MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR Part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available; we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory:_____California_____
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name:	Lesley Cummings	Name:	Stan Rosenstein
Position/Title:	Executive Director	Position/Title:	Deputy Director, Medical Care Services
Department:	Managed Risk Medical Insurance Board	Department:	Department of Health Services

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1. ☐ Obtaining coverage that meets the requirements for a separate child health program (Section 2103); OR

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX); OR

1.1.3. ☒ A combination of both of the above.

Introduction

Shortly after enactment of the federal Children's Health Insurance Program, Governor Wilson developed a program for implementing the Initiative in California. He submitted his legislative package to the legislature in August of 1997 and the legislature worked with the Governor to enact the Healthy Families program in the last weeks of the 1997-98 legislative sessions.

With its Healthy Families Program, California seeks to expand access to health care coverage for uninsured children through:

- Creation of a health insurance program for children whose family incomes are above those which provide eligibility for no cost Medi-Cal up through 200% of poverty;
- Changes to the Medi-Cal system which will improve access by simplifying eligibility; and
- Coverage through the Access for Infants and Mothers (AIM) Program of infants jp to 12 months whose family income is between 200-250% FPL.

California's program consists of the following pieces of legislation, which are included in the plan as Attachment 2.*

- Chapter 623 (AB 1126 -Villaraigosa) outlines the Healthy Families insurance program which provides affordable private health insurance plans for low-income children either through a health insurance purchasing pool or an insurance purchasing credit. The legislation details program administration, eligibility criteria, monthly premiums, benefits, the program application process, and outreach activities;

*Attachment 1 is a glossary of terms used in the State Plan.

- Chapters 626 and 624 (AB 217 - Figueroa and SB 903 - Lee /Maddy) enact several provisions designed to improve access to Medi-Cal for Medi-Cal eligible children; and
- Chapter 625 (AB 1572 - Villaraigosa/ Gallegos) appropriates start-up funds for the Healthy Families program.

Many children will come to Healthy Families through the Healthy Families "gateway" program, the Child Health and Disability Prevention (CHDP) program. Families of uninsured children receiving health screens from CHDP will be informed about the opportunity for health coverage. Those families wishing to pursue comprehensive coverage will be directed either to Medi-Cal or into the insurance program.

In the insurance program, children will receive health coverage like that provided to California's state employees under California's benchmark plan, the California Public Employees Retirement System (CalPERS). They will also receive comprehensive vision and dental coverage patterned after state employee coverage. Children with certain complicated medical conditions will receive treatment of those conditions through California's highly regarded California Children's Services (CCS) program. Similarly, children with serious emotional disturbances will receive treatment of their condition from county mental health departments. This comprehensive child focused benefits package provides children with preventive, full scope, quality health care which will help promote healthier children and, as a result, healthier families for the state of California.

California will seek to ensure that children's health plans become their medical homes by emphasizing preventive services, coordinating with programs that currently serve the uninsured and weaving quality measurement and monitoring into the fabric of the program. California will require specified performance measures in its contracts with plans and will build on these as additional measures are developed.

The Department of Health Services (DHS) will be responsible for implementing the outreach and Medicaid changes proposed in the Title XXI state plan as well as ongoing administration of the CCS and CHDP programs.

The Managed Risk Medical Insurance Board (MRMIB) will be responsible for administering the purchasing pool, the purchasing credit, and the AIM program. MRMIB has a strong commitment to providing affordable quality health care to Californians. MRMIB currently administers three health insurance programs: the Major Risk Medical Insurance Program (MRMIP), a program for medically uninsurable people, the Health Insurance Plan of California (HIPC), a small employer purchasing pool and the Access for Infants and Mothers (AIM) Program, a program for uninsured pregnant women and their newborns. (The state also seeks FFP for infants through age 2, born to mothers enrolled in the AIM program.)

1.2. ☒ **Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))**

1.3. ☒ **Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)**

1.4. ☒ **Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):**

Effective date: February 1, 2004 for the Rural Health Demonstration Projects

Implementation date February 1, 2004 for the Rural Health Demonstration Projects

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.**

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

Overview of the Comprehensive Healthy Families Delivery System

California's approach is to serve targeted low income children through an integrated system of care. The central component of this system is a new program to provide creditable health insurance coverage through managed care, a program which will be administered by MRMIB. MRMIB will provide managed care to targeted low-income children between ages 1 and 19, and children under age 1 with incomes between 200 and 250 percent FPL through a health insurance purchasing pool. Through the purchasing pool the state will deliver a comprehensive range of health services to targeted low income children. The state will use the power of pooled purchasing not only to obtain affordable coverage for uninsured children but also to demand high quality services for children.

Many children will come to Healthy Families through a "gateway" program, the CHDP program. CHDP offers preventive health services to children under 200 percent of poverty. When children receive services from a CHDP provider, they will either be referred to Medi-Cal or to the Healthy Families insurance program. Should follow up treatment be required for a condition identified in the CHDP screen, Medi-Cal or the insurance program (depending on which program the child qualifies for) will cover the cost of care provided to children for 90 days prior to enrollment. Low income children who are ineligible for Medi-Cal or the insurance program will be referred to counties for treatment.

To meet the special needs of children, the Healthy Families program will also ensure the provision of necessary specialized services beyond those offered through the comprehensive insurance package in a coordinated manner. The CCS program and county mental health departments will address the significant needs of the minority of children whose needs may not be fully met under an insurance benefit package. The CCS program will provide case management and treatment for chronic, serious, and complex physically handicapping conditions, while county mental health departments will provide appropriate services to meet the needs of seriously emotionally disturbed children. Both programs will reimburse providers for these specialized services.

