTSS services provided by each plan.	78	10	780
Researches, collects, aggregates, monitors, and reports on independent consumer services and supports as well as provider activities and outcomes.	12	5	60
Researches, designs, develops, remediates, and monitors MLTSS plans adherence to best practices and standards for coordination of care.	24	5	120
Researches, collects, and aggregates data for the State MLTSS Stakeholder Committee.	12	5	60
Lead stakeholder and advisory meetings on data extraction results. Provide subject matter expertise and lead discussions with the stakeholders and ITSD as necessary on program utilization and acuity-based data statistics.	26	16	416
Investigate and develop processes for feasibility of integrating MLTSS programs. Perform complex data mining and develop statistical criteria to ensure program integrity is in place and appropriate processes are implemented to ensure the integration of other programs is done with little to no interruption of program operations.	78	8	624
Research, design, implement, remediate, and monitor metrics and methodologies for the extraction and analysis of data. Develops methodologies for ensuring all data collected has internal validity, reliability, and is sound.	26	10	260
Researches, collects, evaluates, and remediates methods for increasing program efficiency, program effectiveness, quality of performance and enhances the facilitation of services.	26	10	260
Total hours worked			4,040
1,800 hours = 1.0 Position			
Actual number of positions requested			2.0

WORKLOAD STANDARDS**Long-Term Care Division****2-Year Limited-Term Equivalent to (1.0) Research Program Specialist I**

Activities	Number of Items (Weekly, Monthly, Etc.)	Hours per Item	Total Hours
Researches, designs, implements, and remediates methodologies and metrics for evaluating expenditures and activities of independent consumer services received by MLTSS beneficiaries.	12	5	60
Researches, designs, implements, and monitors contracts and/or interagency agreements related to the sharing of data or information between MLTSS providers, Stakeholder Committee, MCO's, and state departments.	78	3	234
Reviews, designs, implements, and remediates metrics for assessing the quality of MLTSS plan performance and quality of services.	26	5	130
Reviews, designs, implements and remediates methodologies for assessing best practices for facilitating the delivery of MLTSS services to Medi-Cal Beneficiaries.	26	5	130
Researches, designs, implements, and monitors various processes for evaluating the capacity of MLTSS in MCO's.	26	5	130
Act as a liaison and subject matter expert between MLTSS, ITSD, IT representatives from the MCO's and community stakeholders to answer program questions, address IT related issues, and facilitate resolution.	12	2	24
Prepares ad hoc reports, executive summaries, or departmental memorandums discussing data findings, quality assurance measures, and methodologies.	24	8	192
Researches, evaluates, and identifies trends in MLTSS MCO data; Researches, evaluates, and identifies discrepancies or variables causing the discrepancies or trends in the data.	26	5	130
Researches, analyzes, implements, and monitors effective measures for ensuring availability of services, availability of providers, and internal practices adhere to State standards.	78	5	390
Researches, designs, develops, aggregates, monitors, and remediates data reflective of the quality of MLTSS and performance and outcomes due to the provision of MLTSS services.	78	5	390
Total hours worked			1,810
1,800 hours = 1.0 Position			
Actual number of positions requested			1.0

WORKLOAD STANDARDS**Long-Term Care Division****2-Year Limited-Term Equivalent to (1.0) Associate Governmental Program Analyst**

Activities	Number of Items (Weekly, Monthly, Etc.)	Hours per Item	Total Hours
Reviews current contracts as well as new contracts developed in conjunction with the final rule and proposes amendments accordingly; Ensures each MLTSS MCO plan adheres to the contractual obligations set forth by the regulations.	13	5	65
Researches, reviews, and monitors contracts for independent consumer services and supports for providers. Ensures MCO's adhere to the provision set forth in each contract.	12	3	36
Functions as subject matter expert and liaison between MLTSS, MCO's, and Stakeholder Committee.	12	3	36
Researches, prepares, and presents reports on MCO's, their MLTSS access, provider capacity, and their quality of services.	78	4	312
Researches and prepares reports documenting the performance and outcomes of services facilitated by MCO's due to the provision of MLTSS.	78	4	312
Investigates and develops processes for feasibility of integrating MLTSS programs. Ensure each program complies with the expectations of the overall integration and State monitoring requirements.	12	5	60
Assist with the preparation, planning and facilitation of the State Stakeholder Committee. Serves as the subject matter expert to the committee.	12	5	60
Review, analyze, and assess the impact of new regulations on MLTSS; Conducts an analysis of proposed bill's and evaluates their impact on the current contracts and the facilitation of MLTSS services.	12	5	60
Researches, reviews, designs, implements, and monitors policies and procedures for MCO's to adhere to when facilitating coordination of care services for MLTSS beneficiaries.	78	2	156
Researches and prepares ad hoc reports and departmental memorandums containing an evaluation of MCO's care of coordination standards, best practices, and standards of care and services provided to MLTS beneficiaries.	78	4	312
Researches, reviews, designs, implements and monitors guidelines for effective communication between the State, MCO's, the Stakeholder Committee, and other entities.	78	2	156
Researches, reviews, designs, implements, and	78	2	156

Activities	Number of Items (Weekly, Monthly, Etc.)	Hours per Item	Total Hours
monitors transition plans for MLTSS MCO's to adhere to when they transition to the new model of services.			
Serves as the subject matter expert on issues related to the transition of MLTSS programs to meet federal standards and requirements of the Final Rule.	78	2	156
Total hours worked			1,877
1,800 hours = 1.0 Position			
Actual number of positions requested			1.0

WORKLOAD STANDARDS
Office of Legal Services
Health Care Financing Team
(1.0) Attorney III / 803-030-5795-xxx
Permanent

