STATE OF CALIFORNIA
Budget Change Proposal - Cover Sheet
DF-46 (REV 10/20)

Fiscal Year	Business Unit	Department	Priority No.
2022-23	4150	Department of Managed Health Care	2

Budget Request Name	Program	Subprogram
4150-013-BCP-2022-GB	3870-Health Plan Program	N/A

Budget Request Description
Office of Plan Monitoring Workload

Budget Request Summary

The Department of Managed Health Care (DMHC) requests 11.0 positions and $3,253,000 in 2022-23, $3,165,000 in 2023-24 and ongoing from the Managed Care Fund to address the additional routine and follow-up medical surveys resulting from the increased number of health plans licensed by the DMHC, the increased rates charged by clinical consultants to assist the DMHC with conducting medical surveys and the additional workload resulting from an increase in network review volume, complexity and technological expertise requirements.

Requires Legislation	Code Section(s) to be Added/Amended/Repealed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 Ralph Cesena	Date 1/10/2022

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. TBD **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
Rita Pearson	1/10/2022	Gita Mehirdel	1/10/2022
Department Director	**Date**	**Agency Secretary**	**Date**
Mary Watanabe	1/10/2022	Brendan McCarthy for Mark Ghaly	1/10/2022

Department of Finance Use Only

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

PPBA	Date submitted to the Legislature
Steven Pavlov	1/10/2022

A. Budget Request Summary

The Department of Managed Health Care (DMHC) requests 11.0 positions and $3,253,000 in 2022-23, $3,165,000 in 2023-24 and ongoing from the Managed Care Fund to address the additional routine and follow-up medical surveys resulting from the increased number of health plans licensed by the DMHC, the increased rates charged by clinical consultants to assist the DMHC with conducting medical surveys, and the additional workload resulting from an increase in network review volume, complexity and technological expertise requirements.

This request includes $858,000 in clinical consultant funding for 2022-23 and ongoing to assist with the completion of health plan medical surveys.

The following table notes the requested positions by division and classification:

Table 1 – Positions Request

Division/ Classification	Positions
DIVISION OF PLAN SURVEYS	
Assistant Chief Counsel	1.0
Associate Governmental Program Analyst	1.0
Attorney IV	1.0
Health Program Specialist II	1.0
Staff Services Manager III	1.0
DIVISION OF PROVIDER NETWORKS	
Assistant Chief Counsel	1.0
Attorney III	1.0
Attorney IV	1.0
Health Program Specialist I	1.0
Health Program Specialist II	1.0
Research Data Specialist II	1.0
Total Positions Requested	**11.0**

B. Background/History

The DMHC's mission is to protect consumers' health care rights and ensure a stable health care delivery system. Embedded in the mission is the task of evaluating and promoting health plan regulatory compliance, quality improvement as related to health care delivery systems, and verifying enrollees have consistent access to timely and medically necessary health care services. To effectuate this task and in accordance with the Knox-Keene Health Care Service Plan Act of 1975(Act), the Division of Plan Surveys (DPS) and Division of Provider Networks (DPN), housed within the DMHC's Office of Plan Monitoring (OPM), perform medical surveys of licensed health plans and review health plan provider networks, respectively.

The number of the DMHC licensed health plans and covered lives under the DMHC's jurisdiction has steadily increased from 121 licensed health plans and 25 million covered lives in 2015 to 132 licensed health plans and 27.7 million covered lives in 2020. This reflects a 9% increase in licensed

health plans and an 11% increase in covered lives between 2015 and 2020. As a result of these increases, the workload for the DMHC has also grown.

The following DMHC OPM program areas have seen growth and experienced an increase in workload.

DIVISION OF PLAN SURVEYS (DPS)

The DPS is required to perform routine medical surveys no less than once every three years, conduct follow-up surveys, and review applications for licensure, material modifications and amendments of the licensed health plans in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Act). The DPS has experienced an increase in workload due to licensing more health plans and the complexity of filings submitted by currently licensed health plans. Health plan operations and processes have increasingly become more complex due to health plans delegating more core functions to various outside entities or delegates (e.g., medical groups, restricted or specialized health plans, administrative services, and management services organizations). This requires health plan filings to include operational documents pertaining to not only the health plan's operations and processes, but also related to their relationships with their delegated entities. At the same time, the DPS has improved its survey review processes and now conducts a more thorough review of the health plans' operations and oversight of their delegated entities.

The routine surveys are on-site evaluations that must be conducted at least once every three years. In this type of survey, DPS staff review procedures for obtaining health services, reviews utilization and peer review mechanisms, and reviews internal procedures for assuring quality of care and the overall performance of the plan in providing health care benefits and meeting the health needs of enrollees.

In addition to routine surveys, the DPS is required to conduct follow-up and non-routine surveys when necessary. The follow-up surveys are performed when deficiencies are identified in a routine survey and remain uncorrected at the time of the final report. The purpose of a follow-up survey is to determine and report on the status of the health plan's efforts to correct uncorrected deficiencies within 18 months of issuance of the routine survey's final report. The non-routine surveys may be performed when deficiencies remain uncorrected at the issuance of the follow-up report, or when the DMHC discovers, or is alerted to, potential flaws in health plan business processes. The findings from the non-routine surveys may result in a referral to the DMHC's Office of Enforcement (OE) and may be subject to enforcement action.

The DPS prepares final survey reports after evaluating corrective action plans (CAPs) submitted by health plans in response to the deficiencies identified in the preliminary survey report. As part of the CAP evaluation, DPS reviews revised policies and procedures for compliance. The DPS performs an assessment of any uncorrected deficiencies identified in the final report during the follow-up survey process. The DPS has experienced an increase in the number of deficiencies to review during follow-up surveys. As more health plans become licensed, the DMHC has seen operations, processes and delegation arrangements of new and existing licensees become increasingly more complex. To address these issues, the DPS has been conducting a more thorough review during the medical surveys process, which has resulted in an increased number of deficiencies that may remain uncorrected at the issuance of the follow-up survey report, thereby necessitating additional referrals and coordination with the DMHC's Office of Enforcement.

The DPS also performs review of health plan filings related to a health plan's quality assurance, utilization management, and language assistance (LAP) policies and procedures. The DPS has experienced an increase in workload related to filing reviews due to the increased number of licensed health plans, changes to health plan operations and processes, and more frequent revisions to health plan documents in response to the increased number of deficiencies in survey reports. Since health plans are increasingly delegating plan functions to other entities, the filings are

more extensive and require additional time to review to ensure compliance with legal requirements.

The following bullets identify staffing and/or consultant funding received by the DMHC to conduct medical surveys:

- 2009-10 Division of Plan Surveys Workload Budget Change Proposal (BCP): 4.0 positions and $934,000 in consultant funding
- 2014-15 Senator Beall Federal Mental Health Parity (May Revise): 3.0 positions and $1,325,000 in consultant funding
- 2015-16 Federal Mental Health Parity BCP: 5.5 positions and net reduction of $50,000 in ongoing consultant funding
- 2016-17 Provider Directories, Sente Bill (SB)137: 2.0 positions
- 2017-18 Prohibition of Surprise Balance Billing, Assembly Bill (AB) 72: 2.0 positions
- 2019-20 Division of Plan Surveys Workload BCP: 4.0 positions and $1,447,000 in consultant funding
- 2020-21 Behavioral Health Focused Investigations: 2.0 positions and $1,248,000 in consultant funding
- 2021-22 Mental Health or Substance Use Disorders SB 855: 0.5 positions and $284,000 in consultant funding

All other resources received were either limited term in nature or removed through DMHC's 2017-18 Interagency (IA) Reduction BCP and therefore are not listed as they do not permanently augment the DMHC's budget. Apart from the 2009-10 and 2019-20 proposals identified above, all proposals were submitted to address specific legislative changes impacting the scope of medical surveys or compliance with the federal Mental Health Parity and Addiction Equity Act of 2008.

DIVISION OF PROVIDER NETWORKS (DPN)

The DPN is responsible for reviewing health plan provider networks to ensure they meet the network adequacy standards established in the Knox-Keene Act, including standards related to the overall availability of providers, the geographic accessibility of providers and the capacity of the providers to deliver timely care. This includes ensuring networks have the right types of providers necessary to deliver services promised under enrollees' contracts, meet geographic access requirements, meet provider to enrollee ratio requirements, and have a sufficient number of providers to offer appointments within timely access standards.

In 2019, the DMHC promulgated Title 28, California Code of Regulations section 1300.49 (28 CCR § 1300.49), establishing a separate license for health plans that take on global risk but do not contract directly with enrollees ("restricted health plans"). Restricted health plans can only operate in a plan-to-plan context and must be licensed for the same product and within the same service area as the primary plan's service area in which the restricted health plan will be delivering care to the primary plan's enrollees. These plans must establish complete network adequacy for all services for which they have been delegated responsibility before receiving licensure or entering into a plan-to-plan arrangement. Due to the increasing layers of plan-to-plan delegations and other network contractual arrangements, the DPN needed to conduct a preliminary assessment prior to engaging in network reviews to understand and validate the accuracy of the network arrangements. These new tasks include:

- Confirming service area agreed to between the primary and subcontracting plan

- Establishing all subcontracting plans are approved for the products being sold by the primary plan
- Identifying the services for which the subcontracting plan is responsible
- Evaluating the adequacy of the subcontracting plan's network to deliver all delegated services and
- Analyzing the availability of providers delivered through multiple plan-to-plan contracts for one complete full-service health plan network (e.g., specialized behavioral health plan, restricted heath plan, and full-service health plan network components)

The additional level of review accounts for an average of two additional hours for each amendment to the network filing. Additionally, the DPN must analyze these plan-to-plan relationships and obligations through the course of its annual network review data collection. This occurs separate and apart from the individual network analyses conducted through the DMHC's electronic filing (eFiling) submission process.

