Department of Developmental Services

REQUEST FOR INFORMATION

RFI_T6655 Addendum #1

EXHIBIT 1

Federal Reimbursement and Revenue Recovery Program

DATE

October 31, 2024

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1 FUTURE REIMBURSEMENT PROGRAM

The California Department of Developmental Services (DDS) uses an internal application, the Federal Programs Information and Billing System (FPIBS), to process data from the Uniform Fiscal System (UFS) and San Diego Information System (SANDIS) to identify eligible claims for reimbursement programs.

As the department seeks to standardize and modernize the case and financial management processes and supporting technology tools, the department also seeks to modernize the federal reimbursement processes and technology tools to ensure seamless integration with the case and financial management processes and technology tools. All processes will need to be realigned to support the use of new applications and data processing. In this document, DDS describes the current system and business environment and conceptualizes a future state for the federal reimbursement programs, consistent with the vision for the case and financial management solution.

1.1 Reimbursement Program Overview

DDS administers the State's intellectual disability and developmental disability (ID/DD) programs that provides services and supports to individuals with ID/DD. The majority of the services delivered to consumers[1] are provided or coordinated by twenty-one (21) contracted, non-profit corporations, referred to as "regional centers". If a regional center determines that a consumer has a qualifying disability according to the State's Lanterman Act and the federal government rules on Medicaid Home and Community Based Services (HCBS), then that consumer may receive services and supports from approved service providers. The services are funded by the State.

As a monthly batch process, the regional centers submit data[2] to DDS for all services and supports provided to the consumers. The data is submitted from each RC instance of UFS to FPIBS. The UFS data files include data supplied by SANDIS. Assessment of the submitted data is performed by FPIBS to determine reimbursement eligibility for various funding sources allowing the State of California to recover some of the costs of services. DDS seeks financial reimbursement from various federal reimbursement programs approved by the Centers for Medicare and Medicaid Services (CMS) for HCBS, including Medicaid Waivers and State Plan Amendments (SPAs), other reimbursement agreements with the Department of Health Care Services (DHCS), and grants with other entities. In essence, for every dollar that the department spends, it seeks to maximize the recovery or reimbursement of that dollar. Different funding sources usually necessitate different processing streams. The department's federal reimbursement and

[1] Individuals with ID/DD and determined eligible for services are referred to as "consumers."

[2] Data includes consumer, service provider, purchase of service, claim data, etc. The department uses the terms "claims" and "invoices" interchangeably.

revenue recovery programs (reimbursement programs) recover approximately $5.0 billion in federal reimbursement dollars each year.

Today, the department utilizes approximately nine (9) distinct federal programs to reimburse the State. The number and nature of the reimbursement programs has changed over the history of DDS to align with new policies and regulations and will continue to evolve in the future. DDS submits federal reimbursement invoices and claims to the Department of Healthcare Services (DHCS), that then submits the invoices to CMS. In the State of California, DHCS is the single state agency that is responsible for financing and administering the State's Medicaid program, branded as Medi-Cal.

1.2 Reimbursement Programs

DDS administers nine (9) federal reimbursement programs. Table 1 provides a brief description of each reimbursement program.

Table 1. Federal Reimbursement Program Descriptions

Program	Description
HCBS Medicaid Waiver (MW) (1915c)	Section 1915(c) of Title XIX of the Social Security Act established the MW program. Under the MW, certain Medicaid requirements are waived so that States may provide a broad array of approved home and community-based services (except room and board) to individuals who, without these services, would require the level of care provided by an institution or intermediate care facility. California's first MW for developmental disability services was approved in November 1982.
Stabilization, Training, Assistance and Reintegration / Crisis Assessment Stabilization Team (STAR/CAST)	DDS operates and provides services and supports for the state-operated Stabilization, Training, Assistance and Reintegration (STAR) homes which provide individuals experiencing an acute crisis with person-centered support and crisis stabilization on a time-limited basis to enable them to successfully return home or transition to more appropriate, less restrictive living settings. The Crisis Assessment Stabilization Team (CAST) which are state-operated mobile crisis services, housed at the STAR homes – (e.g., North, South and Central Valley STAR), providing partnerships, assessments, training and support to individuals continuing to experience crises after the regional centers (RC)s have exhausted all other available crisis services in their catchment areas and who are at risk of having to move from their own or family home or from

Program	Description
	an out-of-home placement to a more restrictive setting. The STAR and CAST services are not treated as separate reimbursement programs and are administered under the 1915c and 1915i reimbursement programs.
Targeted Case Management (TCM)	TCM program was implemented in 1988 to help fund the cost of providing case management services for consumers. DDS is reimbursed for the cost of regional center services performed on behalf of clients, such as making phone calls, completing reports like the required Client Development Evaluation Report (CDER), preparing a required plan for services the client will receive, as well as time spent in personal contact with the clients.
Nursing Home Reform (NHR)	NHR was implemented in 1989 following the Federal Omnibus Budget Reconciliation Action (OBRA 1987), a Federal Nursing Home Reform Act defining requirements for, and assuring quality of care in, skilled nursing facilities. Prior to admission to a nursing facility, an individual must be screened for intellectual or developmental disability that may require specialized services and placement in a nursing facility.
1915(i) State Plan Amendment (1915i)	With federal approval, States are authorized to offer disability services equal to or in addition to their primary Medicaid Waiver and obtain federal reimbursements. The 1915(i) SPA provides habilitation, speech, hearing, and language services for consumers who do not meet the level of care requirements as described under the Medicaid Waiver.
Intermediate Care Facility State Plan Amendment (ICF-SPA)	The ICF-SPA program authorizes the State to secure reimbursement for the cost of day services and transportation services to transport individuals to and from a day service for individuals that reside at an ICF. ICF-SPA operates uniquely compared to the other reimbursement programs in that the State pays the service provider directly before DDS can seek federal reimbursement. In most other cases, DDS pays the regional centers, and regional centers pay the service providers.

Program	Description
Self-Determination Program (SDP)	SDP allows the consumers to elect to participate and work with regional centers to determine and define (self-determine) the services and care to enrich their lives. SDP became operational in 2018.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	The EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are eligible for Medi-Cal. EPSDT ensures that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.
Behavioral Health Treatment (BHT)	Consistent with state and federal requirements, a physician or a psychologist must recommend BHT services as medically necessary based on whether BHT services will correct or ameliorate any physical and/or behavioral conditions. Medi-Cal covers all medically necessary behavioral health treatment (BHT) for eligible beneficiaries under 21 years of age. This may include children with autism spectrum disorder (ASD) as well as children for whom a physician or psychologist determines it is medically necessary.

2 FUTURE REIMBURSEMENT PROGRAM PROCESSES

A goal for the future federal reimbursement program application functionality is to leverage the future case management and fiscal management (CM/FM) solution by utilizing the data sources (e.g., consumers, service providers, claims) for reimbursement determination. Unlike the current environment, where data is coming from various systems and distributed databases, the new CM/FM solution will ensure data comes from a single source of truth and will have a high level of data quality for reimbursement determination.

2.1 Reimbursement Programs To-Be Processes

The Department's vision for the federal reimbursement programs is described in this section. Note, DDS makes a few assumptions regarding how the future system will operate based on the business processes and requirements provided in RFI T6655. The assumptions are as follow:

- Consumer, vendor[3], and services data are managed statewide and integrated.
- Reimbursement program staff will not directly manage data for consumers, vendors, and services provided to or received by consumers, but data will be viewable in the system to these authorized users.
- Data error corrections will not be worked by reimbursement program users, but rather by the primary users responsible for the accuracy of those data domains. For example, consumer data will be corrected by users with permissions to edit consumer data, such as service coordinators.
- Consumer eligibility for Medi-Cal is processed for all consumers every month (according to DHCS file logic). Monthly results of the Medi-Cal and Medicaid determination are saved with the consumer record and viewable by reimbursement program users.
- The application supports the ability for reimbursement program staff to define business rules, where data is indicated as eligible or ineligible for a reimbursement program. For example, if a service is eligible, the authorized user will be able to indicate in the system that it is eligible for a reimbursement program with effective dates, and that the indicator and effective date are viewable to all necessary authorized users.
- The application supports the processing, or system/supportive analysis, of the business-rules to data associated with a claim, such as consumer, service, rate, dates, and vendor. The system processing will automate the eligibility determination of a claim for a reimbursement program and assign eligibility determination results to each claim, such as "eligible for 1915" or "ineligible due to consumer ineligibility".
- The application supports the monthly aggregation and cumulative claim totaling of 10 million claim records each month, without impacting the performance of the case and financial solution(s).
- All user interface displays of data and system processing logic is to support the creation of invoices and supporting detail claims files to be sent to paying entities to reimburse the department. Currently, this equates to approximately $5 billion dollars.

Table 2 provides a narrative description of three primary process domains performed by federal reimbursement programs. Table 2 in Section 3.2 provides the business capabilities model for each domain. The processes are summarized in the tables below and the process workflows can be found in *Section 6: To-Be Workflows*.

[3] For the purposes of this addendum, the term "vendor" may be used interchangeably with the term "service provider". The regional centers may contract with operational vendors (e.g., landscaping), but this type of vendor will not have accounts or access to the future solution.

Table 2. Reimbursement Program Processes

Process	Process Summary
1.0 Reimbursement Program Administration	• Reimbursement program administration activities include capturing and maintaining program characteristics, such as name, effective dates, policy, and contract numbers, and point of contacts. • Authorized users will be able to manage federal reimbursement programs in a system user interface-type menu. • Authorized users will be able to maintain program financial participation percentages and other financial parameters, per reimbursement program.
2.0 Reimbursement Program Eligibility Criteria	• Reimbursement program eligibility involves establishing criteria and associated details such as services, rates, providers, and consumer eligibility. • Authorized users will be able to assign services and sub-services (sub-codes) as eligible or ineligible for each reimbursement program. In an easy to view format, authorized users will be able to view the services associated with and eligible for a program. • Authorized users will be able to manage the assignment of service data to include Healthcare Common Procedure Coding System (HCPCS) codes and feeder form category. • Authorized users will be able to establish department-set rate maximums specific to federal reimbursement billing, retroactively, future-dated, and with effective date ranges. • Authorized users will be able to indicate services and subservices that require rate step-down adjustments. • Authorized users will be able to indicate the ineligibility status of a service provider for a reimbursement program. • Authorized users will be able to define the consumer eligibility criteria for each reimbursement program.
3.0 Reimbursement Billing and Invoicing	• This process domain supports the system processing of the eligibility criteria defined in 2.0 Reimbursement Program Eligibility Criteria. • Authorized users will be able to view for every consumer their enrollment status for DDS services, the enrollment and/or eligibility status for Medi-Cal, and the eligibility status for federal Medicaid.

Process	Process Summary
	• Where applicable, authorized users will be able to view all consumers' program enrollments or view a designation of programs that the consumer is associate with. • The WASPAA team needs configurable rules for eligibility criteria for each reimbursement program.

2.2 Reimbursement Program Business Capability Model (BCM)

The table below includes the DDS reimbursement program's Business Capability Model and all major business processes. The Level 3 Business Processes tie to the mid-level functional requirements.

For the purposes of this RFI, the reimbursement program BCM is documented in a numerical order, beginning with 1.0. The numbering of this list will overlap the BCM numbering of the original RFI until the Department determines the proper placement in the overarching project BCM.

