STATE OF CALIFORNIA

Budget Change Proposal - Cover Sheet

DF-46 (REV 10/20)

Fiscal Year	Business Unit	Department	Priority No.
FY 2021-22	4260	Health Care Services	

Budget Request Name	Program	Subprogram
4260-068-BCP-2021-GB	3960	3960010

Budget Request Description

California Advancing and Innovating Medi-Cal (CalAIM) Initiative

Budget Request Summary

The Department of Health Care Services (DHCS), requests 69.0 permanent positions, limited term resources equivalent to 46.0 positions and expenditure authority of $23,860,000 ($11,041,000 General Fund; $12,819,000 Federal Fund) for fiscal year 2021-22. The resources are needed to implement the comprehensive set of proposals that encompass DHCS's California Advancing and Innovating Medi-Cal (CalAIM) initiative.

Requires Legislation	Code Section(s) to be Added/Amended/Repealed
☒ Yes ☐ No	

Does this BCP contain information technology (IT) components? ☒ Yes ☐ No *If yes, departmental Chief Information Officer must sign.*	Department CIO	Date
	Chris Riesen	1/10/2021

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

Project No. **Project Approval Document:**

Approval 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
Jessica Bogard	1/10/2021	Erika Sperbeck	1/10/2021
Department Director	**Date**	**Agency Secretary**	**Date**
Will Lightbourne	1/10/2021	Brendan McCarthy	1/10/2021

Department of Finance Use Only

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

PPBA	Date submitted to the Legislature
Tyler Woods	1/10/2021

Analysis of Problem

A. Budget Request Summary

The Department of Health Care Services (DHCS), requests 69.0 permanent positions, limited term (LT) resources equivalent to 46.0 positions and expenditure authority of $23,860,000 ($11,041,000 General Fund (GF); $12,819,000 Federal Fund (FF)) for fiscal year (FY) 2021-22. The resources are needed to implement the comprehensive set of proposals that encompass DHCS's California Advancing and Innovating Medi-Cal (CalAIM) initiative.

BCP cost per FY

BCP Cost	2021-22	2022-23	2023-24	2024-25	2025-26
Personal Services	$14,589,000	$17,407,000	$16,622,000	$16,394,000	$13,235,000
Operating Expenses and Equipment	$9,271,000	$10,783,000	$8,571,000	$7,533,000	$7,015,000
Total BCP Cost	$23,860,000	$28,190,000	$25,193,000	$23,927,000	$20,250,000

*Please refer to Section J for more specific funding data.

Positions in CalAIM per FY

Positions	2021-22	2022-23	2023-24	2024-25	2025-26
Permanent Positions	69.0	84.0	84.0	84.0	84.0
LT Resources	46.0	54.0	49.0	47.0	21.0
Total Positions	115.0	138.0	133.0	131.0	105.0

Division	Proposal
Administration Division (Admin): 9.0 Permanent Positions Effective 7/1/2021: • 1.0 Staff Services Manager I (SSM I) • 1.0 Business Services Officer (BSO I) • 2.0 Associate Governmental Program Analysts (AGPA) • 4.0 Associate Personnel Analysts (APA) • 1.0 Office Technician (OT)	• Administrative support (contracting, human resources, facilities) for CalAIM proposals
California Medicaid Management Information System (CA-MMIS) Division: 1.0 two-year LT Positions Effective 7/1/2021 to 6/30/2023: • 1.0 Information Technology Specialist II (ITS II) (two-year LT)	• CA-MMIS System and CD-MMIS System change support for CalAIM proposals • Implement complex program policy in CA-MMIS and CD-MMIS systems • Modify benefit payment methodology in CA-MMIS and CD-MMIS systems. • Behavioral Health (BH) Payment Reform in CA-MMIS system.
Capitated Rates Development Division (CRDD): 6.0 Permanent Positions and 4.0 four-year LT Positions Effective 7/1/2021 and 5.0 Permanent Positions and 4.0 three-year Limited Term Positions Effective 7/1/2022 **Effective 7/1/2021:** • 1.0 Staff Services Manager II (SSM II) (four-year LT) • 1.0 Health Program Specialist I (HPS I) (four-year LT) • 1.0 Research Data Analyst II (RDA II) • 2.0 Research Data Specialist I (RDS I) • 1.0 Research Data Specialist II (RDS II) (four-year LT)	• Enhanced Care Management • In-Lieu-of-Services • Shared Risk, Shared Savings, and Incentive Payments • Managed Care Benefit Standardization

Analysis of Problem

Division	Proposal
• 1.0 SSM I • 2.0 AGPAs • 1.0 AGPA (four-year LT) **Effective 7/1/2022:** • 2.0 AGPAs • 1.0 AGPA (three-year LT) • 1.0 RDS I • 1.0 RDS I (three-year LT) • 1.0 SSM II • 1.0 SSM I (three-year LT) • 1.0 RDA II (three-year LT) • 1.0 RDS II	
Community Services Division (CSD): 4.0 four-year LT Positions Effective 7/1/2021 to 6/30/2025 and 2.0 three-year LT positions Effective 7/1/2022 to 6/30/2025 **Effective 7/1/2021:** • 1.0 Research Data Supervisor I (RD Sup. I) (four-year LT) • 1.0 Research Scientist III (RS III) (four-year LT) • 2.0 RDS I (four-year LT) **Effective 7/1/2022**: • 2.0 RDA II (three-year LT)	• Behavioral Health Data Systems and Data Analysis Support for Behavioral Health Proposals
Enterprise Data and Information Management (EDIM): 1.0 two-year LT Positions Effective 7/1/2021 to 6/30/2023: • 1.0 ITS II (two-year LT)	• Data and Information support for CalAIM proposals
Enterprise Technology Services (ETS): 3.0 two-year LT Positions Effective 7/1/2021 to 6/30/2023 and 3.0 Permanent Positions Effective 7/1/2021: • 1.0 IT Sup II (two-year LT) • 1.0 ITS II (two-year LT) • 1.0 ITS I (two-year LT) • 1.0 ITM I • 2.0 ITS II	• System support for CalAIM proposals and long term support of required system changes, including, but not limited to Enhanced Care Management; Shared Risk, Shared Savings, and Incentive Payments; Managed Care Benefit Standardization; Mandatory Managed Care Enrollment; Transition to Statewide Long-Term Services and Supports, Long-Term Care & Dual Eligible Needs Plans; and Improving Beneficiary Contact and Demographic Information
Integrated Systems of Care Division (ISCD): 8.0 Permanent Positions Effective 7/1/2021 • 1.0 SSM I • 6.0 AGPA • 1.0 HPS I	• Enhancing County Oversight and Monitoring: California Children's Services and Child Health and Disability Prevention

Analysis of Problem

Division	Proposal
Local Governmental Financing Division: 2.0 Permanent Positions Effective 7/1/2021 • 1.0 HPS I • 1.0 AGPA	• BH Payment Reform
Managed Care Operations Division (MCOD): 8.0 Permanent Positions and 4.0 four-year LT Positions Effective 7/1/201 and 2.0 three-year LT Positions Effective 7/1/2022: **Effective 7/1/2021:** • 3.0 AGPAs • 2.0 HPS I • 2.0 HPS I (four-year LT) • 1.0 HPS II • 1.0 Research Data Analyst I (RDA I) (four-year LT) • 1.0 RDA II • 1.0 Research Data Manager (RDM) • 1.0 RD Sup II (four-year LT) **Effective 7/1/2022:** • 2.0 AGPAs (three-year LT)	• Managed Care Benefit Standardization • Mandatory Enrollment • Transition to Statewide Long-Term Services and Supports, Long-Term Care, and Dual Eligible Special Needs Plans
Managed Care Quality and Monitoring Division (MCQMD): 18.0 Permanent Positions and 6.0 LT Positions Effective 7/1/2021 **Effective 7/1/2021:** • 8.0 AGPAs • 2.0 Health Program Manager II (HPM II) • 1.0 HPS II • 2.0 HPS II (four-year LT) • 3.0 Nurse Consultant III (NC III) • 1.0 RDA II (four-year LT) • 2.0 RDS I (four-year LT) • 1.0 RDS II (four-year LT) • 1.0 RS III • 2.0 SSM I • 1.0 SSM II	• Enhanced Care Management Benefit • In Lieu of Services • National Committee for Quality Assurance (NCQA) Accreditation of Medi-Cal Managed Care Plans • Population Health Management Program • Transition to Statewide Long-Term Services and Supports, Long-Term Care, and Dual Eligible Special Needs Plans
Medi-Cal Behavioral Health Division (MCBHD): 21.0 6.5-year LT Positions and 2.0 3-year LT Positions Effective 7/1/21 **Effective 7/1/2021:** • 2.0 SSM II (6.5-year LT) • 5.0 SSM I (6.5-year LT) • 5.0 HPS I (6.5-year LT) • 9.0 AGPA (6.5-year LT) • 1.0 AGPA (3-year LT) • 1.0 HPS I (3-year LT)	• Integration of Infrastructure for Specialty Mental Health and Substance Use Disorder Services • Medical Necessity Criteria for Specialty Mental Health and Substance Use Disorder Services

Analysis of Problem

Division	Proposal
Medi-Cal Dental Services Division (MDSD): 1.0 Permanent Position Effective 7/1/2021 and 10.0 Permanent Positions Effective 7/1/2022 **Effective 7/1/2021** • 1.0 SSM I **Effective 7/1/2022:** • 1.0 SSM I • 1.0 AMA • 7.0 AGPA • 1.0 Dental Hygienist Consultant (DHC)	• New Dental Policies
Medi-Cal Eligibility Division (MCED): 5.0 Permanent Positions Effective 7/1/2021 • 1.0 SSM II • 1.0 SSM I • 3.0 AGPA	• Improving Medi-Cal Eligibility Oversight and Monitoring
Office of Administrative Hearings and Appeals (OAHA): 1.0 Permanent Position Effective 7/1/2021 • 1.0 Administrative Law Judge II	• Hearings and appeals support for CalAIM
Office of Legal Services (OLS): 3.0 Permanent Positions Effective 7/1/2021 and 2.0 Permanent Positions Effective 1/1/2022 **Effective 7/1/2021:** • 3.0 Attorney III **Effective 1/1/2022:** • 1.0 Attorney III • 1.0 Senior Legal Analyst (SLA)	• Legal support for CalAIM proposals
Office of the Medical Director (OMD): 3.0 Permanent Positions (conversion of expiring LT positions to permanent) Effective 7/1/2021 • 2.0 AGPAs • 1.0 Public Health Medical Officer III (PHMO III)	• Transition of Public Hospital Redesign and Incentives in Medi-Cal (PRIME) to Quality Incentive Program (QIP)

B. Background/History

Medi-Cal has significantly expanded and changed over the last ten years due to changes brought by the Affordable Care Act, various federal regulations, and state-level statutory changes. During this time, DHCS has also undertaken many initiatives and embarked on innovative demonstration projects to improve the beneficiary experience. In particular, DHCS has increased the number of beneficiaries receiving the majority of their physical health care through Medi-Cal managed care plans. These plans offer more care coordination and care management than is possible through a fee-for-service system. They can also provide a broader array of services aimed at stabilizing and supporting the lives of Medi-Cal beneficiaries.

Depending on the needs of the beneficiary, some may need to access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, dental, developmental, In Home Supportive Services, etc.). Need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. In addition, the state's experience responding to the COVID-19 pandemic has underscored the existing disparities and inequities in the healthcare system. Therefore, in order to meet the behavioral, developmental, physical, and oral health needs of all members in an integrated, patient-centered, whole-person approach that seeks to reduce existing disparities and inequities, DHCS is seeking to integrate multiple delivery systems to mobilize and incentivize towards common quality goals.

To achieve such outcomes, the CalAIM proposals offer advanced and innovative solutions to support the stability of the Medi-Cal program and allow the critical successes of waiver demonstrations such as Whole Person Care, the Coordinated Care Initiative, public hospital system delivery transformation, and the coordination and delivery of quality care to continue and be expanded to all Medi-Cal enrollees. The initiative seeks to build upon past successes and improve the entire continuum of care across Medi-Cal, allowing the system to more appropriately manage patients over time through a comprehensive array of health and social services spanning all levels of intensity of care, from birth to end of life. The CalAIM proposals change the expectations for the managed care and behavioral health systems. These proposals increase accountability for our delivery system partners and provide a wider array of services and supports for complex, high need patients whose health outcomes are, in part, driven by unmet social needs. These investments will make system changes necessary to close the gap in transitions between delivery systems and expand opportunities for appropriate step-down care.

Drug Medi-Cal Organized Delivery System (DMC-ODS) Renewal and Policy Improvements

Overview

In August 2015, CMS approved the DMC-ODS Waiver as an amendment to DHCS' Bridge to Reform Waiver, which was later renewed as the Medi-Cal 2020 Waiver operating over a five-year period. The DMC-ODS Waiver provides a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for Substance Use Disorder (SUD) treatment services. The DMC-ODS Waiver has enabled more local control and accountability, provided greater administrative oversight, created utilization controls to improve care and efficient use of resources, implemented evidence-based practices in behavioral health treatment, and coordinated with other systems of care. This approach has provided Medi-Cal beneficiaries with access to the care and system interaction needed to achieve sustainable recovery. Counties may choose to participate in this Waiver program or may continue to participate in State Plan Drug Medi-Cal.

Counties make DMC-ODS services available as a Medi-Cal benefit for all individuals who reside within its county borders, have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for a SUD, and meet the medical necessity criteria to receive a particular service based on ASAM Level of Care Criteria for SUD treatment services. The county selectively chose contracts with DMC certified providers, a managed care plan, or offered county-operated DMC-ODS services. Counties that are interested in participating in the DMC-ODS Waiver were required to submit a county implementation plan and undergo an approval process by DHCS and CMS. Counties are considered managed care organizations (MCOs) due to the multiple services they provide under the Waiver.

Analysis of Problem

The DMC-ODS Waiver has fundamentally changed the way counties deliver SUD services. Based on this, counties were challenged to improve and add to the services provided to beneficiaries. This is achieved by coordinating a network of providers to deliver the different levels of SUD services including residential, narcotic treatment programs (NTPs), intensive outpatient, outpatient, withdrawal management, and recovery services. On top of implementing the Waiver, DHCS also rolled out ASAM training for all staff handling beneficiaries, created 24-hour Access Lines for beneficiaries seeking treatment, expanded the use of Medication Assisted Treatment (MAT), added case management and physician consultation services, and wrote policies and procedures for the oversight of the system.

DHCS is helping to make the DMC-ODS Waiver a success for counties, providers, and patients. As the first state in the nation to implement the DMC-ODS, the information provided has benefited counties to improve services, and other states looking to implement an organized delivery system.

DMC-ODS External Quality Review Organization (EQRO) Support Contract

In order to oversee adequate provision of behavioral health services for counties operating under the DMC-ODS, DHCS contracts with an External Quality Review Organization (EQRO), as established in the federal requirements related to Medicaid managed care quality at section 1932(c) of the Social Security Act (the Act) and are set forth in 42 C.F.R. § 438, subpart E. The Centers for Medicare and Medicaid Services (CMS) require that states conduct an annual external independent review of the quality of and access to services under each behavioral health care contract (§ 1932(c)(1) of the Act). Per the federal mandate the EQRO is responsible for annual review and analysis of counties' DMC-ODS Waiver implementation activities. The number of participating counties has increased significantly over the past four years. Presently, 30 counties are participating. During the current FY 2020-21, seven California counties have submitted a single DMC-ODS implementation plan in a unique model with Partnership Health Plan of California (PHC), the Medicaid health plan for local Medi-Cal members in these counties, bringing the total number of counties participating to 37. PHC is a County Organized Health Plan (COHS) which is a unique health plan model in California. The remaining counties are working to meet the requirements, which include having an adequate network of providers to meet the needs of beneficiaries.

The findings from the EQRO's independent reviews are evaluated and analyzed in terms of (1) access, (2) timeliness, (3) quality, and (4) beneficiary outcomes. The quantitative data are supplanted with qualitative information via focus groups with county staff, families, and beneficiaries. Satisfaction with services is additionally analyzed using Consumer Perception Survey results to gain a comprehensive understanding of satisfactorily behavioral health services. The EQRO further determines functionality of each county's electronic health record systems to appropriately collect and analyze data to inform counties' strategic plans to support a dynamic behavioral health service delivery system and ameliorate deficiencies when and where needed. Findings are summarized in a detailed technical report, including (1) a description of the data obtained; (2) conclusions drawn from the data; (3) an assessment of each county's strengths and challenges for the quality, timeliness, and access to behavioral health care services furnished to Medi-Cal beneficiaries; (4) an assessment of the degree to which each county addressed any recommendations for quality improvement made during the previous review; and (5) recommendations for improving the quality of behavioral health care services furnished by each county, including how DHCS can target goals and objectives in the quality strategy. Finally, the EQRO provides extensive training and technical assistance to counties to support timely access to necessary behavioral health services for beneficiaries.

DMC-ODS Evaluation Support Contract

Through an existing contract with DHCS, the University of California Los Angeles Integrated Substance Abuse Program (UCLA-ISAP) conducts an evaluation to measure and monitor the outcomes from the DMC-ODS Waiver. The design of the DMC-ODS evaluation focuses on four areas: (1) access to care, (2) quality of care, (3) cost, and (4) the integration and coordination of SUD care, both within the SUD system and with medical and mental health services. UCLA-ISAP utilizes data gathered from a number of existing state data sources as well as new data collected specifically for the evaluation. In addition, UCLA-ISAP also reviews evaluation plans from participating counties, provides technical assistance services, and compiles an Annual Evaluation Report that focuses on data collected in previous years.

Prior to the existing contract executed on July 1, 2018 between DHCS and UCLA, previous evaluation projects (technical assistance presentations, case study, etc.) conducted by UCLA were funded by a Substance Abuse and Mental Health Services Administration (SAMHSA) grant. Since the DMC-ODS evaluation approval in 2016, all DMC-ODS evaluations and technical assistance services as listed above were integrated to receive federal funds through the DMC-ODS waiver.

DMC-ODS Technical Assistance (TA) Support Contract

With the Waiver extension, the participating counties will continue to need training and TA for all the required elements of the DMC-ODS Waiver such as ASAM Criteria, quality assurance, selective contracting, DMC-ODS Waiver assessment of modality services, medication assisted treatment, a continuum of care, and quality assurance processes. A training and TA contractor will be necessary to provide these services and make training available when the Waiver extension is in effect. The contractor will review and draw upon the prior year's findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. Training needs have shifted from start-up training such as selective provider contracting, general overview of ASAM and ASAM screening tools to more advanced ASAM training, quality assurance processes complying with the CFR section 438 requirements and meeting the training and TA needs to be identified through the Waiver Evaluation and EQRO.

Proposal	**2020-21**	**2021-22**	**2022-23**	**2023-24**	**2024-25**	**2025-26**
Transition of PRIME to QIP	Start					
DMC-ODS Program Renewal & Policy Improvements		Start				
Managed Care Benefit Standardization		Start				
Enhancing County Eligibility Oversight & Monitoring		Start				
Behavioral Health Medical Necessity		Start				
Enhanced Care Management		Start				
In Lieu of Services		Start				

Analysis of Problem

Proposal	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Mandatory Managed Care Enrollment		Start				
Shared Risk/Savings and Incentive Payments		Start				
New Dental Benefits & P4P		Start				
Behavioral Health Payment Reform			Start			
Improving Beneficiary Contact and Demographic Information			Start			
Population Health Management Program			Start			
Transition to Statewide Long-Term Services and Supports, Long Term Care, & Dual Eligible Special Needs Plans			Start			
NCQA Accreditation of Medi-Cal Managed Care Plans & Health Plan Subcontractors						Start
NCQA LTSS Distinction Survey Required of MCPs						Start
Administrative Integration of County MH & SUD Services						Start
SMI/SED Demonstration Waiver			Earliest possible start			

Analysis of Problem

Resource History
(Dollars in thousands)

Administration Division

Program Budget	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**
Authorized Expenditures	$26,887	$25,651	$26,562	$30,679	$33,985
Actual Expenditures	$24,915	$24,476	$26,205	$30,679	$20,924
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	270.7	243.0	244.0	251.0	135.5
Filled Positions	247.7	219.5	229.0	232.4	129.0
Vacancies	23.0	23.5	15.0	18.6	6.5

California Medicaid Management Information System Division

Program Budget	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**
Authorized Expenditures	$13,507	$13,634	$24,842	$67,283	$89,635
Actual Expenditures	$13,492	$13,634	$14,284	$41,629	$60,418
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	118.0	96.0	115.0	140.0	158.0
Filled Positions	107.0	88.2	105.6	118.3	128.9
Vacancies	11.0	7.8	9.4	21.7	29.1

Capitated Rates Development Division

Program Budget	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**
Authorized Expenditures	$8,910	$7,227	$6,523	$7,216	$7,213
Actual Expenditures	$5,646	$3,663	$5,313	$5,437	$6,748
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	45.6	49.0	45.0	45.0	57.0
Filled Positions	25.6	27.0	38.6	37.4	45.4
Vacancies	20.0	22.0	6.4	7.6	11.6

Analysis of Problem

Community Services Division

Program Budget	2015-16	2016-17	2017-18	2018-19	2019-20
Authorized Expenditures	N/A	N/A	N/A	N/A	$129,863
Actual Expenditures	N/A	N/A	N/A	N/A	$39,287
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	N/A	N/A	N/A	N/A	132.5
Filled Positions	N/A	N/A	N/A	N/A	108.4
Vacancies	N/A	N/A	N/A	N/A	24.1

**Effective FY 2019-20 CSD split from SUDPPFD*

Office of the Medical Director

Program Budget	2015-16	2016-17	2017-18	2018-19	2019-20
Authorized Expenditures	N/A	N/A	N/A	N/A	$5,229
Actual Expenditures	N/A	N/A	N/A	N/A	$3,616
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	N/A	N/A	N/A	N/A	9.0
Filled Positions	N/A	N/A	N/A	N/A	8.2
Vacancies	N/A	N/A	N/A	N/A	0.8

*Effective FY 2019-20, Office of the Medical Director split from Director's Office.