Children receiving such services will continue to have their primary health needs served through the insurance program. Allowing those specialized services to be provided as a complement to, but outside of, the managed care setting is consistent with recent actions in the Federal budget reconciliation act which prohibit mandatory enrollment of children with special medical needs in managed care.

To promote a smooth interface between Healthy Families and Medi-Cal, Medi-Cal will be enhanced through a resource disregard for children in the federal poverty level program, accelerated coverage for all children under 100 percent of the federal poverty level, and an additional one month of continued eligibility to allow children whose families become ineligible for Medi-Cal time to become enrolled in the insurance program. In addition to program integration, these features will promote greater coverage of children who are already eligible for, though not enrolled in, Medi-Cal. Under this Medicaid expansion, children without health insurance will receive their coverage under Title XXI funding. Children with health insurance will receive their coverage under Title XIX funding with the applicant's other health coverage requirements being applied.

Targeted low income children under age 2 whose mothers are enrolled in AIM and whose families have incomes between 200- 300% of federal poverty level will be served through the Healthy Families Program. The Healthy Families Program will redetermine eligibility prior to the child's first birthday. Prior to the child's second birthday, the Healthy Families Program will redetermine eligibility for the S-CHIP Healthy Families Program.

The authorizing statute for Healthy Families also requires the state to assess the need for specialized services in two additional areas: rural health and substance abuse.

Rural health. On December 21, 1999, the US Department of Health and Human Services approved a State Plan amendment which included supplemental rural health services. The supplemental services, referred to as the Rural Health Demonstration Projects, were established to improve access to health care services for medically underserved and uninsured populations in rural areas and special populations who have rural occupations (farm workers, loggers, etc.). At the inception of the Rural Health Demonstration Projects, $6 million ($2.038 million State General Fund, and $3.962 million FFP) in augmentation was authorized in state law to develop and enhance existing health care delivery networks through contract amendments with participating HFP health, dental and vision plans. This augmentation addressed geographic access barriers and access barriers for special population subscribers enrolled in the HFP.

In the recent state budget act, the source of state funds for the Rural Health Demonstration Projects has changed. The Tobacco Tax and Health Protection Act of

1988, as added by Proposition 99, established the Cigarette and Tobacco Products Surtax fund. These funds are to be allocated for use in tobacco education and tobacco use prevention programs, tobacco-related disease research, environmental protection and recreational resource enhancement programs, and health care services for low-income, uninsured Californians. MRMIB was appropriated Proposition 99 funds in the State's 2003 Budget Act and authorized in State law (Chapter 161, Statues of 2003) to use these funds as the match to draw Title XXI SCHIP funds for the Rural Health Demonstration Projects.

Substance abuse. The authorizing statute directs MRMIB, in consultation with the Department of Alcohol and Drug Programs, to assess the feasibility of providing supplementary services for substance abusers. The core benefit package includes those services made available to state employees, but some have argued that additional services are necessary for the target population. MRMIB will report to the legislature on the need for additional services by April 15, 1998. The state will submit an amendment to this plan if it wishes to expand substance abuse services.

Healthy Families Purchasing Pool

Delivery System. For the majority of eligible families, MRMIB will offer access to health plans through a subsidized consumer choice purchasing system. The pool will be built around the concepts used successfully by organized purchasers such as the California Public Employees Retirement System (CalPERS) and HIPC -- price competition among managed care health plans, family choice of plans, performance based contracts with plans, and reliance on existing private sector delivery systems. In the purchasing pool, many of the same health plans and networks available in the employer market will be available to beneficiaries, providing broad access to health care providers. Most of the plans participating will be health maintenance organizations (HMOs), but it is possible that one or more preferred provider organizations (PPOs) will also participate. PPO's participate in several of MRMIB's programs and are a particularly effective means of providing coverage in areas with little or no penetration by HMO's.

Plan Contracting. MRMIB is authorized to contract with licensed health plans and health insurers as well as Local Initiatives approved by the Department of Health Services to provide service to Medi-Cal beneficiaries, County Organized Health Systems (COHS), and federal Health Insuring Organization demonstration projects such as Santa Barbara's COHS. Participating plans will be under the regulatory authority of California's Department of Insurance or Department of Corporations, and subscribers will be able to take any benefit grievances to those regulators. Eligibility grievances are appeal able to MRMIB. COHS are presently overseen by the Department of Health Services, but will be required to obtain Knox-Keene licensure

within two years to participate in Healthy Families.

To assure that health care providers currently serving low income families are given the opportunity to participate in the program:

- MRMIB will encourage private managed care plans to subcontract with safety net providers and require them to report annually on the number of subscribers selecting these providers.
- MRMIB will allow the health plan in each county that has the highest percentage of traditional and safety net providers in its provider network to charge a discounted premium.
- County managed care systems (county organized health systems and Local Initiatives) are allowed to participate in the pool and, in the case of COHS's, given two years to obtain licensure as private health plans.
- MRMIB will give priority in contracting to plans with significant numbers of providers who serve uninsured children.

Plan Contracting Process. The process that MRMIB will use to contract with health plans will be the process it uses to contract with health plans under its three existing programs. MRMIB will first adopt (emergency) regulations detailing the eligibility, benefits and appeals process for the program. It will then issue model contracts, one for the administrative function, and one each for health, dental, and vision plans, which specify MRMIB's contracting requirements. The model contracts issued by MRMIB serve as the basis of negotiations with all vendors. These contracts will contain numerous requirements, ranging from quality standards, participation of safety net providers, communication standards, grievance procedures, and manner of payment. Many of the provisions will be aimed at developing a medical home for children. These provisions include:

- Performance standards regarding provision of health promotion service, such as immunizations;
- Requirements that families receive ID cards, evidence of coverage documents, and physician and hospital directories on the effective date of coverage;
- Requirement to report on grievances; and
- Requirements to publish materials in specified languages.