Other innovations in health care delivery models have led to a more comprehensive review of health plan networks, including the advent of tiered networks (in which health plans offer different groups of providers in a network at different cost-share levels), and increased efforts to advance telehealth as a method for establishing compliance with network adequacy standards.

The DPN is experiencing challenges in the following areas:

- Network Reviews - The DPN has seen an increase in the number of network filings, annual network review and the filings of material modifications. The DPN has experienced a 92 percent increase in network filings (from 137 in 2015 to 263 in 2020), an increase of 48 percent in material modification filings (from 52 in 2015 to 77 in 2020) and an increase of 20 percent in annual network review and timely access reporting (from 108 in 2015 to 130 in 2020). In addition, the DPN has also seen an increase in the number of plan-to-plan delegations reported by health plans (from 22 in 2015 to 66 in 2020), further adding to the resources required for network reviews. The DPN has also taken on additional responsibility regarding communicating findings to health plans and pursuing corrective action with health plans as a result of the findings made through annual network review and timely access reviews.

  The DMHC has also seen an increase in the volume of Annual Network Review and Timely Access Reporting data submitted to the DMHC. Over the past five years, there has been a 20 percent increase in the number of networks reported through Annual Network Review and Timely Access Report submissions, resulting in a direct and significant impact to the DMHC's network review workload.

  In 2020, the DPN reviewed 130 health plan networks during its Annual Network Review, compared to 108 health plan networks reviewed in 2015. These networks require additional time and resources spent identifying errors, outreaching to health plans to validate and correct errors (therein preserving the integrity of DPN's network database and the DPN's ability to objectively compare networks and evaluate the adequacy of each network), determining the network's adequacy, reporting deficiencies to the associated health plans and making plan referrals to DMHC's OE. Similarly, the DPN has seen a 300 percent increase in the number of plan-to-plan delegations reported by plans (from 22 delegations in 2015 up to 66 delegations reported in 2020), further adding to the resources required for network reviews.

- Technological Expertise - The DPN also handles vast amounts of network provider and network accessibility data. The network adequacy review process requires staff to manually import, process and export data through several different Access databases, a dated and limited

geographic analysis system and separate visualization and mapping systems. To reduce the time spent manually entering and processing data through multiple tools, the DMHC has begun working with a vendor to develop an efficient consolidated network adequacy solution. This solution uses modern SQL database technology and the industry-standard ArcGIS geographic information system to reach faster, more accurate and more consistent network adequacy decisions.

- Managerial Support - As the DMHC addresses the workload needs described above, the DMHC's DPN will also require an additional Assistant Chief Counsel (ACC) position to provide high-level legal and managerial support. Currently, the DPN has one dedicated ACC to manage 10 attorneys. These 10 attorneys account for four distinct project areas which each require ACC time to brainstorm, coordinate, evaluate the legal merits of the project, write legal analyses and convey project goals to other units and stakeholders.

  Currently, the ACC spends an average of 25 hours per week in scheduled meetings with the legal staff and other members of the DMHC. In addition, the ACC spends 5-10 hours per week in unscheduled phone calls and meetings, providing guidance on specific issues or answering questions. This leaves approximately 5-10 hours per week for the ACC to review written material, draft legal documents, evaluate new legislation and policy, respond to emails and phone calls and complete administrative duties. With the addition of the tasks described herein and the potential increase in legal staff, an additional ACC position will be necessary to manage the ongoing legal obligations of DPN.

The following bullets identify staffing and/or consultant funding received by the DMHC, to conduct provider network reviews:

- 2017-18 Prohibition of Surprise Balance Billing AB 72: 3.0 positions
- 2021-22 Mental Health or Substance Use Disorders SB 855: 0.5 positions

The table below notes the workload history for the OPM.

Table 2 - Workload History

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
DIVISION OF PLAN SURVEYS							
Routine Surveys		24	24	40	23	47	40
Follow Up Surveys		16	41	21	14	47	36
Deficiencies (citations of noncompliance)		287	108	190	218	300	300
Supplemental Responses		110	34	39	46	28	68
Enforcement Referrals		7	17	16	14	20	20
Amendments, material modifications, new license applications and other health plan filings.		388	295	341	231	258	394
DIVISION OF PROVIDER NETWORKS							
Network Filings	137	206	271	223	226	263	263
PRA and Media Information Requests	No Data	No Data	No Data	92	82	78	84
Annual Provider Network Reviews	108	115	116	117	121	130	131
Review of Health Plan responses and corrective action plans to the Network Findings Reports, including enforcement referrals	45	45	45	45	45	45	45

C. State Level Consideration

The continued delays in the completion of medical surveys and potential non-compliant health plans with the Knox-Keene Act may lead to enrollee harm, both physically and financially. Additionally, not meeting statutorily mandated timeframes for completing the medical surveys may subject the DMHC to audit or investigation by control agencies or other governmental entities.

This proposal supports the California Health and Human Services (CHHS) Agency's strategic priority to Build a Healthy California for All by monitoring for and addressing barriers to care in health plans' delivery systems that may lead to an enrollee's harm.

This proposal also supports the DMHC's commitment to ensuring all Californians have timely access to health care services and that health plans maintain adequate networks compliant with the standards established in the Knox-Keene Act.

D. Justification

The growth in the healthcare marketplace and the competitive nature of the highly specialized services, such as clinical consultants, both have direct impacts on DMHC's workload and resource needs. The current staffing and consultant funding levels are not sufficient to provide adequate contract management, the timely writing of reports to meet stringent legal requirements or conduct all required medical surveys and network reviews in a manner consistent with the legislature's intent or the mandated timeframes set forth in HSC Section 1380.

The number of the DMHC licensed health plans and covered lives under the DMHC's jurisdiction has steadily increased over the past five years. By providing the DMHC with the additional resources needed to address the increased number of surveys conducted, this proposal bridges the gap that has resulted from the increase of plans regulated by the DMHC.

The DMHC has identified the following resources and consultant funding needs to address the increased workload.

DIVISION OF PLAN SURVEYS (DPS)

Historically, funding for medical surveys was based on 35 routine surveys, 25 follow-up surveys and 5 non-routine surveys per year. Based on the number of medical surveys conducted the last two fiscal years and the survey calendar for 2022-23, the DMHC anticipates conducting an average of 40 routine surveys (an increase of 5), 36 follow-up (an increase of 11) and 5 non-routine surveys per year on an ongoing basis.

The DMHC has been unable to meet the HSC section 1380 timeframes for report production for preliminary, final and follow-up reports. For example, in 2018 and 2019, 43 percent and 40 percent, respectively, of preliminary reports were issued outside of 90 calendar days from the survey completion, 45 percent and 36 percent of final reports were issued outside of the mandated 180 days from survey completion and 55 percent and 48 percent of follow-up reports were issued beyond the mandated 18 months. There are also several key and high-profile initiatives in which the DPS plays a significant role (implementation of SB 855 and the Mental Health Investigations) and the increased workload on DMHC to implement those initiatives has turned out to be greater than expected.

Additionally, the number of health plans requiring a follow-up survey has increased by 20 percent. Although DPS received additional resources related to medical surveys in 2019-20, these resources were insufficient to address the continued increase of plans regulated by the DMHC and the

increase in deficiencies cited in survey reports. The costs associated with clinical consulting contracts has also increased steadily since 2019-20.

Additional resources are necessary to enable the DMHC to conduct medical surveys and issue the associated reports within the mandated timeframes. The DPS is requesting the following resources to address the additional workload:

1.0 Assistant Chief Counsel
This position will manage one of two attorney units in DPS. This involves overseeing the development of legal memoranda to executive management, overseeing the development of implementation tools and overseeing the provision of legal guidance to DPS staff. The special projects and initiatives for the position include identifying new initiatives, establishing and participating in workgroups to strategize and implement these initiatives.

1.0 Attorney IV

This position will coordinate with the ACC and other attorneys to complete routine surveys and enforcement referrals. This position will also provide legal guidance and consultation to legal and analytical staff in the review of amendments, material modifications, new license applications and other health plan filings such as undertaking reports

1.0 Health Program Specialist II
This position will manage and oversee routine survey activity and follow operational processes and timely execution of follow-up survey activity. This includes providing analytical and project management support functions for referrals to the Office of Enforcement. This position will also review amendments resulting from survey findings and implementation of new legislation.

1.0 Staff Services Manager III
This position will provide senior management to one of two analyst units in DPS. This involves providing oversight of analytical operational functions in support of routine survey activity, including oversight to statutory timelines, deliverables and review and guidance on deficiencies. This position will oversee and ensure consistent operational process and timely execution of follow-up survey activity. This position will also oversee the operational process, analytical support functions for referrals to the Office of Enforcement and manage the analytical and contracted clinical staff.

1.0 Associate Governmental Program Analyst
This position will manage and oversee activities for routine and follow-up surveys and provide technical assistance and guidance to associate analysts with the planning, coordination, and evaluation of medical surveys. This position will also ensure proper organization and documentation of survey working papers and supporting documents supporting deficiencies.