Table 3. Reimbursement Program BCM

Level 1	Level 2	Level 3
1.0 Reimbursement Program Administration	1.1 Maintain Reimbursement Programs	1.1.1 Manage Program Identifiers 1.1.2 Manage Program Parameters 1.1.3 Manage Program Limits: Enrollment and Budget
2.0 Reimbursement Program Eligibility Criteria	2.1 Reimbursement Program Eligibility Criteria	2.1.1 Manage Service Criteria 2.1.2 Manage Rate Threshold 2.1.3 Manage Service Provider Eligibility 2.1.4 Manage Consumer Enrollment Criteria 2.1.5 Manage Consumer Eligibility Criteria

Level 1	Level 2	Level 3
3.0 Reimbursement Billing & Invoicing	3.1 Billing and Invoicing	3.1.1 Check & Determine Reimbursement Billing 3.1.2 Calculate Reimbursement Billing 3.1.3 Generate Reimbursement Program Invoicing

3 FUTURE TECHNOLOGY AND SYSTEMS

This RFI addendum includes a new interface that is needed to support the federal reimbursement program:

- DHCS Medi-Cal Eligibility Determination System (MEDS). The future solution must support a MEDS interface that is a DHCS-defined bi-directional data exchange. The data exchange must support the processing of 1.5 to 2 million consumer records[4] each month. Data received from DHCS must be recorded with the corresponding consumer record and retained by month historically. Certain DHCS MEDS data may need to be viewable by authorized users when performing consumer case management activities. The data received from the MEDS response file will be used as inputs to the consumer eligibility process identified in Section 6 To-Be Workflows processes 2.1.4 Manage Consumer Enrollment Criteria and 2.1.5 Manage Consumer Eligibility Criteria.

Figure 1 illustrates the overall conceptual solution architecture. Figure 2 reflects conceptual data flows to support the additional integrated federal reimbursement processes. The data flow in Figure 2 represents just the reimbursement data and is meant to supplement the To-Be vision for case management and financial management. It does not replace information previously provided in the original RFI. The corresponding reimbursement program workflows are contained in Section 6 To-Be Workflows.

[4] The 1.5 to 2 million record total is an estimate, and subject to change depending on consumer population totals and the future system logic used to create the MEDS request file.

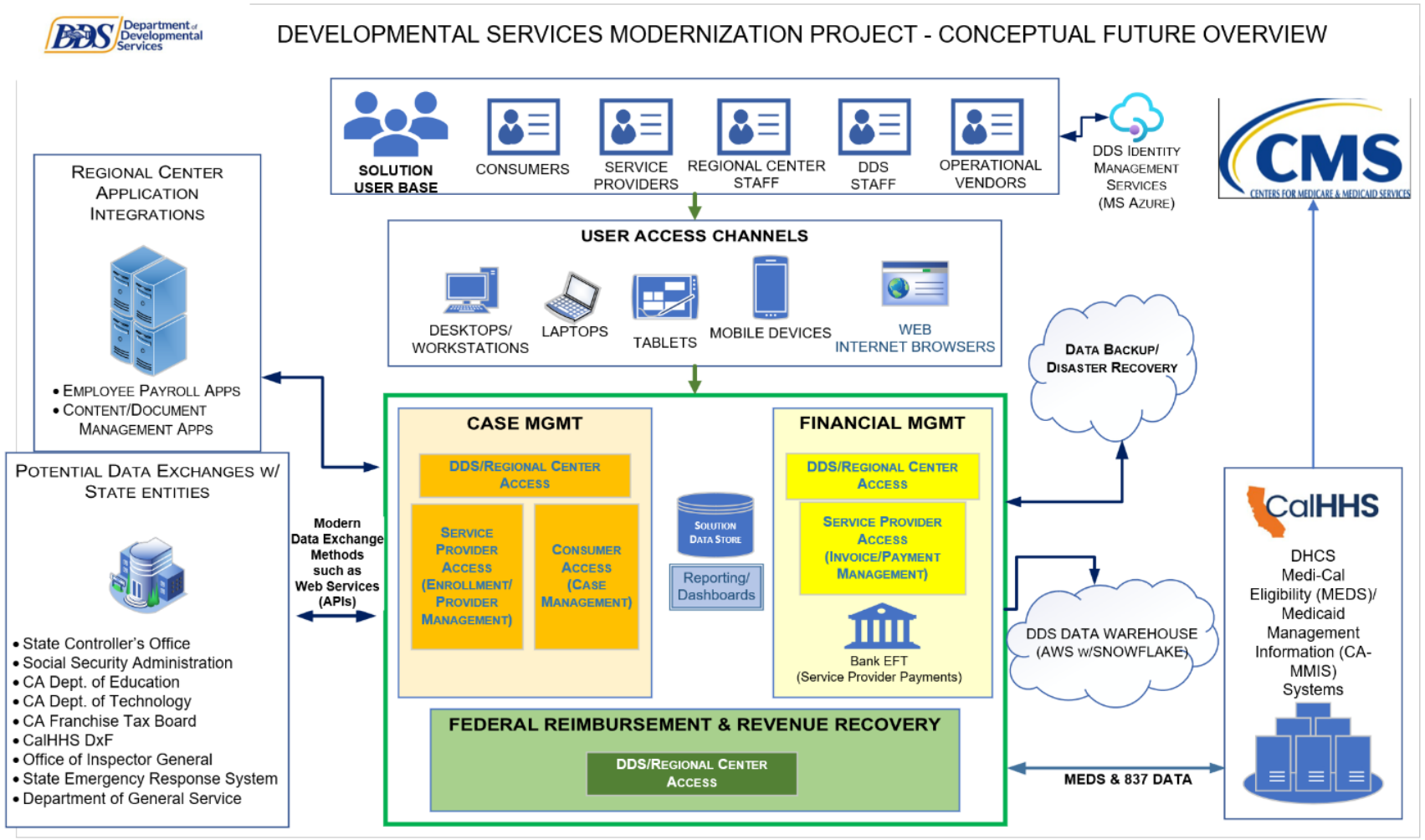


Figure 1. Conceptual Solution Architecture

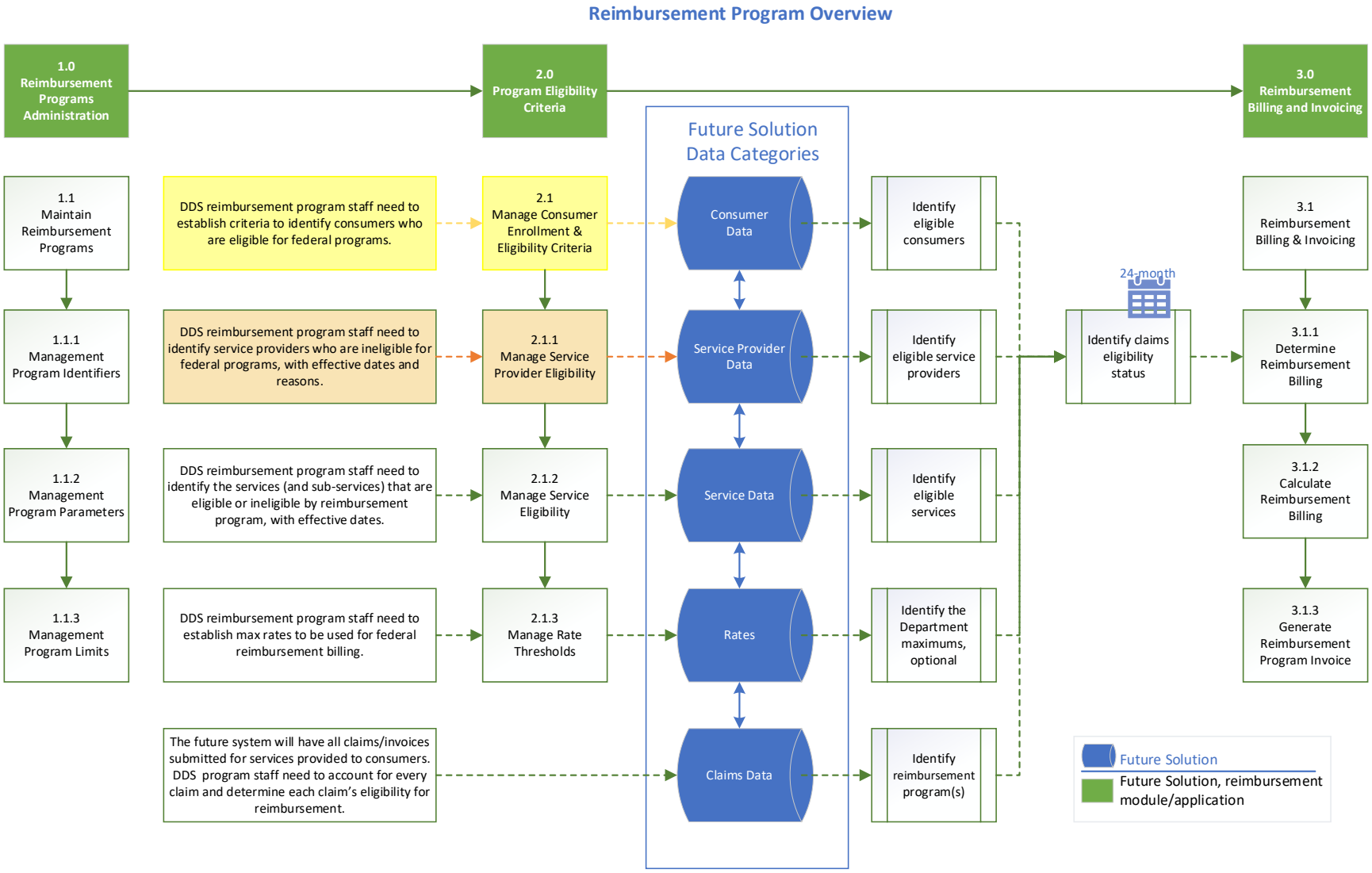
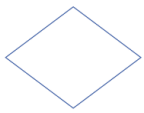


Figure 2. Transition Concept Operations Overview

4 WORKFLOW DIAGRAM LEGEND

All the business process workflows that appear in this Exhibit were created using Microsoft Visio. Each workflow shape is associated with a standard concept. These concepts are outlined below.

Symbol	Name	Definition
	Decision	A 'decision' shows decision point, shown as yes/no or other types of decisions. Each path emerging from the decision is labeled with one of the possible answers.
	Event Start/End	An event that indicates where a particular process starts or ends. The start event starts the flow of the process and does not have an incoming sequence flow but can a trigger. The end event ends the flow of the process, and thus will not have any outgoing sequence flows.
	Document	Any document used/created in the process. This includes forms and reports, electronic or paper-based. If the document is a form, indicate the form and form number.
	Sequence Flow	This connecting object shows the order in which activities are performed in a process. Sequence flows are represented with a solid graphical line.
	Manual Task	A manual task is work that is performed manually. A task is a type of activity.
	Sub-Process	The icon identifies when the process continues to a different, unrelated process.
	System Task	A system task is work that is performed by or within the assistance of a system. A task is a type of activity. The name if the system should be identified within the task. Note: Excel spreadsheet should use the system task symbols.
	Grey Symbol	A gray in symbol indicates when a system task, decision or activity is automated, and does not require manual interaction.

	Scheduled Event	A blue calendar identifies the process as a monthly event that occurs on a specific date.
	Off-page reference	A blue icon that continues the process/step to a different page. If the off-page reference relates to a process described in the original RFI, the icon will indicate this with the following text "RFI T6655". If the off-page reference relates to a process contained within this Exhibit, the icon will indicate this with the following text "RFI T6655-A1".
	Data	A solid blue icon identifies data files.

5 TO-BE WORKFLOWS

This section identifies to-be processes and workflows that correspond to the mid-level requirements. The following to-be process descriptions and process flow diagrams are conceptual and are not intended to convey a specific or required order of process steps.

1.0 Reimbursement Program Administration

The DDS reimbursement program users need to establish and define each program's identifiers, parameters, and limits. These uniquely define the characteristics of each program. Some of these characteristics are used during the invoice process (See workflow 3.1.3) to populate the invoice cover sheet of the invoice packet for each program.

1.1 Maintain Reimbursement Programs

1.1.1 Manage Program Identifiers

This process includes functionality related to establishing and maintaining various data values that define unique characteristics of each program and must be published on each monthly reimbursement invoice. This allows reimbursement program users to minimize manual entry of reoccurring information.