MRMIB traditionally contracts with health plans for two years. It continually refines and improves the requirements of the contract prior to each new contracting period. It will be able to incorporate in subsequent contracts the indicators of a high quality medical home once such measures have been developed.

Both the regulations and the model contracts will be adopted in public session by

MRMIB after the public has had the opportunity to testify on them. Once the model contracts are adopted, MRMIB staff will meet with any and all potential contractors. Those interested in participating will be required to submit signed contracts, together with their price for services, at a certain time. MRMIB staff will review contracts for compliance with requirements and MRMIB will select contractors offering the state the best value. MRMIB can select as few or as many health, dental, and vision plans as it deems appropriate and is not constrained to select the lowest bidder(s).

MRMIB has a reputation for expeditious implementation of the programs it administers. Each of the three existing MRMIB programs opened for enrollment within nine months of enactment of authorizing legislation. Mindful of the urgent needs of California's uninsured children, MRMIB has adopted a similarly aggressive schedule for enrollment to the pool.

Administration. The purchasing pool and purchasing credit components of the program will be privately administered under the oversight of MRMIB. A mail-in application process will be used, and eligibility determination will be completed within an estimated ten days. The application (intended to be as similar as possible to a planned redesigned Medi-Cal application for children) will be designed to verify the income eligibility of families and to screen them for access to employer sponsored coverage as well as coverage under no cost Medi-Cal. As is done in the AIM program, income eligibility will be verified using copies of last year's federal income tax forms or current year wage stubs. A random sample of applications will be audited using the Income Eligibility Verification System (IEVS) on an on-going basis to ensure the fiscal integrity of the program.

The administrative contractor will be responsible for eligibility determination, premium collection, transmission of enrollment information to health plans, and printing and mailing of application materials.

In addition, an application assistance payment will be made to entities able to refer large numbers of children to the program. The types of entities anticipated to be authorized by MRMIB for receipt of the fee include state maternal and child health contractors, school districts, parent-teacher associations, Healthy Start sites, county health departments, county welfare offices, licensed day care operators, and insurance agents or brokers. A flat fee of $50 will be paid to the referring entity for every family that is determined to be eligible for and enrolled in the program.

Quality Oversight. Consistent with its administration of its three existing programs, the MRMIB will look to the state regulatory entities to assure the basic quality of health plans with regard to financial stability, adequacy of network, and appropriateness of medical policy. In addition, to ensure that a health plan becomes a child's medical home, the best practices available for quality improvement and

monitoring will be adopted. Such performance standards could include assuring the accessibility of services (such as wait time for appointments) and the delivery of preventive treatments (such as improvements in the percentage of children that are fully immunized by age two).

Coordination with Other Programs. MRMIB will encourage all plans to develop protocols to screen and refer children needing services beyond the scope of the program's benefit package to public programs providing such services and to coordinate care between the plan and the public programs. This could include the regional centers for the developmentally disabled, county substance abuse programs and local education agencies.

MRMIB will also be coordinating eligibility with the state Medi-Cal program by referring children who appear to be eligible for Medi-Cal to the county for follow-up. MRMIB and Medi-Cal are also assessing the feasibility of using the same application form for both programs so that applications could simply be mailed for processing.

The application assistance fee, which MRMIB will pay for referrals of eligible children, is another feature which will facilitate coordination with public and private entities. MRMIB will specify those agencies and persons in regulation after public hearing, but anticipates authorizing a wide range of entities including insurance agents, PTA's and county maternal and child health contractors.

Outreach Efforts. A statewide outreach effort will be launched to inform parents about the child health services offered through programs such as Healthy Families and Medi-Cal. The outreach program will use mass media, toll free phone lines, community based organizations, and coordination with other state and local programs to deliver messages that are culturally and linguistically appropriate. (See Section 5 for a more detailed description of the outreach activities.)

Child Health and Disability Prevention Program

To maximize access, continuity of care, and ease of administration, the existing CHDP program which provides preventive health screening examinations for children with family incomes of less than 200 percent of the federal poverty level will be integrated into the design of the Healthy Families program. CHDP is a logical point of entry for the target population to be served for many reasons:

- Targeted low income children eligible under Title XXI currently access preventive health services offered through CHDP;
- CHDP providers are likely to be the providers in the child health insurance plans and serve as the "medical home" for children enrolled in plans; and

- Integrating CHDP as a component of Healthy Families provides the new program with acceptability and credibility for providers and families.

To assure that uninsured children in the target population move smoothly into enrollment in either the Healthy Families or Medi-Cal programs, California will adopt a form of limited retroactive eligibility. Once enrolled in one of the programs, a child will be provided 90 day retroactive eligibility to the date of the screening visit for payment for services related to health, dental or vision care needs identified at the initial visit. The cost of these services will be reimbursed on a fee for service basis (at Medi-Cal rates) during the period from application to enrollment and will be paid by Medi-Cal for children enrolled in Medi-Cal and by MRMIB for children enrolled in the insurance program.

A streamlined system will be developed which will provide for identification of eligibility for Healthy Families or Medi-Cal at the time of a health screening so that providers have a mechanism for delivering care and receiving payment. The services available during this period of retroactive eligibility will be specified in regulation. Appropriate referral will also be made to the CCS program if the problem identified through the screening examination appears to be a CCS eligible condition. To ensure continuity of care whenever possible, referrals for treatment services will be made to providers in the Healthy Families insurance plan which the family has chosen. During the period between application and enrollment, the county CHDP program can assist with identification of providers, scheduling appointments for identified health care needs, coordination of services, and completion of the application form.