Information Management Division

Program Budget	2015-16	2016-17	2017-18	2018-19	2019-20
Authorized Expenditures	$22,819	$22,900	$23,534	$19,823	$16,301
Actual Expenditures	$14,632	$14,213	$11,464	$16,609	$15,134
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	69.5	68.5	71.5	75.5	80.5
Filled Positions	60.5	60.5	65.9	66.4	68.9
Vacancies	9.0	8.0	5.6	9.1	11.6

*Effective FY 2020-21 Information Management Division (IMD) and Research & Analytic Studies Division (RASD) have reorganized into Enterprise Data and Information Management (EDIM).

Analysis of Problem

Enterprise Technology Services

Program Budget	2015-16	2016-17	2017-18	2018-19	2019-20
Authorized Expenditures	$52,216	$52,442	$53,831	$68,137	$96,605
Actual Expenditures	$51,271	$50,033	$53,270	$60,528	$85,750
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	307.1	276.5	277.5	278.5	297.5
Filled Positions	283.1	249.2	260.2	256.9	260.0
Vacancies	24.0	27.3	17.3	21.6	37.5

Integrated Systems of Care Division

Program Budget	2015-16	2016-17	2017-18	2018-19	2019-20
Authorized Expenditures	N/A	N/A	N/A	$35,683	$24,087
Actual Expenditures	N/A	N/A	N/A	$21,615	$21,036
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	N/A	N/A	N/A	196.0	193.0
Filled Positions	N/A	N/A	N/A	145.9	141.2
Vacancies	N/A	N/A	N/A	50.1	51.8

Local Governmental Financing Division

Program Budget	2015-16	2016-17	2017-18	2018-19	2019-20
Authorized Expenditures	N/A	N/A	N/A	N/A	$5,736
Actual Expenditures	N/A	N/A	N/A	N/A	$5,736
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	N/A	N/A	N/A	N/A	50.0
Filled Positions	N/A	N/A	N/A	N/A	43.2
Vacancies	N/A	N/A	N/A	N/A	6.8

**Effective FY 2019-20 LGFD split from SNFD and MHSD.*

Analysis of Problem

Medi-Cal Eligibility Division

Program Budget	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**
Authorized Expenditures	$18,118	$20,991	$17,521	$16,992	$34,712
Actual Expenditures	$15,419	$14,541	$15,742	$16,789	$34,712
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	161.0	142.5	137.5	132.5	140.0
Filled Positions	133.0	122.9	119.9	119.3	125.9
Vacancies	28.0	19.6	17.6	13.2	14.1

Medi-Cal Behavioral Health Division

Program Budget	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**
Authorized Expenditures	N/A	N/A	N/A	N/A	$13,909
Actual Expenditures	N/A	N/A	N/A	N/A	$8,619
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	N/A	N/A	N/A	N/A	87.0
Filled Positions	N/A	N/A	N/A	N/A	70.4
Vacancies	N/A	N/A	N/A	N/A	16.6

**Effective FY 2019-20 MCBHD split from MHSD, SUDPPFD and SUDCD.*

Managed Care Operations Division

Program Budget	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**
Authorized Expenditures	$10,011	$11,063	$12,447	$15,075	$16,955
Actual Expenditures	$10,007	$11,914	$12,208	$14,354	$15,653
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	110.1	109.0	119.0	114.0	123.0
Filled Positions	98.1	98.0	98.7	104.1	106.3
Vacancies	12.0	11.0	20.3	9.9	16.7

Analysis of Problem

Managed Care Quality and Monitoring Division

Program Budget	2015-16	2016-17	2017-18	2018-19	2019-20
Authorized Expenditures	$16,638	$24,142	$24,435	$25,786	$39,400
Actual Expenditures	$14,161	$16,644	$20,479	$20,431	$26,758
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	83.1	92.0	92.0	101.0	119.00
Filled Positions	78.1	75.9	85.1	88.6	94.80
Vacancies	5.0	16.1	6.9	12.4	24.20

Medi-Cal Dental Services Division

Program Budget	2015-16	2016-17	2017-18	2018-19	2019-20
Authorized Expenditures	$3,597	$6,922	$8,158	$8,427	$8,172
Actual Expenditures	$3,597	$4,070	$5,833	$7,219	$8,094
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	35.3	39.0	39.0	37.0	39.0
Filled Positions	24.3	29.6	32.7	31.8	36.3
Vacancies	11.0	9.4	6.3	5.2	2.7

Office of Administrative Hearings and Appeals

Program Budget	2015-16	2016-17	2017-18	2018-19	2019-20
Authorized Expenditures	$7,129	$7,370	$7,560	$7,958	$8,654
Actual Expenditures	$7,118	$7,353	$7,560	$7,208	$7,601
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	54.1	52.5	46.0	45.0	48.0
Filled Positions	44.6	45.4	42.4	43.6	43.6
Vacancies	9.5	7.1	3.6	1.4	4.4

Analysis of Problem

Office of Legal Services

Program Budget	2015-16	2016-17	2017-18	2018-19	2019-20
Authorized Expenditures	$15,376	$16,969	$18,243	$19,872	$21,573
Actual Expenditures	$15,339	$16,750	$18,243	$19,872	$21,573
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	113.8	110.5	112.0	117.0	125.0
Filled Positions	93.8	93.9	97.2	102.4	109.1
Vacancies	20.0	16.6	14.8	14.6	15.9

Workload History

Administration Division

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20
Department authorized position count	3,654	3,693	3,811	3,892	3,895
Administration staff	134.5	134.5	139.5	148	150.5
Processing applications for vacancies (MQ review)	1,830	2,198	2,345	5,205	7,916
Processing requests for personnel action	2,384	2,213	2,132	2,265	2,128
Square footage of facilities managed	935,642	924,092	844,737	868,008	862,713
Number of Purchase Orders processed	1670	1862	1814	1648	1440
Number of Draft Contracts/ Amendments Reviewed	N/A*	N/A*	810	990	1,190
Number of Contracts/ Amendments Executed	N/A*	N/A*	550	620	570

Capitated Rates Development Division

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20
Managed Care Spend (cash basis, in billions)	$39	$43	$45	$42	$47

Enterprise Data and Information Management

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20
EPM Cubes in production	N/A	N/A	1	3	9
EPM users	N/A	N/A	7	38	140
Program Areas in EPM	N/A	N/A	1	1	3
Number of Reports	N/A	N/A	4	13	37

Analysis of Problem

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20
Published in EPM					
Number of Custom tools developed (Automated loader, automated test harness etc.) in EPM	N/A	N/A	N/A	N/A	4

Enterprise Technology Services

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20
Number of Rate Types in CAPMAN	15	15	16	19	3426
CAPMAN Invoice Types	85	87	88	90	126
CAPMAN Full Stack Environments	4	6	7	9	1
CAPMAN Storage Capacity (in GB)	9,000	19,300	40,000	60,000	105,179
CAPMAN Audit Requests	1	1	1	4	8
CAPMAN Support Requests	807	1050	1180	861	1750
Number of EDI files received in Post Adjudicated Claims and Encounters System (PACES)	11,136	48,976	75,418	53,640	49,559
Number of encounters received from MC Plans in PACES	639,925,521	247,020,438	230,301,410	238,460,790	239,576,132
Number of issues received in PACES	344	145	294	548	626
Number of crossover claim files received through Cal Medi-Connect in PACES	N/A	N/A	354	3,331	1,873
Test files received in PACES	8,602	1,813	8,667	5,277	5,794
Number of system change requests received in PACES	117	165	148	144	178
Number of documents created, Companion guides, mappings, architecture diagrams, etc. (some are continuously updated and maintained)	10	16	23	32	43

in PACES					

Integrated Systems of Care Division

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20
Annual Child Health and Disability Prevention (CHDP) Program County Budget Review	61	61	61	61	61
CHDP related Policy Changes	2	2	2	2	2
CHDP related Legislative Analyses	1	2	2	2	2
CHDP Program Policy and Procedure Development	2	4	6	8	8
CHDP Program Letters	4	4	10	4	3
CHDP county oversight related to Blood Lead Screenings	61	61	61	61	61
Annual California Children's Services (CCS) Program County Budget Review	58	58	58	58	58
Service Authorization Request (SAR) Adjudication	30,000	32,000	34,000	36,000	38,000
CCS Numbered Letter drafting, development, and disbursement.	7	7	11	16	10
CCS Information Notice drafting, development, and disbursement.	4	4	4	5	5
CCS Program Policy and Procedure Development	2	4	6	8	10
CCS related Policy Changes	12	12	12	12	12
CCS related Legislative Analyses	4	5	5	5	4
CCS related Fair Hearings and Appeals	1	1	1	4	8

Local Governmental Financing Division

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20
Develop Specialty Mental Health Services (SMHS) rates for each county and Healthcare Common Procedure Coding System (HCPCS) code.	616	616	616	616	616

Analysis of Problem

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20
Develop Drug Medi-Cal (DMC) Statewide Maximum Allowance (SMA) rates and Narcotic Treatment Program (NTP) Uniform Statewide Daily Reimbursement (USDR) rates.	15	15	15	15	15

Medi-Cal Behavioral Health Division

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20
External Quality Review Organization (EQRO) Site Reviews/Visits	N/A	N/A	N/A	14	25
EQRO County and Aggregate Report	N/A	N/A	N/A	15	26
Quarterly EQRO/UCLA/DHCS Meeting	N/A	4	4	4	4
DMC-ODS Training and Technical Assistance	2	3	19	10	12
Training and Technical Assistance (TA) ASAM Criteria Continuum of Care Medication Assisted Treatment	N/A	30	57	50	35

**All of the workload measures listed in the above Medi-Cal Behavioral Health Division, Quality and Network Adequacy Oversight Section would be new as this is a new program.*

*** Resources for behavioral health regional contracting will be estimated as DHCS engages discussions with the counties.*

Managed Care Operations Division

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20
Develop and execute contract amendments or policy letters relating to ongoing monitoring and reporting	100	105	105	110	110
Establish and document operational procedures, policies, review tools, and various tracking systems; provide technical assistance, and resolve programmatic and technical questions	500	510	525	525	525
Oversight of the Health Care Options enrollment Broker, including monitoring activities and ongoing,	100	120	140	140	140

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20
meetings with enrollment broker					
Respond to sensitive internal and external communications and facilitate resolution of specialized problems	200	205	215	220	500
Research and make recommendations on monitoring and evaluation methods	100	110	110	115	115
Communicate with health plans on processes for and submission of required documents	385	395	400	1,000	1,010
Review Plan provider directories and verify compliance	100	125	125	125	125
Work with various program areas to identify business/system requirements	350	400	400	425	425
Monitor reports; test new system implementations	200	350	350	350	350
Draft and review correspondence, directives, and system functional design documentation	250	250	250	260	260
Revise current, create new, and implement beneficiary informing materials	N/A	100	100	100	100
Review current processing operations and supporting systems to improve contract compliance	N/A	N/A	200	200	200
Review of provider directories	288	288	576	576	576
Respond to routine inquiries	80	80	80	80	80
Participate in scheduled and ad hoc meetings to discuss or resolve issues	1,280	1,280	1,280	1,280	1,280
Develop and produce statistical reports and publications of findings	480	480	480	480	480
Process administrative support procurements	30	32	34	38	40
Provide technical support and process various IT requests	N/A	N/A	N/A	N/A	1300

Analysis of Problem

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20
Process Requests for Personnel Action (RPA)	76	83	88	92	140
Respond to personnel inquiries	N/A	N/A	N/A	6,396	8,381
Update existing and create new technical guidance documents for managed care plans	N/A	N/A	N/A	20	30
Facilitate and coordinate communication between intra-departmental entities to respond to Federal and State audits	12	14	16	18	20
Respond to audit requests and audit inquiries	N/A	N/A	N/A	1,100	1,230
Process data requests; lead data collection, perform analysis, and implement reporting tools	N/A	N/A	N/A	1,050	1,170
Research on Invoice Payments/Discrepancies	N/A	N/A	N/A	N/A	N/A
Review All Plan Letters and similar guidance to MCPs	80	80	80	80	80
Build Dual Eligible Special Needs Plan (DSNP) contracts; review and approve dual-eligible special needs plans (D-SNPs)	N/A	N/A	N/A	N/A	N/A

Office of the Medical Director

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20
Provide technical assistance to participating hospitals	N/A	N/A	17	17	17
Participate in regular calls with external key partners [California Association of Public Hospitals and Hospital Systems/Safety Net Institute (CAPH/SNI)] who represent participating hospitals	N/A	N/A	52	52	52
Review, analyze, and approve hospital performance reports to determine incentive payment amount	N/A	N/A	17	17	17
Participate in regular calls and work with other DHCS divisions, i.e.	N/A	N/A	12	12	12

Capitated Rates Development Division (CRDD) to align performance and incentive payment					
Review and update clinical performance measures to incorporate into the specification manual	N/A	N/A	26	26	29
Analyze data on each measure and incorporate into the annual internal evaluation as required by CMS	N/A	N/A	26	26	29

Medi-Cal Dental Services Division

Workload Measure	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**
Develop and implement policy related implementation	500	500	600	600	700
Research state and federal laws and regulations; develop and execute contract amendments	75	75	100	100	125
Provide technical assistance to dental contractors in complying with data recording and submission	100	100	200	200	250
Develop research methodologies required to support the collection and analysis of data	500	500	600	600	700
Participate in physical health and oral health committees and work groups to develop and implement oral health care programs	150	150	200	200	250
Develop statistical reports and publications of scientific findings, comprehensive annual reports of dental policies, management briefs, benchmark reports and dashboards	100	100	200	200	250
Assist dental contractors in understanding and executing enhanced standards and processes related to dental policies	22	22	22	22	22

Analysis of Problem

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20
Stakeholder engagement with internal and external entities	50	50	100	100	100
Policy Changes	50	50	50	50	50

Medi-Cal Eligibility Division

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20
Plan, organize, and direct staff related to the priorities of the County Focused Review project	N/A	N/A	504	5,130	4,463
Plan, organize, and direct staff related to the priorities of the external audits project	5,355	5,355	5,355	5,355	5,355
Plan, organize, and direct staff related to the priorities of the Medi-Cal Eligibility Data System Alert Monitoring project	N/A	N/A	N/A	300	114
Plan, organize, and direct staff related to the priorities of the Pre-ACA and Transitional Aid Code Clean-Up project	N/A	N/A	1	1,392	708
Plan, organize, and direct staff related to the priorities of the Medicaid Eligibility Quality Control (MEQC) project	N/A	N/A	24	24	24
Plan, organize, and direct staff related to the priorities of the Payment Error Rate Measurement (PERM) project	N/A	N/A	N/A	12	5,261

*This is a new budget change proposal for CA-MMIS, CSD, MCQMD, OAHA, and OLS. The workload in this proposal has not been measured previously.

C. State Level Consideration

In 2018, the Care Coordination Advisory Committee developed a core set of guiding principles. DHCS built off and refined those principles, in line with the DHCS Strategic Plan and the draft DHCS Comprehensive Quality Strategy, to develop CalAIM. The guiding principles for the development of CalAIM are:

- Improve the member experience.
- Deliver person-centered care that meets the behavioral, developmental, physical, and oral health needs of all members.

- Work to align funding, data reporting, quality, and infrastructure to mobilize and incentivize towards common goals.
- Build a data-driven population health management strategy to achieve full system alignment.
- Identify and mitigate social determinants of health.
- Reduce disparities and inequities.
- Drive system transformation that focuses on value and outcomes.
- Eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation.
- Support community activation and engagement.
- Improve plan and provider experience by reducing administrative burdens when possible.
- Reduce the per-capita cost over time through iterative system transformation.

D. Justification

In order to successfully implement the finalized CalAIM initiative, DHCS requests state operations resources in the following areas:

Administrative support (contracting, human resources, facilities) for CalAIM proposals

Administration Division (9.0 permanent positions effective 7/1/2021)
1.0 SSM I
1.0 BSO I
4.0 APA
2.0 AGPA
1.0 OT-Typing

CalAIM has department-wide impacts. Verifying compliance with new policies will require a significant increase in DHCS workload. This workload will be completed by newly proposed positions and resources, which in turn creates significant administrative work. The Human Resources Branch (HRB) will need to provide administrative support by processing department recruitment and hiring, and retaining the most capable workforce, as well as handle position employment, performance management and consulting, payroll and benefits, injured worker, and labor relations. HRB is requesting 1.0 SSM I, 4.0 APAs, and 1.0 OT-Typing position to oversee the application processing, hiring, employee management and consulting, and support administration of the new staff. These positions are needed to administer the appropriate laws, rules, regulations, and contract language pertaining to personnel transactions, employee relations, selection administration, and performance management and consultation. Without these positions, HRB is unable to complete current workload, along with the new workload related to CalAIM personnel. The workload is ongoing because of retention efforts, necessary HR support for staff, and turnover.

The Contract Services Branch (CSB) is requesting 2.0 AGPA positions to provide support for the necessary overall contracting process. The AGPAs will provide necessary oversight, evaluation, and technical support for the implementation of CalAIM contract requirements, reviewing for compliance with State Contracting Manual (SCM), Public Contract Code (PCC), Government Code (GC) and federal guidelines.

CSB provides a critical role for the Department by providing management and oversight of the contract procurement processes, overseeing contract development and approval for the Department, which consists of approximately 40 Divisions. Currently, CSB processes more than 1,200 contracts per Fiscal Year totaling over $1 billion, which includes general and federal

funds. CSB verifies that all contracts meet SCM, PCC, GC and federal guidelines. To validate that all guidelines are followed, CSB is updating and implementing new policies and procedures that are aimed at streamlining the overall contract flow. This process will improve any outstanding deficiencies and allow CSB to manage current workload within existing resources. Due to the additional funding, size, volume, and complexity of the contracts that will be forthcoming with CalAIM, CSB's workload will increase significantly and will therefore require additional staff.

The Program Support Branch (PSB) is requesting 1.0 BSO I to support the areas of Business Services for the increase of staffing with CalAIM. The increase of staffing will require additional square footage of facilities to be acquired and managed. With the current Public Health Emergency, the Department will continue to monitor the space planning and make any necessary adjustment to align with any new policies.

Administration support requires additional resources to direct an array of central support services to achieve DHCS program and operations objectives and provide management/program support and business control functions for the Department. Much like any new initiative, Administration anticipates there would be an initial front-loading of resources, with continued need for resources for maintenance and operations. To provide excellent services within DHCS, which ultimately facilitates provision of health care services to one in three Californians, it is critical for the Administration Division to receive additional resources to manage the increase of staffing due to CalAIM.

CA-MMIS and CD-MMIS Systems Support

CA-MMIS Operations Division

(Two-year LT resource equivalent to 1.0 position effective 7/1/2021)
1.0 ITS II

CA-MMIS and CD-MMIS systems require moderate to complex changes to support CalAIM initiatives. These changes are managed as system changes, involving both State and Fiscal Intermediary (FI) Vendors. In order to meet CalAIM requirements and implementation targets, the workload must be managed in addition to standard operations. The requested position can accommodate the estimated additional workload.

Population Health Management Program

DHCS currently does not have a specific requirement that Medi-Cal managed care plans maintain a population health management strategy, which is a model of care and a plan of action designed to address member health needs at all points along the continuum of care. Many Medi-Cal managed care plans have a population health management program – often in the context of meeting National Committee for Quality Assurance (NCQA) requirements – but some do not. In the absence of a population health management strategy, beneficiary engagement is often driven by a patchwork of requirements that can lead to gaps in care and a lack of coordination.

The goal of this proposal is to improve health outcomes and efficiency through standardized population health management requirements for Medi-Cal managed care plans. Population health management will also allow managed care plans and DHCS to more effectively address disparities and inequities in the provision of healthcare. The population health management requirements will include NCQA requirements and additional DHCS requirements. The population health management strategy will address the full spectrum of

care coordination – including screenings, health assessments, case management, data collection and monitoring, care transitions, communications, governance, training, and other issues. Additionally, Medi-Cal managed care plans will develop predictive analytics about which patients, communities, or populations are emerging as high risk, as well as identify and address the needs of outliers with more specific services and supports.

MCQMD (5.0 permanent positions effective 7/1/2021 and four-year LT resources equivalent to 6.0 positions effective 7/1/2021)
1.0 HPM II
2.0 HPS II (four-year limited-term)
3.0 NC III
1.0 RS III
2.0 RDS I (four-year limited-term)
1.0 RDS II (four-year limited-term)
1.0 RDA II (four-year limited-term)

The addition of the population health management requirement creates new workload for MCQMD. The requested positions will lead Medi-Cal managed care program development, including a wide variety of activities related to the population health management requirements. This workload will include, but not be limited to:

- Overseeing and coordinating the development, implementation, maintenance, evaluation, and health plan oversight of the population health management strategy.
- Updating and revising population health management assessments, stratification methodologies, templates, and checklists.
- Collaborating with clinical programmatic staff to compile and communicate promising practices related to the population health management strategies to MCPs.
- Analyzing and implementing NCQA population health management requirements.
- Developing key performance indicators for internal and external report production and monitoring.
- Developing analytic queries to extract and analyze data from DHCS information systems for population health management development.
- Developing population health management program data reporting templates, key performance indicators, program monitoring reports, and performance dashboards.
- Collecting and managing population health management program data from MCPs.
- Producing internal and external population health management reports and dashboards.
- Designing research methodologies for population health management strategy evaluations as needed.

Developing the population health management program and guiding implementation over the first few years is likely going to create a large upfront workload. Resources are necessary to meaningfully change managed care plan behavior. While continued monitoring and analysis workload is expected after initial implementation efforts, limited-term resources will assist in the implementation of this program.

Enhanced Care Management Benefit

Depending on the needs of the beneficiary, some individuals may need to access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, developmental, dental, In Home Supportive Services, etc.).

Given the similarities in target populations across Medi-Cal delivery systems, beneficiaries are likely to be eligible for multiple programs that include some level of care management, depending on the efforts that are underway in their county of residence. Additionally, as one would expect, the need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. Both the Health Homes Program and many of the Whole Person Care pilots provide such services. DHCS is proposing the implementation of a single, comprehensive enhanced care management program within Medi-Cal managed care.