Activity	Number of Items	Hours Per Item	Total Hours
Perform complex research and analyze federal and state laws to advise the department and Agency/GO in restructuring programs and ensuring ongoing compliance	30	10	300
Draft and review federal and state legislation and regulations necessary to implement and administer health care financing programs	30	10	300
Draft and review all-plan letters and related policy guidance	25	6	150
Negotiate, draft, and review health care financing related contracts and amendments, inter-agency agreements and amendments	30	5	150
Draft, review and revise necessary federal Medicaid authorities, including waiver or State Plan amendments	25	8	200
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	20	8	160
Participate in CMS discussions, intra- and inter-departmental workgroup efforts, including researching, analyzing, and advising staff in rate setting and policy development	30	8	240
Research, analyze, and advise staff on responding to external inquiries, plan negotiation and communications, and stakeholder questions and concerns to avoid potential litigation	25	6	150
Coordinate with DOF and Agency; respond to correspondence and other inquiries from the public, legislators, and other interested stakeholders within tight timeframes	25	6	150
Total hours worked			1,800
1,800 hours = 1 Position			
Actual number of Positions requested			1.0

WORKLOAD STANDARDS
Office of Legal Services
Health Care Financing Team
2-Year Limited-Term Equivalent - (1.0) Attorney

Activity	Number of Items	Hours Per Item	Total Hours
Research and analyze federal and state laws to advise the department and Agency/GO in restructuring programs and ensuring ongoing compliance	30	10	300
Review federal and state legislation and regulations necessary to implement and administer health care financing programs	30	10	300
Draft and review all-plan letters and related policy guidance	25	6	150
Review health care financing related contracts and amendments, inter-agency agreements and other amendments	30	7	210
Review and revise necessary federal Medicaid authorities, including waiver or State Plan amendments	25	8	200
Provide pre-litigation support, such as assessing potential legal issues and strategic planning to avoid litigation	20	8	160
Provide house counsel legal advice on issues related to health care financing	45	6	270
Research, analyze, and advise staff on responding to external inquiries, plan negotiation and communications, and stakeholder questions and concerns to avoid potential litigation	35	6	210
Total hours worked			1,800
1,800 hours = 1 Position			
Actual number of Positions requested			1.0

WORKLOAD STANDARDS
Office of Legal Services
Health Care Delivery Systems Team
(1.0) Attorney III / 803-030-5795
Permanent

Activity	Number of Items	Hours Per Item	Total Hours
Perform complex research and analyze federal and state laws to advise the department and Agency/GO in restructuring programs and ensuring ongoing compliance	30	10	300
Draft and review federal and state legislation and regulations necessary to implement and administer Medi-Cal managed care programs	30	10	300
Draft and review all-plan letters and related policy guidance	25	6	150
Negotiate, draft, and review managed care plan contracts and amendments, inter-agency agreements and other contracts and necessary contract amendments	30	5	150
Draft, review and revise necessary federal Medicaid authorities, including waiver or State Plan amendments	25	8	200
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	20	8	160
Participate in CMS discussions, intra- and inter-departmental workgroup efforts, including researching, analyzing, and advising staff in managed care issues and related policy development	30	8	240
Research, analyze, and advise staff on responding to external inquiries, plan negotiation and communications, and stakeholder questions and concerns to avoid potential litigation	25	6	150
Coordinate with DOF, Agency, GO; respond to correspondence and other inquiries from the public, legislators, and other interested stakeholders within tight timeframes	25	6	150
Total hours worked			1,800
1,800 hours = 1 Position			
Actual number of Positions requested			1.0

WORKLOAD STANDARDS
Office of Legal Services
Health Care Delivery Systems Team
(1.0) Attorney / 803-030-5778-xxx
Permanent

Activity	Number of Items	Hours Per Item	Total Hours
Research and analyze federal and state laws to advise the department in restructuring programs and ensuring ongoing compliance	30	10	300
Review federal and state legislation and regulations necessary to implement and administer Medi-Cal managed care programs	30	10	300
Draft and review all-plan letters and related policy guidance	25	6	150
Review managed care plan contracts and amendments, inter-agency agreements and other contracts and necessary contract amendments	30	7	210
Review and revise necessary federal Medicaid authorities, including waiver or State Plan amendments	25	8	200
Provide pre-litigation support, such as assessing potential legal issues, strategic planning to avoid litigation	20	8	160
Provide house counsel legal advice on issues arising from the managed care regulations	45	6	270
Research, analyze, and advise staff on responding to external inquiries, plan negotiation and communications, and stakeholder questions and concerns to avoid potential litigation	35	6	210
Total hours worked			1,800
1,800 hours = 1 Position			
Actual number of Positions requested			1.0

WORKLOAD STANDARDS
Office of Legal Services
Health Care Delivery Systems (A&I Support)
2-Year Limited-Term Equivalent - (1.0) Attorney

Activities	Number of Items (Weekly, Monthly, Etc.)	Hours per Item	Total Hours
Perform research, review data, and advise Audits & Investigations on legal issues arising in course of periodic audits on encounter and financial data submitted by Managed Care Organizations (MCO)	2	40	80
Perform research, review data, and advise Audits & Investigations on legal issues arising in course of validation of encounter data for rate setting;	5	20	100
Perform research, review data, and advise Audits & Investigations on legal issues arising in course of provider enrollment disclosure verifications and site visits for managed care providers	50	2	100
Perform research, review data, and advise Audits & Investigations on legal issues arising in course of audits of the contracted and subcontracted managed care providers and medical groups	50	5	250
Perform research, review data, and advise Audits & Investigations on legal issues arising in course of audits of plan performance data per section 438.66	5	110	550
Assist Audits & Investigations with identifying need for development of state statute and regulation to implement requirements of new regulations; assist in development of statutes and regulations	3	40	120
Perform research, review data, and advise Audits & Investigations on legal issues arising in course of Investigations, suspensions and payment withholds for managed care providers	50	6	300
Represent Audits & Investigations in exit conferences for audits of managed care plans and subcontractors	50	2	100
Evaluate requests for audit information, advise program on disclosure of audit information, and assist in response to requestor.	25	10	250
Total hours worked			1,850
1,800 hours = 1 Position			
Actual number of Positions requested			1.0

WORKLOAD STANDARDS
Office of Legal Services
Health Care Delivery Systems (A&I Support)
2-Year Limited-Term Equivalent - (1.0) Attorney III