Specialized Services

Mental Health. A basic benefit package of mental health services will be provided by the health care plans. This basic package for mental health treatment includes 20 outpatient visits, and 30 inpatient mental health days per year. While it is anticipated that the great majority of the mental health needs of children will be met under the insurance benefit package, it is recognized that some seriously emotionally disturbed children will require more specialized mental health services. Consistent with the treatment of similarly situated privately insured populations, these children are eligible for specialized mental health services through the county mental health system of care. Children with serious emotional disturbances (estimated at between 3-5% of the general population) will be referred by the health care plan to the county mental health program for treatments, pursuant to a Memorandum of Understanding (MOU) between the two organizations for any needed additional mental health services.[1] The

1 *Definition of Serious Emotional Disturbance from Welfare and Institutions Code:* "For the purposes of this part, 'seriously emotionally disturbed children or adolescents' means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of he Diagnostic and Statistical Manual of Mental Disorders, other than a

required MOU will formalize this important arrangement. (The description of services available is in Attachment 6.) The county mental health program will coordinate the delivery of mental health and other health services with the health care plan for those children who meet the criteria of serious emotional disturbance.
County mental health programs will provide mental health treatment services directly or through contracts with private organizations and individual providers. The requirements for provider selection and quality improvement for these mental health services will be consistent with those used for the Medi-Cal program for a similar population.

California Children's Services Program. Integrating the CCS program into Healthy Families is a logical way to ensure that uninsured low income children with serious health conditions will continue to have access to a program highly respected by the medical community because of its focus on high quality care. Children with chronic, serious, and complex physically handicapping conditions are best served by systems and programs which have been organized specifically to serve them. It is important that care not be disrupted and that continuity and quality of services be maintained. With these goals in mind, plans will be required to refer CCS-eligible children to the CCS program for the treatment of CCS-eligible conditions.

CCS, the Title V designated program for children with special health care needs, provides medical case management and payment for health care services for those children with eligible medical conditions who live in families with annual incomes below $40,000. Coverage is, and will be, limited to coverage of the specific condition. The program establishes standards for approval of inpatient hospital facilities and pediatric specialty and subspecialty providers delivering care to eligible children. The program also has an extensive system of special care centers located at tertiary medical centers at which multi-specialty, multidisciplinary teams deliver coordinated inpatient and outpatient care to children with chronic medical conditions.

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primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of he following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of he following occur:
  (I) The child is at risk of removal from home or has already been removed from the home.
  (II) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code." [For the purposes of the Child Health Initiative, the age range will be expanded to age 19 years].

The centers include cardiac, chronic pulmonary disease, hematology and oncology, myelomeningocele, hemophisia, sickle cell, renal, infectious disease/immunology, hearing and speech, metabolic disorders, inherited neurologic disease, limb defect, gastroenterology, craniofacial anomalies and endocrinology. The program also approves neonatal intensive care, pediatric intensive care, and pediatric rehabilitation units.

CCS program staff determines the appropriate source of health care for eligible children, assist families in accessing care, and identify other needs of the child and family that could impact the care of the eligible condition.

The services to treat the CCS eligible medical condition of a child enrolled in Healthy Families will not be the responsibility of the contracting health plan in which the child is enrolled. The CCS program will continue to authorize the medically necessary services to treat the condition using the program's regulations, policies, procedures and guidelines in determining the appropriateness of providers, and the necessity for services. CCS will expand the systems of communication that have been instituted to work with Medi-Cal managed care plans that have CCS services "carved out" from their capitation rate. Local CCS programs carefully coordinate the authorization and delivery of specialty and subspecialty services with the primary care provider to which the child is assigned.

Medi-Cal

As part of the Healthy Families program, the state enacted a number of changes to Medi-Cal designed to ease the entry of Medi-Cal eligible children into the Medi-Cal system and establish a more consistent eligibility standard for children. Specifically the state enacted legislation to:

- Disregard resources of the parent and child, for children between ages 1-19 in the Federal Poverty Programs, thereby expanding coverage under Title XXI for children whose families meet Medi-Cal's income standards but who have not met its resource standards;
- Provide one month of continuous eligibility to be used by families who no longer qualify for no share of cost Medi-Cal to transition to Healthy Families private insurance;
- Require development of a simplified Medi-Cal form which can be mailed in; and
- Make eligible for Medi-Cal at 100% or less of FPL, children under age 19 who were born before September 30, 1983 (children age 14-19). This means that children aged 6-19 will be eligible at 100% or less of FPL.

Funding for children who meet the criteria above who are uninsured will be funded by Title XXI while funding for children with private coverage will be by Title XIX.

The delivery system for targeted low income children served by Medi-Cal will be consistent with the existing Title XIX state plan. The appropriate Title XIX state plan amendments are included with this proposal. See Attachment 4.

AIM

The AIM program provides creditable coverage to pregnant women with incomes between 200 percent and 300 percent of FPL and their newborn children through the first two years of life. AIM is administered by MRMIB, which contracts with the private sector to provide subsidized coverage for beneficiaries. Because Medi-Cal currently serves infants under 1 year of age through 200 percent of FPL, infants through age 1 up to 250 percent of poverty served by AIM fall within the income range of targeted low income children. Consistent with the C-CHIP projects, the same income disregards will be applied to children born to mothers enrolled in AIM through age 2. AIM's delivery system and contracting standards are virtually identical to that of Healthy Families' purchasing pool described above. Nine health care service plans participate in AIM, which offers statewide coverage, and the vast majority of all beneficiaries are offered a choice of two plans in each region (three in Los Angeles County).

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- **Planned use of funds, including --**
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.