Consultant Funding
The DMHC contracts with clinical consultants to perform clinical and or medical compliance reviews of health plan programs, policies, procedures, reports and other documents to evaluate the delivery of health care. The work performed by these consultants requires the use of highly specialized medical, dental and other clinical expertise that is not available through the civil service system. The increased number of surveys has resulted in an anticipated shortfall in consultant funding. The tables below display the current level of funding for clinical consultants compared to the anticipated ongoing costs.

Table 3 - Current Ongoing Consultant Funding Level

Fiscal Year	Source	Amount
2000-01	Transfer from Department of Corporations	$725,000
2009-10	Division of Plan Surveys Workload BCP	$934,000
2014-15	Senator Beale Federal Mental Health Parity Implementation (May Revise)	$1,325,000
2015-16	Federal Mental Health Parity BCP *(Net Reduction)*	-$50,000
2019-20	Division of Plan Surveys Workload BCP	$1,447,000
	Total	**$4,381,000**

Table 4 - Projected 2022-23 Consultant Annual Costs

Survey Type	Number Of Surveys	Current Average Cost per Survey	Annual Cost
Routine	40	$88,200	$3,528,000
Follow-up	36	$34,100	$1,227,600
Non-routine	5	$88,200	$441,000
		Total	**$5,196,600** (Rounded to $5,197,000)

Based on these projections (table 3), the existing consultant funding is not sufficient to support the projected costs. The DMHC requests approval for $816,000 ($5,197,000 - $4,381,000)) for consultant funding in 2022-23 and ongoing to fund clinical consultant contracts to assist the DPS with conducting the routine and follow-up surveys.

The DMHC estimates the DPS costs to be 5.0 positions and $1,964,000 in 2022-23, $1,924,000 in 2023-24 and the same amount annually thereafter. These amounts include $816,000 annual consultant funding to assist the DPS with conducting the routine and follow-up surveys and $42,000 annual consultant funding for the clinical review of amendments, new license applications and citations of noncompliance.

DIVISION OF PROVIDER NETWORKS (DPN)

The DPN has seen a significant increase in the number of network filings, annual network review and the filings of material modifications. The DPN has experienced a 92 percent increase in network filings (from 137 in 2015 to 263 in 2020), an increase of 48 percent in material modification filings (from 52 in 2015 to 77 in 2020) and an increase of 20 percent in annual network review and timely access reporting (from 108 in 2015 to 130 in 2020). In addition, the DPN has also seen an increase in the number of plan-to-plan delegations reported by health plans (from 22 in 2015 to 66 in 2020), further adding to the resources required for network reviews. The DPN has also taken on additional responsibility regarding communicating findings to health plans and pursuing corrective action with health plans as a result of the findings made through annual network and timely access reviews.

The DMHC has also seen an increase in the volume of Annual Network Review and Timely Access Reporting data submitted to the DMHC. Over the past five years, there has been a 20 percent increase in the number of networks reported through Annual Network Review and Timely Access Report submissions, resulting in a direct and significant impact to the DMHC's network review workload.

In 2020, the DPN reviewed 130 health plan networks during its Annual Network Review, compared to 108 health plan networks reviewed in 2015. These networks require additional time and resources spent identifying errors, outreaching to health plans to validate and correct errors (therein preserving the integrity of DPN's network database and the DPN's ability to objectively compare networks and evaluate the adequacy of each network), determining the network's adequacy, reporting deficiencies to the associated health plans and making plan referrals to DMHC's OE. Similarly, the DPN has seen a 300 percent increase in the number of plan-to-plan delegations reported by plans (from 22 delegations in 2015 up to 66 delegations reported in 2020), further adding to the complexity and resources required for network reviews.

Due to legal challenges in the lack of clarity in the law that inhibits the DMHC's ability to pursue enforcement action as described in HSC Section 1367.035 (d), the DPN has taken on more responsibility each year to communicate findings to health plans and motivate plans to engage in corrective action. In Measurement Year 2018, the DPN issued Network Findings Reports to 45 plans and received 41 health plan responses and corrective action plans. In Measurement Year 2019, the DPN issued Network Findings Reports to 44 plans and will receive plan responses later in 2021. The DPN is now responsible for reviewing all health plan responses and evaluating the sufficiency of proposed corrective action plans, as this process is largely occurring outside of the enforcement process.

The DMHC has begun working with a vendor to develop an efficient consolidated network adequacy solution to reduce the time spent entering and processing data manually. The DMHC is also working closely with the Department of Health Care Services (DHCS) in developing an automated solution to allow consistency between these two sister agencies in their overlapping network adequacy roles.

Additionally, because health plan network reporting requirements have become more stringent due to the technical methods employed by the DMHC, significant time and resources are dedicated to each filing to ensure accurate data is being received and analyzed. Without sufficient staff resources to address the increased filing workload and technology needs, health plans with inadequate provider networks will not be identified in a timely manner. To address the increased number of network filings, annual network review and the filings of material modifications, the DPN is requesting the following resources:

1.0 Assistant Chief Counsel

This position will oversee annual network review and timely access reports. This position will also process changes, including implementation of new laws and regulations and handle inter-office coordination.

1.0 Attorney III

This position will evaluate each plan network report for legal compliance with network and data submission requirements. This includes developing Network Findings Report to inform plan of the DMHC's determination regarding plan's legal compliance with network and data submission requirements. This position will also oversee the data collection process, including data integrity review, outreach to clarify and or validate data errors and network database collapse, to ensure

processes are consistent with applicable law and do not run afoul of the DMHC's rulemaking authority.

1.0 Attorney IV
This position will conduct legal review of the most complex health network-related plan filings, including review of all submitted health plan documents and reports generated by the geographic access software. This includes identifying applicable law and identifying areas of potential variations in interpretation, as well as assisting with briefing memos.

1.0 Health Program Specialist I
This position will perform data integrity review, perform outreach to clarify and/or validate data errors, and collapse network database during network reviews and timely access reports.

1.0 Health Program Specialist II
This position will review health plan filings and reports generated by the geographic access software and prepare comment letters to health plans and review health plan responses to comment letters. This includes completing the network filing checklist and assisting with briefing memos.

1.0 Research Data Specialist II
This position will serve as the subject matter expert for Tableau data analytics and GIS system. The position will assist in the development, maintenance, testing and documenting of stored procedures (coding).

The modernization of the DMHC network adequacy system brings a myriad of benefits to licensed health plans, related state departments and the public, but it also requires more sophisticated technical handling. This position will serve as a subject matter expert, implementing and updating the required network adequacy processes and serve as a trainer for other staff and allow DMHC to respond to standard network data requests from the public, stakeholders, the media, Agency and the Legislature.

The DMHC estimates the DPN costs to be 6.0 positions and $1,289,000 in 2022-23, $1,241,000 in 2023-24 and the same amount annually thereafter.

E. Outcomes and Accountability

Approval of this proposal will provide the DMHC with the necessary resources to meet the statutorily mandated timeframes for the completion of surveys and issuance of corresponding reports, evaluate health plan provider networks, ensure health plan compliance with federal and California law, provide effective health delivery systems and ensure consumer have access to quality and timely health care services. The non-compliant plans will be asked to develop and implement a corrective action plan and may be referred to the DMHC's Office of Enforcement for further investigation, prosecution and potential penalties.

This proposal requests the necessary resources based on the DMHC's experience reviewing procedures and conducting medical surveys in a timely manner and network reviews.

The table below notes the projected workload measures for the OPM.

Table 5 - Projected Outcomes

Workload Measure	2022-23	2023-24	2024-25	2025-26	2026-27	2027-28 and Ongoing
DIVISION OF PLAN SURVEYS						
Routine Surveys)	40	40	40	41	41	41
Follow-up Surveys	36	36	36	37	37	37
Deficiencies (Citations of noncompliance)	300	300	300	300	300	300
Supplemental Responses	68	68	68	68	68	68
Enforcement Referrals	20	20	20	20	20	20
Amendments, material modifications, new license applications and other health plan filings such as undertaking reports. (Data presented for calendar year)	394	394	394	394	394	394
DIVISION OF PROVIDER NETWORKS						
Network Filings	292	306	320	334	349	363
PRA and Media Information	84	84	84	84	84	84
Annual Provider Network Reviews	135	138	142	146	150	154
Review of health plan responses and corrective action plans to the Network Findings Reports, including referrals to the Office of Enforcement	45	45	46	46	46	47

F. Analysis of All Feasible Alternatives

Alternative 1

Approve the DMHC's requests 11.0 positions and $3,253,000 in 2022-23, $3,165,000 in 2023-24 and ongoing from the Managed Care Fund to address the additional routine and follow-up medical surveys resulting from the increased number of health plans licensed by the DMHC, the increased rates charged by clinical consultants to assist the DMHC with conducting medical surveys, and the

additional workload resulting from an increase in network review volume, complexity and technological expertise requirements.

Pros:

- The DMHC will have the resources necessary to address the increased workload and its medical survey responsibilities, as mandated by HSC Section 1380.
- The DMHC will have necessary resources to address the additional workload resulting from an increase in network review volume, complexity and technological expertise needed to support network adequacy review processes.
- Timely identification and reporting of health plans deficiencies will protect California's health care consumers and fulfill the DMHC's mission to protect consumer' health care rights and ensure a stable health care delivery system.

Cons:

- Increases the size of State government and expenditures.
- Increases health care plan assessments.