Activities	Number of Items (Weekly, Monthly, Etc.)	Hours per Item	Total Hours
Perform complex legal research, review data, and advise Audits & Investigations on legal issues arising in course of periodic audits on encounter and financial data submitted by Managed Care Organizations	5	7	35
Perform complex legal research, review data, and advise Audits & Investigations on complex legal issues arising in course of validation of encounter data for rate setting;	8	20	160
Perform complex legal research, review data, and advise Audits & Investigations on legal issues arising in course of provider enrollment disclosure verifications and site visits for managed care providers	10	2	20
Perform complex legal research, review data, and advise Audits & Investigations on legal issues arising in course of audits of the contracted and subcontracted managed care providers and medical groups	50	4	400
Perform complex legal research, review data, and advise Audits & Investigations on legal issues arising in course of audits of plan performance data per section 438.66	10	10	200
Coordination of complex legal issues between county, state, and federal program integrity units to implement new standards and regulations for Medi-Cal and Medicare-Medical plans	10	10	120
Assist Audits & Investigations with identifying need for development of state statute and regulation to implement requirements of new regulations; assist in drafting and passing statutes and regulations	5	20	100
Perform complex legal research, review evidence, and advise Audits & Investigations on legal issues arising in course of Investigations, suspensions and payment withholds for managed care providers	25	3	65
Represent Audits & Investigations in Informal Hearings requested on audits of managed care plans and subcontractors	50	10	500
Represent Audits & Investigations in exit conferences for audits of managed care plans and subcontractors	100	2	200
Total hours worked			1,800
1,800 hours = 1 Position			
Actual number of Positions requested			1.0

WORKLOAD STANDARDS
Mental Health Services Division
Program Oversight and Compliance Branch
(1.0) Associate Governmental Program Analyst / 806-430-5393-xxx
Permanent

Activities	Number of Items (Weekly, Monthly, Etc.)	Hours per Item	Total Hours
Provide consultation and technical assistance (TA) to MHPs on MMC rule program integrity requirements	56 MHPs and network providers = 100	2	200
Monitoring of ownership and control disclosure information from county MHPs and their network providers.	56 MHPs and network providers = 100	4	4004
Screening providers' eligibility including monthly screening in required databases.	56 MHPs and network providers = 100	2	200
Screening providers' licensure status.	56 MHPs and network providers = 100	2	200
Review of MHP documents.	56 MHPs and network providers = 100	8	800
Total hours worked			1,800
1,800 hours = 1 Position			
Actual number of Positions requested			1.0

WORKLOAD STANDARDS
Mental Health Services Division
Program Policy and Quality Assurance Branch
(1.0) Associate Governmental Program Analyst / 806-430-5393-xxx
Permanent

Activities	Number of Items (Weekly, Monthly, Etc.)	Hours per Item	Total Hours
Continued analysis of federal MMC regulations	Monthly	16	192
Promulgate State regulations and/or amendments to state regulations	1 regulation package	500	500
Draft MHP contracts amendments	1 boilerplate contract	192	192
Process and execute contract amendments	56 MHP contracts	10	560
Draft and issue information notices	5 notices	40	200
Provide consultation and technical assistance (TA) to MHPs on MMC rule	56 MHPs 2 hour/mo. ea. (item = TA contact)	2	224
Total hours worked			1,868
1,800 hours = 1 Position			
Actual number of Positions requested			1.0

WORKLOAD STANDARDS (MRB)
Audits & Investigations Division
(5.0) Nurse Evaluators II / 806-100-8144-xxx
Permanent

Activities	Number of Items (Weekly, Monthly, Etc.)	Hours per Item	Total Hours
Perform field audits of encounter data submitted by Medi-Cal managed care and PACE plans including medical chart reviews of selected encounter data for determining accuracy and completeness of health plan submission	12	475	5,700
Record findings and assist in report preparation	12	60	720
Perform field audits of PACE plan providers which include the following functions:			
Review compliance with case management and coordination of care requirements	5	300	1,500
Review medical records to ensure compliance with initial health assessment requirements	5	300	1,500
Document findings and assist in the preparation of the final audit report	5	40	200
Total hours worked			9,620
1,800 hours = 1 Position			
Actual number of Positions requested			5.0

WORKLOAD STANDARDS
Audits & Investigations Division (MRB)
(1.0) Health Program Auditor III / 806-100-4252-xxx
Permanent

Activities	Number of Items (Weekly, Monthly, Etc.)	Hours per Item	Total Hours
Perform field audits of managed care providers and function as team audit leader	1	500	500
Perform detailed audit of managed care administrative contract requirements	2	2100	2,100
Gather documentation and evidence to formulate recommendations and conclusions	2	240	480
Responsible for developing or contributing to the draft audit report	2	100	200
Respond to rebuttals and post audit comments submitted by the managed care plan	2	60	120
<ul style="list-style-type: none"> • Respond to concerns from managed care plans regarding the final audit report Perform and coordinate audits of encounter data from managed care plans, which include: <ul style="list-style-type: none"> • Working in conjunction with a NE II, develops sample of encounter data • Prepare working papers to detail encounter data validation results Complete statistical analysis and audit report	1	80	80
Working in conjunction with a NE II – Develops sample of encounter data	24	2	48
Prepares working papers to detail encounter data validation results	24	6	144
Completes statistical analysis and audit report	24	8	192
Total hours worked			3,864
1,800 hours = 1 Position			
Actual number of Positions requested			1.0

WORKLOAD STANDARDS
Audits & Investigations Division (MRB)
(2.0) Health Program Auditor IV / 806-100-4249-xxx
Permanent

Activities	Number of Items (Weekly, Monthly, Etc.)	Hours per Item	Total Hours
Performs delegation subcontractor audits of managed care plans with the most complex provider networks which include the following functions (Number of items for each function is 22; which is the number of delegation agreements): Conduct proper planning and scoping of managed care plan delegation agreements and design audit plan	22	24	528
Ensure delegation agreements are consistent with the primary managed care plan requirements	22	8	176
Conduct audit procedures to determine delegated entities compliance with requirements and standards	22	40	880
Prepare working papers to document audit findings and draft audit report	22	40	880
Conduct exit conference to present findings and to respond to additional plan submissions and rebuttal	22	24	528
Finalize audit report and resolve any outstanding issues with management before report issuance	22	40	880
Total hours worked			3,872
1,800 hours = 1 Position			
Actual number of Positions requested			2.0