The types of information that are needed for each program include but are not limited to:

- CMS Federal Waiver Authorization Number
- DHCS Interagency Agreement Number

- DDS Interagency Agreement Number
- DHCS Policy Change Number
- State Plan Amendment Number
- Submitter Contact Information (DDS sender)
- Federal Participation Percentage(s)
- Receiver Contact Information (Payee recipient)
- Account Detail

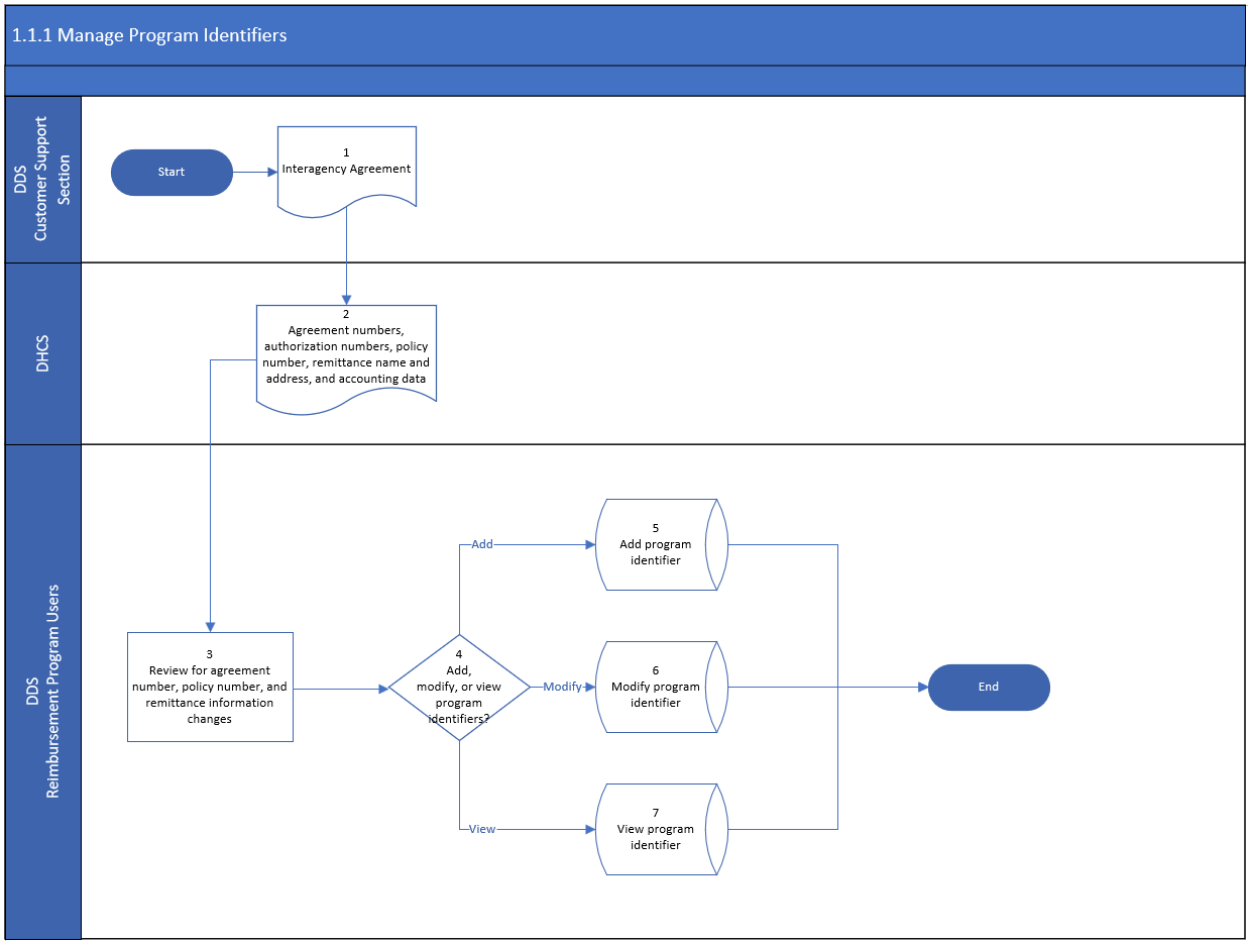


Figure 3. Manage Program Identifiers

1.1.2 Manage Program Parameters

This process includes functionality related to the Department's federal financial participation (FFP) percentage and federal medical assistance percentages (FMAP) for each program. Reimbursement program users will need to establish and maintain these percentages annually, or as federal authorities change. These percentages must be calculated against the total eligible claim expenditures for each program. There might be scenarios where there is a reduction in reimbursement percentage due to penalties.

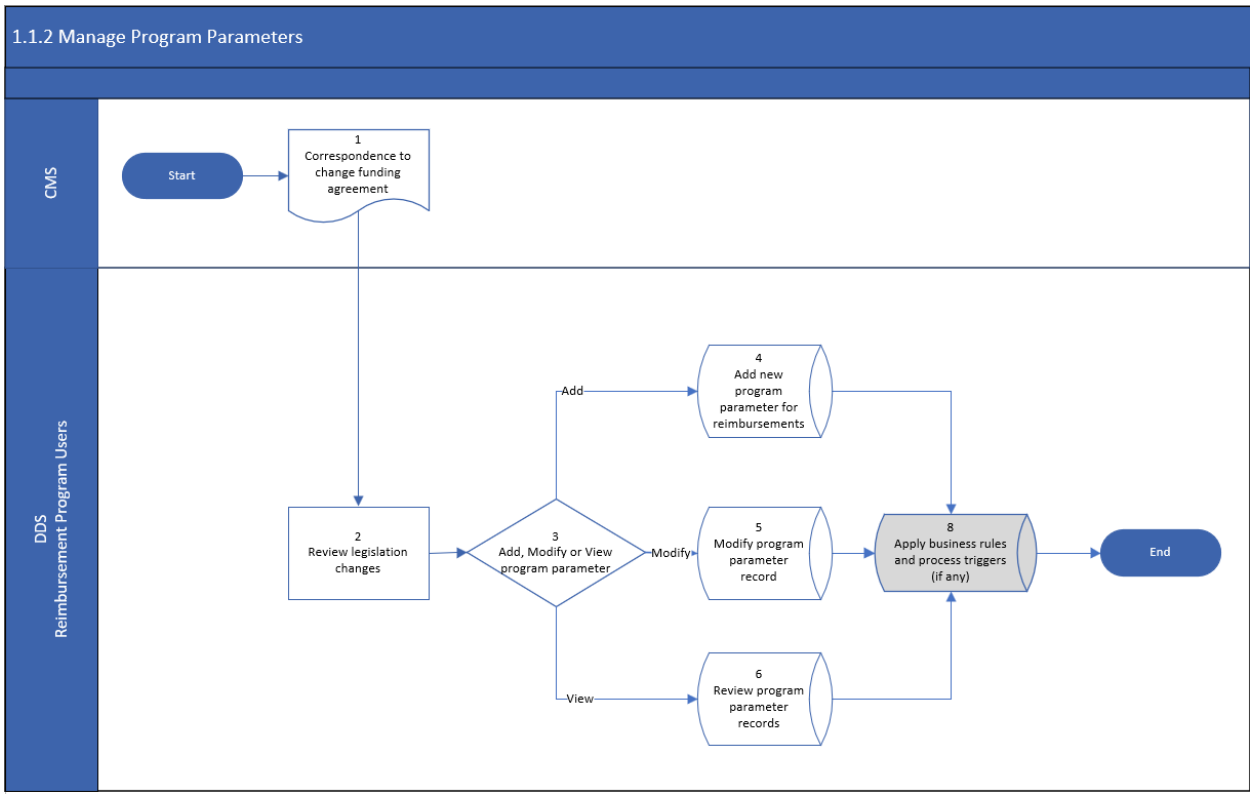


Figure 4. Manage Program Parameters

1.1.3 Manage Program Limits: Enrollment and Budget

This process includes the functionality to set and monitor the maximum total number of consumers enrolled and the budget for each program, referred to as program limits, which are established in the program interagency agreements. Identifying and tracking the number of consumer enrollments and the drawdown of the budget limit allows reimbursement program users to take appropriate and timely action when the enrollment count or budget drawdown reaches a specific threshold within the limit (i.e., 80% of an enrollment maximum). Specifically for budgets, the program limits provides the opportunity for appropriate DDS staff to amend the budget with federal authorities for additional funding to cover the remaining fiscal year expenditures.

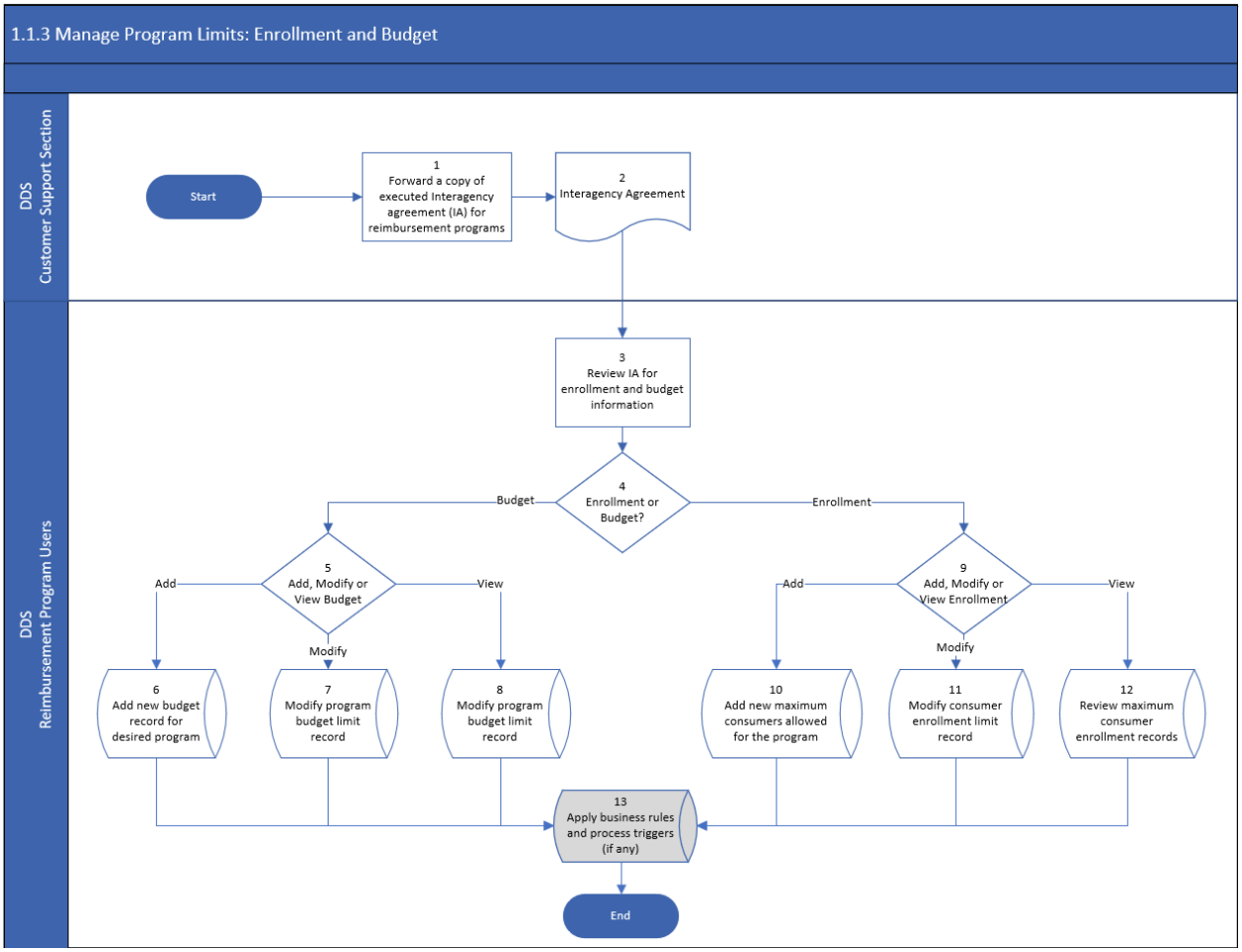


Figure 5. Manage Program Limits

2.0 Program Eligibility Criteria

The DDS reimbursement program users must be able to establish and maintain various eligibility criteria used to identify the specific subset of consumer and claims data that are eligible for a reimbursement program. This process domain provides a conceptual narrative of how these processes may work with an integrated case and financial management system.