Alternative 2

Approve a similar request with limited-term funding for two-years.

Pros: Temporarily provides the DMHC with the necessary resources to address the ongoing workload.

Cons:

- Limits the State's ability to provide timely health plan surveys and meet mandated timeframes for survey completion on an ongoing basis.
- Temporary positions are historically difficult to fill and do not address the ongoing/long-term workload.
- Failure to obtain staffing will result in a continued lack of compliance with State and federal requirements.

Alternative 3

Deny Request

Pros: Does not increase the size of State government and expenditures.

Cons:

- The DMHC would not have the necessary resources to address increased workload.
- Inadequate provider networks will not be identified in a timely manner.
- Failure to comply with State and federal requirements may result in lawsuits and the potential for significant attorney fees and settlements payments.

G. Implementation Plan

The hiring process will begin in late 2021-22 to fill the 11.0 permanent positions once authorized. In addition, the DMHC will start the contract process in late 2021-22 to execute the consultant contract upon enactment of the budget.

H. Supplemental Information

This request will be funded through annual assessments of the health plans that are regulated by the DMHC. The fiscal impact of this request to full service health plans is approximately $0.07 per enrollee.

Attachment A: BCP Fiscal Detail Sheet

Attachment B: Workload Standards

Attachment C: Current Organizational Chart

Attachment D: Proposed Organization Chart

I. Recommendation

Approve the DMHC's requests 11.0 positions and $3,253,000 in 2022-23, $3,165,000 in 2023-24 and ongoing from the Managed Care Fund to address the additional routine and follow-up medical surveys resulting from the increased number of health plans licensed by the DMHC, the increased rates charged by clinical consultants to assist the DMHC with conducting medical surveys and the additional workload resulting from an increase in network review volume, complexity and technological expertise requirements.

Attachment A

BCP Fiscal Detail Sheet

BCP Title: Office of Plan Monitoring Workload

BR Name: 4150-013-BCP-2022-GB

Budget Request Summary

Personal Services

	CY	BY	BY+1	BY+2	BY+3	BY+4
Personal Services						
Positions - Permanent	0.0	11.0	11.0	11.0	11.0	11.0
Total Positions	**0.0**	**11.0**	**11.0**	**11.0**	**11.0**	**11.0**
Salaries and Wages						
Earnings - Permanent	0	1,313	1,313	1,313	1,313	1,313
Total Salaries and Wages	**$0**	**$1,313**	**$1,313**	**$1,313**	**$1,313**	**$1,313**
Total Staff Benefits	0	764	764	764	764	764
Total Personal Services	**$0**	**$2,077**	**$2,077**	**$2,077**	**$2,077**	**$2,077**
Operating Expenses and Equipment						
5301 - General Expense	0	110	22	22	22	22
5302 - Printing	0	11	11	11	11	11
5304 - Communications	0	11	11	11	11	11
5320 - Travel: In-State	0	68	68	68	68	68
5322 - Training	0	11	11	11	11	11
5324 - Facilities Operation	0	99	99	99	99	99
5340 - Consulting and Professional Services -External	0	858	858	858	858	858
5368 - Non-Capital Asset Purchases -Equipment	0	8	8	8	8	8
Total Operating Expenses and Equipment	**$0**	**$1,176**	**$1,088**	**$1,088**	**$1,088**	**$1,088**
Total Budget Request	**$0**	**$3,253**	**$3,165**	**$3,165**	**$3,165**	**$3,165**

Fund Summary

Fund Source - State Operations						
0933 - Managed Care Fund	0	3,253	3,165	3,165	3,165	3,165
Total State Operations Expenditures	**$0**	**$3,253**	**$3,165**	**$3,165**	**$3,165**	**$3,165**
Total All Funds	**$0**	**$3,253**	**$3,165**	**$3,165**	**$3,165**	**$3,165**

Program Summary

Program Funding						
3870 - Health Plan Program	0	3,253	3,165	3,165	3,165	3,165
Total All Programs	**$0**	**$3,253**	**$3,165**	**$3,165**	**$3,165**	**$3,165**

Personal Services Details

	Salary Information								
Positions	Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
4802 - Staff Svcs Mgr III				0.0	1.0	1.0	1.0	1.0	1.0
5393 - Assoc Govtl Program Analyst				0.0	1.0	1.0	1.0	1.0	1.0
5758 - Research Data Spec II				0.0	1.0	1.0	1.0	1.0	1.0
5780 - Atty IV				0.0	2.0	2.0	2.0	2.0	2.0
5795 - Atty III				0.0	1.0	1.0	1.0	1.0	1.0
5871 - Assistant Chief Counsel				0.0	2.0	2.0	2.0	2.0	2.0
8336 - Hlth Program Spec II				0.0	2.0	2.0	2.0	2.0	2.0
8338 - Hlth Program Spec I				0.0	1.0	1.0	1.0	1.0	1.0
Total Positions				**0.0**	**11.0**	**11.0**	**11.0**	**11.0**	**11.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
4802 - Staff Svcs Mgr III	0	109	109	109	109	109
5393 - Assoc Govtl Program Analyst	0	73	73	73	73	73
5758 - Research Data Spec II	0	88	88	88	88	88
5780 - Atty IV	0	302	302	302	302	302
5795 - Atty III	0	137	137	137	137	137
5871 - Assistant Chief Counsel	0	348	348	348	348	348
8336 - Hlth Program Spec II	0	176	176	176	176	176
8338 - Hlth Program Spec I	0	80	80	80	80	80
Total Salaries and Wages	**$0**	**$1,313**	**$1,313**	**$1,313**	**$1,313**	**$1,313**

Staff Benefits							
5150450	-	Medicare Taxation	0	19	19	19	19	19
5150500	-	OASDI	0	81	81	81	81	81
5150630	-	Retirement - Public Employees -Miscellaneous	0	414	414	414	414	414
5150820	-	Other Post-Employment Benefits(OPEB) Employer Contributions	0	36	36	36	36	36
5150900	-	Staff Benefits - Other	0	214	214	214	214	214
Total Staff Benefits			**$0**	**$764**	**$764**	**$764**	**$764**	**$764**
Total Personal Services			**$0**	**$2,077**	**$2,077**	**$2,077**	**$2,077**	**$2,077**

WORKLOAD STANDARDS
Office of Plan Monitoring – Division of Plan Surveys
1.0 Associate Governmental Program Analyst in 2022-23/Ongoing

Activities	Number of Items	Hours Per Item	Total Hours Per Year
Routine Surveys - Lead and coordinate routine survey activity directing assigned analysts and clinical consultants in performing assessment of health plan operations and systems	40	16.8	672
Follow-Up Surveys - Operational processes and timely execution of follow-up survey activity, including administrative support and initial validation of supplemental responses	36	12	432
Enforcement Referrals - Provide analytical and project management support functions for referrals to the Office of Enforcement, including preparation of supporting documents and health plan case flies	20	10	200
Review amendments resulting from survey findings and implementation of new legislation, assume 60% of 362 filings (217) require specialist review	217	1.28	278
Provide analytical, coordination, and administrative support to attorneys and management in identified new initiatives, participating in workgroups, assist in the final preparation and submission of memoranda and reports to executive management, and coordinate with and provide administrative support to DPS attorneys and consultants	26	8.40	218
Total Hours Worked			**1,800**
Number of Positions			**1.0**

Attachment B

WORKLOAD STANDARDS
Office of Plan Monitoring – Division of Plan Surveys
1.0 Staff Services Manager III in 2022-23/Ongoing

Activities	Number of Items	Hours Per Item	Total Hours Per Year
Routine Surveys - Provide senior management to one of two analyst units in DPS, provide oversight of analytical operational functions in support of routine survey activity, including oversight to statutory timelines, deliverables and review and guidance on deficiencies	40	16.8	672
Follow-Up Surveys- Oversee and ensure consistent operational processes and timely execution of follow-up survey activity, including administrative support and initial validation of supplemental responses	36	12	432
Enforcement Referrals- Oversee operational process and analytical support functions for referrals to the Office of Enforcement, including preparation of supporting documents and health plan case files	20	10	200
Provide oversight, guidance, and consultation to analytical and contracted clinical staff in review of amendments. Assume 60% of 394 filings (236) require analyst review	236	1	236
Work with ACC to Identify new initiatives, establish and participate in workgroups to strategize and implement initiatives, oversee development of memos and reports to executive management, guidance and consultation to analytical and contracted clinical staff in the development of implementation tools and oversee consultant contract development as applicable	26	10	260
Total Hours Worked			**1,800**
Number of Positions			**1.0**

Attachment B

WORKLOAD STANDARDS
Office of Plan Monitoring – Division of Plan Surveys
1.0 Health Program Specialist II in 2022-23/Ongoing

Activities	Number of Items	Hours Per Item	Total Hours Per Year
Routine Surveys - Lead and coordinate routine survey activity directing assigned analysts and clinical consultants in performing assessment of health plan operations and systems	40	16.8	672
Follow-Up Surveys - Follow operational processes and timely execution of follow-up survey activity, including administrative support and initial validation of supplemental responses.	36	12	432
Enforcement Referrals - Provide analytical and project management support functions for referrals to the Office of Enforcement, including preparation of supporting documents and health plan case flies	20	10	200
Review amendments resulting from survey findings and implementation of new legislation, assume 60% of 394 filings (236) require specialist review	236	1	236
Work with attorneys and management in identified new initiatives, participating in workgroups to strategize and implement initiatives, contribute to developing memoranda and reports to executive management, work with the attorneys and consultants on development of implementation tools and coordinate with and provide analytical support to DPS attorneys and consultants	26	10	260
Total Hours Worked			**1,800**
Number of Positions			**1.0**