WORKLOAD STANDARDS
Research and Analytic Studies Division
2-Year Limited-Term Equivalent to (1.0) Research Program Specialist I

Activities	Number of Items	Hours per Item	Total Hours
Identifies existing data sources, as well as data still needed to meet reporting requirements. Creates benchmarks and thresholds from previous research.	1	260	260
Reviews file documentation in preparation for probabilistic linkage. Creates data dictionary.	1	120	120
Performs literature review.	1	280	280
Performs data analysis (this includes linking datasets, calculating measures, creating specialty groups, calculating geographic access [distance and drive time] using ArcGIS, and delivering reviewed data).	1	285	285
Creates charts, tables, and other visuals to complement narrative text.	1	268	268
Develops narrative text.	1	490	490
Verifies that deliverables are formatted correctly. Proof-reads and edits materials to ensure accuracy and clarity.	1	17	17
Total hours worked			1,720
1,800 hours = 1 position			
Actual number of positions requested			1.0

WORKLOAD STANDARDS
Research and Analytic Studies Division
(2.0) Research Program Specialist II / 808-820-5758-xxx
Permanent

Activities	Number of Items	Hours per Item	Total Hours
Provides a high-level description of project steps.	2	60	120
Develops benchmark and threshold statistics based on previous research to provide context for deliverables.	2	20	40
Collaborates to develop data collection methods for data not currently collected.	2	50	100
Monitors release dates/update schedules for source files. Requests files from OSHPD, CHIS, and CDPH, and retrieves data upon completion.	2	30	60
Provides SAS server and technical support to RPS I.	2	30	60
Reviews file documentation in preparation for probabilistic linkage. Creates data dictionary.	2	30	60
Performs probabilistic linkage of Medi-Cal administrative data to the following data sources: 1.) OSHPD Inpatient Patient Discharge Data 2.) OSHPD Emergency Department Data 3.) CDPH Birth Statistical Master File 4.) CDPH Death Statistical Master File	2	700	1400
Creates documentation about both the match process and the output data set.	2	30	60
Performs data analysis (calculating measures, creating specialty groups, calculating geographic access [distance and drive time] using ArcGIS, and delivering reviewed data).	2	450	900
Develops narrative text.	2	400	800
Total hours worked		1,800	3,600
1,800 hours = 1 position			
Actual number of positions requested			2.0

WORKLOAD STANDARDS
Research and Analytic Studies Division
2-Year Limited-Term Equivalent to (1.0) Research Scientist II

Activities	Number of Items	Hours per Item	Total Hours
Examines all literature relevant to the evaluation of access to care to identify methods for evaluating access to care and identify new techniques and or the results of access to care monitoring studies at both the national and state levels	1	100	100
Develops access measures based on current and accepted research design methodologies, including studies that control for multiple demographic, social economic, and/or health factors.	1	200	200
Creates written research plans and operationalizes the plan to create access to care reports.	1	200	200
Designs probabilistic linkage methods and processes to link Medi-Cal administrative data to various data sources such as: 1.) OSHPD Inpatient Patient Discharge Data 2.) OSHPD Emergency Department Data 3.) CDPH Birth Statistical Master File 4.) CDPH Death Statistical Master File	1	200	200
Provides technical input to RPS II and RPS I research staff on linking data sets, outcome measures, and ensures examination of statistical significance within each analytic data set.	1	300	300
Reviews statistical files and datasets, checking for outliers and general quality assurance.	1	200	200
Works with complex survey-based datasets such as the California Health Interview Survey (CHIS), making use of proper weighting to develop accurate estimates. Explores and evaluates various survey questions and makes recommendations for new survey questions that will aid in measuring and evaluating access to health care services.	1	150	150
Employs various clinical identification algorithms, including the Clinical Classification Software and chronic condition algorithm from the Agency for Healthcare Research and Quality,	1	150	150
Use risk adjustment models to study how and whether various health conditions found among Medi-Cal subpopulations may be used to identify the need for various provider specialties.	1	200	200
Presents research findings to RASD management, DHCS executive staff, and stakeholders, answering follow up questions as warranted.	1	100	100
Total hours worked			1,800
1,800 hours = 1 position			
Actual number of positions requested			1.0

WORKLOAD STANDARDS
Administration Division
Human Resources Branch
(1.0) Personnel Specialist / 808-102-1303-xxx
Permanent

Activities	Number of Items (Weekly)	Hours per Item	Total Hours
Review and process all departmental employee appointments, through the Request for Personnel Action (RPA), ensuring completeness and accuracy. Update the Business Workflow Automation System for each RPA.	4	1.75	364
Responds to all telephone and email inquiries from departmental employees and management regarding payroll and benefit issues.	20	.5	780
Prepares and processes Personnel Action Requests (PARS) for appointments, separations, promotions, retirements, changes in time base, leaves, alternate range changes, merit salary adjustments, and all other changes generated via the PAR form. Determines appropriate personnel transactions and salary rates.	15	1	780
Prepares accounts receivable documentation for Accounting and correspondence to employee.	1	1	52
Researches and prepares documents for accounts receivables, payroll adjustments such as overtime and wage garnishments, court ordered Chapter XIII proceedings, etc.	5	.5	130
Process State Disability Insurance, Non-Industrial Disability Insurance, FMLA and Catastrophic Leave benefit requests.	1	3	156
Benefits administration – provide employees with benefit administration for programs such as health, dental, vision, Flex-Elect, retirement, financial services, and various insurance options; process all enrollment, cancellation, and change documents.	5	.5	130
Timekeeping and leave balance – audit timesheets, maintain leave records, process changes, corrections, etc.	5	1	260
Dock Cutoff and master payroll release activities	1/month	8	96
Total hours worked			2,488
1,800 hours = 1 Position			
Actual number of Positions requested			1.0

WORKLOAD STANDARDS
Administration Division
Human Resources Branch
(1.0) Associate Personnel Analyst / 808-102-5142-xxx
Permanent