2.1 Reimbursement Program Eligibility Criteria

2.1.1 Manage Service Criteria

This process includes functionality for authorized users to indicate services and subservices that are eligible for a reimbursement program.

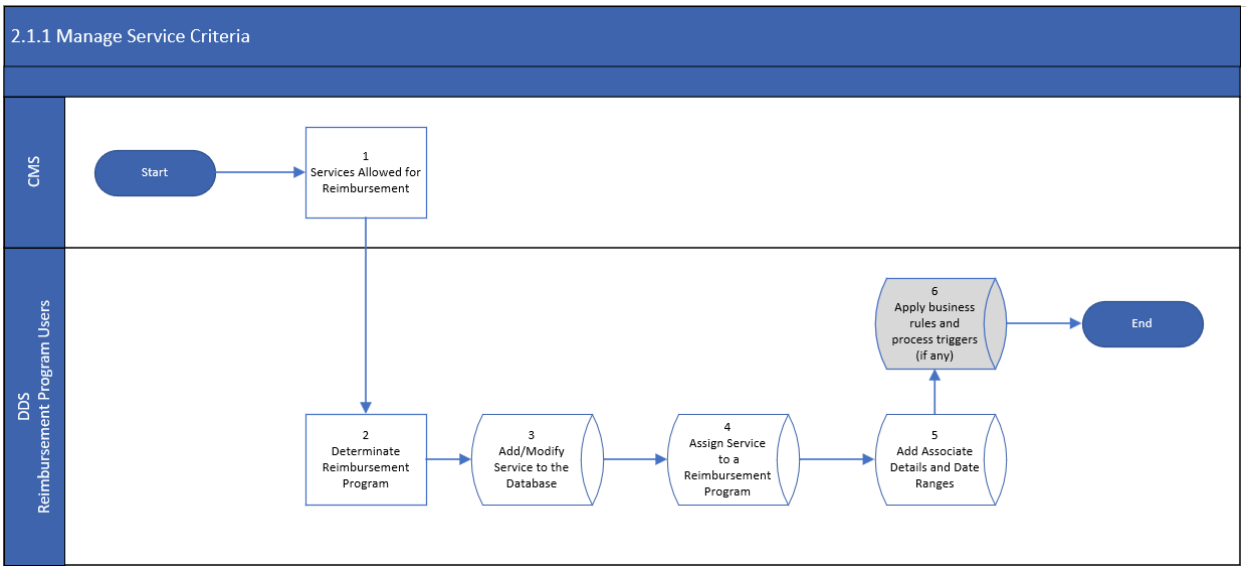


Figure 6. Manage Service Criteria

2.1.2 Manage Rate Threshold

This process includes functionality to establish a department maximum rate for services that are considered high-cost and will require additional step-down adjustments (i.e., dollar amount such as $1,000). This process assumes that the future solution will support a rate hierarchy, where regional centers set rates at the regional center-level, vendor-level, and consumer-level for each service offering. For federal reimbursements, DDS must ensure that what is billed to the federal government does not exceed allowable rates. As such, DDS must be able to set a not-to-exceed federal billing rate per service offering per reimbursement program.

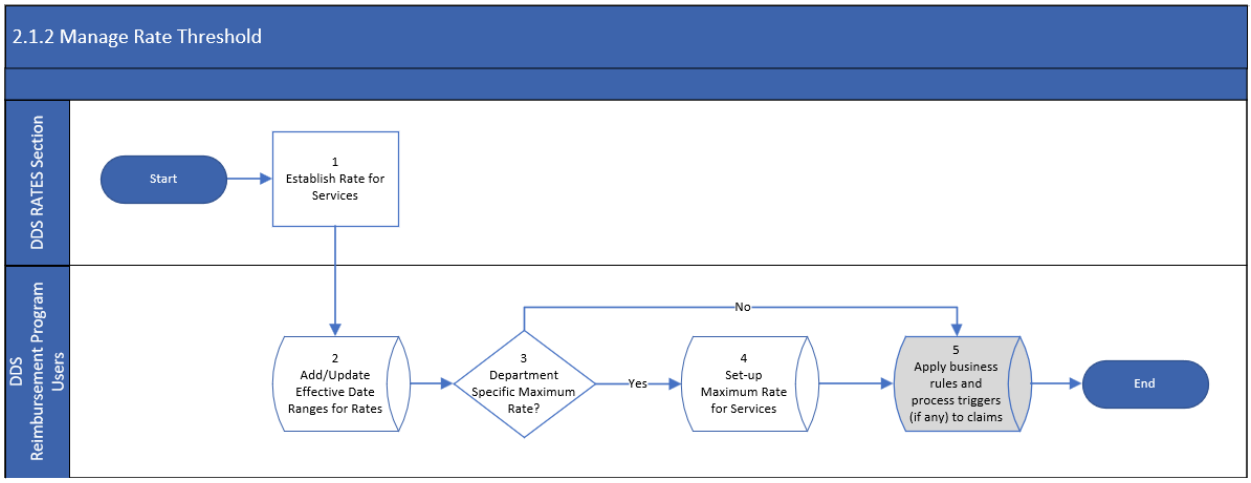


Figure 7. Manage Rate Threshold

2.1.3 Manage Service Provider Eligibility

This process includes functionality for reimbursement program users to indicate ineligibility status of a service provider for federal billing. A service provider may be eligible to provide services to DDS consumers, but the service provider may not meet HCBS criteria, such as an institution or non-HCBS facility. Reimbursement cannot be processed for claims provided by ineligible service providers.

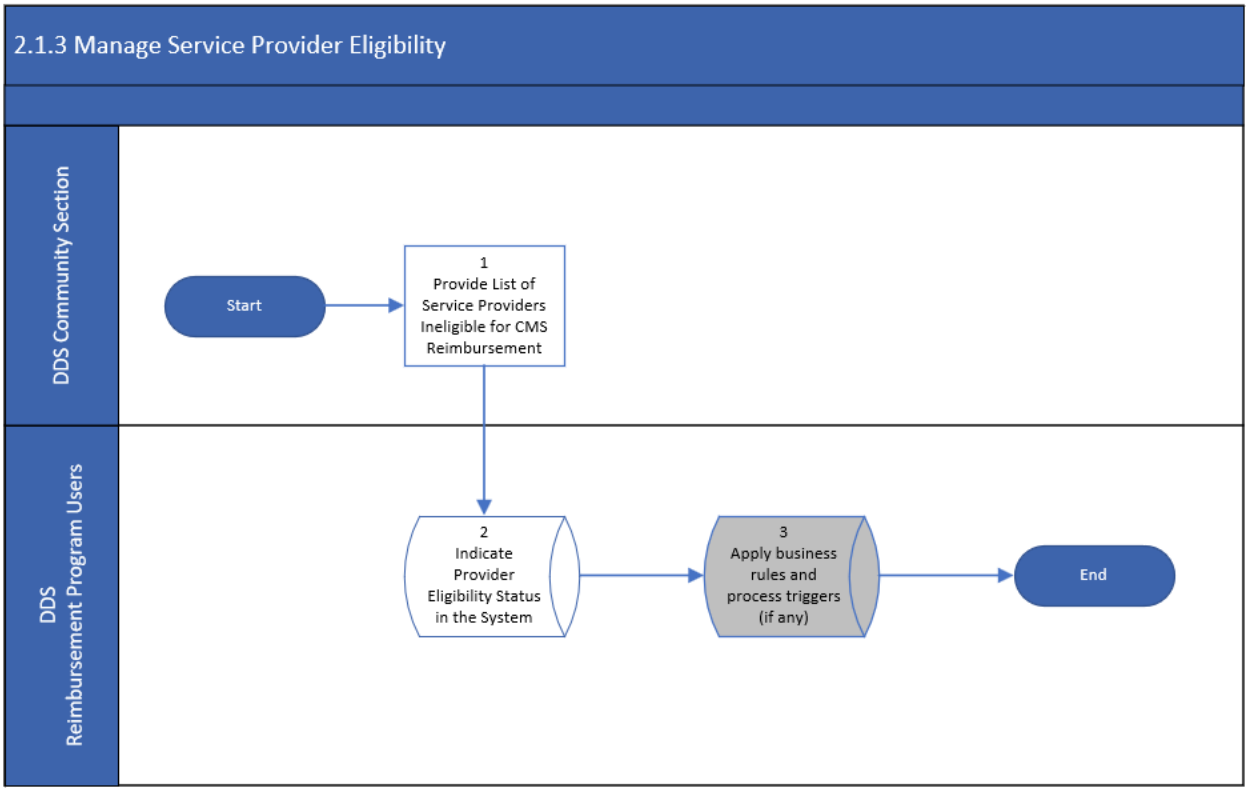


Figure 8. Manage Service Provider Eligibility

2.1.4 Manage Consumer Enrollment Criteria

This process includes functionality to determine an explicit DDS Home and Community Based (HCBS) reimbursement program that a consumer can be enrolled in. Consumers are not to be enrolled in a DDS HCBS reimbursement program, if they are a current recipient of the DHCS administered Home and Community Based Alternatives (HCBA) reimbursement program. There is a separate process that compares consumers enrollments between the DDS HCBS and DHCS HCBA. Overlapping enrollments need to be communicated to the regional centers for appropriate actions. The Department looks for the future solution to automate and streamline the enrollment comparison process to minimize manual comparisons and data corrections.

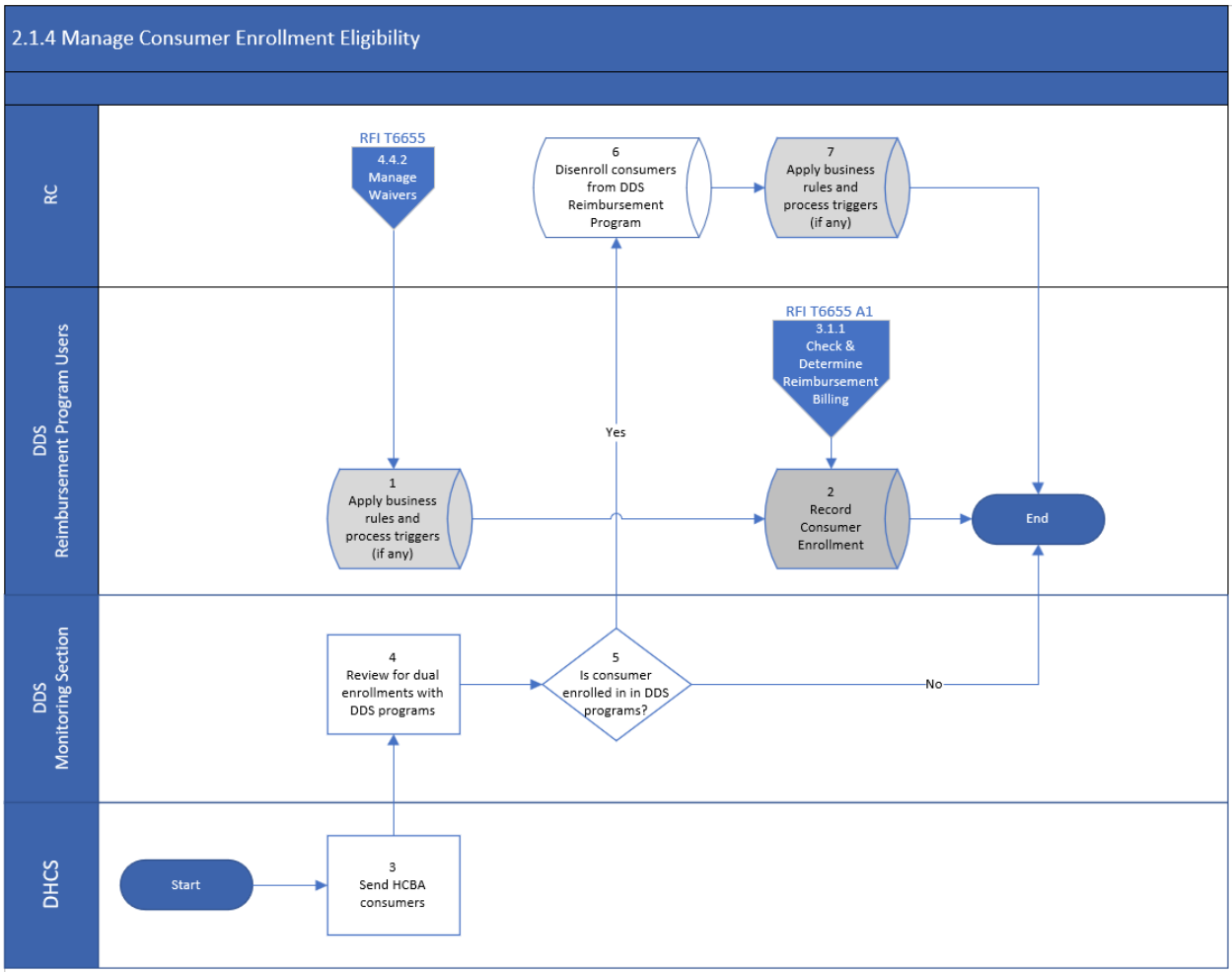


Figure 9. Manage Consumer Enrollment Eligibility

2.1.5 Manage Consumer Eligibility Criteria

This process includes functionality to determine, for each consumer, their eligibility for Medi-Cal and for Medicaid HCBS. This is determined based on a monthly mainframe to mainframe data exchange with DHCS. The determination of a consumer's eligibility for Medicaid programs is a critical step to DDS seeking federal reimbursement. The solution must record and display the consumer's eligibility status for DDS services, Medi-Cal and Medicaid HCBS within the consumer information functionality for every month. Reimbursement staff need the ability to maintain and modify the eligibility criteria according to policies (e.g., Lanterman Act and Medicaid HCBS).