CRDD (1.0 permanent position effective 7/1/2021)
1.0 RDS I

The addition of the enhanced care management benefit presents new workload for CRDD. The requested position will support Medi-Cal managed care rate development and financial analysis activities related to the enhanced care management benefit. Workload will include, but is not be limited to, developing tools and methodologies for systematically collecting cost and utilization data for the enhanced care management benefit; coordinating the collection and compilation of plan-reported data; analyzing cost and utilization patterns across plans, counties and regions, and enrolled populations; and providing requisite data and analyses to actuaries to inform rate development.

MCQMD (4.0 permanent positions effective 7/1/2021)
1.0 SSM I
3.0 AGPAs

The addition of the enhanced care management benefit presents new workload for MCQMD as well. The requested positions will support activities related to the implementation of the benefit. The additional workload will include, but not be limited to:

- Working with MCPs to provide support and monitor compliance.
- Reviewing and tracking deliverables and assisting Department management on issues.
- Reviewing program requirements to comply with State and Federal law, the MCP contract, and implementation guidelines.
- Providing policy support, including development and communication, regulations, and waiver-related development and updates.
- Collaborating with internal and external entities.
- Monitoring and developing program processes, including developing and presenting major policy issues and recommendations to management, to support compliance with all implementation deadlines.
- Performing administrative and supervisory functions.

In-Lieu of Services

The Whole Person Care pilots and Health Homes Program built a foundation for an integrated approach to coordinating medical care, behavioral health and social services to improve beneficiary health outcomes. However, the implementation of these programs has varied across California and did not provide a statewide platform to comprehensively address the needs of beneficiaries with the most complex health challenges.

According to federal Medicaid program rules, "in lieu of services" are medically appropriate and cost-effective alternatives to services covered under the State Plan. They are typically delivered by a different provider or in a different setting than traditional State Plan services. In

lieu of services may be offered only on a voluntary basis (i.e., beneficiaries are not required to use the alternative service or setting) and must be authorized and identified in the Medi-Cal managed care plan contracts.

Once adopted, Medi-Cal managed care plans will integrate in lieu of services into their population health management plans – often in combination with the new enhanced care management benefit – to address gaps in State Plan benefit services. In lieu of services may be focused on addressing combined medical and social determinants of health needs and avoid higher levels of care. For example, in lieu of services might be provided as a substitute for, or to avoid, hospital or nursing facility admissions, discharge delays, and emergency department use.

CRDD (5.0 permanent positions and four-year LT resources equivalent to 3.0 positions effective 7/1/2021)
1.0 SSM II (four-year limited-term)
1.0 SSM I
1.0 RDS II (four-year limited-term)
1.0 RDS I
1.0 RDA II
2.0 AGPAs
1.0 AGPA (four-year limited-term)

The adoption of in lieu of services into the Medi-Cal managed care program presents new workload for CRDD. The requested resources will perform financial analysis to evaluate the cost-effectiveness of in lieu of services as required in federal regulations and support Medi-Cal managed care rate development activities related to in lieu of services. Workload will include, but is not limited to:

- Developing and maintaining tools and methodologies for systematically collecting cost and utilization data for in lieu of services.
- Annually, collecting and compiling data on the utilization and cost of in lieu of services for use in rate development.
- Analyzing the cost effectiveness of in lieu of services relative to State plan covered services.
- Working with actuaries to develop and update rate methodologies that incorporate in lieu of services, and seeking necessary federal approvals from CMS on an annual basis.
- Analyzing in lieu of services cost and utilization patterns across plans, counties and regions, and enrolled populations.
- Evaluating and reporting the impacts of in lieu of services on the utilization of traditional State plan covered services.
- Drafting contract language and implementing guidance related to in lieu of services in conjunction with other divisions.

The creation of in lieu of services presents significant new workload for CRDD. As most of the one-time, policy-focused workload needed for the initial adoption of the 13 in lieu of services proposed under CalAIM must be completed well in advance of implementation, this workload will be absorbed using existing resources. The new positions will perform the ongoing workload of maintaining in lieu of services within the Medi-Cal managed care delivery system, including annual data collection, analysis, monitoring and reporting, and annual rate development activities. In addition, the positions will perform the analytical, programmatic, and research work necessary to provide ongoing guidance/communication in response to requests from plans and other stakeholders for DHCS to authorize new in lieu of services (either statewide or at a plan level) and ad hoc inquiries pertaining to in lieu of services.

MCQMD (5.0 permanent positions effective 7/1/2021)
1.0 HPM II
3.0 AGPAs
1.0 SSM I

The adoption of in lieu of services will require MCQMD to engage in various policy development and oversight activities, resulting in an increased workload for MCQMD. The requested positions will offer policy guidance, conduct oversight, and gather and share best practices regarding in lieu of services. Additionally, the requested positions will categorize and report on trends, services, concerns, and models. Finally, the requested positions will provide general policy support and communication for regulations and other guidance. Workload will include, but will not be limited to:

- Directing and supporting various program communications and administrative activities.
- Conducting workgroups with internal and external stakeholders.
- Analyzing and implementing the recommendations from stakeholders.
- Conducting reporting activities and issuing reports, discussion documents, and policy memos.
- Reviewing MCP-submitted documentation, data, transition plans, proposals, and other related documentation regarding In Lieu of Services.
- Conducting various oversight and monitoring activities of MCPs to support compliance with program requirements.
- Researching and analyzing program requirements to support compliance with State and Federal law, MCP contracts, and implementation guidelines, including introduced legislation and chaptered bills affecting the administration of the program.
- Coordinating with internal DHCS staff on activities relating to the In Lieu of Services program and reporting to executive management on outcomes, best practices, and the status of the In Lieu of Services program.

Integrating these positions into MCQMD will allow DHCS to target these services towards the state's vulnerable populations to improve health outcomes, ultimately contributing to a healthier California.

Shared Risk, Shared Savings, and Incentive Payments

The combination of carving in long-term care statewide and the introduction of enhanced care management and in lieu of services allows for a number of opportunities, including an incentive for building an integrated, managed long-term services and supports program and building the necessary clinically-linked housing continuum for our homeless population.

In order for the State to be equipped with the needed managed long-term services and supports and housing infrastructure, it is important to consider potential incentives and shared savings/risk models that could be established to encourage Medi-Cal managed care plans and providers to fully engage. Shared savings models encourage Medi-Cal managed care plans to pursue innovative models for health care delivery that can improve beneficiary health outcomes and mitigate growth in future expenditures. Shared savings programs aim to refocus payments away from the volume of services provided and toward the value of services and health care outcomes.

In addition, the State will provide Medi-Cal managed care plans with financial incentive payments established to drive plans and providers to invest in the necessary delivery and

systems infrastructure, build appropriate care management and in lieu of services capacity, and achieve improvements in quality performance that can inform future policy decisions.

CRDD (5.0 permanent positions and three-year LT resources equivalent to 3.0 positions effective 7/1/2022)
1.0 SSM II
1.0 SSM I (three-year limited-term)
1.0 RDS II
1.0 RDS I
1.0 RDA II (three-year limited-term)
2.0 AGPA
1.0 AGPA (three-year limited-term)

The implementation of shared risk/savings models and incentive payments presents new workload for CRDD. The requested positions will develop and oversee complex financial policy, collect and analyze large volumes of data, perform intensive financial calculations, and develop reports and exhibits needed to secure federal approvals and implement shared risk/savings model payments to plans or the State. Workload will include, but is not limited to:

- Developing shared risk/savings model programmatic structures and financial policies.
- Developing incentive program measures and financial requirements, in collaboration with other divisions.
- Developing contract language to implement shared risk/savings and incentive programs, and issue financial, policy, and technical guidance to plans.
- Developing new rate methodologies that incorporate shared risk/savings models and incentive payments.
- Preparing required documentation to obtain CMS approval of shared risk/savings models and incentive payments and respond to CMS questions.
- Developing data templates, financial models, and guidance related to shared risk/savings model calculations and requirements.
- Performing calculations to determine achievement of shared risk/savings and incentive targets.
- Developing and reviewing exhibits and other documents required for processing capitation payments and evaluating/reporting program outcomes.
- Fielding ongoing implementation questions up to and including formal guidance through All Plan Letters or other mechanisms.

Managed Care Benefit Standardization

Medi-Cal delivers services through a variety of delivery systems today including fee-for-service, managed care, county mental health plans, drug Medi-Cal organized delivery systems, and substance use disorder fee-for-service. Most full-scope Medi-Cal beneficiaries receive their physical health services through a Medi-Cal managed care plan. While Medi-Cal managed care exists statewide, it is operated under six different model types that differ based on whether certain benefits are part of the Medi-Cal managed care plan's responsibility or provided through a different delivery system.

Under CalAIM, DHCS is proposing to standardize the benefits that are provided through Medi-Cal managed care plans statewide. Regardless of the beneficiary's county of residence or their plan, they will have the same set of benefits delivered through their Medi-Cal managed care plan as they would in another county or plan.

CRDD (2.0 limited-term positions)
1.0 HPS I (four-year limited-term effective 7/1/2021)
1.0 RDS I (three-year limited-term effective 7/1/2022)

The standardization of managed care benefits, specifically the statewide carve-in to Medi-Cal managed care of high-cost services such as long-term care and major organ transplants, presents new workload for CRDD. The requested positions will identify and evaluate the financial impacts of benefit changes, analyze claims and encounter data to inform rate development, and monitor ongoing costs and utilization of high-cost services. Workload will include, but is not be limited to:

- Developing contract language and other plan guidance in conjunction with other divisions;
- Developing tools and methodologies for systematically collecting cost and utilization data for newly added benefits;
- Coordinating the collection and compilation of plan-reported data including claims and encounter data;
- Analyzing cost and utilization patterns across plans, counties and regions, and enrolled populations;
- Providing requisite data and analyses to actuaries to inform rate development.

MCOD (3.0 permanent positions and four-year LT resources equivalent to 2.0 positions effective 7/1/2021 and three-year LT resources equivalent to 2.0 positions effective 7/1/2022)*
2.0 AGPAs (three-year LT effective 7/1/2022)
1.0 AGPA
1.0 RDM
1.0 RDA I (four-year LT)
1.0 RDA II
1.0 RD Supervisor II (four-year LT)

**These positions provide overall support and guidance to the CalAIM initiative.*

The managed care benefit standardization presents an increase in workload for MCOD. This includes significant preparatory workload prior to implementation and ongoing monitoring of Managed Care Health Plans as well as internal monitoring, including call center monitoring and new reporting requirements. The requested positions will support the Medi-Cal managed care program by providing overall support and guidance to the CalAIM initiative. This workload will include, but not be limited to:

- Developing contract language and executing contract amendments and/or policy letters relating to new requirements.
- Ongoing monitoring of MCP's.
- Providing feedback and recommendations to DHCS leadership on necessary policy decisions.
- Responding to sensitive internal and external communications and facilitating the resolution of specialized problems
- Creating required readiness documents including Plan deliverables lists, review tools, and other readiness materials.
- Communicating with health plans on processes for and submission of required documents and deliverables.
- Reviewing Plan provider directories.
- Providing guidance on any new requirements and support compliance.

- Revising current and creating new beneficiary informing materials.
- Responding to routine inquiries from plans, stakeholders, and providers.
- Leading routine implementation and ongoing monitoring calls with MCP's.
- Participating in scheduled and ad hoc meetings to discuss or resolve issues.
- Drafting, reviewing, and providing feedback on All Plan Letters and other guidance documents to MCPs.
- Responding to and working with Centers for Medicare and Medicaid Services (CMS) on implementation and ongoing Plan monitoring and reporting requirements to support meeting all federal compliance activities.
- Establishing and documenting operational procedures, policies, review tools, and various tracking systems.
- Providing technical assistance and resolving programmatic and technical questions.
- Updating existing and creating new technical guidance documents for managed care plans.
- Processing data requests, leading data collection, performing analysis, and implementing reporting tools.
- Researching and making recommendations on monitoring and evaluation methods
- Working with various program areas to identify business/system requirements.
- Reviewing current processing operations and supporting systems to improve contract compliance.
- Developing and produce statistical reports and publications of findings.
- Researching Invoice Payments/Discrepancies.

Mandatory Managed Care Enrollment

Currently, the Medi-Cal program provides benefits through both a fee-for-service and managed care delivery systems. Enrollment into the fee-for-service delivery system or the managed care delivery system is based upon specific geographic areas, the health plan model, and/or the aid code that the beneficiary is determined to qualify for. In some cases, enrolling in managed care is optional for beneficiaries. However, more than 80 percent of Medi-Cal beneficiaries are currently served through the managed care delivery system.

In an effort to enhance coordination of care, increase standardization and reduce complexity across the Medi-Cal program, DHCS is proposing to standardize which aid code groups will require mandatory managed care enrollment verses mandatory fee-for-service enrollment, across all models of care and aid code groups, statewide. Under this proposal, beneficiaries in a voluntary or excluded from managed care enrollment aid code that are currently accessing the fee-for-service delivery system would be required to choose a Medi-Cal managed care plan and will not be permitted to remain in fee-for service.

MCOD (2.0 permanent positions effective 7/1/2021)
2.0 AGPA

Mandatory managed care enrollment presents an increase in workload for MCOD, including significant preparatory workload prior to implementation. The requested positions will support the Medi-Cal managed care program by communicating with the health plans on new processes, working with other Divisions within DHCS including the Medi-Cal Eligibility Division, as well as overseeing and monitoring the Health Care Options enrollment broker. This workload will include, but not be limited to:

- Developing contract language and executing contract amendments and/or policy letters relating to new requirements, ongoing monitoring and reporting of MCP's.

- Responding to sensitive internal and external communications and facilitate resolution of specialized problems.
- Communicating with health plans on processes for and submission of required documents and deliverables.
- Leading routine implementation and ongoing monitoring calls with MCP's.
- Responding to routine inquiries from plans, stakeholders and providers.
- Participating in scheduled and ad hoc meetings to discuss or resolve issues.
- Drafting, reviewing, and providing feedback on All Plan Letters and similar guidance to MCPs.
- Revising current and, creating new beneficiary informing materials.
- Oversight of the Health Care Options enrollment broker, including monitoring activities and ongoing meetings with the enrollment broker.
- Providing guidance on necessary work requests needed to update aid codes and any enrollment system updates.

Transition to Statewide Long-Term Services and Supports, Long-Term Care, & Dual Eligible Special Needs Plans

DHCS leveraged the significant learnings from implementation of Cal MediConnect in developing a statewide policy for dual eligible beneficiaries that aligns with the CalAIM goals of reducing variation and complexity, implementing population health management strategies, improving quality outcomes, and driving delivery system transformation. DHCS is proposing to discontinue the Cal MediConnect component of the Coordinated Care Initiative and begin a transition to a statewide managed long-term services and supports and Dual Eligible Special Needs Plan structure. Effective January 1, 2023 Long Term Care will be carved in to all Managed Care Health Plans. In addition, effective January 1, 2023, dual eligible beneficiaries will be mandatorily enrolled into all Managed Care Health Plans. Dual Eligible Special Needs Plans are Medicare Advantage health care plans that provide specialized care and wrap-around services to dual eligibles.

MCOD (3.0 permanent positions and four-year LT resources equivalent to 2.0 positions effective 7/1/2021)
2.0 HPS I
2.0 HPS I (four-year LT)
*1.0 HPS II**
**The position provides overall support and guidance to the CalAIM initiative*

The transition to Statewide Long-Term Services and Supports and dual eligible special needs plans presents a new workload for MCOD, including significant preparatory workload prior to implementation. The requested positions will support the Medi-Cal managed care program as it transitions from Cal MediConnect to a statewide MLTSS and D-SNP structure. This workload will include, but not be limited to:

- Developing and executing contract amendments or policy letters relating to new requirements, ongoing monitoring and reporting.
- Responding to and working with Centers for Medicare and Medicaid Services (CMS) on implementation of new DSNP contracts
- Leading policy related discussions and creating necessary D-SNP technical guidance.
- Determining contract requirements and build, review, and approve contracts.
- Communicating with health plans on processes for and submission of required documents and deliverables.
- Developing review and approval processes for implementing D-SNP requirements.

- Serving as the primary point of contact in MCOD for MCPs.

MCQMD (1.0 permanent position effective 7/1/2021)
1.0 HPS II

The transition to Statewide Long-Term Services and Supports and D-SNPs expands MCQMD's workload. The requested position will oversee the transition from Cal MediConnect to D-SNP. This workload will include, but not be limited to: leading the development of an updated D-SNP policy; drafting All Plan Letters/Duals Plan Letters, memos, and contract language as related to the updated D-SNP policy; and acting as the primary point of contact for issues and inquiries related to the transition to Statewide Long-Term Services and Supports, Long-Term Care, and D-SNPs.

NCQA Accreditation of Medi-Cal Managed Care Plans

In order to streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS will require all Medi-Cal managed care plans and their subcontracted managed care plans to be NCQA accredited by 2026. DHCS may use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain State and federal Medicaid requirements.

MCQMD (3.0 permanent positions eff. 7/1/2021)
1.0 SSM II
2.0 AGPA

The implementation of NCQA accreditation presents new workload for MCQMD. Workload will include, but not be limited to:

- Attending onsite NCQA MCP accreditation and re-accreditation reviews of MCPs, at least initially, in order to become familiar with the NCQA's review and auditing process. These reviews will occur prior to 2026, as many MCPs are already accredited and undergoing reviews between now and 2026 and as non-accredited MCPs start the accreditation review process in order to meet the 2026 timeline process.
- Reviewing NCQA reports of MCP accreditation and re-accreditation reviews.
    - These detailed reports will also help DHCS staff become familiar with the NCQA review and auditing process and will help DHCS staff modify future DHCS compliance audits.
- Developing internal monitoring processes and enforcement activities to support MCP compliance with program requirements.
- Developing new, targeted annual compliance audits that are less duplicative of NCQA accreditation audits and would expand DHCS' current monitoring and oversight process.

Behavioral Health Data Systems and Data Analysis Support for Behavioral Health Proposals

CSD (Four-year LT resources equivalent to 4.0 positions and three-year LT resources equivalent to 2.0 positions)
1.0 RD Sup. I (four-year LT Eff 7/1/2021)
1.0 RS III (Social/Behavioral Sciences) (four-year LT Eff 7/1/2021)
2.0 RDS I (four year LT Eff 7/1/2021)
2.0 RDA II (three-year LT eff 7/1/2022)

Analysis of Problem

CSD Behavioral Health Analytics and Research Branch (BHARB) provides data systems and analytic and research support for non-Medi-Cal and Medi-Cal behavioral health programs. CalAIM will require significant changes to existing behavioral health data systems and data collection. It will also require data analytic and research support to evaluate the impacts of the various behavioral health proposals in CalAIM.

The scope of this new data system, data collection, and analytic and research support includes such functions as:

- Conducting research to identify and assess disparities related to behavioral health conditions and access and utilization of services;
- Analyzing variations in utilization of Medi-Cal services among beneficiaries with behavioral health diagnoses;
- Evaluating changes in service access and utilization over time as CalAIM proposals are implemented;
- Data systems analyses and modifications to accommodate changing data collection and reporting needs resulting from CalAIM implementation;
- Training and technical assistance to plans as well as data management and monitoring to encourage timely and accurate data collection in support of CalAIM.

Data & System Support for CalAIM Proposals

EDIM (Two-year LT resource equivalent to 1.0 position; and three-year LT contract resources of $1,000,000)
1.0 ITS II (two-year LT Eff 7/1/2021)

Enterprise Performance Monitoring (EPM)
EPM is responsible for designing, development, and delivery of secure business intelligence solutions and services that drive health care quality and strategy formulation. EPM uses enterprise department tools to interface with a complex collection of program systems, including but not limited to the Medi-Cal Eligibility Data System (MEDS), Post Adjudicated Claims and Encounter System (PACES) and the Management Information System/Decision Support System (MIS/DSS). EPM gathers and transforms data from these various systems to form program specific data marts (subsets/data extracts from the data warehouse specific to a given program area, to support automated data reporting) resulting in enhancements to speed, usability, and data quality. In addition to these improvements, the EPM project also provides business process improvements resulting from the automation of repetitive, complex, or time-consuming tasks.

EPM supports the CalAIM initiative through the implementation of additional data marts, including the Department's county performance monitoring tool identified in State law at Welfare and Institutions Codes (WIC) 14154 and 14154.5. EPM will allow DHCS to monitor performance standards related to timeliness standards for processing new applications, annual renewals, and MEDS alerts. This data will be compiled into a county performance dashboard and published to the California Health and Human Services Agency Open Data Portal.

EDIM ($1,000,000 contract resources three-year LT effective 7/1/2021)
The request is for additional contracted resources of $1,000,000 ($250,000 GF; $750,000 FF) which includes positions that require specialized advanced analytical skills. These include significant experience using business intelligence tools and techniques.

ETS (Two-year LT resources equivalent to 3.0 positions effective 7/1/2021 and 3.0 permanent positions effective 7/1/2021)
Capitation Payment Management System (CAPMAN) (3.0 LT positions)
1.0 IT Sup II
1.0 ITS II
1.0 ITS I

Post Adjudicated Claims and Encounters (PACES) (3.0 Permanent positions)
1.0 ITM I
2.0 ITS II

Capitation Payment Management System
The CAPMAN system supports the calculation and payment of over $40 billion in annual premium payments for all members in DHCS-contracted managed care plans. This system must be updated in order to adapt to the majority of the CalAIM proposals. The proposals will have an impact on the CAPMAN system due to changes in one or more of the following: model types, supplemental payments, increments, aid code group reassignments, plan types, regional types, contract types, space increases, payment methodologies, and tracking of new data elements with calculations on those elements. The system also requires a significant amount of processing power and infrastructure space and support. Major changes that increase structure, such as those listed above, potentially require infrastructure upgrades. If the increase is significant enough, such as fundamental changes to how the calculations are currently calculated, then CAPMAN will need a full system refactor due to the increased calculation load on the system (internal code restructuring).