Activities	Number of Items (Weekly)	Hours per Item	Total Hours
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.	30	.5	780
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	4	240
Performs analysis and responds to reorganization proposals, researches feasibility and practicality of various types of classification and pay proposals and prepares responses	2/monthly	6	144
Reviewing, editing, and finalizing all personnel related documents and personnel actions, i.e. probationary reports, individual development plans, counseling memorandums.	1	4	208
Rejections on probation, adverse actions, AWOL separations, non-punitive medical actions, etc.	5/yr	160	800
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.	6	1	312
Consults with OCR and Health and Safety regarding reasonable accommodations, fair hiring practices, allegations of harassment, discrimination, workplace violence, etc.	1	1	52
Total hours worked			2,596
1,800 hours = 1 Position			
Actual number of Positions requested			1.0

WORKLOAD STANDARDS
Administration Division
Program Support Branch
(1.0) Associate Governmental Program Analyst / 808-202-5393-xxx
Permanent

Activities	Number of Items (Yearly)	Hours per Item	Total Hours
Provide management and oversight of the contract procurement processes, review, and contract approval of the most complex contracts as they relate to the final rule 2390-P.	100	10	1000
Ensuring all final rule 2390-P contracts are in compliance by independently researching, interpreting, and communicating contract related laws, regulations, policies and procedures appearing in various resources including the Public Contract Code, State Contracting Manual, applicable control agency websites, State Administrative Manual and management memos.	40	10	400
Provide technical advice to the department for all aspects of the contract development process as they relate to the implementation of the final rule 2390-P.	30	10	300
Serve as the lead trainer/analyst by developing contract training to line programs. The training will provide a detailed layout of developing a comprehensive scope of work, bid development, contract development, form completion, statutory exemptions, etc.	10	10	100
Total hours worked			1,800
1,800 hours = 1 Position			
Actual number of Positions requested			1.0

Workload History*
Managed Care Quality and Monitoring Division

Workload Measure	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
MCQMD PMCB PDS Identify and apply research methods required to ensure the collection and analysis of appropriate, meaningful, and unbiased data. Identifies required data, information, materials, and resources needed to complete/perform a project.	100	250	500	650	750	1500
MCQMD PMCB PDS Conduct and interpret descriptive and/or inferential statistical analyses using appropriate software (SPSS, SAS, and Excel) to test research hypotheses and to formulate conclusions and recommendations.	100	150	200	500	650	1000
MCQMD PMCB PDS Research state and federal laws and regulations, write contract language, work with other internal/external entities, attending meetings.	0	50	100	100	250	500
MCQMD PMCB PDS Review legislation for its impact on MCQMD and make operational the impact of any new legislation that will impact waivers. Draft and presents proposed legislation and regulations. Assist actuaries in testifying at public hearings, legislative meetings, and judicial proceedings as necessary.	0	0	50	50	100	400
MCQMD PMCB PDS 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.	250	500	500	750	1250	1750

Workload Measure	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
<p>MCQMD PMCB PDS Uses sound research methods and principles; analyzes statistics to reach sound conclusions and/or make recommendations to MCQMD regarding policy and other related issues. Prepares detailed reports that clearly and concisely identify the problem, potential solutions, and a proposed course of action. Write reports, policies, and procedures.</p>	100	250	250	500	1000	1500
<p>MCQMD PMMB PRCU* Analyze state and federal legislation for impact on MCQMD, MCOB and DHCS. Develop legislative proposals and trailer bill language to implement changes to existing programs or to develop new programs. Coordinate and meet with inter and intra departmental agencies and legislative staff on bill related issues. Assist in testifying at legislative hearings. Respond to legislative and constituent related inquiries and questions. Coordinate legislative reports.</p>	1000	1250	1500	1750	2000	2250
<p>MCQMD PMMB PRCU** Identify, develop, and amend regulations as necessary. Research and review past and present federal and state statutes, regulations, policy documents and contract language. Assist in testifying at public hearings. Respond to public comments. Coordinate with Department and Division program staff, OLS, OOR and OAL. Seek stakeholder input. Respond to inquiries from Agency, Department of Finance, and Fiscal Forecasting.</p>	500	750	1500	2500	2500	5000

Workload Measure	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
MCQMD PMMB PRCU Provide policy support for MCQMD and MCOD. Identify, research, and assess policy related statutory, regulatory, program, procedural, contractual, and operational issues and questions.	500	500	500	750	1250	1300
MCQMD PMMB PRCU Draft and coordinate all plan letters and duals plan letters for MCQMD, MCOD, other DHCS Divisions, and inter and intra departmental entities. Draft and review managed care plan contract language.	40	40	60	60	70	70

* In addition to bill assignments, activities include email and phone correspondence, responses to inquiries, research, meetings, hearings and briefings.

** In addition to drafting and multiple related amendments to the regulation packages themselves, activities include research of past/related regulations packages, email and phone correspondence, meetings, briefings and workgroup coordination, hearing coordination, and response to public inquiries and all public comments.

Workload History
 Managed Care Operations Division
 Managed Care Systems and Support Branch

Workload Measure	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Develop and execute contract amendments or policy letters relating to the ongoing monitoring and reporting.	100	100	100	105	105	
Establish and document operational procedures, policies, review tools, and various tracking systems. Provide technical assistance, resolve programmatic and technical questions.	460	480	500	510	525	
Liaison for HCO monitoring activities, including meetings with HCO staff and enrollment broker (Maximus).	90	95	100	120	140	
Respond to Sensitive Internal and External Communications and Facilitate Resolution of Specialized Problems.	190	190	200	205	215	
Research and make recommendations on monitoring and evaluation methods.	90	100	100	110	110	
Communicate with health plans on processes for and submission of required documents.	360	375	385	395	400	
Review and certify the plan networks	90	100	100	125	125	
Review and approve provider directories	185	190	200	205	210	

In addition to the above chart, the associated workload for these MCO positions takes into account a variety of duties, including, but not limited to, plan communication; contract processing, monitoring quality of care, holding regular stakeholder meetings; completing staff training; developing and updating policies; completing research; preparing and executing contract amendments; and overseeing all required mailings and member informing material.