- **Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.**

Attached is a budget sheet which updates the Healthy Families Program budget and includes changes reflecting costs for the Rural Health Demonstration Projects. The non-Federal share for the Rural Health Demonstration Projects is from funds derived from a tax imposed on tobacco products through a State Proposition (Prop 99).

The budget for the program for FFY's 1998, 1999 and 2000 is detailed on the chart below. The following pages document the assumptions used in estimating expenditures. These estimates reflect our best assumptions at this point in time, related to projected costs for the Healthy Families program. These estimates should be used for planning purposes and will be updated, if needed, once final decisions have been made for inclusion in the state budget scheduled for release in early January. In addition, the state and local funds reflected as proposed state match are subject to appropriation by the Legislature as well. It is the intent of the State to maximize the receipt of permissible federal matching funds. To the extent that state costs for administrative and outreach expenses exceed the 10 percent cap, these costs will be paid with state-only funds

Sources of the non-Federal share of plan expenditures will be the state funds for all program elements except for:

- County mental health which will be matched by local funds;
- California Children's Services (CCS) which will be matched by General Fund and local funds;
- Child Health and Disability Prevention program (CHDP) which will be matched by General Fund and local funds.

Start Up Costs. It is not possible for the percentage of administrative costs to be as

low as ten percent of expenditures until a sizeable number of children have been enrolled. In fact, the estimates below indicate that the percentage of administrative cost will not decline to ten percent until the second FFY of operation. The Federal government must fully participate in the costs to start-up state programs if the children's health insurance program is to succeed nationally.

MRMIB will implement a uniform system for determining costs in accordance with Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments." To ensure the proper determination of allowable costs, all costs charged to Title XXI will be reviewed to ensure that they are necessary, reasonable, adequately documented, and properly reconciled. Additionally, MRMIB will establish periodic review of our cost structure to ensure that operating costs are properly allocated among the appropriate federal and state programs.

For example, personal service costs, i.e., salaries and wages and employee benefits, will be properly documented and certified to ensure proper allocation to Title XXI. Specifically, MRMIB is implementing a time reporting system that uses detailed activity reports and monthly certifications to document and account for the total activity of each employee and for time charged to Title XXI and/or the three existing state programs.

Indirect costs will be determined according to cost objectives and program goals. Using OMB A-87 guidelines, its supplements, and checklists, we will develop a comprehensive cost allocation system that clearly defines the nature of the costs, i.e., direct or indirect.

Currently, the operating costs of MRMIB's three existing state programs are separately tracked and reported in the state accounting system. All administrative contracts are assigned separate control numbers for proper tracking and reporting of financial activities related to their respective programs.

DHS has in place a program cost accounting system, CALSTARS, which tracks and allocates direct and indirect costs in accordance with Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments." This system uses a clearly defined set of program cost account codes, object (type of cost) codes and fund source codes to support the accurate allocation of benefit costs, as well as administrative and overhead costs, among all programs, including Title XXI accounting as well. A key component of this system is the Indirect Cost Rate Plan (ICRP) which is reviewed and approved by HCFA. The ICRP process applies a predetermined, approved-budget-based, percentage rate to direct salary and benefit costs in order to allocate departmental and statewide overhead (executive and administrative support) uniformly to all direct programs and fund sources.

Healthy Families Program
Title XXI State Plan Amendment
Enrollment and Cost Assumptions
Federal Fiscal Years 1999, 2000 & 2001

CASELOAD ESTIMATE ASSUMPTIONS

HFP Monthly Enrollment – Base Program

At the time the State Plan was submitted in November 1997, Current Population Survey (CPS) data estimated that, for children ages 1 to 18 between 100 percent and 200 percent of the federal poverty level, as many as 580,000 may be uninsured, and thus could be potentially served by the Healthy Families Program (HFP). The UCLA Center for Health and Policy Research provided this estimate. An aggressive goal of 34.5% of all eligible children was adopted for the 1st year of program operation. Based on this goal, estimated monthly enrollment by the end of Federal Fiscal Year (FFY) 1998, 1999 and 2000 was 57,000, 261,000, and 501,000 respectively.

At the request of DHS, the UCLA Center for Health Policy Research conducted research in early 1997 to estimate the number of children ages 1 through 18 between 100 and 199 percent of poverty who were uninsured and ineligible for Medi-Cal. Using the March 1996 Current Population Survey (CPS), UCLA arrived at an estimate of 580,000 children in the specified age and income bracket, who were thus potentially eligible for HFP. This estimate was included in California's Title XXI State Plan, which was submitted in November 1997.

In 1998, the UCLA Center for Health Policy Research released revised estimates based on the March 1997 CPS. UCLA estimated that there were approximately 1.74 million uninsured children in California. Of those, an estimated 400,000 were eligible for HFP, and 668,000 were eligible for no-cost Medi-Cal. The 1998 estimates provided by the UCLA Center for Health Policy Research were based upon the March 1997 CPS. The authors of the UCLA estimates reduced prior estimates to reflect the number of undocumented uninsured children who are ineligible for HFP. UCLA also adjusted the data to account for the fact that some sources of income counted by CPS that are not included under HFP and MC. Furthermore, income under CPS is based upon a larger family size than is counted under HFP and Medi-Cal eligibility guidelines. These adjustments further reduced the number of children eligible for HFP and increased the number of children eligible for MC. UCLA further lowered the estimate of the number of children eligible for HFP to account for the fact that income deductions would not be applied for the HFP.2

2 Steve P. Wallace et al. "Technical Notes for *New Estimates find 4000,000 Children Eligible for Healthy Families Program, Policy Brief 98-4.*" UCLA Center for Health Policy Research. October 1998.