Post Adjudicated Claims and Encounters
PACES supports the CalAIM initiative by collecting encounter data in industry-standard formats, supporting the work of the initiative to improve the data completeness and quality of managed care data, delivering data to various downstream systems and program areas, including MIS/DSS. PACES will be responsible for establishing and supporting the overall data architecture, ensuring the data PACES is receiving and transmitting to MIS/DSS meets all of their requirements. PACES will coordinate with other DHCS areas to verify data standards, data use, sharing protocols and processes are followed so as to effectively collect and package encounter data as required in the CMS regulation. PACES will also be responsible for reporting performance metrics.

Enhancing County Oversight and Monitoring: CCS and CHDP

ISCD (8.0 permanent positions effective 7/1/2021)
6.0 AGPAs
1.0 SSM I
1.0 HPS I

The California Children's Services program serves as an agent of Medi-Cal for diagnostic and treatment services, medical case management, and physical and occupational therapy services to children and youth under age 21 with CCS-eligible medical conditions. CCS also provides medical therapy services delivered at public schools through the Medical Therapy Program (MTP). The CHDP program provides health screens (i.e. well child health assessments) and immunizations to Medi-Cal children under 21 years of age and non-Medi-Cal eligible children at or under 18 years of age whose family income is at or below 200% of the Federal Poverty Level (FPL). CHDP also provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services and

authorizes EPSDT in-home Private Duty Nursing (PDN) and Certified Home Health Aide (CHHA) services based on medical necessity.

The staffing required to carry out the day-to-day functions of county monitoring and oversight for these programs are essential to verifying consistency within the programs operated by the counties. State oversight provides additional resources to the counties via technical assistance, guidance, and development of processes and procedures. These processes and procedures will enhance the collaboration between the State and counties through efforts to build a consistent Medi-Cal infrastructure. The State's assessment of emerging trends, technology, medical advances and intervention allows the counties to be compliant with State and Federal guidelines.

The State's current staffing model does not allow for consistent monitoring and oversight of county activities for these programs, which results in significant variation of service delivery to beneficiaries. The additional staff will be the core team that will be responsible for developing and implementing program expectations. The team will serve as subject matter experts and will be able to provide real time support and assistance to counties. Other activities that the team is responsible for include, but are not limited to: enforcement of MOU deliverables, holding counties accountable for their actions/activities, conducting desk and/or on-site audits, identifying Corrective Action Plans, and providing training and development processes, as needed.

These programs continue to grow and provide the necessary services to the beneficiary population. With that same growth, staffing at the State level will need to grow to support the beneficiaries. In order to meet the CalAIM objective of reducing variation in the beneficiary experience between counties, DHCS needs to increase its oversight over county administration of these programs. Absent new resources, existing processes and procedures lack the ability to provide consistency in county compliance and oversight, which result in varying levels of care throughout the 58 counties and three cities (Berkeley, Long Beach and Pasadena). Routine monitoring and oversight by DHCS over these programs will help verify regulated services throughout the State are adhered to by the counties and cities.

Behavioral Health Payment Reform

LGFD (2.0 permanent positions effective 7/1/2021)
1.0 HPS I
1.0 AGPA

In order to incentivize additional investment in the delivery systems and reduce overall burden on counties and the State, DHCS is proposing to reform behavioral health payment methodologies for both managed care and fee-for-service systems. Under the current Certified Public Expenditure methodology, counties are not able to retain revenue when implementing cost-reduction efforts thereby limiting the ability to fully invest in the delivery system to improve access and quality. A shift from certified public expenditures to an intergovernmental transfer system may allow for more timely review and final payment to counties. In addition, it may enable the county behavioral health system, for the first time, to participate in and design true outcomes and value-based reimbursement structures that reward better overall results and quality of life for Medi-Cal beneficiaries.

The HPS I in LGFD will perform more specialized and policy-focused workload related to behavioral health payment reform including identifying challenges, opportunities, and applicable federal and state requirements related to this change. The AGPA will be

performing the analytical and programmatic workload related to the payment reform including gathering necessary data to establish rates for each CPT and HCPCS code.

Integration of Infrastructure for Specialty Mental Health and Substance Use Disorder Services

MCBHD (21.0 6.5-year limited term positions effective 7/1/2021)
2.0 SSM II
5.0 SSM I
5.0 HPS I
9.0 AGPA

California's specialty mental health services program operates under the authority of a 1915(b) waiver and the Drug Medi-Cal Organized Delivery System (DMC-ODS) operates under the authority of an 1115 demonstration waiver, and the Drug Medi-Cal program is authorized through California's Medicaid State Plan.

For the specialty mental health services program and the DMC-ODS, DHCS contracts with counties to act as prepaid inpatient health plans to provide, or arrange for the provision of, specialty mental health services and substance use disorder treatment services to beneficiaries. While the specialty mental health services program is a statewide benefit, the DMC-ODS is only covered in counties that have "opted-in" and are approved to participate by DHCS and CMS.

Medi-Cal specialty mental health and substance use disorder treatment services are currently administered through separate, unique structures at the county level. Beneficiaries with co-occurring mental health and substance use disorder services needs must navigate multiple systems to access care. Beneficiaries must review multiple handbooks and provider directories, navigate separate intake and assessment processes, and often travel to multiple locations to receive care. Counties and providers face challenging documentation and coding requirements, especially for beneficiaries with both substance use disorders and mental health conditions. At the system level, counties must demonstrate compliance with two sets of requirements and are subject to multiple reviews. For DMC-ODS counties, administering two distinct prepaid inpatient health plans must demonstrate compliance with federal managed care requirements twice, essentially running two almost entirely separate managed care programs with duplicative processes for quality improvement and performance measurement, beneficiary appeals, and program integrity.

DHCS is proposing integration of infrastructure for specialty mental health and substance use disorder services into one behavioral health managed care program. Additionally, DMC counties will also be able to integrate such services; however, slight variations may apply due to the differences of federal requirements for DMC verses prepaid inpatient health plans.

The workload associated with the integration of infrastructure for specialty mental health and substance use disorder services is substantial. Additional positions are necessary for DHCS to successfully integrate specialty mental health and substance use disorder services and improve access for Medi-Cal beneficiaries. Below are examples of the areas that would need to be integrated, each of which will involve significant and necessary workload. The new workload includes: research and analysis of state and federal laws and regulations; the development of project and implementation plans, as well as the development of associated work products/deliverables; facilitation and incorporation of stakeholder input; and county/provider training technical assistance and monitoring.

Clinical Integration

- Access Line - Counties are required to have a 24-hour access line for specialty mental health and DMC-ODS programs. Some DMC counties may also have 24-hour access lines, even though it is not a requirement. Many counties already use their access lines in an integrated manner to triage, screen, and refer beneficiaries for both specialty mental health and substance use disorder treatment services; however, some counties maintain separate lines. Under an integrated model, the goal would be for all counties to have an integrated, 24-hour access line for beneficiaries seeking either specialty mental health and/or substance use disorder services.
- Intake/Screening/Referrals - Processes for intake, screening and referral vary by county. Integrated screening would make it easier for counties to be able to promptly initiate an integrated treatment path for beneficiaries that screen positive for both mental health conditions and substance use disorder services, emphasizing a "no wrong door" approach.
- Assessment - Assessment processes and tools for specialty mental health and substance use disorder services also vary by county. DHCS would develop a uniform, standardized assessment for use across the behavioral health delivery system.
- Treatment Planning - Currently, treatment planning for specialty mental health and substance use disorder treatment services is conducted separately and is not integrated. For beneficiaries receiving both types of services, this can result in having multiple treatment plans that include different documentation requirements. To improve efficiency, counties would implement a standardized and streamlined treatment plan for both specialty mental health and substance use disorder services. These plans would also have aligned documentation requirements that are less burdensome on the counties, providers and beneficiaries.
- Beneficiary Informing Materials - Currently, beneficiaries who receive specialty mental health services through the county Mental Health Plans and substance use disorder services through DMC-ODS receive two beneficiary handbooks. The handbooks are not exactly the same, but both address elements that are required by federal managed care regulations, such as information regarding the grievance, appeals and state fair hearing processes. The goal is to consolidate beneficiary information materials in order to streamline them into one user-friendly handbook, reduce confusion, increase access, and achieve administrative efficiencies. Consideration would need to be given to implementing this element in DMC counties since they are not currently required to have a beneficiary handbook.

Infrastructure Integration

- Contracts - Currently, there are three separate contracts between DHCS and counties. DHCS contracts with county Mental Health Plans for the provision of specialty mental health services, and also with DMC-ODS counties and DMC counties. Under an integrated system, DHCS would work towards one contract in every county that would cover both specialty mental health and substance use disorder services. In the long-run, this should simplify operations and workload for both DHCS and the counties. However, there will be substantial workload over several years to develop integrated contracting.
- Data Sharing/Privacy Concerns - Counties are responsible for managing data-sharing at two levels: within and across county plans and at the provider level. Data sharing and privacy concerns need to be explored to determine what areas can be addressed, since there are different considerations and regulations pertaining to data sharing for specialty mental health services and substance use disorder services. Addressing these concerns will

be critical in determining whether and when counties can integrate assessments, treatment plans, and electronic health records, among other processes.

- Electronic Health Record Integration and Re-Design – DHCS would take a closer look at separate records for specialty mental health and substance use disorder electronic health records to see if any efficiencies can be achieved with standardization, where possible. Many counties currently operate separate electronic health records or maintain differently configured and completely separate records for specialty mental health and substance use disorder services. This is largely in response to federal regulations, but also due to historical bifurcation of the two programs and different documentation and data-reporting requirements for the specialty mental health and substance use disorder programs.
- Cultural Competence Plans – County Mental Health Plans are required to have a Cultural Competence Plan (CCP), also referred to as Cultural Humility Plan (CHP), for specialty mental health services. DMC-ODS counties are also required to have a CHP. Under an integrated system, counties would have only one integrated CHP instead of two, separate plans. Considerations would need to be given to how this element would be implemented in DMC counties since they are currently not subject to these same requirements.
- Quality Improvement - Some counties have integrated quality improvement and performance measurement programs for specialty mental health services and substance use disorder managed care. However, most programs – or components of them – are still separate. Under an integrated system, counties would develop and operationalize a consolidated quality improvement plan, have a single quality improvement committee, and develop a comprehensive list of performance measures for specialty mental health services and substance use disorder services.
- External Quality Review Organizations - Pursuant to federal Medicaid managed care requirements, an external quality review is required for both specialty mental health services program and drug Medi-Cal organized delivery systems. Currently, Behavioral Health Concepts is the contractor that acts as EQRO for both programs. However, there are separate contracts, review processes, timelines, and protocols. In addition, counties must develop separate performance improvement plans for each program. The goal is to implement a combined external quality review process, which would result in one external review and integrated performance improvement plans, and ultimately having one single EQRO report for each county. Since an external quality review is not required for DMC counties, further exploration will be needed to determine the extent to which these elements would play a role under an integrated model.
- Compliance Reviews - Current compliance reviews conducted by DHCS for specialty mental health services, DMC-ODS, and DMC counties are separate. Under an integrated model, the goal would be to consolidate compliance reviews into a single review with an integrated protocol. This will help reduce duplicative documentation requirements and mitigate audit/compliance risk that stems from the need to meet disparate requirements for the specialty mental health and substance use disorder programs. These changes may help incentivize more behavioral health providers to offer effective, evidence-based models for integrated care.
- Network Adequacy - Network adequacy certification processes are separate for specialty mental health services and DMC-ODS, and there are currently no network adequacy requirements for DMC counties. Under an integrated model, DHCS would certify one network for specialty mental health services and DMC-ODS services for each county, instead of certifying two networks as currently required.
- Other workload related to implementation of integrated care models - Successful implementation of integrated care models would also necessitate a discussion on non-

administrative changes that may be needed, such as workforce development, cross-training of existing providers, and adoption of new evidence-based practices.

The goal of this behavioral health integration project is to have a single, integrated behavioral health managed care plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and substance use disorder services under the next 1915(b) waiver in 2026. This will streamline processes and procedures and allow for more efficient use of existing resources upon integration.

The majority of the research and planning activities will occur within the first two to three years, and implementation and continuous quality improvement activities estimated to occur in the years thereafter. DHCS anticipates that there may be some administrative efficiencies gained from integrating behavioral health services due to efforts to refine behavioral health policies and program administration through continuous quality improvement efforts, which is a key goal of CalAIM.

DHCS requests resources within MCBHD to support this project, beginning on July 1, 2021. Multi-year limited-term resources are needed due to the complexity, scope, and timeframe of the system changes. Staffing resources are needed beyond the timeframes generally allocated for limited-term positions since the CalAIM 1915(b) and 1115 Demonstration waivers are scheduled to be in effect until December 31, 2026. Accordingly, this work will take more than five years to complete, and staff will be largely responsible for addressing new, and complex workload.

Given that integration efforts are to begin as soon as possible due to the fact that the current system configuration is burdensome, inefficient and, at times, unmanageable, DHCS requests additional staffing resources to carry out this effort. The integration process would present new and increased workload for MCBHD, including significant preparatory workload prior to implementation. The requested resources will be responsible for addressing the new and substantial workload associated with clinical- and system-level integration, both within the county behavioral health system, as well as across delivery systems, as needed. The requested resources will also support developing and executing contract and policy letters, as well as communicating with behavioral health plans, new requirements related to integration plans, and processes. Lastly, the requested resources will be responsible for addressing the new and substantial workload associated with project integrations, both within the county behavioral health system, as well as across delivery systems.

Medical Necessity Criteria for Specialty Mental Health and Substance Use Disorder Services

MCBHD (Three-year LT resources equivalent to 2.0 positions effective 7/1/2021)
1.0 HPS I
1.0 AGPA

DHCS contracts with counties to deliver specialty mental health and substance use disorder services to Medi-Cal beneficiaries who meet medical necessity criteria for the programs. Today, for specialty mental health and substance use disorder services, the medical necessity criteria for each program specifies requirements that beneficiaries must meet to be eligible for such services. The medical necessity criteria for each program also delineates service and intervention requirements that must be met. With the CalAIM initiative, DHCS seeks to design a cohesive plan to address beneficiaries' needs across the continuum of care, encourage coordinated services for all Medi-Cal beneficiaries, and improve health outcomes. DHCS is discussing with stakeholders the concept of developing new approaches to care delivery and

system administration that could improve beneficiary experience, increase efficiency, and encourage cost effectiveness. As part of this discussion, DHCS is exploring opportunities to improve the specialty mental health and substance use disorder programs by updating and making clearer the corresponding eligibility and medical necessity criteria. This will lead to improved treatment planning and documentation and help beneficiaries better understand the criteria that must be met in order to access specialty mental health and substance use disorder services.

Accordingly, DHCS is proposing to modify the existing medical necessity criteria for both outpatient and inpatient specialty mental health services and substance use disorder services in order to align with State and federal requirements and more clearly delineate and standardize the benefit statewide. The success of this modification to the existing medical necessity criteria requires adequate and appropriate clinical and technical staff resources to support the development of a an evaluation methodology, to analyze current county capacities, and to produce needed reports. Furthermore, technical assistance and quality improvement staff are required to provide counties with the support that is necessary to interpret reports and develop strategies to monitor and improve local outcomes.

The major steps for these requested positions are as follows:

- Implement the updated medical necessity criteria, including updating relevant regulations, implementing the identified screening and transition of care tools, and assessing impact on documentation requirements, which will be revised as part of the Behavioral Health Integration efforts.
- Prepare and train DHCS staff and collaborate with counties on the necessary training for county staff, all of whom will analyze and make decisions based on the new medical necessity criteria.
- Identify system improvements and methods for documenting and reporting medical necessity data to DHCS.

Drug Medi-Cal Organized Delivery System Renewal and Policy Improvements

DHCS proposes to incorporate DMC-ODS into a comprehensive Section 1915(b) waiver that would include the Medi-Cal managed care plans, county Mental Health Plans, and county Drug Medi-Cal Organized Delivery Systems. The expenditure authority for residential treatment provided in an Institution for Mental Disease will continue to be authorized through Section 1115 waiver authority. DHCS also intends to provide counties with another opportunity to opt-in to participate in the Drug Medi-Cal Organized Delivery System in hopes of promoting state wideness.

DMC-ODS External Quality Review Organization Contract ($11,500,000 over five years [between January 1, 2022 and December 31, 2026])
FY 2021-22 $1,150,000
FY 2022-23 $2,300,000
FY 2023-24 $2,300,000
FY 2024-25 $2,300,000
FY 2025-26 $2,300,000
FY 2026-27 $1,150,000

DHCS requests $11,500,000 ($5,750,000 GF; $5,750,000 FF) between January 1, 2022 and December 31, 2026, to continue contracting with an EQRO for the DMC-ODS Waiver, as required in 42 CFR 438. The contract funding will allow the EQRO to continue conducting

independent reviews of DMC-ODS counties for quality of care, timeliness of services, and access to services as required by the Waiver. External quality reviews are to begin after approximately 12 months of each county's commencement of Waiver services. Due to the extensive requirements to be approved to deliver DMC-ODS services, implementation of services and external quality reviews were delayed. From the time when the first DMC-ODS counties began services in 2017, the EQRO was able to complete reviews for eight counties in calendar year (CY) 2018, 19 reviews in CY 2019, and 27 reviews in CY 2020 The EQRO is projected to conduct reviews for 37 counties in CY 2021, and 16 visits have been scheduled for the first six months in CY 2021 as the contract term ends on June 30, 2021. The reviews conducted by the EQRO annually are essential to counties and DHCS to provide data and reports regarding the delivery of services in the counties. These reports illustrate the effective methods and areas in need of improvement.

DMC-ODS Evaluation Contract ($5,655,000 over five years [between January 1, 2022 and December 31, 2026])
FY 2021-22 $565,000
FY 2022-23 $1,131,000
FY 2023-24 $1,131,000
FY 2024-25 $1,131,000
FY 2025-26 $1,131,000
FY 2026-27 $566,000

DHCS requests $5,655,000 ($2,828,000 GF; $2,827,000 FF) between January 1, 2022 and December 31, 2026, to continue to contract with the University of California, Los Angeles, Integrated Substance Abuse Programs (UCLA-ISAP) for the 1115 DMC-ODS Waiver Evaluation for the duration of the CalAIM 1115 demonstration waiver (which will end on December 31, 2026).

The evaluation component of the DMC-ODS Waiver is part of the Waiver's Special Terms and Conditions (STCs) as required by the federal government. Having the evaluation contract in place with UCLA-ISAP supports DHCS compliance with the DMC-ODS Waiver STCs and reduces the risk of losing federal funding due to noncompliance with the Waiver STCs.

The implementation of the DMC-ODS Waiver is a huge lift for the State and counties. The Waiver fundamentally shifts the way Substance Use Disorder (SUD) services are assessed, delivered, reimbursed, overseen, and evaluated. UCLA-ISAP provides extensive data collection and reporting technical assistance to counties, and also reviews each county's evaluation findings with county leadership to provide tailored technical assistance to address identified issues. The amount of technical assistance provided by UCLA-ISAP will continue to be a significant need for the providers and counties**.** DHCS would like to continue working with UCLA-ISAP on the DMC-ODS Waiver evaluation and technical assistance services to support uninterrupted compliance with the DMC-ODS Waiver STCs.

DMC-ODS County Technical Assistance Contract ($2,500,000 over five years [between January 1, 2022 and December 31, 2026])
FY 2021-22 $250,000
FY 2022-23 $500,000
FY 2023-24 $500,000
FY 2024-25 $500,000
FY 2025-26 $500,000
FY 2026-27 $250,000

Analysis of Problem

DHCS requests $2,500,000 ($1,250,000 GF; $1,250,000 FF) between January 1, 2022 and December 31, 2026, for a DMC-ODS County Technical Assistance contract to provide funding for the duration of the 1115 CalAIM waiver (which will end on December 31, 2026).

With the Waiver renewal, the participating counties will continue to need training and TA for all the required elements. Whereas the UCLA-ISAP provides training and technical assistance related to data collection and reporting and quality improvement, this technical assistance funding supports program implementation efforts of the DMC-ODS Waiver such as ASAM Criteria, quality assurance, selective contracting, DMC-ODS Waiver assessment of modality services, medication assisted treatment, a continuum of care, and quality assurance processes. The previous contractor for this work was the California Institute for Behavioral Health Solutions. A training and TA contractor will be necessary to provide these services and make training available when the Waiver renewal is in effect. The contractor will review and draw upon the prior year's findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. For the existing DMC-ODS counties, training needs have shifted from start-up training such as selective provider contracting, general overview of ASAM and ASAM screening tools to more advanced ASAM training, quality assurance processes complying with the CFR section 438 requirements and meeting the training and TA needs to be identified through the Waiver Evaluation and EQRO. Some of the recommended areas for technical assistance and trainings from the 2019 UCLA Report and the EQRO Report included: recovery support services, case management, documentation, MAT stigma, data collection and submission, ASAM criteria, Evidence Based Practices, Electronic Health Records, MOUs, treatment planning, and youth treatment practices.

DHCS also anticipates the need for start-up training and TA for additional counties as they opt-in to participate in the DMC-ODS model.

The DMC-ODS Waiver established the framework for a series of fundamental changes in the SUD treatment service delivery system in California. Counties and providers have transitioned to a new set of business and clinical models, new regulatory requirements and new relationships within counties and with external entities. DHCS is helping to make the DMC-ODS Waiver a success for counties, providers, and patients. As the first state in the nation to implement the DMC-ODS, the information provided has benefited counties to improve services, and other states looking to implement an organized delivery system. If this funding is not secured, counties would lack the expertise to implement the DMC-ODS, which is complex, thus risking beneficiary access to timely and quality substance use disorder services.