Attachment B

WORKLOAD STANDARDS
Office of Plan Monitoring – Division of Plan Surveys
1.0 Assistant Chief Counsel in 2022-23/Ongoing

Activities	2022-23/ 2023-24 Number of Items	2024-25/ Ongoing Number of Items	2022-23/ 2023-24 Hours Per Item	2024-25/ Ongoing Hours Per Item	2022-23/ 2023-24 Total Hours	2024-25/ Ongoing Total Hours
Routine Surveys - Oversee legal team operations, provide leadership and guidance regarding routine survey activity, including oversight and legal review and legal and strategic guidance on deficiencies (estimated at 300 per year)	40	40	10	10	400	400
Follow-Up Surveys - Oversee the legal review of Follow-Up Survey activity, including review and assessment of Supplemental Responses (estimated at 68 per year)	36	40	9	9	324	360
Enforcement Referrals - Consult with Attorney III and Attorney IV on referrals to OE, review OE referrals and provide assistance to OE with enforcement actions	20	20	18.5	18.5	370	370
Provide ongoing leadership, supervision, and guidance/assistance to legal staff in the review of amendments, material modifications, new license applications and other health plan filings such as undertaking reports. Assume 40% of 394 filings (158) require legal review	158	158	2	2	316	316
Identify new initiatives, establish and participate in workgroups to strategize and implement initiatives, oversee development of legal memoranda to executive management, oversee development of implementation tools and participate in consultant contract development as applicable and oversee the provision of legal guidance to DPS attorneys, analysts, and consultants	26	26	15	13.6	390	354
Total Hours Worked					**1,800**	**1,800**
Number of Positions					**1.0**	**1.0**

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WORKLOAD STANDARDS
Office of Plan Monitoring – Division of Plan Surveys
1.0 Attorney IV in 2022-23/Ongoing

Activities	2022-23/ 2023-24 Number of Items	2024-25 Number of Items	2022-23/ 2023-24 Hours Per Item	2024-25 Hours Per Item	2022-23/ 2023-24 Total Hours	2024-25/ Ongoing Total Hours
Routine Surveys - Coordinate with DPS Attorney IIIs and Attorneys on legal guidance regarding routine survey activity, including oversight and most complex legal review and guidance on deficiencies (estimated at 300 per year)	40	40	9.75	9.75	390	390
Follow-Up Surveys - Provide guidance and assistance to Attorney IIIs on follow-up surveys and ensure legal review of follow-up survey reports and assessment of Supplemental Responses (estimated at 68 per year)	36	40	8.50	8.50	306	340
Enforcement Referrals - Consult with Attorney III and ACC about assistance to OE with enforcement actions	20	20	18.5	18.5	370	370
Provide most complex legal guidance and consultation to legal and analytical staff in the review of amendments, material modifications, new license applications and other health plan filings such as undertaking reports, assume 40% of 394 filings (158) require legal review	158	158	3	3	474	474
Work with the ACC and attorneys in identified new initiatives, participating in workgroups to strategize and implement initiatives, work with the ACC and attorneys in development of legal memoranda to executive management, work with the attorneys, analysts and consultants on development of implementation tools and provide legal guidance to DPS attorneys, analysts and consultants	26	26	10	8.7	260	226
Total Hours Worked					**1,800**	**1,800**
Number of Positions					**1.0**	**1.0**

Attachment B

WORKLOAD STANDARDS
Office of Plan Monitoring – Division of Provider Networks
1.0 in Attorney III 2022-23/Ongoing

Activities	Number of Items	Hours Per Item	Total Hours Per Year
Oversee the data collection process, including data integrity review, outreach to clarify and/or validate data errors and network database collapse, to ensure processes are consistent with applicable law and do not run afoul of the Department's rulemaking authority	45	5	225
Evaluate each plan network report for legal compliance with network and data submission requirements	45	8	360
Develop Network Findings Report to inform plan of DMHC's determination regarding plan's legal compliance with network and data submission requirements	45	5	225
Track plan's deficiencies and refer relevant issues to DMHC's Office of Enforcement	45	2	90
Oversee the data collection process, including data integrity review, outreach to clarify and/or validate data errors and network database collapse, to ensure processes are consistent with applicable law and do not run afoul of the Department's rulemaking authority	45	5	225
Evaluate each plan Timely Access report for legal compliance with network and data submission requirements	45	8	360
Develop Network Finding Report to inform plan of DMHC's determination regarding plan's legal compliance with network and data submission requirements	45	5	225
Track plan's deficiencies and refer relevant issues to DMHC's Office of Enforcement	45	2	90
Total Hours Worked			**1,800**
Number of Positions			**1.0**

Attachment B

WORKLOAD STANDARDS
Office of Plan Monitoring – Division of Provider Networks
1.0 Attorney IV in 2022-23/Ongoing

Activities	Number of Items	Hours Per Item	Total Hours
Serve as lead attorney for the network filings received and reviewed through the eFiling system. Provide legal guidance and advice to other attorneys and analysts and review comment letters	50	5	250
Conduct legal review of the most complex health network-related plan filings, including review of all submitted health plan documents and reports generated by the geographic access software. Identify applicable law and identify areas of potential variations in interpretation	16	20	320
Prepare follow-up inquiries to health plans via Comment Letters and review additional evidence presented via health plan responses to comment letters	16	51	816
Prepare Briefing Memo for Assistant Chief Counsel and Deputy Director review and approval	16	14.8	236
Prepare order of approval documentation	16	1	16
Engage in ad hoc meetings with health plans and other stakeholder to address issues identified in the network review process	16	2	32
Analyze complex technical data and research from multiple sources to determine legal compliance with data integrity requirements	16	2	32
Coordinate with other DMHC Offices in areas of joint review to ensure consistent application of the law and timely completion of joint filings, manage the workload to ensure review will be completed within required timeframes or alternative messaging is being delivered	6	1	6
Mentor and train staff and other attorneys on complex network adequacy issues, discuss areas of the law that lack clarity to reach consistent and common resolutions	12	1	12
Attend pre-filing meetings with plans/applicants and other DMHC Offices for the triaging and early identification of potential networks issues	16	2	32
Coordinate Covered CA and Medi-Cal plan reviews with DHCS and Covered California, participate in inter-departmental meetings, ensure appropriate messaging is delivered surrounding Department filings that impact other departments	24	2	48
Total Hours Worked			**1,800**
Number of Positions			**1.0**

Attachment B

WORKLOAD STANDARDS
Office of Plan Monitoring – Division of Provider Networks
1.0 Assistant Chief Counsel in 2022-23/Ongoing

Activities	2022-23 Number of Items	2023-24 Number of Items	2024-25 Number of Items	2022-23 Hours Per Item	2023-24 Hours Per Item	2024-25 Hours Per Item	2022-23 Total Hours	2023-24 Total Hours	2024-25/ Ongoing Total Hours
Review and approve briefing memos prior to closing a Notice of Material Modification or License Application	45	45	45	1	1	1	45	45	45
Train eFiling review staff in legal issues arising in the area of network adequacy	26	26	26	3	3	3	78	78	78
Prepare and update reviewer guidance and templates	4	4	4	10	10	10	40	40	40
Identify areas for policy updates and process change	5	5	5	2	2	2	10	10	10
Resolve novel legal issues	8	8	8	10	10	10	80	80	80
Meet regularly with eFile Management and legal staff to discuss workload, policy concerns, and questions of law	84	84	84	3	3	3	252	252	252
Oversee the development of network adequacy standards for capacity and geographic access	2	2	0	63	30	0	126	60	0
Lead team in developing new definitions, processes, and templates for network	3	3	1	25	15	15	75	45	15
Identify areas for coordination across the Knox-Keene Act	1	1	1	40	40	40	40	40	40
Apply new network rule standards to all areas of DPN operation.	0	1	1	0	70	100	0	70	100
Develop All Plan Letters to provide guidance to health plans in the submission of network filings	0	1	1	0	44	73	0	44	73
Conduct complete reviews of the network rule in its various iterations, issue-spot areas of potential legal conflict	1	1	1	44	44	70	44	44	70

Attachment B

Activities	2022-23 Number of Items	2023-24 Number of Items	2024-25 Number of Items	2022-23 Hours Per Item	2023-24 Hours Per Item	2024-25 Hours Per Item	2022-23 Total Hours	2023-24 Total Hours	2024-25/ Ongoing Total Hours
Review public comment and identify issues that need to be raised to executive staff	0	1	1	0	20	20	0	20	20
Provide guidance and legal advice to the Attorney III and Attorney IV leads on the Network Rule	52	52	52	3	3	3	156	156	156
Oversee updates to the block transfer regulation to account for new delivery models and PPO/EPO products	2	2	0	30	15	0	60	30	0
Lead team in revising definitions for block transfer terminology	1	1	0	10	5	0	10	5	0
Develop All Plan Letters to provide guidance to health plans in the submission of block transfer filings	0	1	1	0	50	70	0	50	70
Conduct complete reviews of the block transfer rule in its various iterations, issue-spot areas of potential legal conflict	1	1	1	50	50	70	50	50	70
Review public comment and identify issues that need to be raised to Executive Staff	0	1	1	0	5	5	0	5	5
Provide guidance and legal advice to the Attorney leads on the Network Rule	26	26	26	1	1	1	26	26	26
Develop methodology for review of block transfer filings for PPO and EPO products and provide ongoing review of data collection tools and measures used to evaluate network impacts of block transfer filings	0	2	2	0	5	5	0	10	10
Implement new laws and regulations	3	3	3	20	20	20	60	60	60
Assist IT, HPS, and RDS staff in developing the data capture and validation methods for network and block transfer filings to ensure all tasks are legally compliant	1	1	1	40	40	40	40	40	40
Review standardized methods for gathering health plan data, reviewing data, and storing data to ensure legal compliance	1	1	1	40	40	40	40	40	40