Workload History
 Managed Care Operations Division
 Managed Care Systems and Support Branch

Workload Measure	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Work with program to identify business/system requirements		250	250	350	400	400
Define project scopes		200	200	200	200	200
Provide contractor oversight		150	200	200	300	300
Monitor reports; test new system implementations		150	200	200	350	350
Develop testing criteria; review test results		200	200	350	350	350
Draft c-letters, change orders, and system development notices		200	200	250	250	250
Monitor call center activities; provide new Customer Services Representative scripts; perform site visits; conduct random call screening; conduct undercover callings				400	400	400
Provide recommendations for new call material and alteration of existing material					100	100
Initiates research and conducts in-depth studies of erroneous enrollments and disenrollments in the Health Plan Enrollment system; reviews current processing operations and supporting systems to ensure contract compliance.						200

Workload History
Capitated Rates Development Division

Workload Measure	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Conduct studies and reviews of financial information of Medical Loss Ratio (MLR) calculations and performs reconciliations of Intergovernmental Transfers (IGT)	522 hrs.	576 hrs.	552 hrs.	3,420	3,591	3,771 hrs. estimated

Workload History
Mental Health Services Division
Program Oversight and Compliance Branch

Workload Measure	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Medi-Cal Site Certifications	60	60	65	80	100	150
System Reviews	20	17	18	20	17	25
Outpatient Chart Reviews	20	17	18	20	17	25
Inpatient Chart Reviews	6	6	6	6	6	6
Respond to inquiries from county MHPs pertaining to chart documentation and clinical issues	Average 15 inquiries per month x 12 months = 180	180	180	180	180	180
Statewide Training for MHPs	5	5	5	5	6	8

Workload History
Mental Health Services Division
Program Policy and Quality Assurance Branch

Workload Measure	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Analyze MMC federal regulations	N/A	N/A	N/A	N/A	N/A	1,000 hours
Promulgate new and/or amend state regulations	N/A	N/A	N/A	2,000 hours	2,000 hours	4,000 hours
Amend MHP Contracts	N/A	N/A	N/A	N/A	N/A	2,000 hours
Review, approval, and technical assistance to MHPs on Implementation Plan (IP) Updates.	3-5 MHP IPs	3-5 MHP IPs	Approx. 5 IPs	Approx. 5 IPs	Approx. 5 IPs	Approx. 50 IPs

Workload Measure	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Respond to technical assistance calls from counties	Approx. 3,168 calls/year	Approx. 3,168 calls/year	Approx. 3,168 calls/year	Approx. 3,168 calls/year	Approx. 3,168 calls/year	Approx. 3,802 calls/year
Monitor progress following Medi-Cal oversight reviews	N/A	N/A	18 counties (review reports)	18 counties (monitor county MHP status)	18 counties (monitor county MHP status)	18 counties (monitor county MHP status)
Monitor progress following EQRO reviews	N/A	N/A	56 counties (review reports)	56 counties (review reports)	56 counties (review reports)	56 counties (review reports)
Special MHP TA visits	0	0	0	0	2	5
MHP Focus Reviews	0	0	0	1	1	6
Appeals Received / Processed	20	20	10	10	10	20

Workload History
Administration 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

*Since the majority of the proposed regulations are new, most divisions do not have a workload history.

External Accountability:

Projected Outcomes
Managed Care Quality and Monitoring Division

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
MCQMD-PMCB Develop policy letters related to the implementation of enhanced standards and processes	2	8	8	8	8	8
MCQMD-PMCB Research state and federal laws and regulations related to the implementation of enhanced standards and processes	25	20	20	20	20	20
MCQMD-PMCB Work with internal/external entities and attend meetings	3	12	12	12	12	12
MCQMD-PMCB Research and make recommendations to management on program monitoring and evaluation methods related to the new federal rulemaking	3	10	10	10	10	10
MCQMD-PMCB Establish and document operational procedures, policies, review tools, and tracking systems.	3	10	10	10	10	10
MCQMD-PMCB Provide technical assistance related to the new federal rulemaking health plans, other programs, and State and federal agencies.	5	20	20	20	20	20
MCQMD-PMCB Analyze nonclinical aspects of managed care plan policies, procedures, and other deliverables for compliance with specific requirements of the new federal rulemaking.	5	20	20	20	20	20

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
MCQMD-PMCB Assists in data collection and analysis relating to managed care plan provider networks, beneficiary populations, enrollment levels, utilization, and other data-related tasks.	5	20	20	20	20	20
MCQMD-PMCB Independently design and develop statistical studies and research on the most complex issues of high value to the Department related to monitoring the performance of health plans.	2	6	6	6	6	6
MCQMD-PMCB Prepare detailed statistical reports that clearly and concisely identify the problem, potential solutions, and a proposed course of action.	2	6	6	6	6	6
MCQMD-PMCB Provide expert statistical research support related to legislative analysis, initiatives, and hearings.	3	12	12	12	12	12
MCQMD-PMCB Facilitate meetings and discussions regarding MCQMD-related topics.	3	12	12	12	12	12
MCQMD-PMCB Participate in meetings and conference calls related to expert subject areas; act as a liaison for the MCQMD.	12	50	50	50	50	50
MCQMD-PMCB Help design and develop statistical studies and research on the most issues of value to the Department related to monitoring the performance of health plans.	2	6	6	6	6	6
MCQMD-PMCB Prepare detailed statistical reports that clearly and concisely identify the problem, potential solutions, and a proposed course of action.	2	6	6	6	6	6

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
MCQMD-PMCB Provide statistical support related to legislative analysis, initiatives, and hearings.	3	12	12	12	12	12
MCQMD-PMCB Facilitate and participate in meetings and discussions regarding statistical research topics.	16	62	62	62	62	62
MCQMD-PMCB Direct the work of three teams of research program specialists, research analysts, and other analytical staff in the planning, organizing, and performance of large-scale data collection processes; establishing goals, objectives, priorities, and procedures for evaluating the compliance of health plans with State and federal regulations; and ensuring that the studies undertaken result in valid results.	50	200	200	200	200	200
MCQMD-PMCB Perform other Branch Chief activities related to program coordination and communication with internal and external stakeholders.	40	160	160	160	160	160
MCQMD-PMCB Perform other Unit Chief activities related to program coordination and communication with internal and external stakeholders.	40	160	160	160	160	160
MCQMD-PMMB Review and evaluate reports from managed care plans (MCPs) required under federal rulemaking CMS-2390 related to quality improvement and performance measurement.	25	100	100	100	100	100
MCQMD-PMMB Coordinate monitoring activities related to Medical and Knox-Keene requirements with internal and external stakeholders.	5	20	20	20	20	20