Serious Mental Illness/Serious Emotional Disturbance Waiver

On November 13, 2018, CMS issued a State Medicaid Director Letter that outlines opportunities for states to design innovative service delivery systems to improve care for adults with serious mental illness and children with serious emotional disturbance who are enrolled in Medicaid. Due to the long-standing federal exclusion of Medicaid matching funds for services provided in these settings, California's counties have historically paid the full cost of inpatient mental health services provided to Medi-Cal beneficiaries in these settings. This new serious mental illness/serious emotional (SMI/SED) waiver allows states to receive federal matching funds for services provided to Medicaid beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as an Institution for Mental Diseases; however, participation requires CMS' approval of an 1115 demonstration waiver application, which is complex and requires a significant amount of research to produce and include the following information:

- A comprehensive description of the demonstration, including the state's strategies for addressing the goals and milestones discussed above for this demonstration initiative.
- A comprehensive plan to address the needs of beneficiaries with serious mental illness or serious emotional disturbance, including an assessment of how this demonstration will complement and not supplant state activities called for or supported by other federal authorities and funding streams.
- A description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost sharing (premiums, copayments, and deductibles) required of individuals who will be impacted by the demonstration, to the extent such provisions would vary from the State's current program features and the requirements of the Social Security Act.
- A list of the waivers and expenditure authorities that the State believes to be necessary to authorize the demonstration;
- An estimate of annual aggregate expenditures by population group impacted by the demonstration, including development of baseline cost data for these populations.
- A fiscal analysis that demonstrates how the proposed changes will be budget neutral, i.e., will not increase federal Medicaid spending.
- Enrollment data including historical mental health care coverage and projected coverage over the life of the demonstration, of each category of beneficiary whose health care coverage is impacted by the demonstration.
- Written documentation of the State's compliance with the public notice requirements at 42 CFR 431.408, with a report of the issues raised by the public during the comment period and how the State considered those comments when developing the final demonstration application submitted to CMS.
- Development of research hypotheses related to the demonstration's proposed changes, goals, and objectives, and a general plan for testing the hypotheses including, if feasible, the identification of appropriate evaluation indicators.
- An implementation plan describing the timelines and activities necessary to achieve the demonstration milestones including a financing plan.
- A Health IT plan (health information technology plan) that describes the state's ability to leverage health IT, advance health information exchange(s), and support health IT interoperability in support of the demonstration's goals.
- Development and implementation of monitoring protocols that identify expectations for quarterly and annual monitoring reports including agreed upon performance measures, measure concepts, and qualitative narrative summaries. Once approved, DHCS would be required to submit to CMS demonstration monitoring reports including information detailing the state's progress toward meeting the milestones and timeframes outlined in the implementation plan, as well as information and data so that CMS can monitor budget neutrality.
- Development of interim and final evaluations that will draw on the data collected for the milestones and performance measures, as well as other data and information needed to support the evaluation that will describe the effectiveness and impact of the demonstration using quantitative and qualitative outcomes and a cost analysis. Note: *An evaluation design will be developed by the state, with technical assistance from CMS, to be finalized within 180 days of the demonstration approval.*

MCBHD Technical Assistance contract ($4,000,000 for contract resources over two years [between July 1, 2021 and June 30, 2023; $2,000,000 GF and $2,000,000 FF])

To support the substantial workload outlined above associated with developing an 1115 demonstration application for a SMI/SED waiver, working with stakeholders, developing an implementation plan, creating a county application process and an evaluation design, DHCS

requests $4,000,000 over two years to secure a contractor [$2,000,000 General Fund and $2,000,000 Federal Fund]. The SMI/SED waiver is new workload for DHCS, and timing of the need for additional staff resources will depend on if/when DHCS applies and is approved for this waiver; the soonest would be by July 1, 2022.

New Dental Policies

To meet the new and ongoing workload associated with pay-for-performance dental and two new benefit policies described below, MDSD requests 11.0 full-time, permanent positions, for the planning, implementation, evaluation, and monitoring of the dental components under CalAIM. 10.0 of the 11.0 positions are conversions of LT resources (expiring June 30, 2022) to permanent positions and 1.0 additional SSM I to support the increased data analytics workload associated with the proposal.

MDSD (11.0 permanent positions)
1.0 SSM I (effective 7/1/2021)
1.0 SSM I (effective 7/1/2022)
1.0 AMA (effective 7/1/2022)
7.0 AGPAs (effective 7/1/2022)
1.0 DHC (effective 7/1/2022)

DHCS is introducing policies in an effort to increase statewide preventive service utilization for children and adults as well as align with the Legislature's charge of achieving a 60% annual dental visit utilization for members of all ages, pursuant to Welfare and Institutions Code Section 1400.276(a). This effort within CalAIM builds upon the lessons learned from the Dental Transformation Initiative that is part of the expiring 1115 Medi-Cal 2020 waiver.

DHCS remains steadfast in its commitment to improving oral health outcomes for Medi-Cal beneficiaries as well as maintaining the increased utilization momentum the Dental Transformation Initiative (DTI) via the 1115 waiver as well as its subsequent extension has created. The dental policy initiatives under CalAIM seek to improve the access and delivery of care to the Medi-Cal population through a set of Medi-Cal Dental Program (Program) policies that have demonstrated success in the DTI.

Performance Payments:
In an effort to increase statewide preventive service utilization for children and adults, DHCS is proposing to provide a flat rate performance payment to specific preventive services rendered by an enrolled Medi-Cal service office location. The performance payment would be made at the same time the approved claim is paid.

Additionally, DHCS is committed to establishing a dental home for Medi-Cal beneficiaries and encouraging enrolled providers to render corresponding exam services. As such, DHCS will provide a flat rate performance payment to an enrolled Medi-Cal service office location for each paid claim for Current Dental Terminology (CDT) exam codes D0120, D0150, or D0145, for the same Medi-Cal beneficiary seen for two or more consecutive years. Payments to the corresponding service office location(s) would only take place annually.

Additional Benefits:
DHCS proposes adding coverage of a Caries Risk Assessment (CRA) bundle for Medi-Cal children ages 0 to 6 years. The CRA bundle would include associated CDT codes (D0601, D0602, and D0603) to educate and influence behavior change, including nutritional

counselling. Additionally, based on risk level associated with each individual Medi-Cal dental beneficiary aged 0 to 6, the policy would allow the following frequency of services:

- Low – comprehensive preventive services two times per year.
- Moderate – comprehensive preventive services three times per year.
- High – comprehensive preventive services four times per year.

Additionally, DHCS proposes to add coverage of a caries arresting medicament (CDT code D1354), more commonly referred to as Silver Diamine Fluoride (SDF), for Medi-Cal children aged 0 to 6 years, residents in a skilled nursing facility/intermediate care facility, and developmentally disabled populations. The SDF benefit would provide two visits per beneficiary per year, four to ten teeth per visit, at a per-tooth rate.

MDSD Resources:
CalAIM seeks to not only further the positive momentum and demonstrated improvements of children's access and utilization of preventive dental services, but also expand and evolve DTI strategies across various innovations to approximately 13 million Medi-Cal beneficiaries. Through this evolution, MDSD will remain responsible for the development, data collection, quality improvement strategies, integration with other entities, enhanced monitoring, and oversight of the three CalAIM dental policies. All units across MDSD are integral to support the dental policies of CalAIM in the same way they have each contributed to the DTI.

MDSD will work closely with the dental fiscal intermediary, dental administrative services organization, stakeholders, providers, and beneficiaries to provide technical assistance to implement the various policies seamlessly.

2.0 SSM I
Effective July 1, 2022, 1.0 SSM I will continue oversight for the existing Dental Policy Unit (DPU) to lead and guide staff at the first level of intervention and provides guidance related to Medicaid dental benefit policy, which will incorporate CalAIM activities. Under the oversight of the SSM I, DPU's mission is to interpret, develop, and implement CalAIM policies, in accordance with federal and state provisions. The Unit also works in coordination with other units within MDSD as well as internal and external stakeholders, and contractors to maintain timely and accurate CalAIM policy developments and implementation that may affect the California Dental Medicaid Management Information System (CD-MMIS).

Specific to CalAIM, the SSM I will oversee 4.0 AGPAs in DPU to monitor utilization and expenditure reports for trend analyses, inform internal and external stakeholders, respond to stakeholder questions/concerns, and research and resolve any concerns or issues. The SSM I will also review data to verify CalAIM benefits are being utilized and result in positive trends or direct staff to research causes for concern upon any decreases in the data. Due to the heightened importance and critical nature of the CalAIM policy initiatives, continued communication with stakeholders is vital to meet CalAIM objectives to effectively improve the quality of life and health outcomes of the Medi-Cal population. Through stakeholder organizations, DPU will capture input from providers and members on a regular basis on CalAIM policies and processes that are working well, areas that need improvement, and ideas for solutions that benefit all parties impacted by CalAIM. DPU facilitates approximately 38 stakeholder engagement meetings annually and the stakeholder groups range from 5 to 180 participants.

The SSM I, effective July 1, 2021, is requested to establish a first level supervisor over the existing Research Analytics Unit (RAU) to lead, guide, and manage the workload and performance of a Research Data Specialist II and three Research Data Analysts II. This team performs duties

related to Medi-Cal dental program, which incorporates CalAIM in the development, determination, and/or establishment of research, evaluation, data analysis policies and practices, and analytical methodologies. The SSM I will coordinate and oversee the CalAIM dental data functions including compliance with Health Insurance Portability and Accountability Act (HIPAA) and privacy policies, data quality assurance, continuous improvement, and analyses of CalAIM dental data systems and warehouses including development and implementation of CalAIM data collection and/or changes to data collection systems. The SSM I will also maintain knowledge of CalAIM programs and policies that affect Medi-Cal dental research, evaluation, and data analysis. For CalAIM, the SSM I will oversee the development, research, and analysis of CalAIM utilization by beneficiaries and providers in various elements such as age, county, and delivery system, and create new reporting of CalAIM outcomes. Moreover, the SSM I will coordinate discussions with internal and external stakeholders to share findings, validate the statistical analyses, and refine methodologies as needed to accurately capture beneficiary and provider experiences, which will promote utilization of CalAIM and positive health outcomes for beneficiaries.

1.0 DHC

The DHC is responsible for collaborating with the Dental Program Consultants (DPCs) on CalAIM recommendations for program policy related to benefits and services. This resource will provide input on the clinical aspects of dental hygiene and make recommendations to maximize this provider type and their participation as enrolled providers in Medi-Cal. The DHC will initiate program policy strategies to utilize dental hygienist providers at the peak of their licensure and within the Program's Manual of Criteria as well as clinical monitoring of this provider type through the dental ASO contractor. In support of the CalAIM efforts and to further the dental provider awareness of this effort, the DHC plays a critical role in establishing and maintaining partnerships with the Dental Hygiene Board of California, California Dental Hygienists Association, as well as working with local voluntary and dental organizations to maintain current CalAIM awareness and outreach, with the goal of increasing the number of dental hygiene enrolled providers, referrals for dental hygiene, prevention services, and improving provider health education. Specifically for CalAIM, The DHC resource will partner with the DPCs to review and update clinical policy that will optimally serve the beneficiary population while maintaining prevention as the focal point, and will make recommendations to adapt and evolve CalAIM policy as such. The DHC is a critical clinical subject matter expert and resource to leadership as well as offers an additional provider perspective and licensure to the dental policy making process.

1.0 AMA

The AMA will continue supporting all fiscal related CalAIM changes. The AMA will spearhead the biannual estimate cycle and the CalAIM Policy Change. This requires intimate knowledge of each dental component and its policies, as well as the ability to make assumptions to prepare forecast models to inform DHCS executives the Director's Office, as well as the Department of Finance. Furthermore, the AMA facilitates communications with sister divisions, sharing information and presenting it to help inform proper claiming of federal funds. The AMA will monitor CalAIM expenditures to identify trends and help inform potential modifications to policy. In addition, the AMA will address all CalAIM fiscal questions at various stakeholder meetings.

7.0 AGPAs

These 7.0 AGPAs are strategically spread across the division to support proper oversight and monitoring of the CalAIM components in each impacted unit. They would be allocated as follows:

- 1.0 AGPA - Beneficiary Services Unit (BSU)

This AGPA is responsible for developing and monitoring outreach plans which will incorporate CalAIM and generate awareness of the availability and importance of preventive dental services for children and adults included in CalAIM. Upon CalAIM implementation, this resource will monitor the dental FFS vendor who assists beneficiaries through the Telephone Service Center (TSC), general correspondence, state hearings, and the Conlan reimbursement process. The workload is expected to increase further as CalAIM expands the prior DTI waiver pilot statewide and extends to adults. The AGPA is responsible for monitoring the TSC effectiveness, reviewing dental FFS vendor invoices for payment, outreach reports, and contract oversight of both dental FFS vendors to improve beneficiary access and prevent negative impacts on Medi-Cal beneficiaries. The AGPA will monitor the dental FFS vendors during the implementation of the CalAIM policies as it relates to beneficiary outreach and education, work closely to develop activities that will improve awareness of benefits, encourage beneficiaries to follow up with dental visits and increase preventive care for both children and adults.

- 3.0 AGPAs - Provider Services Unit (PSU)
  These resources are responsible for monitoring the FFS provider network participating in CalAIM, including provider outreach, utilization review, monitoring of the Surveillance and Utilization Review Subsystem, program integrity operations, provider enrollment functions, provider referral list operations, and provider support and training. In addition, the AGPAs will work closely with the FFS vendors to develop activities that will enhance provider outreach and encourage providers to enroll in the Program to achieve the performance payments for rendering dental services to the Medi-Cal population.

- 2.0 AGPAs - Contract Management and Policy Unit (CMPU)
  These resources are responsible for contract management and oversight of MDSD's dental FFS contracts with the dental fiscal intermediary and the dental administrative services organization, which directly oversee the administration of CalAIM. These resources will continue to track claims and treatment authorization request volumes, as well as promote processing metrics compliance with state level agreements, provide subject matter expertise and policy guidance on the CalAIM CRA and silver diamine fluoride proposal, and monitor the contractors during and after the implementation of the new policies.

- 1.0 AGPA – Administrative Services Unit (ASU)
  This resource will continue supporting all fiscal related CalAIM changes. The resource will assist the AMA will the biannual estimate cycle, specifically the CalAIM Policy Change. This AGPA is the fiscal subject matter expert with intimate knowledge of each dental component and its policies, as well as the ability to make assumptions to prepare forecast models to inform DHCS executives, the Director's Office, and the Department of Finance. This resource will assist the AMA in ad hoc research and assist in communications with internal DHCS financial management staff to secure approval of CalAIM estimate models.

Improving Medi-Cal Eligibility Oversight and Monitoring

MCED (5.0 permanent positions effective 7/1/2021)
1.0 SSM II
1.0 SSM I
3.0 AGPA

DHCS is the designated single state agency for the administration and oversight of California's Medicaid and Children's Health Insurance Programs (CHIP). As the Medicaid State Agency, DHCS is granted legal authority to develop, and revise rules and regulations governing these

programs, and to delegate the administration of these programs to county human services agencies and contractors.

As the Single State Agency for the Medicaid and CHIP programs, DHCS is required to perform various oversight and monitoring activities to promote the overall integrity in eligibility determinations, and administration of these programs (both at the county and state levels). MCED is tasked with the responsibility to verify that beneficiary enrollment into these programs adhere to federal and state regulations. The MCED Quality Assurance team, supported by these requested CalAIM BCP resources, intends to monitor and perform oversight activities and to utilize the tiered corrective action approach to increase collaboration with counties that under-perform.

All recent audits performed by federal and state oversight agencies found weaknesses in the Department's oversight practices, and suggest that both increased monitoring and the development and implementation of additional oversight activities are needed to reduce erroneous eligibility determinations and facilitate increased accuracy in the administration of the program. This includes, but is not limited to:

- Incorporation of monitoring processes that detect discrepancies between eligibility systems, and support prompt resolution by county staff.
- Develop and monitor systems alerts that identify cases that have not had an annual renewal performed.
- Develop and monitor system alerts that indicate concurrent eligibility in the various segments of the Medi-Cal Eligibility Data System (MEDS).
- Develop and conduct new trainings for county staff, designed to:
    - Provide clarification of program policy as performance gaps are identified through internal and external audits, and at county request.
    - Emphasize the importance of timely and appropriate resolution of system alerts in order to establish SAWS/MEDS alignment and prevent improper payments due to inaccurate eligibility determinations.
- Continue to update existing or create additional oversight activities, and develop additional monitoring mechanisms upon identification of new problematic areas in county performance and/or system related defects.

In response to these recommendations from oversight agencies, DHCS implemented focus reviews to verify the accuracy and timeliness of eligibility determinations. In addition, DHCS implemented the MEDS Alert Monitoring Pilot where DHCS is working with a sub-set of pilot counties to assess and identify both county specific and statewide error trends that attribute to inaccurate eligibility determinations, and develop new and/or modify existing MEDS Alerts to aid in prompting counties to correct SAWS/MEDS discrepancies and misalignment. The first series of focus reviews specifically targeted counties' annual renewal processes. These focus reviews found that on a statewide basis, there are substantial issues with renewal related activities that require increase oversight, monitoring and targeted activities, where applicable, when pervasive issues are identified. Continuing these focus reviews will allow for prompt identification of counties with problematic issues, and overall trends (i.e. misapplication of state/federal policies) that render the Department vulnerable to similar findings in future audits. DHCS continues to explore various oversight practices that may be employed to improve accuracy of eligibility determinations, increase timeliness of required case actions, and improve the overall administration of the program.

Similar to the extraordinary impact the Affordable Care Act had on accuracy of eligibility determinations, the Coronavirus Disease 2019 (COVID-19) public health emergency (PHE) will

have a long-standing impact on counties' operations. This is largely due to temporary changes in policy that, with very limited exceptions, prevents counties from terminating eligibility, and fully processing annual renewals. This heightens the need for effective oversight and monitoring activities to guarantee counties address any backlogs at an acceptable pace, and maintain the integrity of eligibility determinations.

Currently, MCED has to redirect senior-level managerial resources from other critical program and policy areas to fill in administrative gaps to implement these recommendations. This is not an effective and sustainable approach. Full-time, dedicated resources are needed to support business continuity from the Medi-Cal programmatic perspective and to expeditiously implement these recommendations. As reflected in the Outcomes and Accountability section some of this workload represents a significant expansion of current activities and some of this workload is new. The combined efforts associated with this workload will result in advancing county oversight and monitoring activities, and provide innovative mechanisms to strengthen DHCS' ability to oversee Medi-Cal eligibility program integrity.

Additional staff is needed to expand current oversight activities to:

- Inform and facilitate recommended modifications to MEDS that would allow for (a) prompt detection of cases with an overdue annual renewal, and (b) beneficiaries with duplicate and/or concurrent enrollment in various CHIP and Medi-Cal programs,
- Expand focus reviews on an as needed basis,
- Develop additional quality control measures, and
- Monitor counties' activities post-PHE.

Collectively, these activities serve as the foundation for a strong oversight presence that is likely to facilitate overall improvement in casework related activities, accuracy of enrollment, and initiate an overhaul in business practices at the county level that will increase the integrity the Medi-Cal program, thereby significantly reducing the likelihood of future audit findings.

As part of DHCS' commitment to developing a comprehensive approach to county oversight, and imposing fiscal sanctions as part of a disciplinary approach for non-responsive counties, the 5.0 positions requested under this BCP will collaborate with the two permanent positions previously provided in the 2020 Budget Act (4260-062-BCP-2020-BCP). These newly approved permanent positions,1.0 SSM I and 1.0 AGPA, are assigned to the County Administrative Unit of MCED, where they manage the financial aspects and tasks associated with the Medi-Cal administrative budget for counties, such as analyzing and reconciling county administrative expenditures. Working closely with the 5.0 positions requested under this BCP, the County Administrative Unit will assist with the final disciplinary step of developing and executing county fiscal sanctions should corrective actions escalate for underperforming and non-responsive counties that require fiscal sanctions.

1.0 SSM II (County Oversight and Monitoring Section Chief): The SSM II would report directly to the Program Review Branch Chief (SSM III) within MCED and manage the newly formed County Oversight and Monitoring Section. The new Section consists of the existing field office units located in San Francisco, Los Angeles, and San Bernardino, and an additional unit in Sacramento (proposed County Monitoring Unit), which would be added to support increased oversight and monitoring activities. This reporting structure would allow for dedicated mid-level managerial support at the section level to direct the work of the field office staff and HPS Is, and be vested with the managerial authority to represent MCED during external audits and internal county focused review audits. This reporting structure would also support the implementation of a county performance monitoring project that would fulfill the monitoring recommendations as indicated in California State Auditor (CSA) Audit report 2018-603, and

evaluate where current gaps exist between federal rules and regulations as compared to current county performance monitoring goals. This structure will also allow DHCS to increase our oversight of county performance by strengthening collaboration with county partners through regular meetings and open lines of communication, conduct outreach efforts to identify and isolate areas in policy where additional training guidance is needed and identify where systematic deficiencies exist. Additionally, this reporting structure will allow DHCS to clearly define expectations in terms of county roles and responsibilities and introduce a tiered corrective action approach.

Specific Duties Include:
• Manage all aspects of MCED's participation in external audits, to include Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC).
• Manage all aspects of MCED's participation in the County Focused Review project.
• Manage all aspects of MCED's county performance monitoring project.
• Manage the development and implementation of MCED's tiered corrective action plan.
• Manage all aspects of MCED's Aid Code Clean-Up project.
• Collaborate with internal and external stakeholders, SAWS consortia staff and management, Centers for Medicare and Medicaid Services, Department of Finance, Legislative Analyst's Office, and all levels of DHCS management.
• Communicate at various forums, including but not limited to County Welfare Director's Association, Status Meetings, and stakeholder engagement meetings.
• Collaborate with MCED Data Analytics Section and Eligibility Administration Section regarding implementation of the tiered corrective action approach.
• Review, approve and deliver new county training materials to clarify policy and emphasize the importance of timely and appropriate resolution of system alerts in order to establish SAWS/MEDS alignment and prevent improper payments due to inaccurate eligibility determinations.

1.0 SSM I (County Monitoring Unit Chief)
The SSM I would report directly to the County Oversight and Monitoring Section Chief (SSM II) within MCED, and manage the newly formed County Monitoring Unit, serving as the county performance monitoring program lead. The SSM I would have the full responsibility in managing the evolving timelines of implementing the measurement of all county performance monitoring metrics, to include the monitoring of Medi-Cal Eligibility Data System (MEDS) alerts, application processing timeliness, and renewal processing timeliness, as well as developing a county monitoring dashboard the respective to all monitoring metrics.