In January 1999, UCLA again updated projections of the number of children eligible for HFP and MC. Basing their work on data from the March 1998 CPS, researchers from UCLA now estimate that 328,000 children are eligible for HFP and 788,000 children are eligible and unenrolled for no-cost Medi-Cal. The researchers explain the decrease in the estimated number of HFP children and the increase in MC children due to changes in the income distribution of the target population.3

Based on this revision and on the actual monthly enrollment through February 1999, estimated monthly enrollment is projected as follows:

	Base Program	Cost
FFY 1999	156,250 by 10/1	$ 84,886,683
FFY 2000	281,251 by 10/1	$213,608,109
FFY2001	328,000 by 10/1	$309,040,744

DMH FOR SED SERVICES

- Assumes 3% of the average annual HFP enrollment.

	Cost
FFY 1999	$ 8,541,844
FFY 2000	$20,319,937
FFY 2001	$30,535,090

HFP EXPANSION ENROLLMENT ASSUMPTIONS

Use of Income Disregards up to 250% FPL and Income Deductions

- Caseload estimates assume enrollment will begin 7/99.
- Assumes 132,000 potentially eligible children with net family income under 250 percent of fpl, in addition to above estimated 328,000 base eligible children.
- Of the 328,000 identified as potentially eligible, assumes 129,370 children will be enrolling in the HFP. This estimate is based on the January 1999 UCLA estimate of 132,000 children between 0-19 years old that would be eligible if income deductions and income disregards were used to determine income eligibility reduced by MRMIB's estimate of 2,630 children between 0-1 years old. The exclusion of the 0-1 age band was made because the 0-1 years children whose net family incomes (when using Medi-Cal income deductions) are below 200% fpl are eligible for free Medi-Cal and therefore are ineligible for HFP. Estimated monthly enrollment is projected as follows:

3 Helen Halpon Schauffler et al. "The State of Health Insurance in California, 1998." UC Berkeley Center for Health and Public Policy Studies and the UCLA Center for Health Policy Research. January 1999. Page 24.

	250% Expansion	Cost
FFY 1999	5,337 by 10/1	$ 815,139
FFY 2000	48,514 by 10/1	$29,557,097
FFY 2001	87,325 by 10/1	$71,346,890

Department of Mental Health (DMH) Services for Treatment of Serious Emotional Disturbance (SED)

- Assumes enrollment will begin 7/99.
- Assumes 3% of the average annual HFP enrollment

FFY 1999	$ 428,038
FFY 2000	$ 2,689,752
FFY 2001	$ 6,533,562

Only MRMIB and DMH estimate costs for this proposal. The DHS estimates no additional costs for Child Health Disability Program (CHDP) because the program eligibility ceiling is 200% FPL and does not use income deductions in eligibility determinations. DHS also estimates minimal costs for California Children's Services (CCS).

LEGAL IMMIGRANTS POST 8/22/96
(Cost for legal immigrants are funded from 100 percent State Funds and are excluded in the budget display)

- Caseload estimates assume enrollment will begin 7/99.
- Assumes 40,000 potentially eligible legal immigrant children will enter the United States in a five year period (or 8,000 legal immigrant children annually) based on the revised UCLA report dated 1/99.
- Assumes the 40,000 potentially eligible children will enroll over a seven year period.
- Assumes 8,000 eligible children for every 12-month period beginning 8/22/96.
- Assumes a cumulative backlog of 22,667 eligible children for the 34-month period ending 7/1/99.
- Estimated monthly enrollment is projected as follows:

	Legal Immigrants	Cost
FFY 1999	920 by 10/1	$ 133,632
FFY 2000	8,520 by 10/1	$ 4,518,707
FFY 2001	17,799 by 10/1	$12,384,323

This expansion program will be 100% State-funded (requiring no federal matching Title XXI funds) unless federal matching funds are made available by Congress.

DMH FOR SED SERVICES

- Assumes enrollment will begin 7/99.
- Assumes 3% of the average annual HFP enrollment.

FFY 1999	$ 71,844
FFY 2000	$ 480,067
FFY 2001	$ 1,275,720

Only MRMIB, CCS and DMH estimate costs for this proposal. Estimated CCS costs are $137,000 total funds. The DHS estimates no additional costs for Child Health Disability Program (CHDP).

MRMIB Payments to Health, Dental and Vision Plans. These health services costs are the estimated insurance premium costs as the served population grows over time.

Estimated payments (or premiums) for health, dental, vision per month are: $71.50 per enrolled child per month (PCPM) for October 1998 through June 1999 and $80.08 pcpm for the period July 1999 through September 2001. For children under age 1, estimated premiums are 230.00 pcpm.

MRMIB Offsetting Premium Payments. The total health services costs are offset by a monthly premium (or contribution) payment per child paid by the family. The administrative vendor, on behalf of MRMIB collects these premiums. These premiums will be collected by the health plan.

Estimated offset of premium payments per child per month is $5.00. *Payments for Application Assistance Fee (One time)*. The application assistance fee which MRMIB will pay for referrals of eligible subscribers is another feature which will facilitate coordination with public and private entities. MRMIB will specify those agencies and persons in regulation after public hearing, but anticipates authorizing a wide range of entities including insurance agents, county child health and disability prevention program providers, clinics, and hospitals.

Estimated payment for application assistance fee per family is $50.00; estimated monthly enrollment by end of FFY 1, 2, and 3 is 57,000, 261,000, and 501,000 respectively.

Case Management Costs. The cost of assisting families to maintain their child's enrollment in the HFP will be $66,995 in FFY 1999. Each HFP subscriber is re-evaluated annually prior to their anniversary date in the program to determine continued eligibility for the program. The provision of annual eligibility review by qualified application assistants helps to assure continuity of coverage for enrolled children. The maintenance of a medical home for children is a core objective for the

HFP.