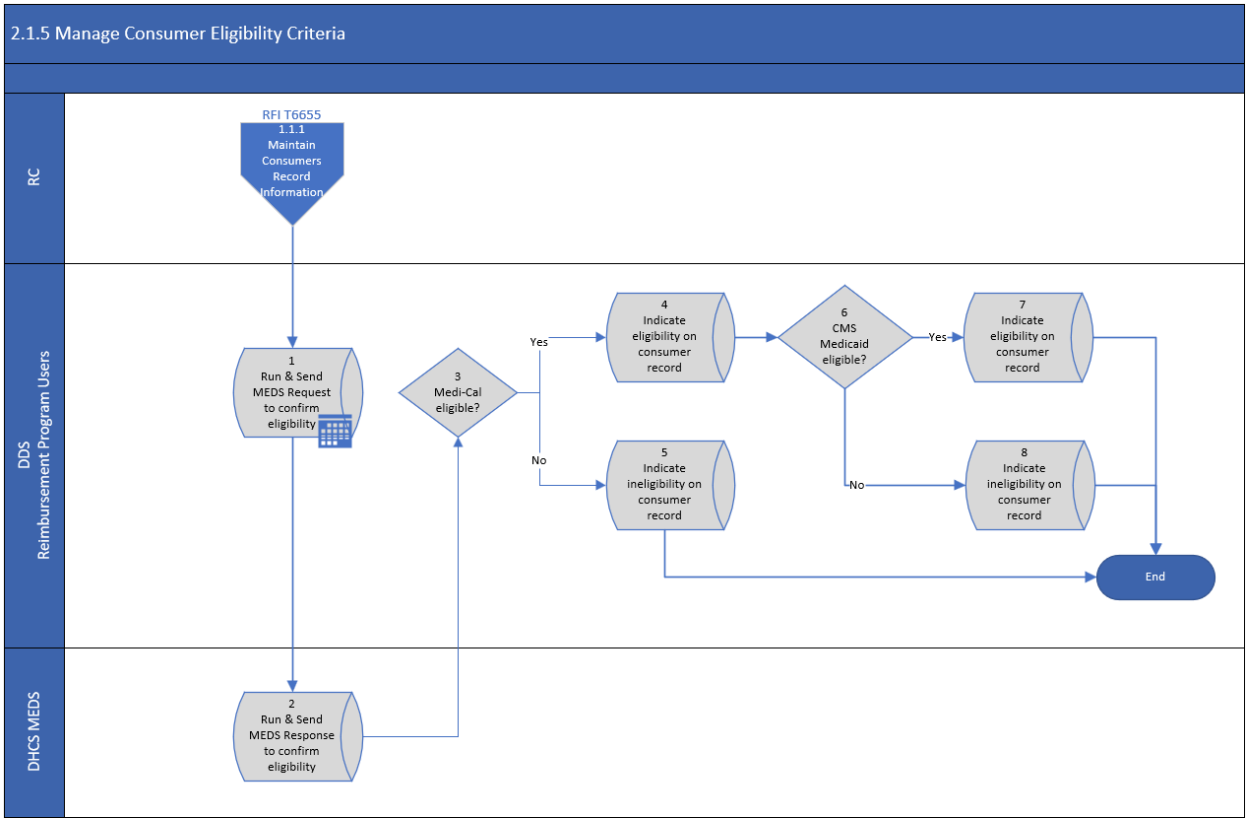


Figure 10. Management Consumer Eligibility Criteria

3.0 Reimbursement Billing & Invoicing

Reimbursement program billing must only include expenditures for services and consumers that meet Medicaid HCBS criteria. Each reimbursement program invoice includes 24 months of claims data for approximately 10 million claim records. Claims are submitted by the regional centers to DDS for services provided to consumers. The claims must be evaluated, calculated, and validated against a series of Medicaid eligibility requirements to generate aggregated reimbursement program invoices. Since the consumers and services are entitlement based, the system needs to identify the subset of claims that meet the criteria defined in to-be process 2.0. This process domain provides a conceptual narrative of how these processes may work with an integrated case and financial management system.

3.1 Reimbursement Billing and Invoicing

3.1.1 Check & Determine Reimbursement Billing

The reimbursement program billing determination process evaluates claims received from the regional centers for services provided to the consumers for reimbursement eligibility.

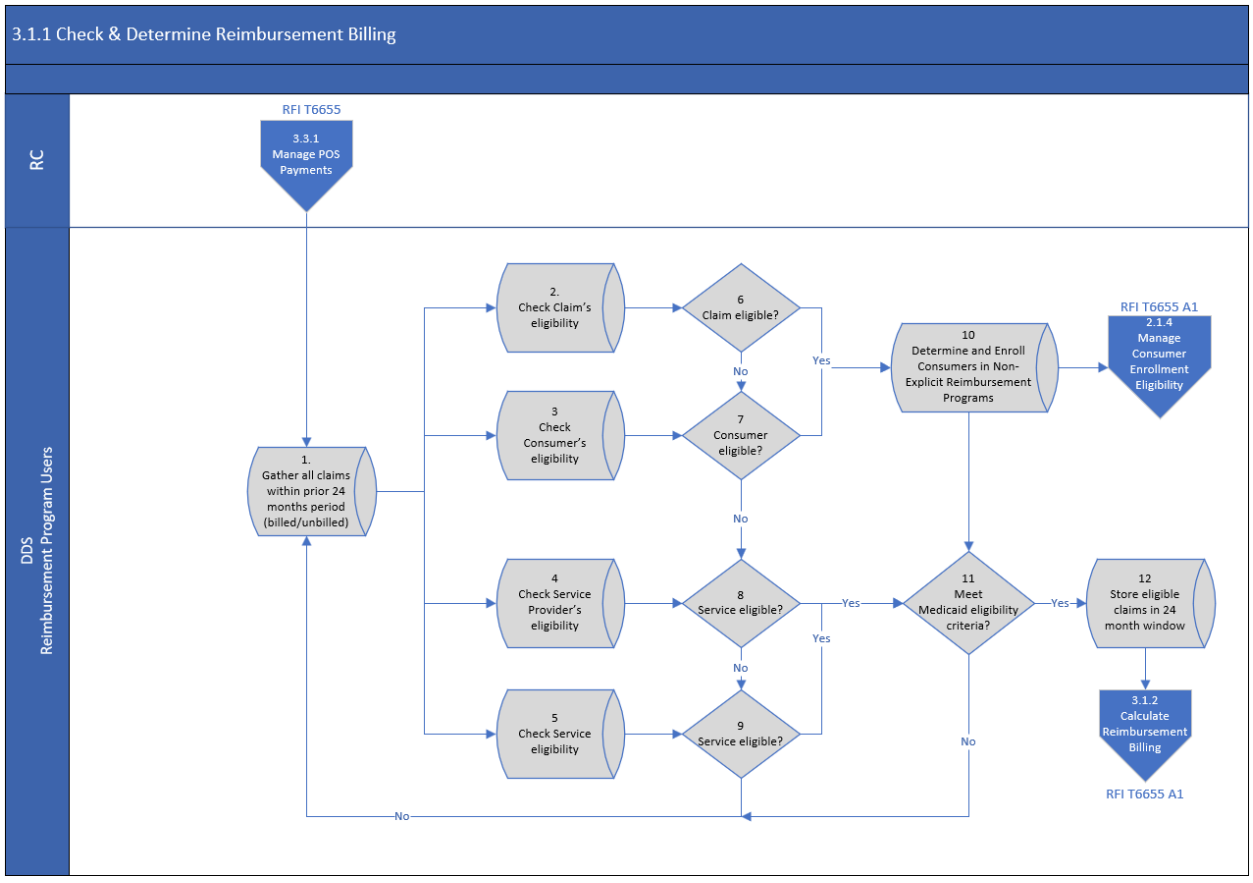


Figure 11. Determine Reimbursement Billing

3.1.2 Calculate Reimbursement Billing

This process continues from 3.1.1 when the monthly reimbursement program billing cycle runs. It will include functionality that determines if the total claim charge amount needs to be adjusted or stepped down per CMS and DDS agreements.

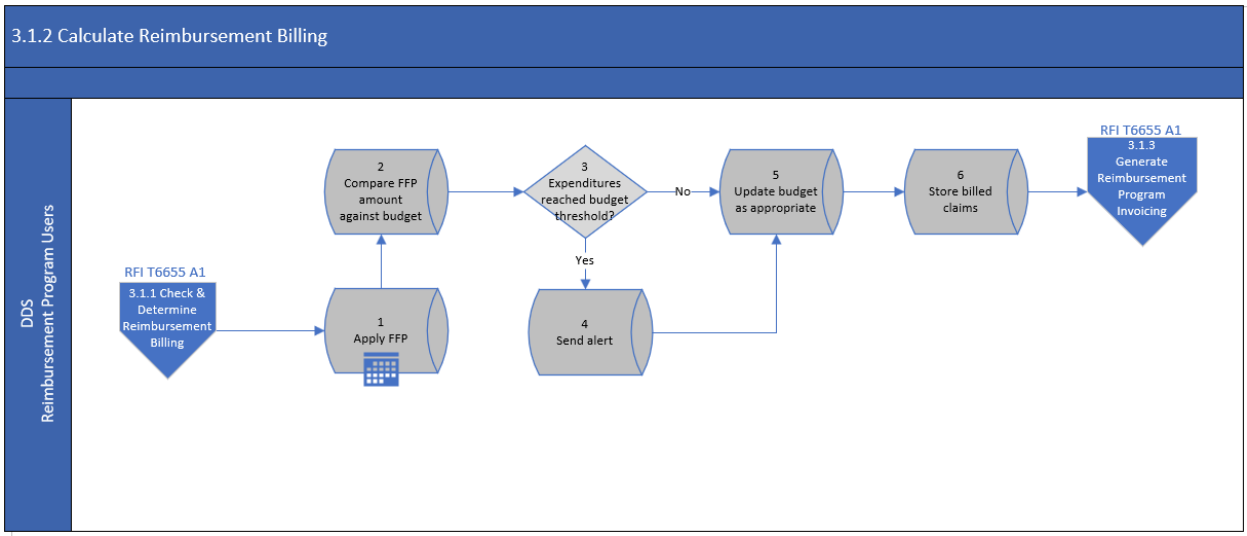


Figure 12. Calculate Reimbursement Billing

3.1.3 Generate Reimbursement Program Invoicing

This process includes the functionality related to the process of generating the required invoice components. This process details the Program Invoicing process. This allows the department to submit invoices and supporting information to DHCS, which will forward the invoice to CMS to seek reimbursement.