Attachment B

Activities	2022-23 Number of Items	2023-24 Number of Items	2024-25 Number of Items	2022-23 Hours Per Item	2023-24 Hours Per Item	2024-25 Hours Per Item	2022-23 Total Hours	2023-24 Total Hours	2024-25/ Ongoing Total Hours
Consult on new software and IT applications developed for the purposes of conducting network adequacy reviews and block transfer reviews to ensure all programmed evaluation tools comply with legal standards	1	1	1	20	20	20	20	20	20
Oversee and review final findings reports developed in the timely access (TAR) and annual network review (ANR) process	45	45	45	2	1	1	90	45	45
Review the final compliance determinations made by Attorney III and Attorney IV after completing review of health plan responses and corrective action plans	45	45	45	2.5	2	2	113	90	90
Consult with Attorney III and Attorney IV on the necessity of Enforcement referrals with regard to the ANR and TAR reports and review all referrals made to the Office of Enforcement	30	30	30	3	3	3	90	90	90
Meet regularly with TAR/ANR team	72	72	72	3	3	3	216	216	216
Meet regularly with Office of Plan Licensing to identify policy issues that affect both programs and resolve process questions	8	8	8	1.4	1.4	1.4	11	11	11
Meet regularly with Office of Enforcement and other Offices impacted by network review projects, including Director's Office	6	6	6	1.4	1.4	1.4	8	8	8
Meet with DHCS and coordinate on legislation, regulations, network adequacy software and review approach	14	14	14	1.4	1.4	1.4	20	20	20
Total Hours Worked							**1,800**	**1,800**	**1,800**
Number of Positions							**1.0**	**1.0**	**1.0**

WORKLOAD STANDARDS
Office of Plan Monitoring – Division of Provider Networks
1.0 in Research Data Specialist II 2022-23/Ongoing

Activities	2022-23 Number of Items	2023-24 Number of Items	2024-25 Number of Items	2022-23 Hours Per Item	2023-24 Hours Per Item	2024-25 Hours Per Item	2022-23 Total Hours	2023-24 Total Hours	2024-25/ Ongoing Total Hours
Oversee legal team operations, provide leadership and guidance regarding routine survey activity, including oversight and legal review and legal and strategic guidance on deficiencies (estimated at 300 per year)	84	84	84	1	1	1	84	84	84
Create and maintain data from external sources for DPN use, including CDPH, CMS, OSHPD, and licensing boards, extract and format the data and incorporate into network review tools to support DPN staff network review queries	16	16	16	4	4	4	64	64	64
Create and maintain MS Access data queries for network adequacy to match updated reporting formats, new data sources, and newly developed adequacy measures, allowing network reviewers to measure, filter, analyze and extract data for reporting and decision making	8	4	4	4	4	4	32	16	16
Use Pivot Tables, Power Query, and Tableau for querying data on an ad hoc basis	24	24	24	3	3	3	72	72	72
Develop, maintain, test and document SSIS stored procedures in SQL Server and/or Python scripts within ArcGIS	18	18	18	12	12	12	216	216	216
Maintain Annual Network Review and Timely Access database, identify solutions to improve the accuracy of data received from health plans, manage	12	12	12	6	6	6	72	72	72

Attachment B

Activities	2022-23 Number of Items	2023-24 Number of Items	2024-25 Number of Items	2022-23 Hours Per Item	2023-24 Hours Per Item	2024-25 Hours Per Item	2022-23 Total Hours	2023-24 Total Hours	2024-25/ Ongoing Total Hours
DMHC Timely Access Web Portal updates and enhancements									
Respond to and present responses for more complex data requests from the public, stakeholders, the media, Agency, and the Legislature	6	6	6	7	7	7	42	42	42
Create, maintain, test and document interactive Tableau workbooks (desktop or server-based) for network review, utilizing plan network data	24	24	24	4	4	4	96	96	96
Publish and maintain Tableau server dashboards for network review	26	26	26	2	2	2	52	52	52
Create onboarding documentation and create and run ongoing trainings for DPN staff on data preparation and data analysis in Tableau to support network adequacy review	12	12	12	15	15	15	180	180	180
Liaise with Geographic Information System contractor regarding implementation and testing of network adequacy business requirements	52	0	0	3	3	3	156	0	0
Create onboarding documentation and create and run ongoing training for DMHC staff (various branches of DPN, but also DPS, Racial Equity and cross-office trainings) on GIS capabilities and data analysis/visualization tools to support network adequacy review	52	52	26	2	2	2	104	104	52

Attachment B

Activities	2022-23 Number of Items	2023-24 Number of Items	2024-25 Number of Items	2022-23 Hours Per Item	2023-24 Hours Per Item	2024-25 Hours Per Item	2022-23 Total Hours	2023-24 Total Hours	2024-25/ Ongoing Total Hours
Generate and document comprehensive, interactive ArcGIS maps, dashboards and applications for network review, utilizing plan network data	52	52	52	5	5	5	260	260	260
Create updated ArcGIS service area map and network provider map at the conclusion of each network eFiling to maintain a to-date source of network information	200	210	220	1.3	2	2.156	250	422	474
Assist network reviewers with ad hoc GIS analyses based on unique circumstances of a complex eFiling	40	40	40	3	3	3	120	120	120
Total Hours Worked							**1,800**	**1,800**	**1,800**
Number of Positions							**1.0**	**1.0**	**1.0**

WORKLOAD STANDARDS
Office of Plan Monitoring – Division of Provider Networks
1.0 Health Program Specialist I in 2022-23/Ongoing

Activities	Number of Items	Hours Per Item	Total Hours Per Year
Perform data integrity review, perform outreach to clarify and/or validate data errors, and collapse network database	45	6	270
Evaluate each plan network report for compliance with network and data submission requirements	45	8.8	396
Develop Network Finding Report to inform plan of DMHC's determination regarding plan compliance with network and data submission requirements	45	2.45	110
Track plan's deficiencies and refer relevant issues to DMHC's Office of Enforcement	45	1.25	56
Perform data integrity review, outreach to clarify and/or validate data errors, and network database collapse	45	7	315
Evaluate each plan Timely Access report for compliance with network and data submission requirements	45	10	450
Develop Network Finding Report to inform plan of DMHC's determination regarding plan compliance with network and data submission requirements	45	3	135
Track plan's deficiencies and refer relevant issues to DMHC's Office of Enforcement	45	1.5	68
Total Hours Worked			**1,800**
Number of Positions			**1.0**

Attachment B

WORKLOAD STANDARDS
Office of Plan Monitoring – Division of Provider Networks
1.0 Health Program Specialist II in 2022-23/Ongoing