Specific Duties Include:
• Manage the collection and review of county MEDS alert processing.
• Manage county performance measurement dashboard.
• Meet with counties concerning performance measurement dashboard.
• Manage staff's participation in the development and implementation of the tired corrective action project.
• Manage staff's participation in conducting eligibility reviews during external audit activities, to include during MEQC, PERM and County Focused Review programs.
• Manage staff's participation in Aid Code Clean-Up project.
• Communicate at various forums, including but not limited to County Welfare Director's Association, Status Meetings, and stakeholder engagement meetings.
• Collaborate with MCED Data Analytics Section and Eligibility Administration Section regarding the tiered corrective action project.

• Review and approve new county training materials to clarify policy and emphasize the importance of timely and appropriate resolution of system alerts in order to establish SAWS/MEDS alignment and prevent improper payments due to inaccurate eligibility determinations.

3.0 AGPAs (County Monitoring Unit Analysts)
The AGPAs would report to the County Monitoring Unit Chief (SSM I), and be the dedicated Medi-Cal program analysts for the direct monitoring of county performance standards. These three positions would work independently with each county and Statewide Automated Welfare System (SAWS) consortia to monitor and correct performance deficiencies, and be vested with the program authority to make Medi-Cal program-related decisions, and oversee all aspects of programmatic impacts to Medi-Cal. The 3.0 AGPA resources would also be responsible for assisting the section in the reviewing of components of Medi-Cal eligibility in accordance with federal and state rules and relations and identifying where cross-sectional impacts exist and assisting MCED with maintain the consistency of Medi-Cal policies across all systems and projects.

Specific Duties Include:
• Serve as the MCED subject matter expert responsible for the collection, verification, and analysis of county performance standards associated with county performance and processing of MEDS alerts.
• Provide direct follow up with counties concerning county specific performance, including the processing of MEDS alerts.
• Maintain county performance measurement dashboard.
• Participate in the development and implementation of the tired corrective action project.
• Conduct eligibility reviews during external audit activities, to include during MEQC, PERM and County Focused Review programs.
• Participate in the MCED Aid Code Clean-Up project.
• Collaborate with counties, SAWS consortia, internal and external stakeholders to support consistent Medi-Cal monitoring policy implementation across all systems.
• Collaborate with MCED Data Analytics Section and Eligibility Administration Section regarding the tiered corrective action project.
• Review/draft/provide recommendations to management on findings.
• Develop new county training materials to clarify policy and emphasize the importance of timely and appropriate resolution of system alerts in order to establish SAWS/MEDS alignment and prevent improper payments due to inaccurate eligibility determinations.

Hearings and Appeals Support for CalAIM Proposals

Office of Administrative Hearings & Appeals (OAHA) (1.0 permanent position)
1.0 ALJ II (effective 7/1/2021)

DHCS requests 1.0 permanent position in the OAHA to manage the increased workload resulting from the implementation of the CalAIM Initiative. According to Health and Safety Code section 100171, whenever the Department is authorized or required by statute, regulation, due process or a contract to conduct an adjudicative hearing leading to a final decision of the Director or Department, it must provide a hearing before an administrative law judge (ALJ) that comports with the Administrative Procedure Act (APA). The APA provides for a full evidentiary hearing before an ALJ in which the parties, nearly always represented by counsel, have the right to engage in discovery, examine and cross-examine witnesses, submit documentary evidence, engage in oral and written argument, and obtain a written decision based upon the record that includes the factual and legal bases of the decision. ALJs preside over these hearings; rule on pre- and post-hearing motions and evidentiary issues; engage in settlement conferences; assess and weigh the evidence; perform complex legal research; and produce well-reasoned, legally sound

proposed decisions that are submitted to the Chief Administrative Law Judge (Chief ALJ) for review and final decision. The Chief ALJ holds the Director's delegated authority to issue final decisions. If the final decision denies the appeal, the appellant may seek review in superior court.

DHCS anticipates an increased annual workload of 30 appeals. Of these appeals, it is anticipated that 10 appeals will conclude with a formal hearing and decision in compliance with the APA. OAHA requests a new staff position to carry out the above-described functions in accordance with the law, which will consist of 1.0 ALJ II.

Legal Support for CalAIM Proposals

OLS (5.0 permanent positions)
1.0 Attorney III (effective 1/1/2022)
1.0 Senior Legal Analyst (effective 1/1/2022)
3.0 Attorney III (effective 7/1/2021)

DHCS will rely on dedicated legal services from various OLS teams during this delivery system modernization and payment reform. The requested Attorney IIIs and Senior Legal Analyst described below are critical to the success of the CalAIM initiative. These attorneys will provide legal counsel on complicated and sensitive issues; navigate the legal complexities and controversial matters related to this initiative and protect its fiscal integrity; provide in-depth research, analysis and advice concerning legislative and regulatory proposals, State Plan Amendments and contract development; negotiate agreements; and litigate complex administrative appeals.

1.0 Attorney III - OLS Administrative Litigation (Ad Lit)
1.0 Senior Legal Analyst – OLS Administrative Litigation (Ad Lit)

The Attorney III will be involved with various proposals of the CalAIM initiative including: Population Health Management Program; Shared Risk, Shared Savings, and Incentive Payments; and Enhancing County Eligibility Oversight and Monitoring, including ensuring Network Adequacy of Specialty Mental Health and Substance Use Disorder Services, Licensing and Certification, and Program Integrity of new incentive payment programs such as dental performance payments.

The Attorney III will advocate for the DHCS position on complex administrative appeals to protect the fiscal integrity of the initiative, including supporting and defending the enhanced enforcement activity and prosecution contemplated by CalAIM.

The Attorney III will be assigned to support and prosecute all enforcement actions taken by DHCS against providers, managed care organizations, and counties; and to defend all appeals related to the implementation of new rate setting processes and incentive payments. These initiatives represent new areas of law, and as such, will likely result in several legal challenges to new DHCS' processes and decisions implementing CalAIM. DHCS/OLS anticipates an increased annual workload of 30 appeals. Of these appeals, it is anticipated that 10 appeals will conclude with a formal hearing in compliance with the Administrative Procedure Act. OLS-Ad Lit requests two new positions to carry out the above described functions, which will consist of 1.0 Attorney III and 1.0 Senior Legal Analyst.

Upon receipt of a formal hearing notice or appeal, the Attorney III immediately initiates the discovery process to protect DHCS and verify it is fully informed during the formal hearing. The Attorney III identifies the basis for each and every issue identified by program, reviews and evaluates any investigation, drafts an accusation (when appropriate), engages in discovery, and

prepares witnesses for hearing. The Attorney III also engages program staff and DHCS experts involved in identifying and exploring potential areas for settlement or resolution, engages with opposing counsel to assess appropriate settlement opportunities, prepares settlement conference briefs, and participates in a formal settlement conference. If the case does not settle, the Attorney III represents DHCS at the evidentiary hearing, presenting exhibits and witnesses, cross-examining witnesses, and making opening and closing arguments. The Attorney III is also responsible for pre-hearing and post-hearing briefings, and working closely with the Office of the Attorney General (AGO) in the event the administrative decision is challenged in Superior Court.

The official record created at the formal administrative level controls throughout the life of the case. In superior and appellate courts, no new evidence can be submitted by the parties. Only the administrative record created can be reviewed. Thus, it will be critical for the Attorney III to develop accurate and comprehensive administrative records for subsequent review, and to support the AGO if there is a challenge to the ALJ's final decision and defend the anticipated appeals.

DHCS intends to increase its oversight and assessment of the annual quality assurance reviews and plans submitted by managed care plans, and issuance of corrective action plans (CAPs) and sanctions when appropriate. Sanctioned managed care plans have the right to appeal any sanction and have an evidentiary hearing before the OAHA. Accordingly, an increased sanction will result in an increase in appeals. DHCS has recently begun sanctioning managed care plans in the past year, and all sanctions over $100,000 have been appealed. Managed care plans have not appealed sanctions under $50,000. Accordingly, OLS anticipates increased workload due to an increase in sanctions and appeal beginning January 2022.

DHCS intends to establish new incentives linked to delivery system reform, quality and performance improvements, and reporting in various areas relating to long-term services and supports and other cross-delivery system metrics. Managed care plans participating in these incentive plans would have appeal rights relating to their participation in the Medi-Cal program and the DHCS' calculation of the incentive payment due to the managed care plan. Accordingly, any new incentive plan will necessarily create an increase in appeals relating to that new plan, similar to the Electronic Health Record Incentive Plan, which has resulted in 42 appeals since 2017. OLS anticipates increased workload due to new incentive payment plans in or about January 2022.

2.0 Attorney IIIs – OLS Health Care Delivery Systems (HCDS)

The 2.0 Attorney IIIs will provide advice and legal support for the ongoing implementation of the CalAIM initiative to ISCD, MCOD, and MCQMD. These positions will handle the most complex legal research, analysis, and advice as well as drafting and negotiating agreements with stakeholders, providers, and managed care plans.

The legal work associated with the CalAIM initiative will be among the most complex and specialized at DHCS in large part because it requires an elevated working familiarity with the various intricacies of Medi-Cal Managed Care, Long-Term Care, and Waiver delivery systems in addition to the primary subject matter expertise regarding Medicaid infrastructure and processes. It requires experience and expertise across the entire spectrum of legal contexts, including legislative, regulatory, contractual, and litigation support work. In addition, the need for multifaceted legal counsel is specific to the highly specialized and specific subject matters and sub-topics in both waiver services and managed care.

For example, the CalAIM initiative contemplates enhancing oversight of the CCS and CHDP programs by ISCD. These programs will continue to grow and provide necessary services to the beneficiary population. Growth in legal work will correspond to program growth. Attorney IIIs will work closely with ISCD staff to consider interplay between various benefit and delivery systems, advise on legal steps necessary to obtain appropriate federal and state authority through state plan amendments and the state regulatory process as well as provide legal support on contract questions. Attorney IIIs will assist with addressing provider and stakeholder questions connected to both programs including, but not limited to enrollment requirements and program integrity.

Attorney III work on the managed care components of CalAIM will involve ongoing drafting, review and amendment to contracts as well as All Plan Letters (APLs). Attorney III work will also include assisting the Department with reviewing and drafting MCP sanctions and corrective action plans for those plans that fail to comply with program requirements. In addition to this general ongoing work, each CalAIM initiative will have unique legal needs. For example, the managed care benefits standardization component of CalAIM, will necessitate Attorney III research of benefits offered in fee-for-service and managed care and how best to standardize benefits across plans and counties. Legal work related to National Committee for Quality Assurance (NCQA) requirements will include research, review and analysis of federal and state law, regulations and NCQA guidelines on NCQA accreditation standards as well as managed care plan quality improvement standards. Once NCQA requirements have been implemented, Attorney IIIs will assist with the annual review of MCPs to verify that all federal, state and contractual accreditation requirements are met. The managed care Population Health Management (PHM) provisions of CalAIM will require Attorney III assistance with developing program standards, delivery infrastructure, resources and service. Attorney IIIs will need to conduct research to make certain that standards are consistent with federal and state laws, regulation and guidance. As well as assisting with the review of MCP PHM strategies to support compliance with all applicable legal authority.

The legal work associated with the initiative involves new and still-developing theories and practice. Given the wide-ranging state and federal legal ramifications involved with this initiative and the centrality of the CalAIM initiative to the Medi-Cal program, these Attorney III positions are integral to Medi-Cal because of their high level of experience and specialization in the various affected areas. As the initiative develops, OLS will work with ISCD, MCOD, and MCQMD to verify continued legal compliance and to minimize risk of litigation. The workload associated with this area will be ongoing and constant given the size of the Medi-Cal program. As stated above, the complexity of the legal work associated with the Medi-Cal program warrants Attorney III positions in this instance. Highly specialized legal experts are needed to efficiently and competently perform the complex legal work related to managed care and the 1115 Waiver issues, which will continue to arise, and it is essential that this work is performed at the Attorney III level.

1.0 Attorney III – OLS Health Care Financing and Rates (HCFR)

The OLS-HCFR team supports as house counsel the following Divisions within DHCS: CRDD; Fee-For-Service Rates Development (FFSRDD); LGFD; and SNFD; the team also directly supports the Deputy Director of Health Care Finance in all matters of legal significance. Accordingly, the requested Attorney III will provide advice and legal support for the ongoing implementation of the CalAIM initiative to CRDD, FFSRDD, SNFD, and LGFD by independently managing the most complex legal research and analysis, and providing technical advice as well as by taking the lead in drafting and negotiating agreements with stakeholders, providers, and managed care plans. The incumbent must demonstrate a command of Medi-Cal financing and reimbursement principles including Medi-Cal provider and facility reimbursement rates; Medi-Cal hospital

payment methodologies; Medi-Cal managed care plan capitation rates; Medi-Cal provider fee programs, and federal claiming.

This position will provide legal support for all CalAIM activities, including those matters pertaining to the implementation of the Waiver itself, with a focus on the various financing initiatives.

The legal work associated with the CalAIM initiative will be among the most complex and specialized at DHCS in large part because it requires expertise related to Medi-Cal Managed Care, Behavioral Health payment, and Waiver delivery systems in addition to primary subject matter expertise in federal, state, and local financing mechanisms and requirements. It requires experience and expertise across the entire spectrum of legal contexts, including legislative, regulatory, contractual, and litigation support work. The litigation cases assigned to the HCFR team are often designated as Significant Matter litigation as the cases involve high-profile rates cases.

Unique to the role of the OLS-HCFR team in the administration of an 1115 Waiver is the inclusion of legal support to the Director's Office and all affected divisions for more general issues that arise in negotiating approval and implementing an initiative like CalAIM, including issues of federal claiming, budget/cost neutrality, administrative activities/contracting, or waiver authorities/mechanics in both the 1115 and 1915 settings. The federal requirements for developing, implementing, and maintaining an 1115 Waiver include compliance with matters related to public notice, sophisticated financing calculations and payment methodologies, restrictions on funding streams and partnerships, as well as the detailed strategies applicable to federal claiming. The OLS-HCFR Attorney III must have the requisite knowledge, training, and experience handling such matters and reporting on such issues to individuals in the highest levels of administration at DHCS.

Independent of general Waiver guidance, the requested Attorney III will be responsible for directly supporting one of the recently reorganized Behavioral Health divisions, the behavioral health financing unit, on issues related to the significant state-county realignment and fiscal considerations embodied in the CalAIM initiative. CalAIM seeks to institute an ambitious schedule of behavioral health payment reform that will move the industry from a cost reporting system to one more focused on capitated rates. Accordingly, this position would be responsible for a variety of legal tasks associated with the initiative, including drafting and/or advising on waiver terms and conditions, state legislation, policy guidance, managed care plan/county/provider contracts, State Plan Amendments, directed payment preprints, and administrative/consultant contracts.

As part of the implementation of the Waiver, the requested position will also provide legal advice and support necessary to properly structure provider, hospital, facility and managed care plan rate setting methodologies and to enable the Department to draw down billions of federal dollars annually. For example, the Global Payment Program (GPP) is vital for the Department and its public hospital partners. It is not uncommon for OLS-HCFR team members to interact with representatives from the representative stakeholder group (the California Association of Public Hospitals) on issues related to GPP. This can include a range of issues such as the appropriate means and methods for calculating payments, the impact the program may have on other supplemental payments, or technical compliance with all terms and conditions set in the Waiver. The requested Attorney III must be able to address any and all issues related thereto.

Transition of PRIME to Quality Incentive Pool (QIP) Program

Subject to obtaining the necessary federal approvals, DHCS is in the process of transitioning the quality improvement work and funding that has been available through PRIME into the QIP Program and permitting the District and Municipal Public Hospitals (DMPH) to begin participating in the program. The first phase of the transition is complete and approved by CMS (covering July-December 2020). The second phase of the transition (Jan 2021 and ongoing) is still pending CMS approval but moving forward programmatically. The goal is to continue quality improvement efforts underway at all 52 PRIME entities after PRIME expired on June 30, 2020. This transition will promote value-based purchasing and ties funding to quality outcomes. Additionally, this transition aligns PRIME entities' transition to the QIP Program with California's transition to the calendar year rating period for Medi-Cal managed care plans.

OMD (Conversion of 3.0 LT to Permanent effective 7/1/2021)
2.0 AGPAs
1.0 PHMO III

It is crucial that DHCS transition the quality improvement work and funding for Designated Public Hospitals (DPHs) and DMPHs that occurred through PRIME to QIP. This work involves adding the 35 DMPHs to QIP, along with adding additional quality metrics and funding for the 17 DPHs already participating in QIP. The PRIME to QIP transition will provide critical financial support to California's public hospitals by transitioning approximately $1 billion in annual payments (federal funds matched by local funds) from the ending 1115 Waiver to the QIP managed care directed payment program. This transition will be accomplished pursuant to WIC 14197.4 and in alignment with the Medicaid Managed Care and Children's Health Insurance Program (CHIP) Managed Care Final Rule (Final Rule).

The 3.0 LT positions (2.0 AGPAs and 1.0 PHMO III) will annually review, update, and incorporate approximately 60 clinical performance measures into a QIP specification manual for participating hospital systems to use. They will also develop policy documents and review, analyze, and approve 52 annual hospital performance reports to determine hospital payment amounts on approximately 40 reported metrics per hospital. For each of these tasks;

- The 2.0 AGPAs will perform the analytical, non-clinical work while the PHMO III will provide clinical expertise and support. The monitoring and review of these performance reports are an integral part of program operations and evaluating the success of hospital system improvement and transformation. The 2.0 AGPAs will also provide continuous support and technical assistance to 17 DPH participating hospital systems and 35 DMPHs, participate in regular calls with key external partners who represent participating hospitals, and liaison with other DHCS divisions and external partners to align performance and incentive payment.

- The PHMO III will also analyze reported data on the approximately 60 metrics, draft the annual internal evaluation as required by CMS, and work to confirm that incentive funding earned by participating hospital systems is tied to quality outcomes which align with the DHCS Comprehensive Quality Strategy, as required by CMS.

OMD ($900,000 contract resources)

Contract to maintain QIP data reporting portal	*$250,000 annually*
Contract for QIP data integrity	*$500,000 annually*
Contract for QIP annual conference	*$150,000 annually*

Analysis of Problem

OMD is requesting funding to work with an external contractor to update and maintain the web-based QIP data reporting portal that DPHs currently use to report QIP data. The portal will need to be updated to add 35 DMPHs, approximately 34 new customizable metrics, flexibility to add race and ethnicity reporting to existing metrics to help address health disparities, and additional functionality to facilitate production of the CMS-required annual internal evaluation. These costs represent ongoing maintenance and operations costs since annual portal changes are required to accommodate annual national-level metric changes. The portal provides DHCS staff and approved external users with the functionality to enter, pull, and analyze data.

The contract for QIP data integrity will allow OMD to work with an external data auditor entity, preferably certified by the National Committee for Quality Assurance (NCQA), to perform validation of all hospital-submitted metric data to support consistency with the published QIP reporting manual. This contract would enable independent third party assessment of raw data submitted by hospitals, and would provide technical assistance to hospitals regarding accurate reporting. This contract would help verify that the over $1 billion in annual QIP payments that will be made to hospitals are based on actually meeting important clinical quality benchmarks.

OMD is also proposing to work with an external contractor to continue the important annual quality improvement conference that has occurred through PRIME, attended by all 52 participating hospitals. The contractor would coordinate meeting logistics, materials, speakers, etc. The annual conference allows participating hospitals to convene and share best practices to promote access, health equity, value-based payment, and tie funding to quality outcomes, and further align State, Managed Care Plan (MCP), and hospital system goals. In light of the public health emergency, the annual conference may be conducted virtually.