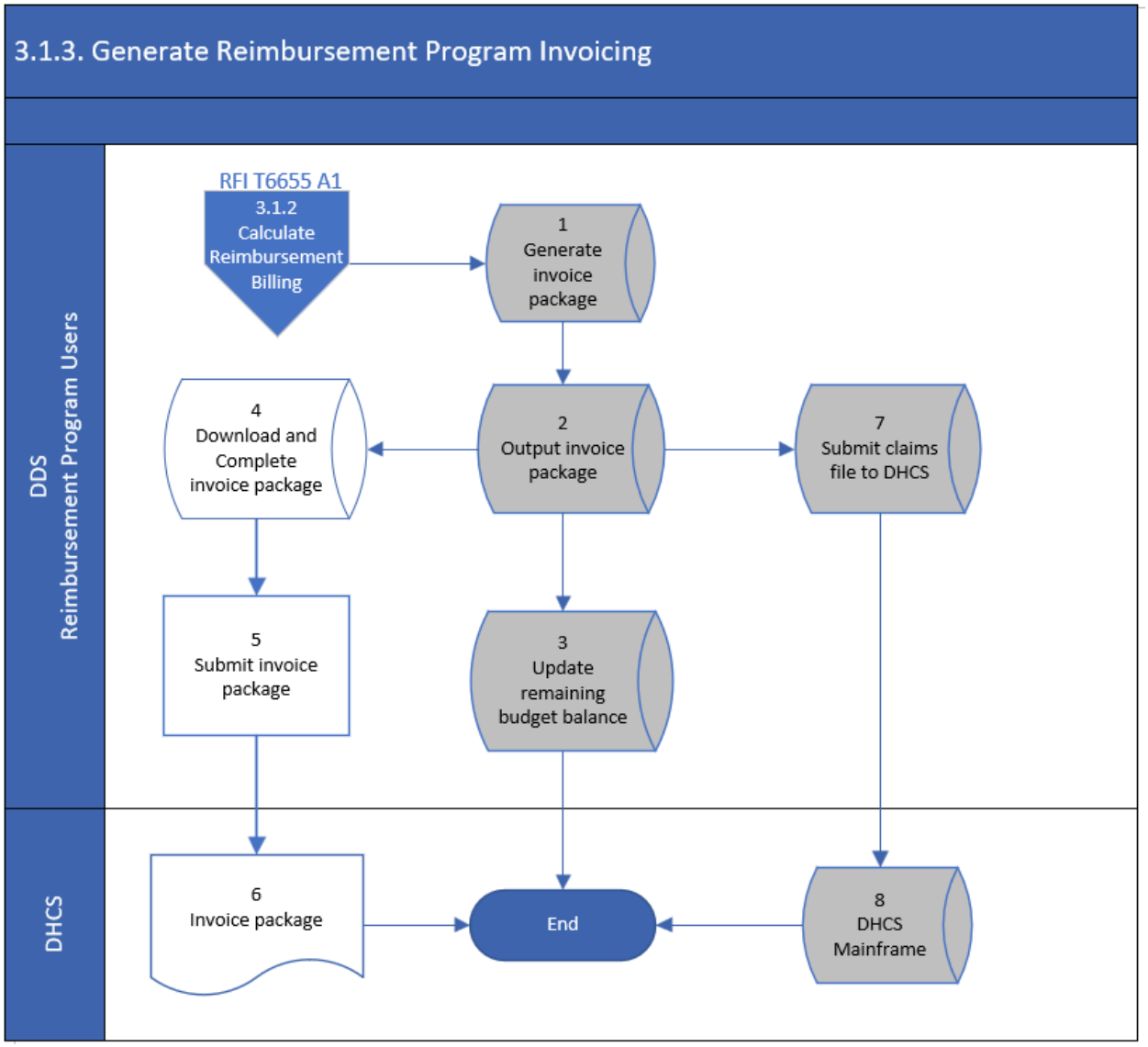


Figure 13. Generate Reimbursement Program Invoicing

6 AS-IS NARRATIVE AND WORKFLOW (Additional Info/Supplemental)

This section describes the current, as-is technology tools and processes that support the reimbursement programs.

6.1 Current Technology Overview

The department relies on the Federal Programs Information and Billing System (FPIBS)[5], to assist in managing the data exchanges, complex computations, and processes required to secure reimbursement dollars. The system was originally built in the 1980's to support a single reimbursement program and a consumer population of less than 1,000 consumers. Since then, DDS significantly expanded its service offerings and increased its consumer population.

FPIBS is hosted at the State Data Center on the IBM Mainframe environment. The application is written in the Natural programming language. The application is primarily a series of batch processes run once each month and some limited online functionality. The application code currently consists of approximately 1,060 programs/subprograms with approximately 350,000 lines of code. Some of the data resides on an ADABAS database with approximately 30 production files, and some of the data resides in flat files. Total production database size is approximately 16.5 gigabytes and contains over 45 million records. Three to five waiver years are available online and prior years are archived. The system generates over 80 reports during a single monthly billing process for a variety of purposes (validation, summation, error reporting, invoicing, etc.).

FPIBS performs five primary functions:

- Aggregates 16 data files from each of the 21 Regional Centers every month. Monthly totals average 3 million records for approximately 450,000[6] consumers but varies based on the file.
- Determines eligibility for consumers and claims, including the validation of consumer eligibility for services based on Medicaid eligibility via a monthly interface with DHCS Medi-Cal Eligibility Data System (MEDS).
- Performs data validation, generates reports, and has online functions which allow staff to work adjustments to consumer and claims data to support invoice generation for reimbursement. DDS recovers approximately five billion dollars annually from reimbursement invoicing.
- Supports operational and ad-hoc reporting to support internal and external business processes.
- Generates applicable long-paid claims (35C) details necessary to support invoicing to Department of Healthcare Services for state and federal reimbursement.

6.2 System Interfaces

FPIBS relies on a set of system interfaces to receive data and perform essential functions. The following are key interfacing systems:

[5] FPIBS goes by many names: the Waiver System, Waiver Billing System, the mainframe, etc.

[6] Consumer totals are from the September 2024 Monthly Consumer Caseload report.

- **Uniform Fiscal System (UFS)** – UFS is the business application that generates data of interest to FPIBS. Each of California's 21 regional centers maintains a separate instance of the UFS application. UFS generates a set of monthly files that are loaded into FPIBS for federal reimbursement processing.
- **Medi-Cal Eligibility Data System (MEDS)** – DDS's federal reimbursement processes are governed by Medicaid. MEDS is the State of California's system of record for Medicaid beneficiaries. FPIBS interfaces with MEDS at least once per month through a two-way flat-file exchange (request and response). The file transmits eligible consumers records, based on DDS business rules, to DHCS to determine Medi-Cal eligibility data such as identifiers, demographics, and aid codes. The DHCS MEDS interface provides monthly eligibility data for consumers for up to the prior 15 months. The record size of the average monthly MEDS data exchange is 1.5 million consumer records.
- **DHCS Mainframe** – FPIBS submits the long-paid claim file (35-C) each month, which details the claims associated with the monthly reimbursement invoicing for 1915c, 1915i, and SDP. The DHSC mainframe interface also provides access to numerous reports.
- **Microsoft Access Databases to support the ICF-SPA reimbursement program**: three databases support the ICF-SPA process to identify consumers and aggregate data specific to ICF-SPA. Interactions with FPIBS is manually performed by ITD staff, who upload data files and run system programs, the results of which are extracted from FPIBS and loaded into MS Access databases.

In addition, there are other systems that do not directly interface with FPIBS but are relevant to FPIBS business processes. These systems appear throughout this document and are defined here for reference:

- **San Diego Information System (SANDIS)** – California's regional centers perform both accounting and case management functions. UFS is the regional center business application for accounting. SANDIS is the primary regional center business application for case management. DDS has a stake in SANDIS, and works to harmonize data between SANDIS, UFS, and FPIBS, but SANDIS records are not solely relevant to federal reimbursement programs.
- **e-Billing** - The eBilling system is a front-end web application with MySQL backend. Service Providers use this application to complete and submit invoices for services provided to consumers. RC staff access eBilling for invoice verification and manage Service Providers roles and access to eBilling. DDS IT Support also supports the eBilling system. eBilling was developed with hypertext pre-processor (PHP) language and is hosted in a Zend server environment on the RCs IBM Power 8/9 iSeries server.
- **OMViewer** – OMViewer is a web-based report viewing application that is available to both DDS and regional center staff. OMViewer provides online access to some FPIBS reports, but it is not an integrated component of FPIBS, and there is no direct interface between FPIBS and OMViewer.
- **Snowflake** – FPIBS interfaces with the DDS enterprise data warehouse, which is used for a variety of operational analytic purposes.

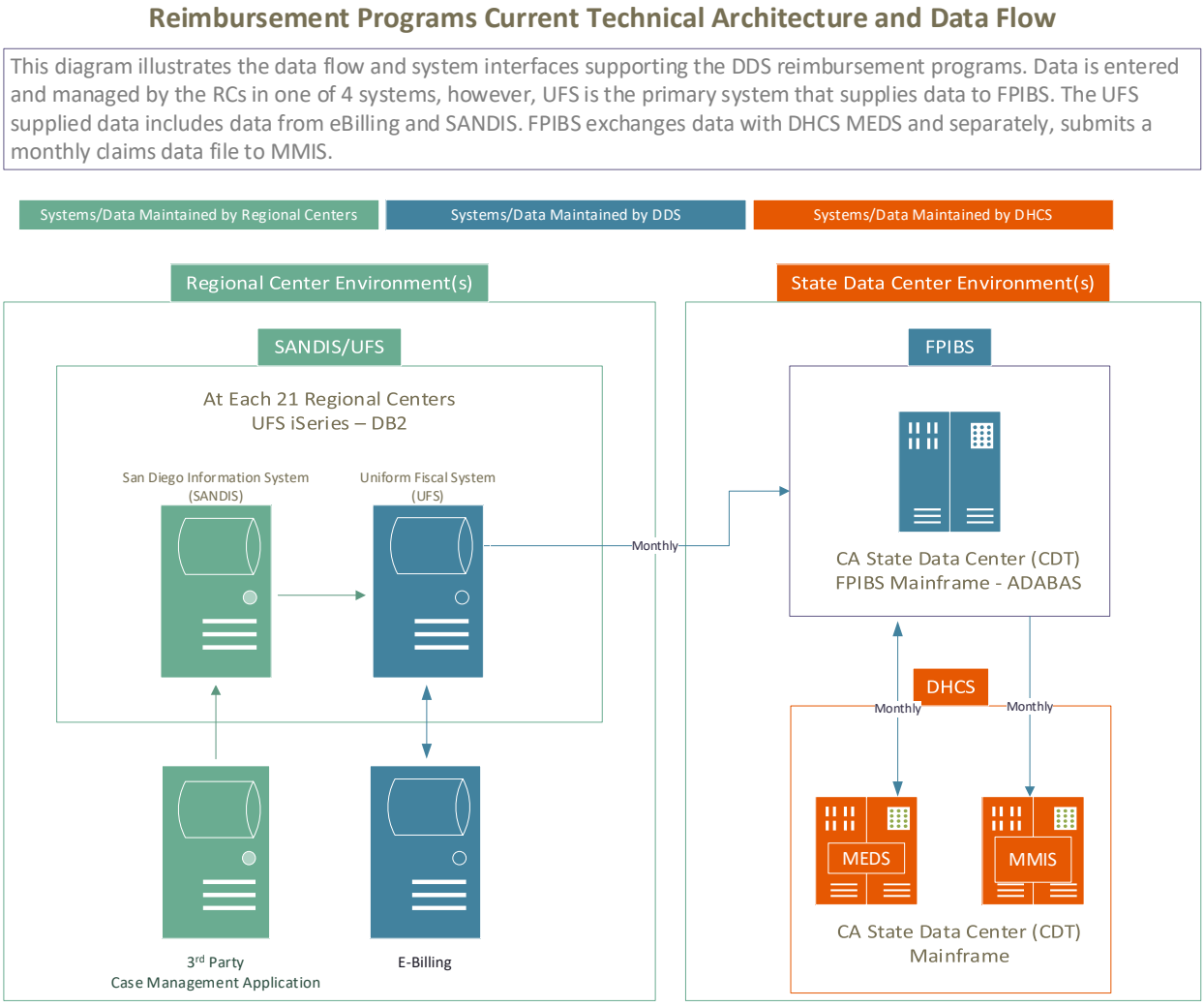


Figure 14. Conceptual Current Technical Architecture and Data Flow

6.3 As-Is Narrative and Workflows (Additional Info/Supplements)

The project team categorized the "as-is" reimbursement program processes and narrative descriptions into five process domains. The process domains are summarized in the table below.