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
MCQMD-PMMB Assist MCQMD staff in conducting research and developing policies and analyses; provide technical assistance to MCPs and DHCS staff and management.	8	30	30	30	30	30
MCQMD-PMMB Participate in Medi-Cal Advisory Group and other workgroup meetings as assigned, and provide responses to stakeholder requests.	5	20	20	20	20	20
MCQMD-PMMB Collaborate with clinical staff in development of medical monitoring protocols and tools for specific beneficiary populations.	2	5	5	5	5	5
MCQMD-PMMB Evaluate and report on beneficiary requests for medical exemption from MCP enrollment; clinical issues related to beneficiary grievances, State Fair Hearings, and Independent Medical Reviews; and clinical impacts of mandatory enrollment on specific beneficiary populations.	25	100	100	100	100	100
MCQMD-PMMB Conduct onsite medical monitoring reviews to determine a health plan's readiness to operate as an MCP.	3	10	10	10	10	10
MCQMD-PMMB Attend and report on training and other education forums to become familiar with and stay current and developing managed care issues related to SPDs, medical/nursing practice.	3	10	10	10	10	10
MCQMD-PMMB Act as a liaison and lead consultant to prepare, coordinate, and monitor MCQMD issues or projects addressing highly sensitive and complex healthcare issues	2	6	6	6	6	6

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
MCQMD-PMMB Independently help develop health-related projects, expertly applying knowledge of health care regulations, policies and procedures; participate in monitoring and evaluating health programs and projects.	2	6	6	6	6	6
MCQMD-PMMB Provide expert leadership and guidance to revise, monitor, and help finalize various MCQMD issues or projects with internal and external stakeholders and workgroups.	3	12	12	12	12	12
MCQMD-PMMB Serve as a technical program consultant in areas of high sensitivity regarding health care data monitoring and health care data collection processes.	3	12	12	12	12	12
MCQMD-PMMB Represent MCQMD in meetings and other forums on issues related to the Medi-Cal benefits and performs other duties as required	12	50	50	50	50	50
MCQMD-PMMB Render clinical determinations of beneficiary requests for medical exemption from mandatory enrollment in managed care plans.	25	100	100	100	100	100
MCQMD-PMMB Develop and update MCQMD medical policy relevant to monitoring and quality-improvement activities specified in federal rulemaking CMS-2390.	10	40	40	40	40	40
MCQMD-PMMB Provide medical consultation in participation on committees and workgroups developed to discuss quality improvement and monitoring issues	5	20	20	20	20	20

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
MCQMD-PMMB Participate in education/training efforts involving quality improvement and monitoring issues both within and outside the Department and performs other duties as necessary.	2	10	10	10	10	10
MCQMD-PMMB Analyze data related to quality improvement and performance standards and make recommendations to management regarding corrective actions and improvement projects.	12	50	50	50	50	50
MCQMD-PMMB Develop operational processes and procedures for tracking corrective actions, and calculate potential sanctions in the event of chronic underperformance.	2	10	10	10	10	10
MCQMD-PMMB Guide and collaborate with coworkers in data-related analysis and reporting as required for internal and external stakeholders.	11	11	11	11	11	11
MCQMD PMMB PRCU Analyze state and federal legislation for impact on MCQMD, MCOD and DHCS. Develop legislative proposals and trailer bill language to implement changes to existing programs or to develop new programs. Coordinate and meet with inter and intra departmental agencies and legislative staff on bill related issues. Assist in testifying at legislative hearings. Respond to legislative and constituent related inquiries and questions. Coordinate legislative reports.	2250	2500	2750	3000	3250	3250

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
<p>MCQMD PMMB PRCU Identify, develop, and amend regulations as necessary. Research and review past and present federal and state statutes, regulations, policy documents and contract language. Assist in testifying at public hearings. Respond to public comments. Coordinate with Department and Division program staff, OLS, OOR and OAL. Seek stakeholder input. Respond to inquiries from Agency, Department of Finance, and Fiscal Forecasting.</p>	5000	7500	10,000	12,500	12,500	12,500
<p>MCQMD PMMB PRCU Provide policy support for MCQMD and MCOD. Identify, research, and assess policy related statutory, regulatory, program, procedural, contractual, and operational issues and questions.</p>	1300	1350	1400	1450	1500	1550
<p>MCQMD PMMB PRCU Draft and coordinate all plan letters and duals plan letters for MCQMD, MCOD, other DHCS Divisions, and inter and intra departmental entities. Draft and review managed care plan contract language.</p>	70	80	90	100	110	120

Managed Care Operations Division

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
MCOD – MCSSB Develop and Execute Contract Amendments or Policy Letters Relating to the Ongoing Monitoring and Reporting.	110	297	297	297	297	297
MCOD – MCSSB Establish and document operational procedures, policies, review tools, and various tracking systems. Provide technical assistance, resolve programmatic and technical questions.	550	1485	1485	1485	1485	1485
MCOD – MCSSB Liaison for HCO monitoring activities, including meetings with HCO staff and enrollment broker (Maximus).	160	432	432	432	432	432
MCOD – MCSSB Respond to Sensitive Internal and External Communications and Facilitate Resolution of Specialized Problems.	220	594	594	594	594	594
MCOD – MCSSB Research and make recommendations on monitoring and evaluation methods.	125	337	337	337	337	337
MCOD – MCSSB Communicate with health plans on processes for and submission of required documents.	400	1080	1080	1080	1080	1080
MCOD – MCSSB Review and certify the plan networks	125	337	337	337	337	337
MCOD – MCSSB Review and approve provider directories	210	567	567	567	567	567

Capitated Rates Development Division

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Conduct studies and reviews of financial information of Medical Loss Ratio (MLR) calculations and performs reconciliations of Intergovernmental Transfers (IGT)	3,771 hrs.	10,976 hrs.	10,976 hrs.	10,976 hrs.	10,976 hrs.	10,976 hrs.
Rate Setting, actuarial review of new MLR federal requirements for rates	1,800 hrs.					