MRMIB Payments to Access for Infants and Mother (AIM) Health Plans. AIM is administered by the MRMIB, which contracts with the private sector to provide subsidized coverage for uninsured and underinsured women and their newborn infants through two years of age. To cover the full cost of care, California uses Cigarette and Tobacco Products Surtax Funds (Proposition 99) to subsidize subscriber co-payments and contributions, while the subscriber pays a premium amount equal to two percent of the family's average annual income. Roughly four percent of AIM enrollees have access to high deductible insurance coverage, or have insurance coverage for their children. Based on HCFA's technical guidance, MRMIB agreed not to claim Title XXI matching funds for infants enrolled with access to high deductible insurance coverage (identified through the application process), since their insured status excludes them from the definition of Title XXI's population.

California Children's Services (CCS). The CCS Program component of the HFP reflects estimated costs of providing services for the eligible children (under 200percent of poverty) enrolled in CCS. CCS provides specialty and sub-specialty services to children with special health care needs, which require case management and authorization of services to ensure that appropriate treatment and services are provided. CCS will be responsible for all medical, dental, and vision services necessary to treat an enrolled child's CCS eligible condition in coordination with the HFP plan delivery of primary and preventative health care services.

Average cost per eligible per month is $124.00. It is also assumed that the county and state will participate equally in the match requirement.

Child Health & Disability Prevention (CHDP) (Without EDS processing costs). The CHDP estimate reflects payment to CHDP providers for screening exams and initial follow-up treatment for new HFP enrollees during a period up to 90 days during which their application to the Program is pending. It is anticipated the CHDP providers would be a significant source of referral for the Program.

a) Average cost of a CHDP screening for age 1 through 18, per eligible per month is $64.38.
b) Average cost of a 30-day follow-up treatment is $18.50.
c) Estimated average one time cost per case is $82.88 for screening and treatment combined.

Rural Health Demonstration Projects – MRMIB & DHS. The Healthy Families rural demonstration projects were established to improve access to health care services for medically under-served and uninsured populations in rural areas, and special populations who have rural occupations (farm workers, loggers, etc.).

The MRMIB's $6 million ($2.038 million GF and $3.962 million FFP) augmentation is to develop and enhance existing health care delivery networks through contract amendments with participating HFP health dental and vision plans. This augmentation addresses geographic access barriers and access barriers for special population subscribers enrolled in the HFP (seasonal and migrant farm workers, and American Indians).

Mental Health – For SED Services. The mental health component of the Healthy Families Program (HFP) represents the total estimated costs of providing mental health services to eligible children with serious emotional disturbance (SED) consistent with the Bronzan/McCorkadale Act. These services are provided through a single, local, public entity because the expertise and resources for serving this special needs population is currently in the county mental health programs. The HFP health plans are responsible to provide psychiatric inpatient hospital services to this population up to the limit of the benefit, which is 30 days on an annual basis. The costs associated with the basic benefit have not been included here. Medically necessary mental health services for the SED population beyond the basic inpatient benefit are the responsibility of the county mental health programs. The proportion of SED children enrolling is estimated to be three percent of the average annual HFP enrollment. Three percent is a conservative estimate of the incidence of SED based on national and state prevalence and usage data used by the Department of Mental Health (DMH) when estimating services and funding needs for the Medi-Cal population ages 0 to 21.

The estimated average cost per child per month is $229.00. The estimated monthly enrollment of children with SED in HFP for1999, 200 and 2001 is 2,965, 7,510 and 11,840 respectively.

Accelerate Coverage of Children Under 100 Percent of Federal Poverty Level (FPL). The DHS 100 percent program previously provided coverage to children whose families have income in excess of the maintenance need but less than 100 percent of poverty if they were born after September 30, 1983. In March 1998, the program was expanded to cover children under the age of 19.

The estimated average cost per child is $89 per month and the estimated number of eligible children is 15,818 average monthly. Eligibles are expected to phase-in over 19 months. The cost estimates reflect Title XXI federal funding available for these eligibles in excess of the Title XIX federal funding. The full costs for these eligibles are included in the Medi-Cal base estimate.

Asset Waiver for Children. Resources will not be counted in determining the Medi-Cal eligibility for children eligible under the various Percentage Program limits.

The estimated average cost per child under 15 years of age is $48, and 15through 18 years of age is $89. There were 592 eligible children in February 1999. It is assumed that this population will continue to grow at a rate of 250 per month.

One Month Bridge from Medi-Cal to Healthy Families. A federally acceptable One Month Bridge Program of Title XXI funded health care for children becoming ineligible for free Medi-Cal was established by AB 2780, Chapter 310 Statutes of 1998. This program (which covers one month only) was implemented on November 1, 1998. To be eligible, families' income must be between 100 percent and 200 percent of the federal poverty level. The estimated average cost per child is $43 per month and the estimated number of eligible children, once the program is fully implemented is 8,036 per month. In February 1999 there were 471 children eligible. It is assumed that the caseload will grow at a rate of 250 per month to the total 8,036.

MRMIB Payments to Administrative Vendor. MRMIB payment to the HFP administrative vendor for eligibility determination and enrollment services are classified as administrative costs in accordance with Health Care Financing Administration (HCFA) guidelines for claiming Title XXI funds. The administrative vendor contract (contract) with Electronic Data Systems (EDS) includes final negotiated per child per month (PCPM) costs of $52.00 for the first 10,000 subscribers and $3.85 thereafter. Also included are minimal costs for the state share of transactions fees for families' cash and credit card payments, and bad check fees from the families' first month premium payments.

Statewide Outreach Campaign. The State has implemented various activities to provide information to families regarding both Medi-Cal and HFP, and to encourage and increase enrollment of children in both programs. Full year outreach activities are

estimated at $12 million annually.