Table 4. Reimbursement Program Process Domains

Process	Process Summary
1.0 Administration	The Department administers more than nine reimbursement programs, the majority of which are federal financial participation programs, such as the Medicaid Waiver and State Plan Amendments. Staff manage program details, financial parameters, and eligibility criteria for consumers, service providers, services, and rates.
2.0 Data Intake and Interfaces	FPIBS loads and processes data files pulled from each instance of UFS. FPIBS also interfaces with DHCS MEDS for Medi-Cal eligibility determination data on consumers. Essentially, FPIBS attempts to stage the data environment so that it can identify or assist the staff in identifying consumers and claims eligible for reimbursement programs.
3.0 Consumer Enrollment and Eligibility	FPIBS indicates for each consumer for each month the status of the consumer to receive DDS services, enrollment status at a regional center, enrollment status in a reimbursement program (specific to 1915c and SDP), eligibility for Medi-Cal, and eligibility for Medicaid. Staff perform many error correction processes in FPIBS, largely due to deficiencies in the case management record capabilities and how these transmit in a flat file to FPIBS.
4.0 Billing and Invoicing	FPIBS assesses each claim, each month, for the prior 24 months of claims based on a variety of business rules. The assessment determines if a claim meets criteria to be submitted for reimbursement. FPIBS produces data extracts used by staff to generate invoices and produces a detailed claims file that is submitted to DHCS via the mainframe.
5.0 Reporting and Analytics	FPIBS produces numerous standard and paginated reports for staff to review and perform business processes.

1.0 Administration

DDS staff use FPIBS administrative menus to manage business objects and reference data, such as reimbursement program parameters, service codes, rates, accounting codes, object identifiers, and so on.

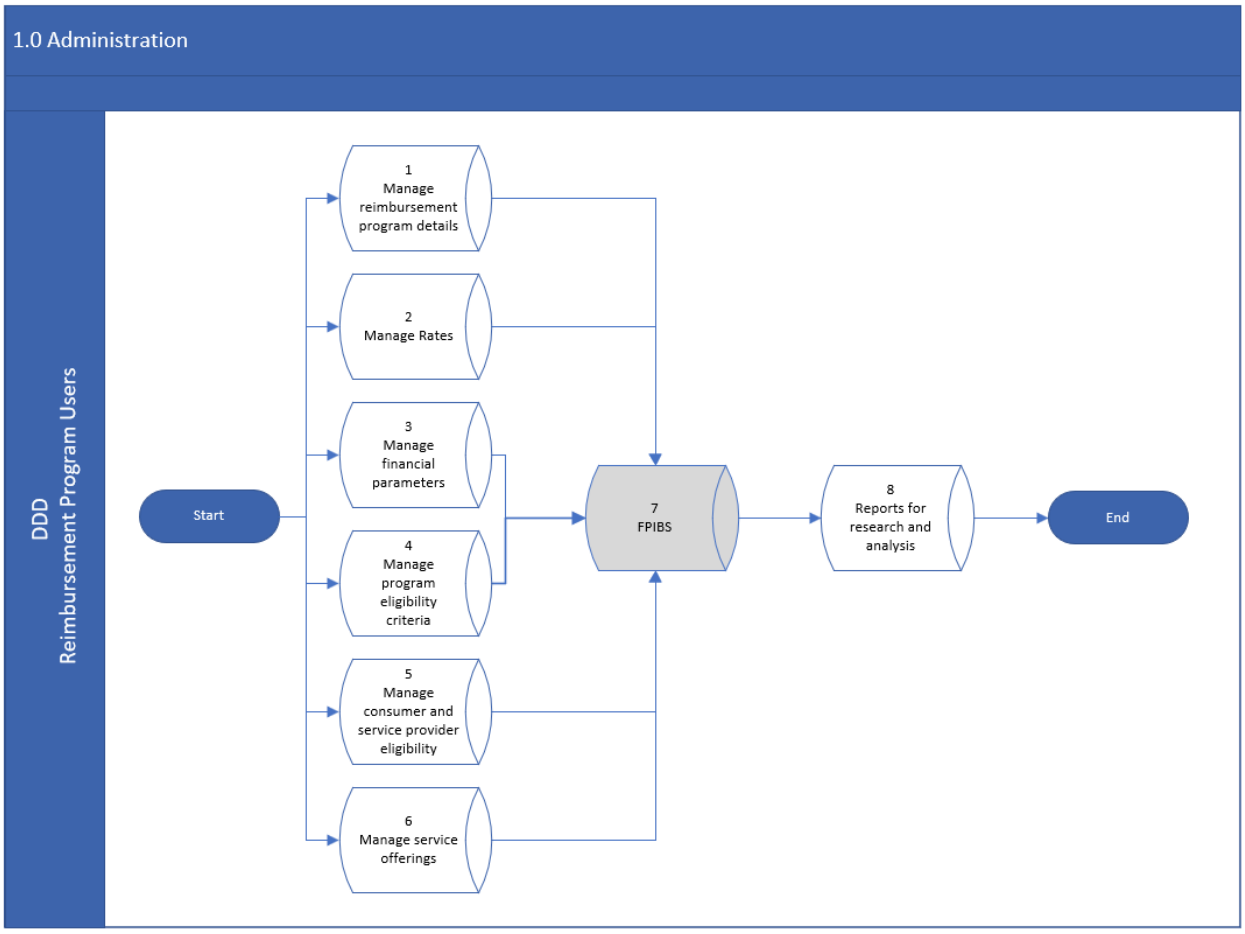


Figure 15. Administration

2.0 Data Intake and Interfaces

Each of the regional centers submit sixteen (16) data files to the Department via Secure File Transfer Protocol (SFTP). FPIBS pulls the submitted data files and performs front-end verifications, identifies completeness of the data files, and provides data quality information back to the regional centers. Once the data passes completeness and quality checks, FPIBS then performs data summation processes where 336 files (21 regional centers x 16 files) are merged into one file for each file type. The files are reviewed and formatted for mainframe loading to update the master files.

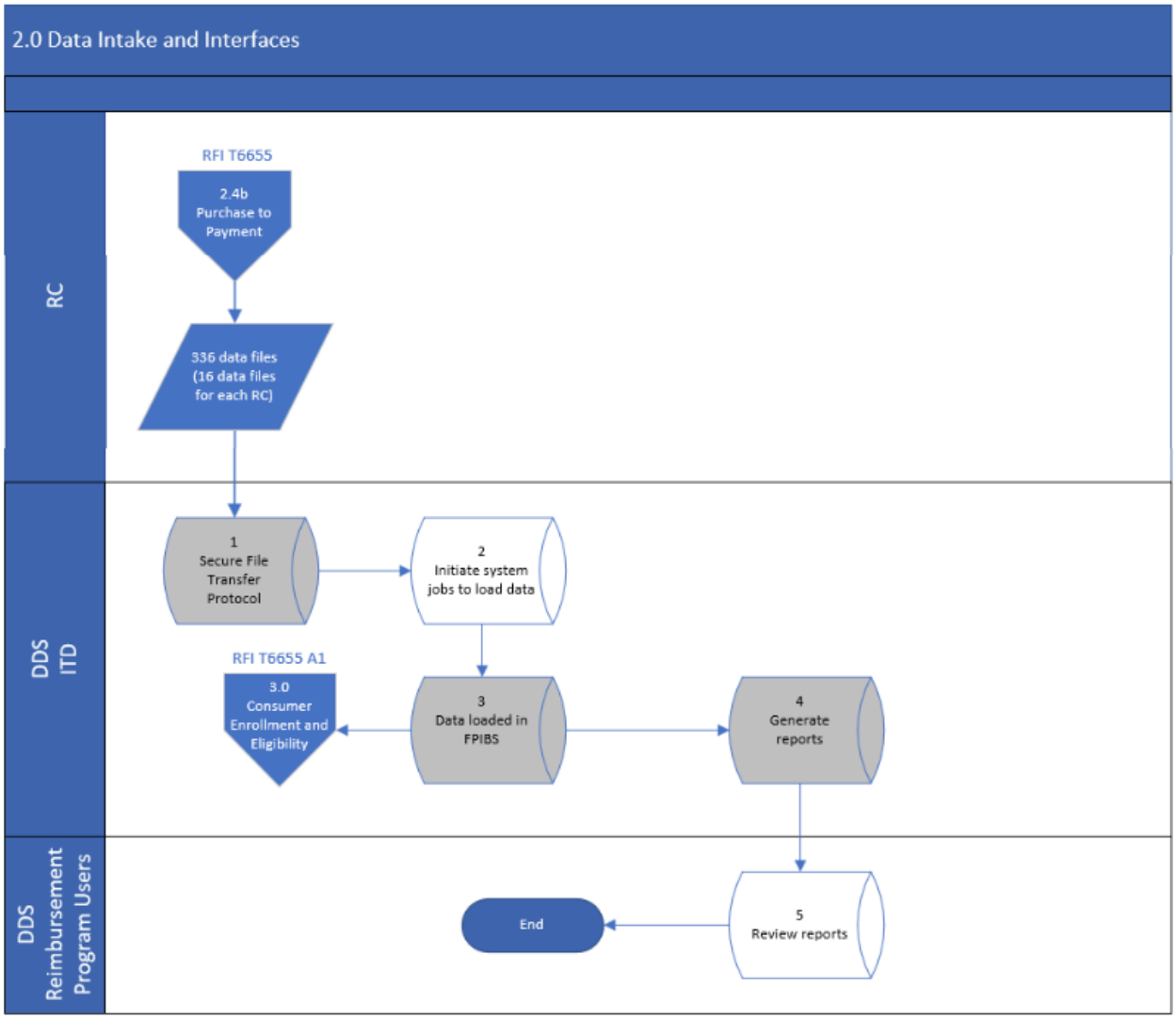


Figure 16. Data Intake and Interfaces

3.0 Consumer Enrollment and Eligibility

The consumer eligibility process determines if the consumer is eligible for Medi-Cal and Medicaid. To verify Medi-Cal eligibility, consumer data is shared with Department of Healthcare Services (DHCS), as a secure mainframe-to-mainframe exchange.