E. Outcomes and Accountability

Projected Outcomes

Administration Division

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Department authorized position count	4,095	4,095	4,095	4,095	4,095	4,095
Admin. staff	162.5	162.5	162.5	162.5	162.5	162.5
Processing applications for vacancies (MQ review)	8,200	9,200	10,200	11,200	12,200	13,200
Processing requests for personnel action	2,200	2,400	2,400	2,500	2,500	2,600
Square footage of facilities managed	962,000	1,012,000	1,062,000	1,062,000	1,062,000	1,062,000
Number of Purchase Orders processed	1,950	1,900	1,900	1,900	1,900	1,900
Number of Draft Contracts/ Amendments Reviewed	1,490	1,690	1,890	1,990	2,190	2,390
	680	780	800	820	840	860

Analysis of Problem

California Medicaid Management Information System Division

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
System Development Notice	60	62	64	62	63	64
Operating Instruction Letter	400	420	425	410	415	420

Capitated Rates Development Division

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Enhanced care management financial data by plan	0	25	25	25	25	25
In lieu of services in contracts and rates	0	13	15	17	19	21
Shared risk/savings models by plan	0	0	50	50	50	50
Incentive programs	0	0	25	25	25	25
Managed Care Spend (cash basis, in billions)	$55	$58	$61	$64	$67	$71

Community Services Division

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Report of disparities related to behavioral health.		N/A	1,800 hours	N/A	N/A	
Evaluation framework for population health outcomes related to behavioral health proposals		N/A	N/A	1,800 hours		
Analysis of CalAIM related data collection needs relative to existing data systems/collection		N/A	1,800	N/A		
Documentation of data collection and related data systems modifications		N/A	N/A	1,800		
Ongoing communication, training, and technical assistance with plans related to data systems, data collection, and data reporting		N/A	N/A	3,360 hours	3,360 hours	
Maps, reports, and data analyses related to various components of CalAIM; plan-level profiles and reports		N/A	1,800 hours	7,200 hours	7,200 hours	

Enterprise Data and Information Management

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
EPM Cubes in production	15	30	45	60	75	90

Analysis of Problem

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
EPM users	200	260	320	380	440	500
Program Areas in EPM	5	7	9	11	13	15
Number of Reports Published in EPM	72	110	150	190	230	270
Number of Custom tools developed (Automated loader, automated test harness etc.) in EPM	6	8	10	12	14	16
In Lieu of Service (ILOS) Organizations Integrated	0	3	10	20	35	50
Program Areas Assisted by HSIS	0	2	5	10	20	30

Enterprise Technology Services

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Number of Rate Types in CAPMAN	32	42	48	54	60	66
CAPMAN Invoice Types	219	240	260	280	300	320
CAPMAN Full Stack Environments	16	17	19	21	23	25
CAPMAN Storage Capacity (in GBs)	229,570	261,500	331,500	397,407	464,337	531,297
CAPMAN Audit Requests	11	13	14	15	16	17
CAPMAN Support Requests	2,000	2,300	2,600	2,900	3,200	3,500
Number of EDI files received in PACES	55,786	72,521	93,651	112,381	134,857	161,828
Number of encounters received from MC Plans in PACES	244,367,654	254,142,360	256,683,784	259,250,621	264,435,634	267,079,990
Number of issues received in PACES	816	1,060	1,211	1,234	1,117	1,034
Number of crossover claim files received through Cal Medi Connect in PACES	2,371	2,371	2,371	2,371	2,371	2,371
Test files received in PACES	5,794	5,794	5,794	5,794	5,794	5,794
Number of system change requests received in PACES	217	223	229	231	236	242
Number of documents	51	62	74	77	81	86

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
created, Companion guides, mappings, etc. (some are continuously updated and maintained) in PACES						

Integrated Systems of Care Division

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Review of current program standards and guidelines	20	25	30	35	40	45
Development of monitoring and oversight policies and procedures	2	4	6	8	8	8
Development of performance measures and metrics	10	10	10	12	14	16
Development of auditing tools	1	1	1	1	1	1
County guidance via technical assistance meetings	12	12	12	24	24	24
Report of findings for counties	170	170	170	170	170	170
Execution of County Memorandum of Understanding	0	0	0	0	170	0
County Corrective Action Plans	0	0	0	0	10	10
Automated Plan and Fiscal Guideline (PFG) Submission Development from the County	0	170	170	170	170	170
Automated PFG Submission Maintenance	0	0	170	170	170	170

Local Governmental Financing Division

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Develop rates for each CPT and HCPCS code by rate region.	800	800	800	800	800	800
Process monthly invoices for intergovernmental transfers.	1,344	1,344	1,344	1,344	1,344	1,344

Analysis of Problem

Medi-Cal Behavioral Health Division

BH Administrative Integration of MH and SUD Services

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Research federal/state requirements for an integrated 24-hour access line	N/A	252 hours	120 hours	N/A	N/A	N/A
Develop/update existing requirements for an integrated 24-hour access line	N/A	N/A	N/A	120 hours	120 hours	N/A
Training/TA/ Communication to counties on an integrated 24-hour access line	N/A	N/A	N/A	N/A	N/A	120 hours
All counties have an integrated 24-hour access line for beneficiaries seeking SMHS and SUD services	N/A	N/A	N/A	N/A	N/A	N/A
Research federal/ state requirements for intake/ screening/referrals	N/A	252 hours	120 hours	N/A	N/A	N/A
Develop/update standardize processes	N/A	N/A	120 hours	120 hours	120 hours	N/A
Training/TA to counties/plans on integrated intake/ screening/referrals	N/A	N/A	N/A	N/A	N/A	120 hours
All counties/plans have an integrated intake/screening/ referrals	N/A	N/A	N/A	N/A	N/A	N/A
Research federal/ state requirements for assessment processes and tools	N/A	252 hours	120 hours	N/A	N/A	N/A
Develop/update existing requirements for a standardize assessment process and tools	N/A	N/A	N/A	120 hours	120 hours	120 hours
Training/TA to counties/plans on assessment processes and tools	N/A	N/A	N/A	N/A	N/A	120 hours
All counties/plans have an standardize assessment process and tools	N/A	N/A	N/A	N/A	N/A	N/A
Research federal/state requirements for integrated clinical	N/A	252 hours	N/A	N/A	N/A	N/A

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
documentation standards (i.e., problem lists and progress reports)						
Develop/update existing requirements for integrated clinical documentation standards	N/A	N/A	252 hours	120 hours	120 hours	120 hours
Training/TA/ Communication to counties on integrated clinical documentation standards	N/A	N/A	N/A	240 hours	240 hours	120 hours
All counties have an integrated clinical documentation standards for beneficiaries seeking SMHS and SUD services	N/A	N/A	N/A	N/A	N/A	56 MHPs/57 DMC Counties (State Plan and ODS)
Research federal/state requirements for integrated beneficiary informing material	N/A	N/A	240 hours	120 hours	120 hours	N/A
Develop/update existing requirements for an integrated beneficiary informing materials	N/A	N/A	N/A	240 hours	120 hours	N/A
Training/TA/ Communication to counties on integrated beneficiary informing materials	N/A	N/A	N/A	N/A	N/A	120 hours
Consolidated beneficiary informing materials and grievance / appeal processes.	N/A	N/A	N/A	N/A	N/A	N/A
Research federal and state requirements for counties to operate as a single PIHP under a single contract	N/A	N/A	N/A	672 hours	480 hours	N/A
Develop a single PIHP consolidated contract	N/A	N/A	N/A	N/A	N/A	480 hours
Training/TA to counties on the single PIHP contract requirements	N/A	N/A	N/A	N/A	N/A	252 hours
All counties have a single PIHP consolidated contract for SMHS and SUD services	N/A	N/A	N/A	N/A	N/A	N/A
Research federal/state requirements	N/A	N/A	N/A	252	252	120

Analysis of Problem

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
on data sharing/ privacy concerns				hours	hours	hours
Research/ stakeholder process to develop new data sharing/privacy guidance	N/A	N/A	N/A	176 hours	N/A	N/A
Develop/update requirements for data sharing/privacy concerns to provide clarity and consistency in policies and practices, including the SHIG	N/A	N/A	N/A	N/A	252 hours	120 hours
Training/TA to counties on revised data sharing/privacy concerns requirements	N/A	N/A	N/A	N/A	252 hours	120 hours
Research federal/state requirements for EHR integration	N/A	N/A	N/A	252 hours	252 hours	120 hours
Develop/update existing EHR requirements	N/A	N/A	N/A	252 hours	252 hours	120 hours
Develop approach to redesign EHR integration	N/A	N/A	N/A	252 hours	252 hours	120 hours
Training/TA to counties on EHR requirements and integration	N/A	N/A	N/A	N/A	N/A	252 hours
All counties have integrated EHR systems	N/A	N/A	N/A	N/A	N/A	56 MHPs/57 DMC Counties (State Plan and ODS)
Research federal/state Cultural Competence Plan (CCP), also referred to as Cultural Humility Plan (CHP), requirements to develop an integrated CHP	N/A	N/A	N/A	252 hours	120 hours	120 hours
Develop/update existing requirements for integrated CHP	N/A	N/A	N/A	252 hours	120 hours	120 hours
Training/TA to counties on integrated CHP requirements	N/A	N/A	N/A	N/A	252 hours	252 hours
Counties will submit integrated CHPs	N/A	N/A	N/A	N/A	56 MHPs/57 DMC Counties (State	30 CHPs

Analysis of Problem

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
					Plan and ODS)	
Research federal/state requirements for and integrated QI and performance measurement programs	N/A	N/A	N/A	480 hours	252 hours	252 hours
Develop/update existing requirements for an integrated QI and performance measurement programs	N/A	N/A	N/A	N/A	480 hours	252 hours
Training/TA to counties on requirements for an integrated QI and performance measurement programs	N/A	N/A	N/A	N/A	N/A	252 hours
All counties have an integrated QI and performance measurement programs, including a QI Committee, and a list of SMHS SUD measures.	N/A	N/A	N/A	N/A	N/A	56 MHPs/57 DMC Counties (State Plan and ODS)
Research federal/state requirements to consolidate the EQRO contracts, review processes, timelines, and protocols.	N/A	N/A	N/A	980 hours	490 hours	N/A
Develop/update existing federal and state requirements to consolidate the EQRO contracts, review processes, timelines, and protocols.	N/A	N/A	N/A	N/A	672 hours	490 hours
Trainings/TA to counties on consolidated EQRO contracts, review processes, timelines, and protocols.	N/A	N/A	N/A	N/A	N/A	252 hours
Implement a combined EQRO process including integrated performance improvement plans, integrated reviews, and a single report	N/A	N/A	N/A	N/A	N/A	N/A
Research federal/state requirements for an	N/A	480 hours	252 hours	N/A	N/A	N/A

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
consolidated review process and integrated protocol						
Develop/update existing requirements for an consolidated review process and integrated protocol	N/A	N/A	480 hours	252 hours	120 hours	120 hours
Training/TA to counties on the single review process	N/A	N/A	N/A	N/A	N/A	252 hours
All counties compliance reviews are consolidated into a single review with an integrated protocol	N/A	N/A	N/A	N/A	N/A	56 MHPs/57 DMC Counties (State Plan and ODS)
Research federal/ state requirements for an consolidated network adequacy certification processes	N/A	N/A	N/A	480 hours	252 hours	N/A
Develop/update existing requirements for an consolidated network adequacy certification processes	N/A	N/A	N/A	N/A	480 hours	252 hours
Training/TA to counties on network adequacy certification processes	N/A	N/A	N/A	N/A	N/A	252 hours
All counties[1] network adequacy certification processes are consolidated	N/A	N/A	N/A	N/A	N/A	56 MHPs/37 DMC-ODS Counties PLUS All State Plan

Medi-Cal Behavioral Health Division

Changes to Medical Necessity Criteria

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Develop regulatory text and rulemaking file components, internal review and development, consult with stakeholders.	N/A	480 hours	340 hours	264 hours	N/A	N/A
Publish Notice of proposed rulemaking, incorporate stakeholder	N/A	60	180 hours	120 hours	N/A	N/A

[1] Number of DMC-ODS counties could change if more DMC State Plan counties opt in to the waiver.

Analysis of Problem

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
feedback, complete final regulations package.						
Update policy guidance to reflect the change in medical necessity criteria (Information Notices, Contract language, etc.)	N/A	252 hours	252 hours	252 hours	N/A	N/A
Develop/update existing requirements for new medical necessity criteria	N/A	640 hours	960 hours	480 hours	N/A	N/A
Training/TA to counties on delivery system screening/referral processes, as well as level of care assessment processes	N/A	1,280 hours	2,880 hours	1,440 hours	N/A	N/A

Medi-Cal Behavioral Health Division

BH Regional Contracting Proposal

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Draft new guidance/add additional guidance for counties	TBD	TBD	TBD	TBD	TBD	TBD
Research federal/state requirements for Behavioral Health Contract (projected in July 2020)	TBD	TBD	TBD	TBD	TBD	TBD
Update licensing/ certification requirements for counties for MH/SUD	TBD	TBD	TBD	TBD	TBD	TBD
Training/TA/Communication to counties on new Behavioral Health Contract	TBD	TBD	TBD	TBD	TBD	TBD
Counties would develop and operationalize a consolidated QI Plan, QI Committee, and develop a comprehensive list of SMHS and SUD measures	TBD	TBD	TBD	TBD	TBD	TBD
Implement new Behavioral Health Contract	TBD	TBD	TBD	TBD	TBD	TBD
Counties operate under a single contract with DHCS for both SMHS and SUD services	TBD	TBD	TBD	TBD	TBD	TBD

Medi-Cal Behavioral Health Division

Drug Medi-Cal Organized Delivery System Renewal and Policy Improvements

(Note: workload measures represent project units rather than staffing hours)

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
EQRO Site Reviews/Visits	N/A	15	40	50	53	53

Analysis of Problem

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
EQRO County and Aggregate Report	N/A	16	41	51	54	54
Quarterly EQRO/UCLA/DHCS Meeting	N/A	2	4	4	4	4
Webinar/Trainings/ Training Material • DMC-ODS Toolkit for Preparation for EQRs • Key Components Standards and Review Tool • EQRO 101 • Thinking through a PIP • Access Call Center Critical Indicators • Information Systems Capabilities Assessment • PIP Development Tool Instructions and Checklist • DMC-ODS PIP Master List for 2017-18 • PIP Clinics • Clinical Committee Meetings Performance Measures	N/A	10	20	20	20	20
Training and Technical Assistance (TA) • ASAM Criteria • Continuum of Care • Medication Assisted Treatment	N/A	35	35	35	35	35

Medi-Cal Eligibility Division

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Plan, organize, and direct staff related to the priorities of the external audits project, to include Payment Error Rate Measurement (PERM) and Medicaid Eligibility	N/A	300	300	300	300	300

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Quality Control (MEQC) activities						
Plan, organize, and direct staff related to the priorities of the county focused review project and county performance dashboard	N/A	200	200	200	200	200
Plan, organize, and direct staff related to the priorities of the county oversight and monitoring project	N/A	100	100	100	100	100
Development and implement tiered corrective action project.	N/A	100	100	100	100	100
Represent DHCS in all stakeholder engagement meetings.	N/A	100	100	100	100	100
Develop management briefs, reports, issue papers for DHCS Executive management	N/A	50	50	50	50	50
Develop All County Welfare Directors' Letters and Medi-Cal Eligibility Division Informational Letters to provide county instruction on performance standards and performance monitoring changes	N/A	30	30	30	30	30

Managed Care Operations Division

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Develop and execute contract amendments or policy letters relating to ongoing monitoring and reporting	N/A	297	297	297	297	297
Establish and document operational procedures, policies, review tools, and various tracking systems; provide technical assistance, resolve programmatic and technical questions	N/A	1485	1485	1485	1485	1485

Analysis of Problem

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Oversight of the Health Care Options enrollment Broker, including monitoring activities and ongoing, meetings with enrollment broker	N/A	432	432	432	432	432
Respond to sensitive internal and external communications and facilitate resolution of specialized problems	N/A	594	594	594	594	594
Research and make recommendations on monitoring and evaluation methods	N/A	337	337	337	337	337
Communicate with health plans on processes for and submission of required documents	N/A	1,200	1,200	1,200	1,200	1,200
Review Plan provider directories and verify compliance	N/A	567	567	567	567	567
Determine, create, review and approve all readiness related activities and procedures for Managed Care Standardization and MLTSS transitions	N/A	104	104	104	104	104
Work with various program areas to identify business/system requirements	N/A	400	400	425	425	425
Monitor reports; test new system implementations	N/A	275	275	275	275	275
Draft and review correspondence, directives, and system functional design	N/A	300	300	300	300	300
Revise current, create new, and implement beneficiary informing materials	N/A	200	200	200	200	200
Review current processing operations	N/A	250	250	250	250	250

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
and supporting systems to improve contract compliance						
Research, analyze, and advise staff on responding to external inquiries, communications, and stakeholder questions and concerns	N/A	80	80	80	80	80
Participate in scheduled and ad hoc meetings to discuss, resolve, and provide guidance	N/A	1,325	1,325	1,325	1,325	1,325
Develop and produce statistical reports and publications of findings	N/A	530	530	530	530	530
Research on Invoice Payments/Discrepancies	N/A	1,304	1,304	1,304	1,304	1,304
Review All Plan Letters and similar guidance to MCPs	N/A	80	80	80	80	80
Process administrative support procurements	N/A	48	50	52	54	56
Provide technical support and process various IT requests	N/A	1,900	1,900	1,900	1,900	1,900
Process RPAs	N/A	235	255	270	285	300
Respond to personnel inquiries	N/A	9,500	9,700	9,800	9,900	10,000
Update existing and create new technical guidance documents for managed care plans	N/A	55	60	65	70	75
Facilitate and coordinate communication between intra-departmental entities to respond to Federal and State audits	N/A	26	28	30	32	34
Respond to audit requests and audit inquiries	N/A	1,400	1,450	1,500	1,550	1,600

Analysis of Problem

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Process data requests; lead data collection, perform analysis, and implement reporting tools	N/A	1,550	1,700	1,850	2,000	2,150
Build DSNP contracts; review and approve D-SNPs	N/A	26	26	26	26	26

Managed Care Quality and Monitoring Division

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Plan, organize and direct staff related to ILOS, ECM, and PHM	N/A	450	450	450	450	450
Workgroup facilitation for methodology development, validation of methodology, and presenting to DHCS leadership and external stakeholders	N/A	600	600	600	600	600
Collaborates with internal and external stakeholders, clinicians, and researchers	N/A	52	52	52	52	52
Draft APLs, memos and discussion documents for PHM	N/A	36	36	36	36	36
Development of procedures and goals necessary for the implementation of PHM	N/A	12	12	12	12	12
Develop key performance indicators for report production and monitoring	N/A	36	36	36	36	36
Assist with measuring compliance for PHM and compliance actions such as technical assistance, corrective actions plans and sanctions	N/A	52	52	52	52	52
Compile and communicate promising practices related to PHM to MCPs	N/A	104	104	104	104	104

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Review and approve PHM for 26 MCPs	N/A	130	130	130	130	130
Review and approve ECM models of care and procedures for 26 MCPs	N/A	26	26	26	26	26
Draft APLs, memos and discussion documents for ECM	N/A	36	36	36	36	36
Assist with measuring compliance for ECM and compliance actions such as technical assistance, corrective actions plans and sanctions	N/A	52	52	52	52	52
Compile and communicate promising practices related to ILOS to MCPs	N/A	104	104	104	104	104
Draft APLs, memos and discussion documents for ILOS	N/A	36	36	36	36	36
Review and approve ILOS for 26 MCPs	N/A	26	26	26	26	26
Review and approve ILOS procedures for 26 MCPs	N/A	52	52	52	52	52
Assist with measuring compliance for ILOS and compliance actions such as technical assistance, corrective actions plans and sanctions	N/A	52	52	52	52	52
Monitor performance on quality indicators	N/A	N/A	N/A	N/A	20	20
Collaborate with clinical and nonclinical staff to support efforts to reduce disparities	N/A	25	25	25	25	25
Compile and communicate promising practices related to D-SNPs to MCPs	80	80	80	80	80	80
Review and approve D-SNPs MCPs	N/A	26	26	26	26	26
Research and analyze legislation for D-SNPs	N/A	26	26	26	26	26
Assist with measuring compliance for D-SNPs and	N/A	26	26	26	26	26

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
compliance actions such as technical assistance, corrective actions plans and sanctions						
Draft APLs, memos and discussion documents for D-SNPs	N/A	5	5	5	5	5
Plan and conduct MCP readiness activities of the Integration Pilots						
Develop the methodology used to certify the MCP Pilots' networks, including continuous revision of methodology used to certify the MCP provider network	900	800	700	700	700	500
Evaluate and certify the MCP Pilots' networks	250	500	400	600	900	500
Provide technical assistance to the Pilots	N/A	400	400	750	800	600
Develop, monitor, and maintain requirements of the Pilots for the transition of populations	500	800	700	700	800	800
Form workgroup to develop NCQA deeming processes and procedures	250	1,400	1,100	500	250	250
Develop, define, and maintain scope of NCQA deeming	250	700	700	1,000	500	250
Develop and standardize submission requirements and review criteria	N/A	1,400	1,250	900	100	50
Develop review tools for review of policies and procedures submitted by MCPs	N/A	1,400	1,000	200	100	50
Provide technical assistance to MCPs	N/A	350	900	1,225	1,225	1,225
Review MCP submissions	N/A	N/A	N/A	500	1,000	750
Monitor and provide appropriate	N/A	N/A	N/A	100	1,800	1,800

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
oversight of NCQA requirements						
Extract and analyze data for Population Health Management (PHM) program requirement development	N/A	100	100	100	100	100
Develop PHM monitoring protocols and data reporting templates	N/A	500	500	100	100	100
Develop internal and external PHM key performance indicators, monitoring reports, and performance dashboards	N/A	500	500	100	100	100
Develop database SQL queries to extract PHM data for analysis	N/A	500	500	500	500	500
Design research methodologies for PHM program evaluation	N/A	100	100	500	500	500
Collect PHM program data from MCPs. Manage PHM data and produce internal and external PHM reports and dashboards.	N/A	600	600	600	600	600
Facilitate workgroups to discuss PHM analytic and data management processes	N/A	52	52	52	52	52
Plan and conduct MCP readiness activities of the Integration Pilots	500	700	600	600	600	N/A
Develop the methodology used to certify the MCP Pilots' networks, including continuous revision of methodology used to certify the MCP provider network	900	700	600	600	600	100
Evaluate and certify the MCP Pilots' networks	250	300	200	200	300	200

Analysis of Problem

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Provide technical assistance to the Pilots	N/A	350	300	200	400	700
Develop, monitor, and maintain requirements of the Pilots for the transition of populations	500	800	700	700	700	800
Form workgroup to develop NCQA deeming processes and procedures	250	1,400	1,500	500	250	250
Develop, define, and maintain scope of NCQA deeming	250	900	800	1,000	500	250
Develop and standardize submission requirements and review criteria	N/A	1,400	1,250	900	100	50
Develop review tools for review of policies and procedures submitted by MCPs	N/A	1,500	1,000	200	100	50
Provide technical assistance to MCPs	N/A	450	1,225	1,225	1,225	1,225
Review MCP submissions	N/A	N/A	N/A	500	1,000	750
Monitor and provide appropriate oversight of NCQA requirements	N/A	N/A	N/A	100	1,800	1,800

Medi-Cal Dental Services Division

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Provider Publications	N/A	12	24	24	24	24
Member Informing Materials	N/A	15	30	30	30	30
Stakeholder meetings, including provider organizations and control agencies	N/A	19	38	38	38	38
Audits	N/A	10	40	40	40	40
Regular Vendor Meetings	N/A	25	50	50	50	50
Bi-Annual Estimates	N/A	37	75	75	75	75
State Hearings	N/A	1,045	2,090	2,090	2,090	2,090
Beneficiary (Conlan) Reimbursements	N/A	48	97	97	97	97
Ad Hoc Cost Analysis	N/A	25	50	50	50	50
Provider Payments	N/A	6	12	12	12	12