Long Term Care Division

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Develop, review and amend requirements for monitoring State contracts related to oversight of the Final Rule	15	25	25	20	20	25
Develops and oversees network adequacy standards; Standards include a review of time and distance standards for LTSS providers	N/A	78	85	85	100	100
Develop, review, and implement a plan for assessing network adequacy standards for MLTSS	3	78	85	85	100	100
Researches, develops, and designs methods for implementing appropriate coordination of care services	26	78	85	85	100	100
Researches, develops and designs assessments and metrics for determining the quality and level of performance of an MLTSS program	N/A	100	150	200	250	300
Researches, develops, and designs a metric for monitoring expenditures and activities for independent consumer services and supports available to MLTSS beneficiaries.	N/A	25	50	75	100	125
Designs and implements mechanisms for outreach and facilitates permanent MLTSS Stakeholder Committee.	5	12	24	24	24	24
Facilitates and manages the MLTSS Stakeholder Committee to ensure best practices and recommendations for delivery of MLTSS services to beneficiaries.	2	24	24	30	48	48
Extracts, reviews, and analyzes the data obtained from metrics designed to assess program performance, program efficiency, program effectiveness, and quality of services by MLTSS providers.	N/A	100	200	300	400	500

Office of Legal Services

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Draft state legislation and regulations related to final rule implementation/ administration	120	120	120	120	120	120
Draft all-plan letters and related policy guidance	125	125	125	125	125	125
Draft managed care contracts, amendments, and interagency agreements	120	120	120	120	120	120
Draft Medicaid authority, including waiver amendments and State Plan amendments	100	100	100	100	100	100
Provide responses to public, legislative, and stakeholder inquiry on federal final rule issues	100	100	100	100	100	100
Represent divisions in informal hearings and exit conferences	350	350	350	350	350	350

Mental Health Services Division
Program Oversight and Compliance Branch

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Collect, track and monitor ownership and control disclosures from 56 county MHPs and their network providers	56 county MHPs and all network providers					
Screen and monitor eligibility of all network providers	56 county MHPs and all network providers	56 county MHPs and all network providers	56 county MHPs and all network providers	56 county MHPs and all network providers	56 county MHPs and all network providers	56 county MHPs and all network providers
Screen and monitor licensure status of all network providers	56 county MHPs and all network providers	56 county MHPs and all network providers	56 county MHPs and all network providers	56 county MHPs and all network providers	56 county MHPs and all network providers	56 county MHPs and all network providers

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Receive and investigate information from whistleblowers	56 county MHPs and all network providers					
Outpatient Chart Audits	56 county MHPs and all network providers					
Inpatient Chart Audits	56 county MHPs and all network providers					
Upload required audit information on DHCS website	56 county MHPs and all network providers					
Medi-Cal On-Site Certifications	56 county MHPs and all network providers					
Assess preliminary investigations of fraud, waste and abuse and QMBs	56 county MHPs and all network providers					
Provide consultation to A&I on formal investigations of fraud waste and abuse	56 county MHPs and all network providers					

Mental Health Services Division
Program Policy and Quality Assurance Branch

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Analyze MMC federal regulations	1000 hrs	1000 hrs	500 hrs	500 hrs	200 hrs	200 hrs
Promulgate new and or amend state regulations	4000 hrs	4000 hrs	3000 hrs	2000 hrs	2000 hrs	2000 hrs
Amend MHP contracts	2000 hrs	2000 hrs	1000 hrs	1000 hrs	1000 hrs	1000 hrs
Review, approve, and technical assistance to MHPs on Implementation Plan updates	Approx. 50 Impl. Plans	Approx. 5 Impl. Plans	Approx. 5 Impl. Plans	Approx. 5 Impl. Plans	Approx. 5 Impl. Plans	Approx. 5 Impl. Plans
Respond to technical assistance calls from counties	Approx. 3802 calls per year	Approx. 3802 calls per year	Approx. 3802 calls per year	Approx. 3168 calls per year	Approx. 3168 calls per year	Approx. 3168 calls per year
Monitor progress following Medi-Cal oversight reviews	18 counties					

Audits & Investigations Division
Financial Audits Branch

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Rate Development Templates	N/A	27	27	27	27	27

Audits & Investigations Division
Medical Review Branch

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Encounter Data Validation Audits		117	117	117	117	117
Subcontractor Delegation Audits		22	22	22	22	22

Administration Division

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Hire/oversee positions	78	78	78	78	78	78
Process Request for Personnel Action (RPA)	520	520	520	520	520	520
Respond to telephone and email inquiries from departmental employees and management regarding payroll and benefit issues; respond to reorganization, classification, and pay proposals	2288	2288	2288	2288	2288	2288
Process Personnel Action Requests (PARS) and determine appropriate personnel transactions and salary rates.	780	780	780	780	780	780
Prepare accounts receivable & payroll adjustment documents for Accounting	312	312	312	312	312	312
Process State Disability Insurance, Non-Industrial Disability Insurance, FMLA and Catastrophic Leave benefit requests.	52	52	52	52	52	52
Provide employees with benefit administration and process all enrollment, cancellation, and change documents.	260	260	260	260	260	260
Timekeeping and leave balance – audit timesheets, maintain leave records, process changes, corrections, etc.	260	260	260	260	260	260
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.	60	60	60	60	60	60

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Complete probationary reports, individual development plans, counseling memorandums, probation rejections, adverse actions, AWOL separations, non-punitive medical actions, etc.	57	57	57	57	57	57
Oversee contract procurement processes; Review and contract approval of CRDD and MMCD contracts for the final rules	2	2	2	2	2	2
Develop contract training to line programs	10	10	10	10	10	10