Note: The Outreach budget includes the one-time application assistance fees and annual eligibility review fees.

Payments for Application Assistance Fee (One time). The application assistance fee which MRMIB will pay for referrals of eligible subscribers is another feature which will facilitate coordination with public and private entities. MRMIB will specify those agencies and persons in regulation after public hearing, but anticipates authorizing a wide range of entities including insurance agents, county health and disability prevention program providers, clinics, and hospitals.

Mental Health County Administration. This is the administrative cost portion of the Healthy Families Program county mental health funding.

Medi-Cal Conforming Costs - County Administration. This represents the total estimated cost for counties to determine eligibility for a) Accelerated Coverage of Children Under 100 percent FPL; b) Asset Waiver for Children.

EDS Costs - Fiscal Intermediary (FI). Provider reimbursement for all fee-for-service elements of expanded access is processed by EDS, the Medi-Cal Fiscal Intermediary (FI) through an automated payment system integrated with the California-Medi-Cal Management Information System (CA-MMIS). It is assumed that all providers would utilize the HCFA 1500 and UB92 standardized Medi-Cal claim forms as well as the CHDP PM 160. The current CA-MMIS models for expanded access for HFP. The CHDP system will allow assessments and the CA-MMIS will accommodate any treatment claims. Both systems require enhancements to comply with Title XXI requirements.

One Month Bridge. This is the county administration cost associated with implementation of the One Month Bridge Program described in Section I.B.5.

State Administration - MRMIB. MRMIB administers the HFP estimates health care for approximately 497,000 children of moderate income working individuals through subsidized private health insurance plans. The current state fiscal year 1999/00 budget includes authority for 28.0 positions and $3.314 million total funds ($1.342 million General Fund).

State Administration - DHS. The Department of Health Services has, in the current state fiscal year 99/00, budget authority for 12 positions and $1.268 million ($.387 million General Fund). These resources are necessary to meet requirements of the HFP legislation, conduct the activities necessary to expand Medi-Cal health coverage for low-income uninsured children, and provide education and outreach activities.

Attached are a series of exhibits which explain how the amounts for benefits and other cost components were calculated.

Exhibit 1- Estimated enrollment and related costs for Healthy Family program benefits, premium payments, contractor payments and assistance fees.
Exhibit 2- Enrollment assumptions
Exhibit 3- Benefit cost assumptions
Exhibit 4- Average premium calculation
Exhibit 5- Basis for Title XXI-eligible Access for Infants and Mothers program costs (the AIM estimate has since been reduced by 4 percent in response to HCFA's concern that AIM covers infants with access to insurance coverage)
Exhibit 6- Basis for Title XXI-eligible California Children's Services program costs
Exhibit 7- Basis for Title XXI-eligible Child Health and Disability Prevention program costs
Exhibit 8- Basis for Title XXI- Mental Health Services benefit and associated administrative costs
Exhibit 9- Assumptions and calculations for conforming Medi-Cal program costs for accelerated coverage, asset waiver, extended eligibility and outreach program costs (First year outreach costs revised to match chaptered legislation. First year estimate for extended eligibility has been reduced because California will have to pass state clean-up legislation before it can implement extended eligibility in accordance with HCFA's parameters. Original extended eligibility estimate assumed a May 1, 1998 implementation date, while amended estimate assumes a July 1, 1998 implementation date.)
Exhibit 10- Basis for cost estimate for the Fiscal Intermediary requirements (Revised cost estimate. California will claim Fiscal Intermediary costs under Title XIX rather than seek the enhanced FFP under Title XXI)
Exhibit 11- The state budget proposal for DHS administrative staff costs (Revised cost estimate includes amount for overhead costs consistent with the HCFA-approved indirect cost rate plan and additional application printing costs)
Exhibit 12- The state budget proposal for MRMIB administrative staff costs (Revised cost estimate includes additional financial accounting and processing staff in response to HCFA draft guidelines)
Exhibit 13- Revised State Plan budget table with revised administrative cost amounts and percentage calculations

SCHIP Budget Plan Template
COST OF APPROVED SCHIP PLAN AND ADDITIONAL COSTS ASSOCIATED WITH THE RURAL HEALTH DEMONSTRATION PROJECTS

	FFY 2004
Enhance FMAP Rate	65.00%
Benefit Costs	
Insurance Payments	
Managed Care	$775,147,014
per member/per month rate @ # of eligibles	
Fee for Service	$176,132,453
Total Benefit Costs	$951,279,467
(Offsetting beneficiary cost sharing payments)	-$45,457,251
Net Benefit Costs	$905,822,216
Administration Costs	
Personnel	
General Administration	$59,770,290
Contractors/Brokers (e.g., enrollment contractors)	
Claims Processing	
Outreach/marketing costs	$0
Other	$1,896,770*
Total Administration Costs	$61,667,060
10% Administrative Cost Ceiling	$100,646,913
Federal Share	$628,868,029
State Share	$338,621,247
TOTAL PROGRAM COSTS	$967,489,276

Rural Health Demonstration Projects: The Tobacco Tax and Health Protection Act of 1988, as added by Proposition 99, established the Cigarette and Tobacco Products Surtax fund. These funds are to be allocated for use in tobacco education and tobacco use prevention programs, tobacco-related disease research, environmental protection and recreational resource enhancement programs, and health care services for low-income, uninsured Californians. MRMIB was appropriated $1.896 million in the State's 2003 Budget Act and is authorized in State law (Chapter 161, Statues of 2003) to use Proposition 99 funds as the match to draw Title XXI SCHIP funds for the Rural Health Demonstration Projects. Of the $1.896 million total funds, $663,870 are Proposition 99 funds and $1,232,901 is FFP.