Stakeholder Technical Assistance Hours	N/A	75	150	150	150	150
Fact Sheets	N/A	6	24	24	24	24
Provider Correspondence	N/A	140	280	280	280	280
Beneficiary Correspondence	N/A	2,460	4,920	4,920	4,920	4,920
Internal and external stakeholder meetings regarding data analyses and reports	N/A	12	24	24	24	24
Develop/monitor and refine data reports	N/A	10	20	20	20	20
Develop/monitor and refine data systems	N/A	6	12	12	12	12
Monthly assessment and monitoring of data reports for progress	N/A	6	12	12	12	12
State Plan Amendment	N/A	1	N/A	N/A	N/A	N/A
Provider Training	N/A	4	8	8	8	8
Clinic Training	N/A	10	20	20	20	20
Dental Hygiene Policy	N/A	35	70	70	70	70
Trend Analyses Reports	N/A	25	50	50	50	50
Telephone Service Center Oversight with Vendor	N/A	24	48	48	48	48
Program Integrity Measures	N/A	15	30	30	30	30
Partnership with California Department of Public Health (CDPH) Oral Health Team	N/A	6	12	12	12	12

Office of Administrative Hearings and Appeals

Workload Measure	**2020-21**	**2021-22**	**2022-23**	**2023-24**	**2024-25**	**2025-26**
Incoming Formal Hearing Requests	N/A	N/A	30	30	30	30
Formal Appeal Hearings & Decisions	N/A	N/A	10	10	10	10

Analysis of Problem

Office of Legal Services - Ad Lit

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Open File – draft letters of representation, establish contact with program staff	N/A	N/A	30	30	30	30
Discovery, preparation of witness list, and pre-hearing brief	N/A	N/A	30	30	30	30
Pre-hearing preparation, correspondence, motions, pre-hearing telephone conferences, hearing schedules/travel arrangements	N/A	N/A	30	30	30	30
Pre-hearing settlement negotiations and conference	N/A	N/A	30	30	30	30
Preparation for hearing, including witness preparation, preparing exhibit packages	N/A	N/A	20	20	20	20
Conducting hearing/travel	N/A	N/A	10	10	10	10
Post-hearing brief and reply brief preparation	N/A	N/A	10	10	10	10
Review Proposed Decision; preparation of comments for reconsideration, review final decision	N/A	N/A	10	10	10	10
Coordinate defense of Administrative decision in superior court with AGO	N/A	N/A	N/A	4	4	4
Consult with an Attorney IV and ACC	N/A	N/A	30	30	30	30

Office of Legal Services - HCDS

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Perform complex legal research and analyze federal and state laws to advise DHCS, Agency, and AGO in restructuring programs and verifying ongoing compliance	2	10	17	17	20	20
Draft and review state legislation and regulations related to CalAIM initiative implementation/ administration	2	6	8	10	15	15

Analysis of Problem

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Draft and review all-plan letters, bulletins and related policy guidance	2	10	10	10	10	10
Negotiate, draft, and review contracts and amendments, inter-agency agreements and other contracts and necessary contract amendments	6	6	6	10	10	10
Draft Medicaid authority, including State Plan Amendments and Waivers	1	1	1	1	1	1
Research, analyze, and advise staff on responding to external inquiries, and communications, and stakeholder questions and concerns to avoid potential litigation	2	10	20	20	20	20
Represent divisions in informal hearings and meetings	2	2	2	3	3	3
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	1	1	1	1	1	1
Participate in CMS discussions, intra- and interdepartmental workgroup efforts, including researching, analyzing, and advising staff on managed care and integrated systems of care issues and related policy development	2	10	10	10	10	10

Office of Legal Services - HCFR

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Perform complex legal research and analyze	4,030	4,030	2,040	20	1,020	10

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
federal and state laws to advise DHCS, Agency, and OAG in restructuring programs and verifying ongoing compliance						
Draft and review state legislation and policy guidance related to CalAIM initiative implementation/ administration	20	20	20	20	20	20
Draft and review all-plan letters, directed payment guidance and related policy guidance	2,010	2,010	1,420	14	14	14
Negotiate, draft, and review managed care plan contracts and amendments, inter-agency agreements and other contracts and necessary contract amendments	2,010	2,010	1,020	10	10	2,010
Draft Medicaid authority, including State Plan Amendments, Directed Payment Approval Preprints, and Waiver Special Terms and Conditions	2,010	2,010	20	20	20	3,020
Research, analyze, and advise staff on responding to external inquiries, plan negotiation and communications, and stakeholder questions and concerns to avoid potential litigation	10	10	2,010	3,020	4,030	40
Represent divisions in informal hearings and meetings	2,010	2,010	20	3,020	4,030	40
Provide pre-litigation support, such as assessing potential legal issues, strategic planning to avoid litigation, and responding to demand letters and advocate	6	6	6	106	1,410	2,014

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
concerns having large fiscal implications						
Participate in CMS discussions, intra- and interdepartmental workgroup efforts, including researching, analyzing, and advising staff on financing and rate development and related policy development	4,020	4,020	2,040	20	20	3,020

Office of the Medical Director

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Provide technical assistance to participating hospitals	52	52	52	52	52	52
Participate in regular calls with external key partners, i.e. California Association of Public Hospitals and Health Care Systems/Safety Net Institute (CAPH/SNI) and District Hospital Leadership Forum (DHLF) who represent participating hospitals	52	52	52	52	52	52
Review, analyze, and approve hospital performance reports to determine incentive payment amounts	52	52	52	52	52	52
Participate in regular calls and work with other DHCS divisions, i.e. CRDD, to align performance and incentive payment	24	24	24	24	24	24

Analysis of Problem

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Review and update clinical performance measures to be incorporated in the specification manual	60	60	60	60	60	60
Analyze data on each performance measure and incorporate into the annual internal evaluation as required by CMS	60	60	60	60	60	60

F. Analysis of All Feasible Alternatives

Alternative 1: Approve 69.0 permanent positions, LT resources equivalent to 46.0 positions and expenditure authority of $23,860,000 ($11,041,000 GF; $12,819,000 FF) for FY 2021-22 (including funding for contract resources).

Pros:

- Allows DHCS the resources to improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform.
- Allows DHCS the resources to identify and manage member risk and need through Whole Person Care Approaches and addressing the Social Determinants of Health and disparities and inequities in the current system.
- Provides advanced and innovative solutions to support the stability of the Medi-Cal program.
- Expands the coordination and delivery of quality care to all Medi-Cal beneficiaries.
- Integrates multiple delivery system to meet the behavioral, developmental, physical, and oral health needs for Medi-Cal beneficiaries.
- Workload associated with implementing CalAIM will be completed in a timely manner.

Cons:

- Increases in state personnel costs.
- Expands state government.

Alternative 2: Approve LT resources equivalent to 115.0 positions and expenditure authority of $23,860,000 ($11,041,000 GF; $12,819,000 FF) for FY 2021-22 (including funding for contract resources).

Pros:

- Limited term impact to the GF if positions are not renewed/extended.
- Allows DHCS the resources to improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform.
- Allows DHCS the resources to identify and manage member risk and need through Whole Person Care Approaches and addressing the Social Determinants of Health and disparities and inequities in the current system.
- Would provide temporary support to the initiative's proposals.

Cons:

- This approach does not guarantee continuity of program operations and maintenance.
- DHCS may not be able to implement the initiatives in timely manner.
- Loss of knowledge from staff after limited-term resources expire.
- Difficulty in recruiting and maintain staff in LT positions.

Alternative 3: Redirect existing staff.

Pros:

- No impact in state personnel costs.

- No increase to the state's workforce.

Cons:

- Does not give DHCS the resources needed to implement the comprehensive set of proposals that encompass DHCS's CalAIM initiative.

DHCS may not be able to meet its single state agency responsibilities related to financial oversight, program integrity and quality of care.

G. Implementation Plan

Upon approval of this proposal, the impacted divisions will initiate the necessary steps to secure the positions with start dates of July 1, 2021. All positions will be recruited and filled according to DHCS' standard recruitment processes, which are outlined in both internal DHCS-produced and external CalHR-produced policies, procedures, and requirements for hiring qualified state staff.

H. Supplemental Information

The request includes one-time funding for office automation and cubicle buildouts, including cabling of $1,008,000 ($482,000 GF; $526,000 FF). The request also includes travel costs of $213,000 ($105,000 GF; $108,000 FF) for FY 2021-22.

Contractual Services Costs

Division	Contract Description	Effective Start Date	Term	FY 2021-22	FY 2022-23
EDIM	Reporting and Business Intelligence	7/1/21	3-year LT	$1,000,000	$1,000,000
MCBHD	DMC - Evaluation	1/1/22	5-year LT	$565,000	$1,131,000
MCBHD	DMC – External Quality Review Organization	1/1/22	5-year LT	$1,150,000	$2,300,000
MCBHD	DMC ODS – Technical Assistance to Counties	1/1/22	5-year LT	$250,000	$500,000
MCBHD	SMI/SED Waiver	7/1/21	2-year LT	$2,000,000	$2,000,000
OMD	Contract to maintain QIP data reporting portal	7/1/21	Ongoing	$250,000	$250,000
OMD	QIP Data integrity	7/1/21	Ongoing	$500,000	$500,000
OMD	QIP annual conference	7/1/21	Ongoing	$150,000	$150,000
Total				$5,865,000	$7,831,000

I. Recommendation

Analysis of Problem

Alternative 1: Approve 69.0 permanent positions, LT resources equivalent to 46.0 positions and expenditure authority of $23,860,000 ($11,041,000 GF; $12,819,000 FF) for FY 2021-22 (including funding for contract resources) to implement the comprehensive set of proposals that encompass DHCS's approach to the CalAIM initiative.

J. BCP Fiscal Detail Sheet

BCP Title: California Advancing and Innovating Medi-Cal (CalAIM) Initiative

BR Name: 4260-068-BCP-2021-GB

Budget Request Summary

Personal Services

Personal Services	FY21 Current Year	FY21 Budget Year	FY21 BY+1	FY21 BY+2	FY21 BY+3	FY21 BY+4
Positions - Permanent	0.0	69.0	84.0	84.0	84.0	84.0
Total Positions	**0.0**	**69.0**	**84.0**	**84.0**	**84.0**	**84.0**
Salaries and Wages Earnings - Permanent	0	5,700	6,921	6,921	6,921	6,921
Salaries and Wages Earnings - Temporary Help	0	3,706	4,302	3,796	3,649	1,612
Total Salaries and Wages	**$0**	**$9,406**	**$11,223**	**$10,717**	**$10,570**	**$8,533**
Total Staff Benefits	0	5,183	6,184	5,905	5,824	4,702
Total Personal Services	**$0**	**$14,589**	**$17,407**	**$16,622**	**$16,394**	**$13,235**

Operating Expenses and Equipment

Operating Expenses and Equipment	FY21 Current Year	FY21 Budget Year	FY21 BY+1	FY21 BY+2	FY21 BY+3	FY21 BY+4
5301 - General Expense	0	684	578	532	524	420
5302 - Printing	0	230	276	266	262	210
5304 - Communications	0	230	276	266	262	210
5320 - Travel: In-State	0	213	213	213	213	189
5322 - Training	0	115	138	133	131	105
5324 - Facilities Operation	0	1,035	1,242	1,197	1,179	945
5340 - Consulting and Professional Services - External	0	5,865	7,831	5,831	4,831	4,831
5344 - Consolidated Data Centers	0	115	138	133	131	105
539X - Other	0	784	91	0	0	0
Total Operating Expenses and Equipment	**$0**	**$9,271**	**$10,783**	**$8,571**	**$7,533**	**$7,015**

Total Budget Request

Total Budget Request	FY21 Current Year	FY21 Budget Year	FY21 BY+1	FY21 BY+2	FY21 BY+3	FY21 BY+4
Total Budget Request	**$0**	**$23,860**	**$28,190**	**$25,193**	**$23,927**	**$20,250**

Fund Summary

Fund Source

Fund Source	FY21 Current Year	FY21 Budget Year	FY21 BY+1	FY21 BY+2	FY21 BY+3	FY21 BY+4
State Operations - 0001 - General Fund	0	11,041	13,230	11,975	11,592	9,754
State Operations - 0890 - Federal Trust Fund	0	12,819	14,960	13,218	12,335	10,496
Total State Operations Expenditures	**$0**	**$23,860**	**$28,190**	**$25,193**	**$23,927**	**$20,250**
Total All Funds	**$0**	**$23,860**	**$28,190**	**$25,193**	**$23,927**	**$20,250**

Program Summary

Program Funding

Program Funding	FY21 Current Year	FY21 Budget Year	FY21 BY+1	FY21 BY+2	FY21 BY+3	FY21 BY+4
3960010 - Medical Care Services (Medi-Cal)	0	23,860	28,190	25,193	23,927	20,250
Total All Programs	**$0**	**$23,860**	**$28,190**	**$25,193**	**$23,927**	**$20,250**

Personal Services Details

Positions

Positions	FY21 Current Year	FY21 Budget Year	FY21 BY+1	FY21 BY+2	FY21 BY+3	FY21 BY+4
1139 - Office Techn (Typing) (Eff. 07-01-2021)	0.0	1.0	1.0	1.0	1.0	1.0
1405 - Info Tech Mgr I (Eff. 07-01-2021)	0.0	1.0	1.0	1.0	1.0	1.0
1414 - Info Tech Spec II (Eff. 07-01-2021)	0.0	2.0	2.0	2.0	2.0	2.0
4159 - Assoc Mgmt Auditor (Eff. 07-01-2022)	0.0	0.0	1.0	1.0	1.0	1.0
4720 - Bus Svc Officer I (Spec) (Eff. 07-01-2021)	0.0	1.0	1.0	1.0	1.0	1.0
4800 - Staff Svcs Mgr I (Eff. 07-01-2021)	0.0	7.0	7.0	7.0	7.0	7.0
4800 - Staff Svcs Mgr I (Eff. 07-01-2022)	0.0	0.0	1.0	1.0	1.0	1.0
4801 - Staff Svcs Mgr II (Supvry) (Eff. 07-01-2021)	0.0	2.0	2.0	2.0	2.0	2.0
4801 - Staff Svcs Mgr II (Supvry) (Eff. 07-01-2022)	0.0	0.0	1.0	1.0	1.0	1.0
5142 - Assoc Pers Analyst (Eff. 07-01-2021)	0.0	4.0	4.0	4.0	4.0	4.0
5333 - Sr Legal Analyst (Eff. 01-01-2022)	0.0	1.0	1.0	1.0	1.0	1.0
5393 - Assoc Govtl Program Analyst (Eff. 07-01-2021)	0.0	27.0	27.0	27.0	27.0	27.0
5393 - Assoc Govtl Program Analyst (Eff. 07-01-2022)	0.0	0.0	9.0	9.0	9.0	9.0
5605 - Research Scientist III (Eff. 07-01-2021)	0.0	1.0	1.0	1.0	1.0	1.0
5731 - Research Data Analyst II (Eff. 07-01-2021)	0.0	2.0	2.0	2.0	2.0	2.0

Positions	FY21 Current Year	FY21 Budget Year	FY21 BY+1	FY21 BY+2	FY21 BY+3	FY21 BY+4
5740 - Research Data Mgr (Eff. 07-01-2021)	0.0	1.0	1.0	1.0	1.0	1.0
5742 - Research Data Spec I (Eff. 07-01-2021)	0.0	2.0	2.0	2.0	2.0	2.0
5742 - Research Data Spec I (Eff. 07-01-2022)	0.0	0.0	1.0	1.0	1.0	1.0
5758 - Research Data Spec II (Eff. 07-01-2022)	0.0	0.0	1.0	1.0	1.0	1.0
5795 - Atty III (Eff. 01-01-2022)	0.0	1.0	1.0	1.0	1.0	1.0
5795 - Atty III (Eff. 07-01-2021)	0.0	3.0	3.0	3.0	3.0	3.0
6178 - Administrative Law Judge II (Spec) (Eff. 07-01-2021)	0.0	1.0	1.0	1.0	1.0	1.0
7705 - Public Hlth Med Officer III (Eff. 07-01-2021)	0.0	1.0	1.0	1.0	1.0	1.0
8181 - Nurse Consultant III (Spec) (Eff. 07-01-2021)	0.0	3.0	3.0	3.0	3.0	3.0
8336 - Hlth Program Spec II (Eff. 07-01-2021)	0.0	2.0	2.0	2.0	2.0	2.0
8338 - Hlth Program Spec I (Eff. 07-01-2021)	0.0	4.0	4.0	4.0	4.0	4.0
8387 - Dental Hygienist Consultant (Eff. 07-01-2022)	0.0	0.0	1.0	1.0	1.0	1.0
8428 - Hlth Program Mgr II (Eff. 07-01-2021)	0.0	2.0	2.0	2.0	2.0	2.0
TH00 - Temporary Help (Eff. 07-01-2021)(LT 06-30-2023)	0.0	0.0	0.0	0.0	0.0	0.0
TH00 - Temporary Help (Eff. 07-01-2021)(LT 06-30-2024)	0.0	0.0	0.0	0.0	0.0	0.0
TH00 - Temporary Help (Eff. 07-01-2021)(LT 06-30-2025)	0.0	0.0	0.0	0.0	0.0	0.0
TH00 - Temporary Help (Eff. 07-01-2021)(LT 12-30-2027)	0.0	0.0	0.0	0.0	0.0	0.0
TH00 - Temporary Help (Eff. 07-01-2022)(LT 06-30-2025)	0.0	0.0	0.0	0.0	0.0	0.0
Total Positions	**0.0**	**69.0**	**84.0**	**84.0**	**84.0**	**84.0**

Salaries and Wages

Salaries and Wages	FY21 Current Year	FY21 Budget Year	FY21 BY+1	FY21 BY+2	FY21 BY+3	FY21 BY+4
1139 - Office Techn (Typing) (Eff. 07-01-2021)	0	43	43	43	43	43
1405 - Info Tech Mgr I (Eff. 07-01-2021)	0	113	113	112	112	112
1414 - Info Tech Spec II (Eff. 07-01-2021)	0	210	210	210	210	210
4159 - Assoc Mgmt Auditor (Eff. 07-01-2022)	0	0	80	80	80	80
4720 - Bus Svc Officer I (Spec) (Eff. 07-01-2021)	0	59	59	59	59	59
4800 - Staff Svcs Mgr I (Eff. 07-01-2021)	0	577	577	577	577	577
4800 - Staff Svcs Mgr I (Eff. 07-01-2022)	0	0	82	82	82	82
4801 - Staff Svcs Mgr II (Supvry) (Eff. 07-01-2021)	0	181	181	181	181	181
4801 - Staff Svcs Mgr II (Supvry) (Eff. 07-01-2022)	0	0	90	90	90	90
5142 - Assoc Pers Analyst (Eff. 07-01-2021)	0	283	283	283	283	283
5333 - Sr Legal Analyst (Eff. 01-01-2022)	0	37	74	74	74	74
5393 - Assoc Govtl Program Analyst (Eff. 07-01-2021)	0	1,910	1,910	1,910	1,910	1,910

Salaries and Wages	FY21 Current Year	FY21 Budget Year	FY21 BY+1	FY21 BY+2	FY21 BY+3	FY21 BY+4
5393 - Assoc Govtl Program Analyst (Eff. 07-01-2022)	0	0	637	637	637	637
5605 - Research Scientist III (Eff. 07-01-2021)	0	98	98	98	98	98
5731 - Research Data Analyst II (Eff. 07-01-2021)	0	149	149	149	149	149
5740 - Research Data Mgr (Eff. 07-01-2021)	0	105	105	105	105	105
5742 - Research Data Spec I (Eff. 07-01-2021)	0	155	155	155	155	155
5742 - Research Data Spec I (Eff. 07-01-2022)	0	0	78	78	78	78
5758 - Research Data Spec II (Eff. 07-01-2022)	0	0	85	85	85	85
5795 - Atty III (Eff. 01-01-2022)	0	64	130	130	130	130
5795 - Atty III (Eff. 07-01-2021)	0	389	389	389	389	389
6178 - Administrative Law Judge II (Spec) (Eff. 07-01-2021)	0	131	131	131	131	131
7705 - Public Hlth Med Officer III (Eff. 07-01-2021)	0	164	164	164	164	164
8181 - Nurse Consultant III (Spec) (Eff. 07-01-2021)	0	377	377	377	377	377
8336 - Hlth Program Spec II (Eff. 07-01-2021)	0	168	168	168	168	168
8338 - Hlth Program Spec I (Eff. 07-01-2021)	0	306	306	306	306	306
8387 - Dental Hygienist Consultant (Eff. 07-01-2022)	0	0	67	67	67	67
8428 - Hlth Program Mgr II (Eff. 07-01-2021)	0	181	181	181	181	181
TH00 - Temporary Help (Eff. 07-01-2021)(LT 06-30-2023)	0	505	505	0	0	0
TH00 - Temporary Help (Eff. 07-01-2021)(LT 06-30-2024)	0	147	147	147	0	0
TH00 - Temporary Help (Eff. 07-01-2021)(LT 06-30-2025)	0	1,442	1,442	1,442	1,442	0
TH00 - Temporary Help (Eff. 07-01-2021)(LT 12-30-2027)	0	1,612	1,612	1,612	1,612	1,612
TH00 - Temporary Help (Eff. 07-01-2022)(LT 06-30-2025)	0	0	595	595	595	0
Total Salaries and Wages	**$0**	**$9,406**	**$11,223**	**$10,717**	**$10,570**	**$8,533**

Staff Benefits

Staff Benefits	FY21 Current Year	FY21 Budget Year	FY21 BY+1	FY21 BY+2	FY21 BY+3	FY21 BY+4
5150350 - Health Insurance	0	2,260	2,697	2,576	2,541	2,051
5150600 - Retirement - General	0	2,923	3,487	3,329	3,283	2,651
Total Staff Benefits	**$0**	**$5,183**	**$6,184**	**$5,905**	**$5,824**	**$4,702**

Total Personal Services

Total Personal Services	FY21 Current Year	FY21 Budget Year	FY21 BY+1	FY21 BY+2	FY21 BY+3	FY21 BY+4
Total Personal Services	**$0**	**$14,589**	**$17,407**	**$16,622**	**$16,394**	**$13,235**