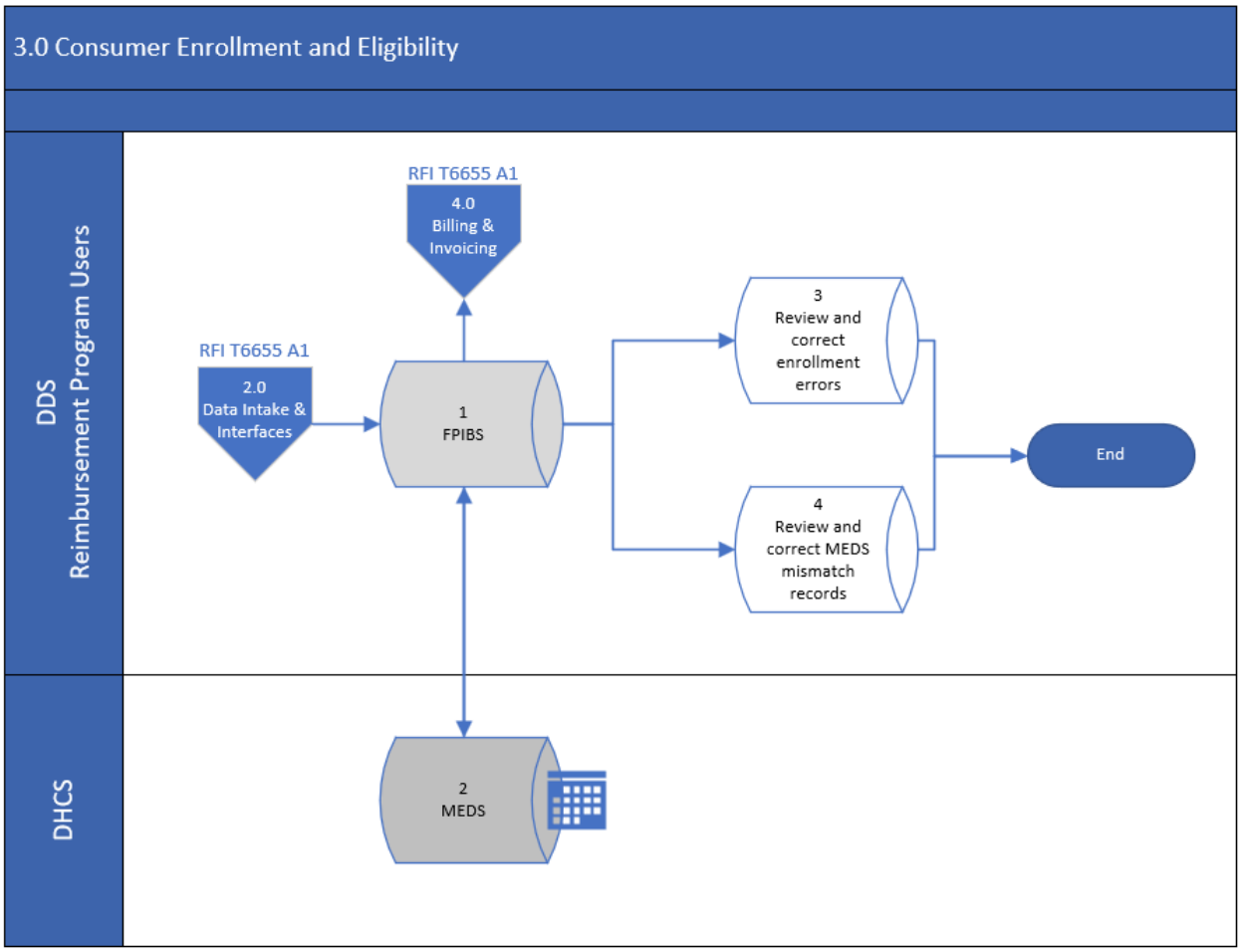


Figure 17. Consumer Enrollment and Eligibility

4.0 Billing and Invoicing

The eligible claims are aggregated by reimbursement program. Currently, FPIBS identifies claims for the Medicaid Waiver reimbursement program first; the remaining claims are then assigned to the other reimbursement programs. FPIBS generates billing reports which are used to create paper invoices and accounting details for each reimbursement program. FPIBS creates a long-paid claim detail file while the CMS Feeder Form is created through a service request to the Enterprise Data Operations team to categorize and sum up the different service codes per CMS requirement and accompany the invoice. The long-paid claim file is submitted mainframe-to-mainframe, and the invoice is submitted to DHCS in hardcopy.

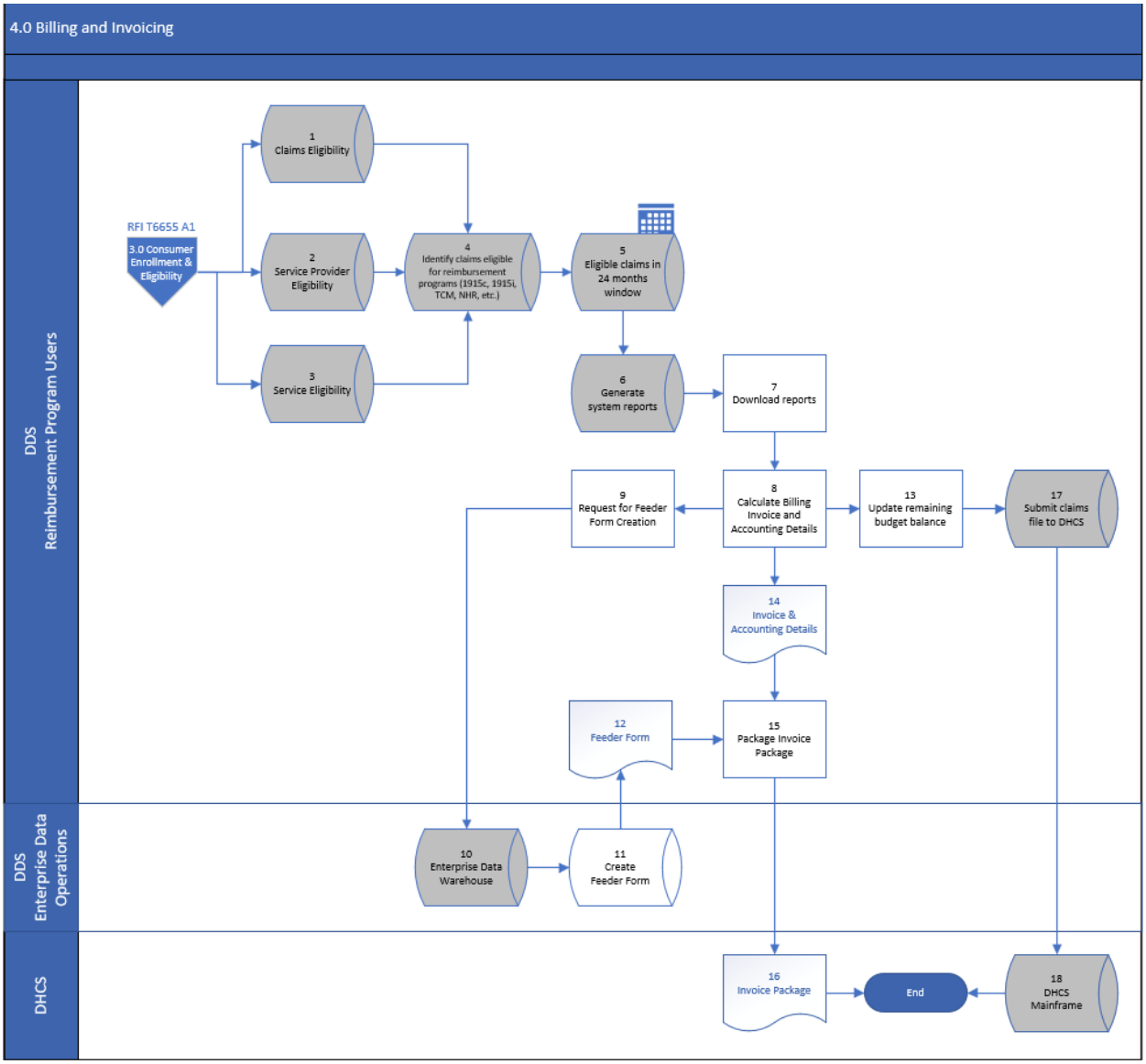


Figure 18. Billing and Invoicing

5.0 Reporting and Analytics

FPIBS generates and distributes a set of reports as part of the monthly billing process. DDS use many of these reports for routine analytical activities, such as quality assurance. Staff also perform numerous on-demand consumer and claims reporting and research activities at the request of the regional centers and other units within the department.

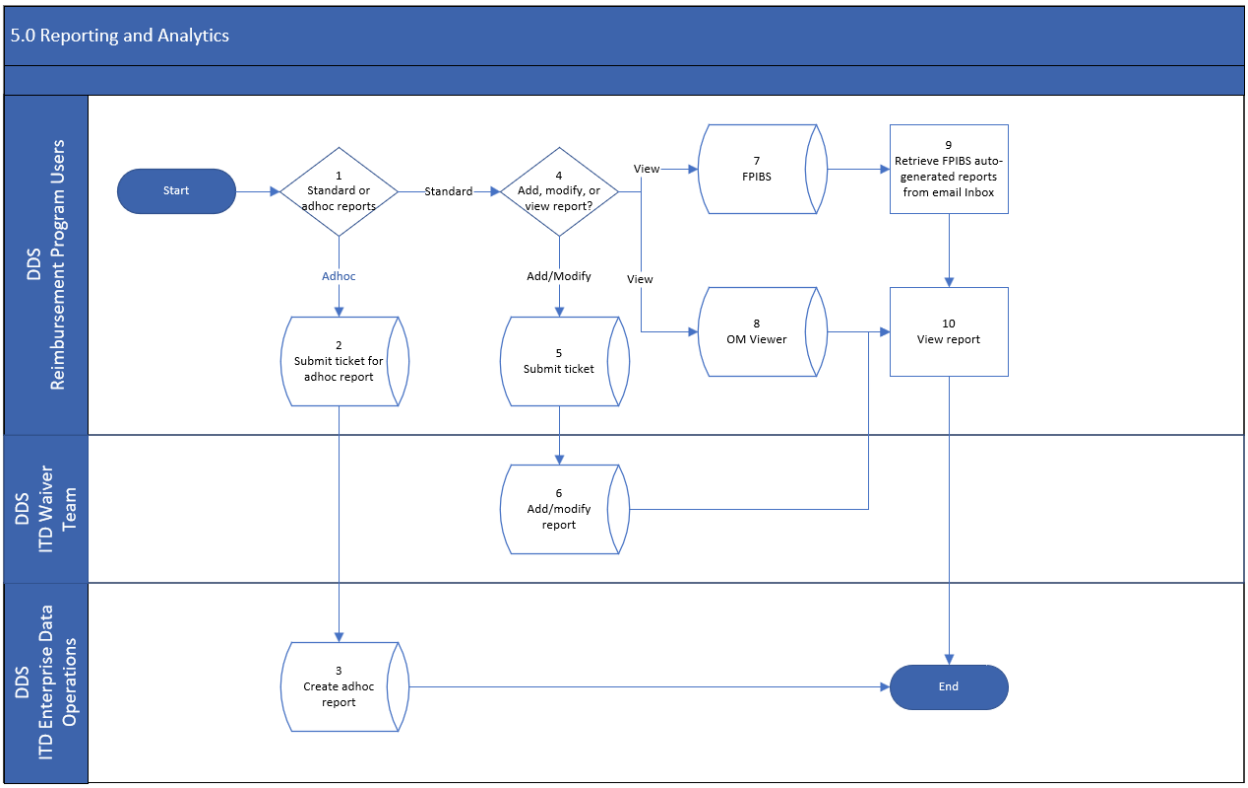


Figure 19. Reporting and Analytics

7 GLOSSARY

The table below includes terms and acronyms used throughout the RFI document which may require additional definition.

Term or Acronym	Description
Agreement Number	Interagency agreement number assigned for DDS/DHCS
Authorization Number	Federal waiver authorization number
CMS	Center for Medicare & Medicaid Services
DDS	California Department of Developmental Services
DHCS	California Department of Health Care Services
FFP	Federal Financial Participation is the reimbursement ratio determined for Medicaid reimbursement.
FPIBS	Federal Programs Information and Billing System, maintained and operated by CDDS.
HCBS	Home and Community Based Services, established within section 1915(c) of Title XIX of the Social Security Act.
HCPCS	Healthcare Common Procedure Coding System is a set of standardized codes used across Medicare and other health insurance programs to process claims in an orderly and consistent manner.
Medi-Cal	It is a no-cost and low-cost health coverage for eligible individuals who reside in California. It is California's version of the Federal Medicaid program. The program is overseen by the Department of Health Care Services.
MEDS	Medi-Cal Eligibility Data System, maintained and operated by DHCS.
Policy Number	For each reimbursement program, or federal waiver or State Plan Amendment agreement, the Department of Health Care Services assigns a policy number. Typically, this is assigned annually.
RC	Regional Centers
SPA	State Plan Amendment

Term or Acronym	Description
SANDIS	San Diego Information System
UFS	Uniform Fiscal System
WASPAA	Waiver and State Plan Amendment Administration team oversees the reimbursement programs.