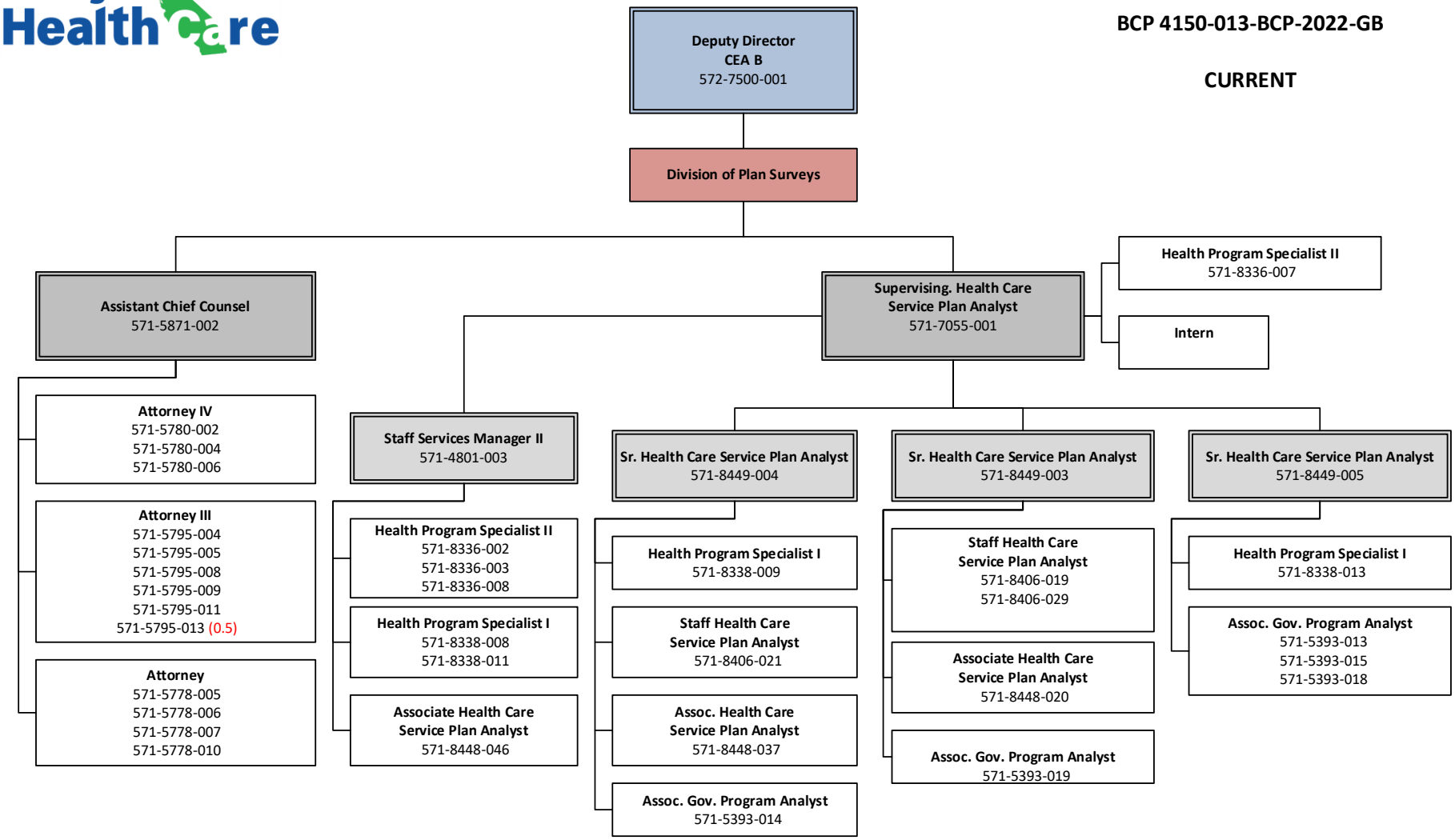
Activities	Number of Items	Hours Per Item	Total Hours Per Year
Review, format and prepare health plan submitted documents for upload into DPN's access database and geographic software for analysis	11	8	88
Review health plan filings and reports generated by the geographic access software, complete analysis and draft follow up comments to the plans for provider and facility network issues	11	50	550
Document Analysis/Review - Complete Network Filing Checklist	11	20	220
Prepare Comment Letters to health plans and review health plan responses to comment letters	11	60	660
Coordinate and collaborate with DPN Attorneys on legal matters pertaining to the filing	22	1.45	32
Prepare Briefing Memo for Assistant Chief Counsel and Deputy Director review and approval. Prepare order of approval documentation if material modification filing	11	15	165
Provide technical and logistical assistance to health plans regarding network filings and network adequacy requirements	11	2	22
Perform complex technical data analysis and research and summarize qualitative and quantitative data from multiple sources to determine data integrity and statutory compliance	11	2	22
Mentor and train staff and other attorneys on complex network adequacy issues. Discuss issues to reach consistent and common resolutions	4	2	8
Attend pre-filing meetings with plans/applicants and other DMHC Offices for the triaging and early identification of potential networks issues	11	2	22
Coordinate review with other Offices within the DMHC and Agency Departments (e.g., Cov. CA and DHCS)	11	1	11
Total Hours Worked			**1,800**
Number of Positions			**1.0**

DEPARTMENT OF Managed Health Care

Office of Plan Monitoring

BCP 4150-013-BCP-2022-GB

CURRENT

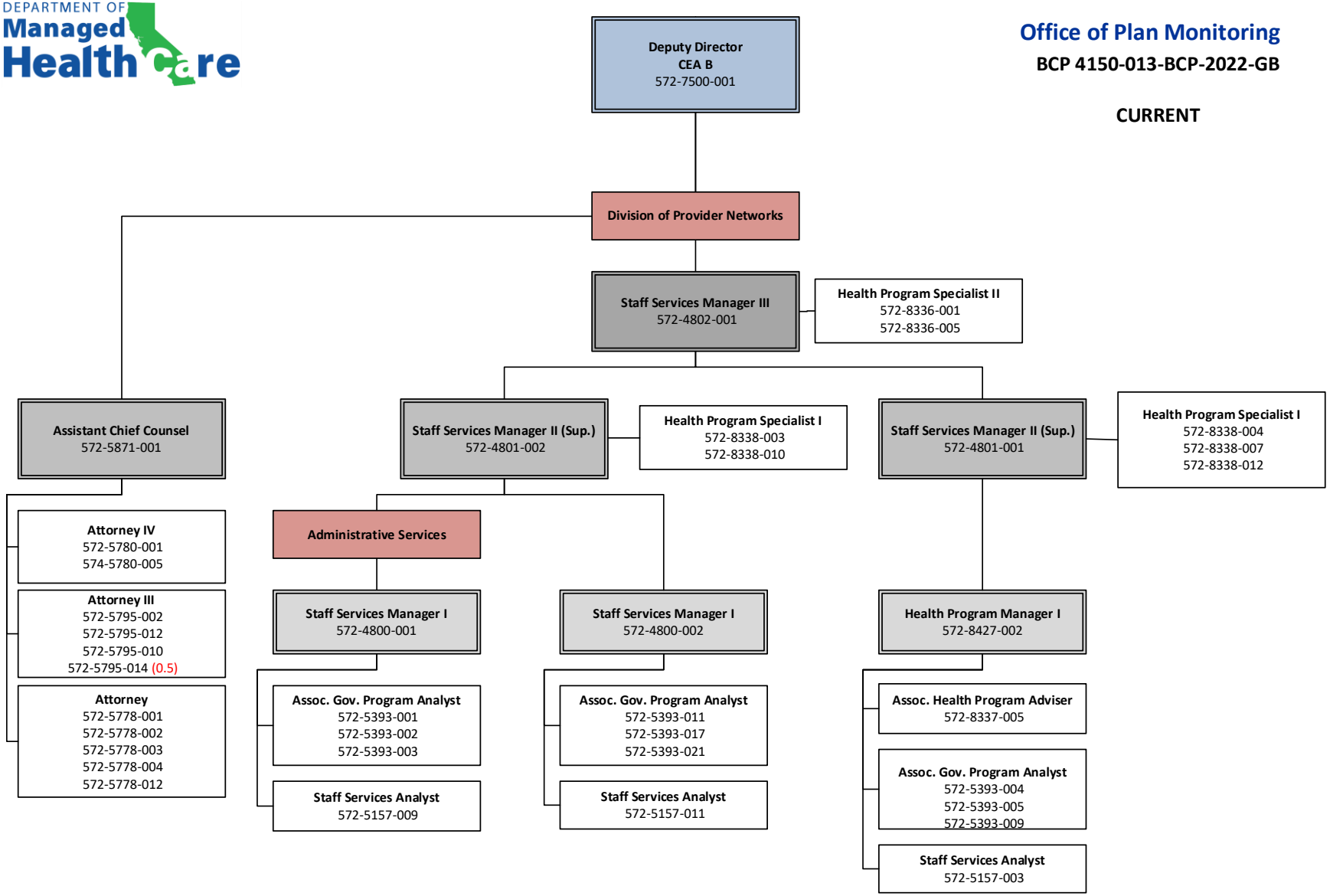


DEPARTMENT OF Managed Health Care

Office of Plan Monitoring

BCP 4150-013-BCP-2022-GB

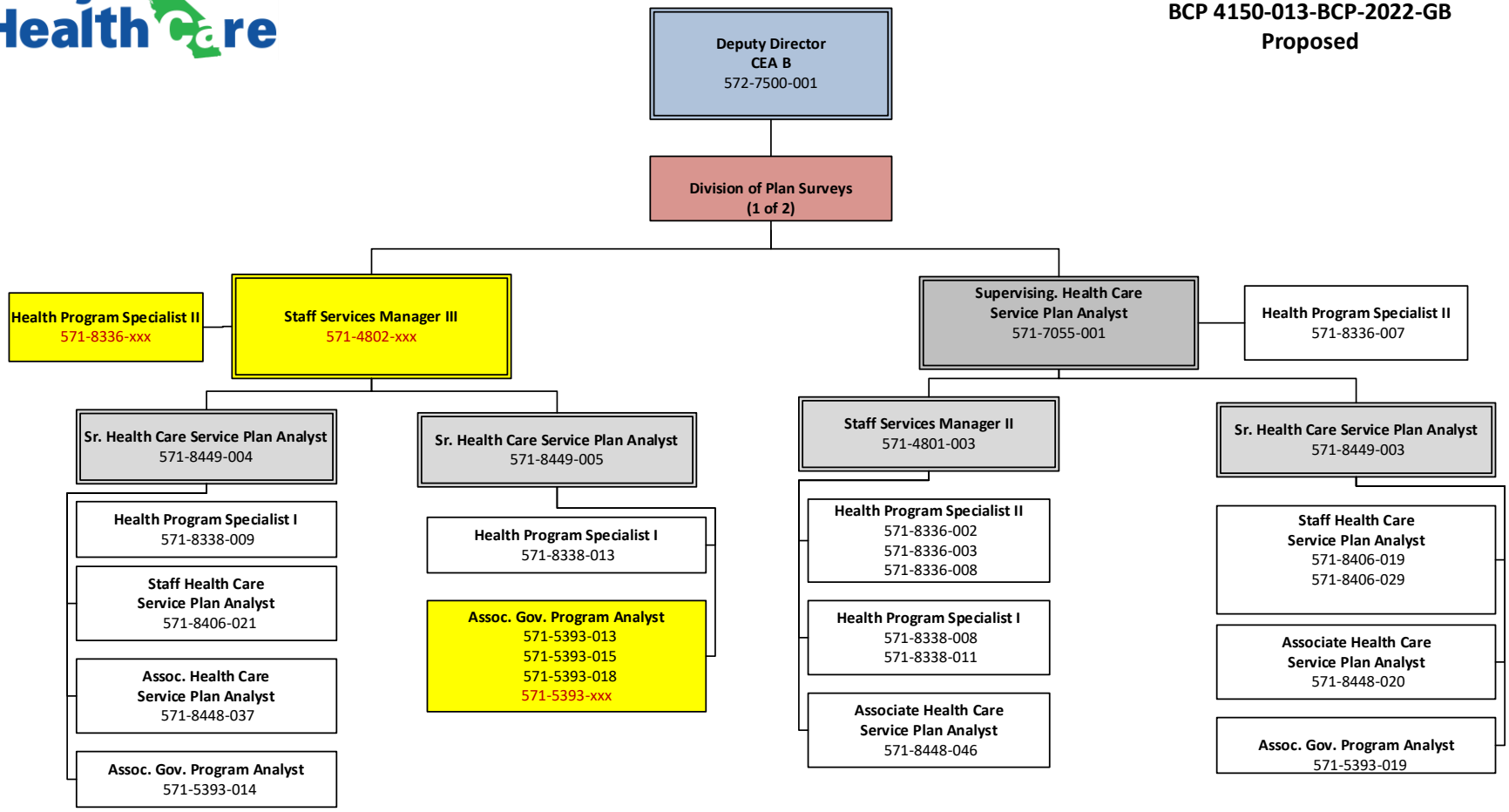
CURRENT



DEPARTMENT OF Managed Health Care

Office of Plan Monitoring

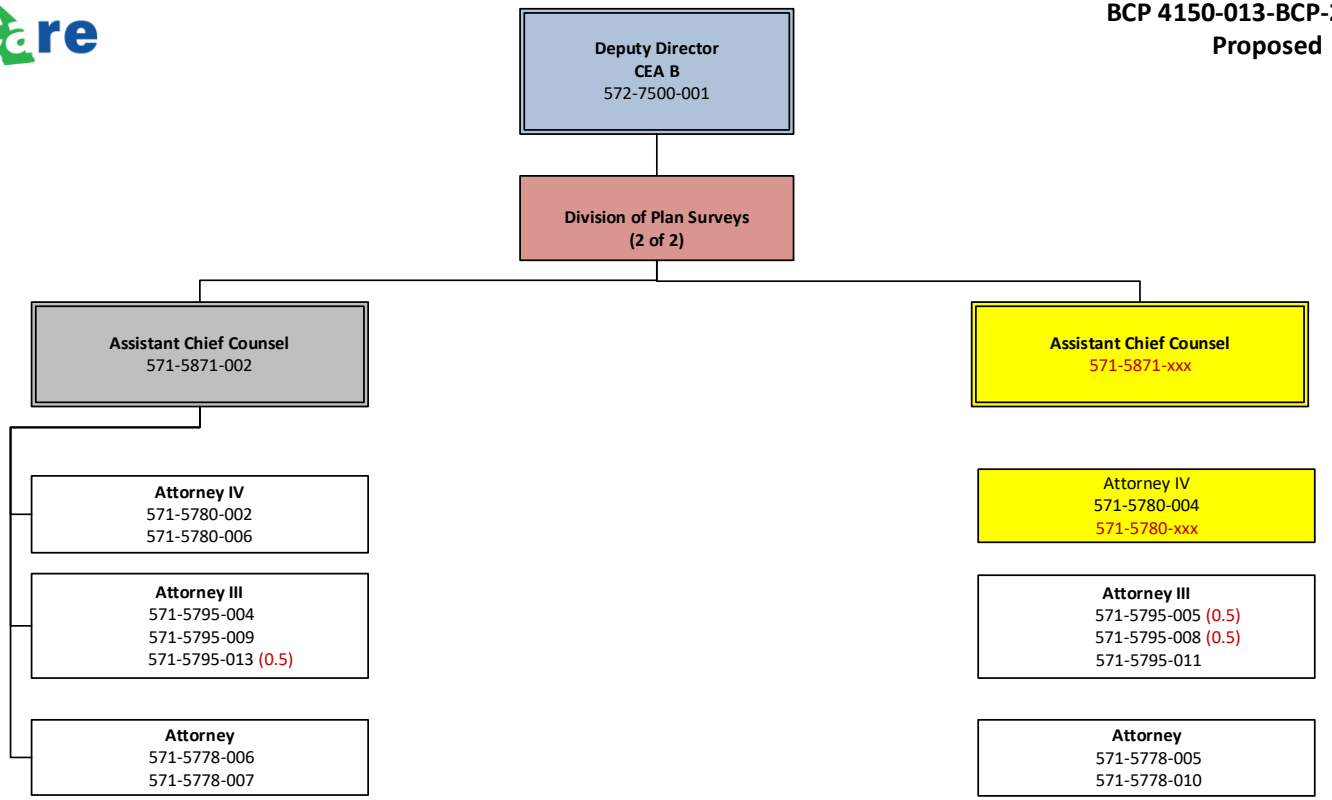
BCP 4150-013-BCP-2022-GB
Proposed



DEPARTMENT OF Managed Health Care

Office of Plan Monitoring

BCP 4150-013-BCP-2022-GB
Proposed



DEPARTMENT OF Managed Health Care

Office of Plan Monitoring

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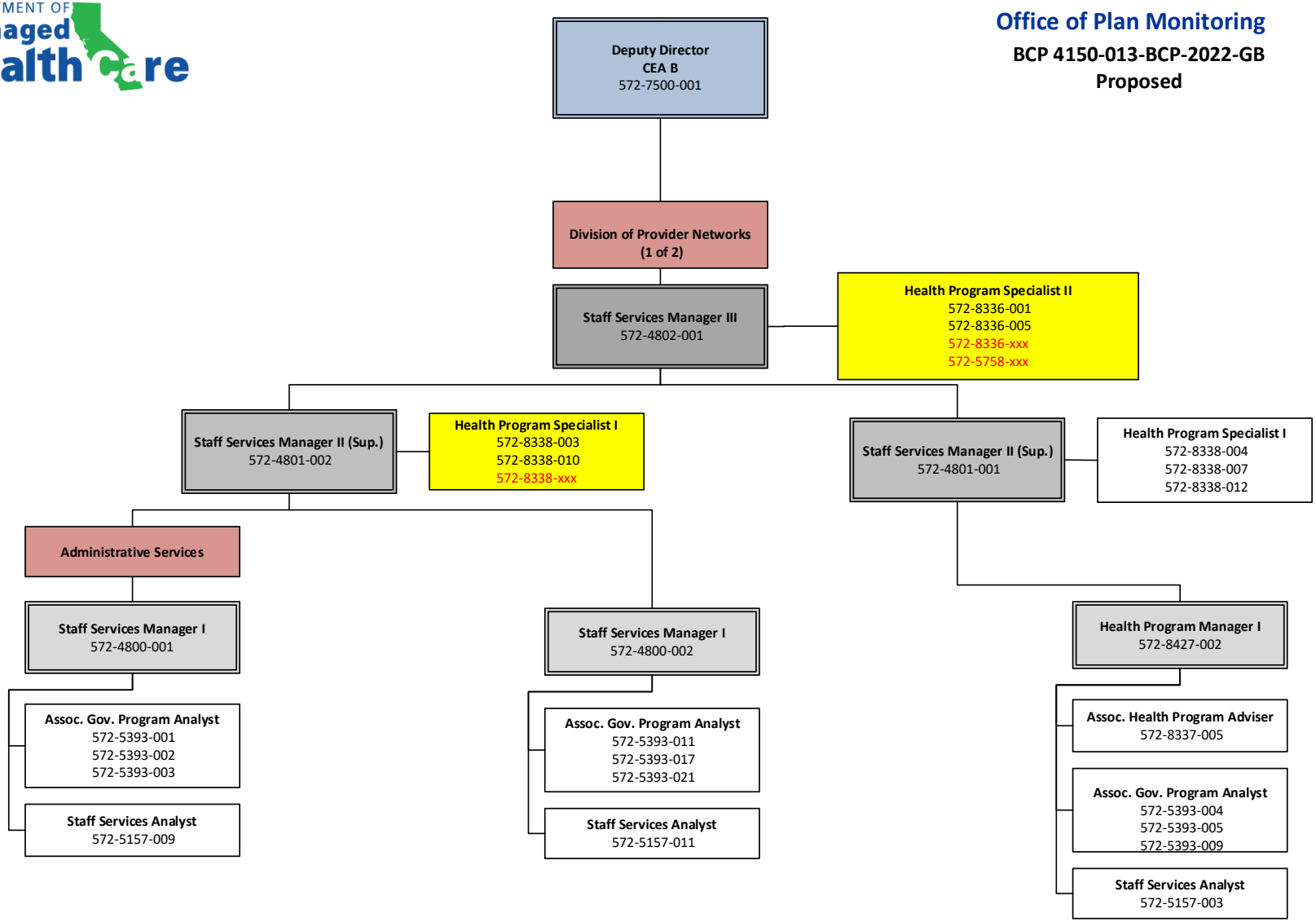

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