California CARTS FY2022 Report

Welcome!

We already have some information about your state from our records.
If any information is incorrect, please contact the CARTS Help Desk.

1. State or territory name:

California

2. Program type:

- (●) Both Medicaid Expansion CHIP and Separate CHIP
- ( ) Medicaid Expansion CHIP only
- ( ) Separate CHIP only

3. CHIP program name(s):

All, California

Who should we contact if we have any questions about your report?

4. Contact name:

Saralyn M. Ang-Olson

5. Job title:

Chief Compliance Officer

6. Email:

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7. Full mailing address:

Include city, state, and zip code.

Department of Health Care Services, Office of Compliance P.O. Box 997413; MS 1900; Sacramento, CA 95899-7413

8. Phone number:

(916) 345-8380

PRA Disclosure Statement.
This information is being collected to assist the Centers for Medicare & Medicaid Services (CMS) in partnership with States with the ongoing management of Medicaid and CHIP programs and policies. This mandatory information collection (42 U.S.C. 1397hh) will be used to help each state meet the statutory requirements at section 2108(a) of the Social Security Act to assess the operation of the State child health plan in each Federal fiscal year and to report the results of the assessment including the progress made in reducing the number of uncovered, low-income children. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 0938-1148 (CMS-10398 #1). The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather all data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Part 1: Medicaid Expansion CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

(•) Yes

2a. Are your premiums for one child tiered by Federal Poverty Level (FPL)?

(•) Yes

( ) No

2b. Indicate the range for premiums and corresponding FPL for one child.

Premiums for one child, tiered by FPL

FPL starts at		FPL ends at
160	→	266

Premium starts at		Premium ends at
$ 0	→	$ 0

( ) No

3. Is the maximum premium a family would be charged each year tiered by FPL?

◉ Yes

3a. Indicate the range for premiums and corresponding FPL for a family.

Maximum premiums for a family, tiered by FPL

FPL starts at		FPL ends at
160	→	266

Premium starts at		Premium ends at
$ 0	→	$ 0

○ No

4. Do premiums differ for different Medicaid Expansion CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

N/A

5. Which delivery system(s) do you use?
Select all that apply.

☑ Managed Care

☐ Primary Care Case Management

☑ Fee for Service

6. Which delivery system(s) are available to which Medicaid Expansion CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

All CHIP children are enrolled into a Medi-Cal managed care plan (MCP). Children enrolled into Presumptive Eligibility receive FFS Medi-Cal until they have finalized their enrollment. Children eligible for California Children's Services (CCS) receive primary care through their MCP, while CCS services are delivered on a FFS basis. In some counties, the plan is responsible for CCS services. CHIP eligible children receive Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) services through a county behavioral health plan.

Part 2: Separate CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

(•) Yes

2a. Are your premiums for one child tiered by Federal Poverty Level (FPL)?

(•) Yes

( ) No

2b. Indicate the range of premiums and corresponding FPL ranges for one child.

Premiums for one child, tiered by FPL

FPL starts at		FPL ends at
266	→	322

Premium starts at		Premium ends at
$ 0	→	$ 0

( ) No

3. Is the maximum premium a family would be charged each year tiered by FPL?

◉ Yes

3a. Indicate the range of premiums and corresponding FPL for a family.

Maximum premiums for a family, tiered by FPL

FPL starts at		FPL ends at
266	→	322

Premium starts at		Premium ends at
$ 0	→	$ 0

○ No

4. Do your premiums differ for different CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

No, the premiums do not differ between Separate CHIP populations.

5. Which delivery system(s) do you use?
Select all that apply.

☑ Managed Care

☐ Primary Care Case Management

☑ Fee for Service

6. Which delivery system(s) are available to which CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

All CHIP children are enrolled into a Medi-Cal managed care plan (MCP). Children enrolled into Presumptive Eligibility receive FFS Medi-Cal until they have finalized their enrollment. Children eligible for California Children's Services (CCS) receive primary care through their MCP, while CCS services are delivered on a FFS basis. In some counties, the plan is responsible for CCS services. CHIP eligible children receive Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) services through a county behavioral health plan.

Part 3: Medicaid Expansion CHIP Program and Policy Changes

Indicate any changes you've made to your Medicaid Expansion CHIP program policies in the past federal fiscal year.

1. Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2. Have you made any changes to the eligibility redetermination process?

- ○ Yes
- ◉ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrollees?
For example: adding benefits or removing benefit limits.

- ○ Yes
- ◉ No
- ○ N/A

5. Have you made any changes to the single streamlined application?

- ○ Yes
- ◉ No
- ○ N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ○ Yes
- ◉ No
- ○ N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Medicaid Expansion CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- (●) Yes
- ( ) No
- ( ) N/A

9. Have you made any changes to the substitution of coverage policies?
For example: removing a waiting period.

- ( ) Yes
- (●) No
- ( ) N/A

10. Have you made any changes to the enrollment process for health plan selection?

- ( ) Yes
- (●) No
- ( ) N/A

11. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to eligibility for "lawfully residing" pregnant individuals?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made changes to any other policy or program areas?

- ○ Yes
- ◉ No
- ○ N/A

17. Briefly describe why you made these changes to your Medicaid Expansion CHIP program.

With an effective date of July 1, 2022, SPA 22-0042, was approved by CMS to reduce the dollar amount for monthly premiums for this coverage group to zero dollars. Additionally, the temporary policies allowed by SPA 20-0024 during the COVID-19 public health emergency (PHE) are still in place. These flexibilities include expanding Presumptive Eligibility for ages 65 and over.

18. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- (●) Yes
- ( ) No
- ( ) N/A

Part 4: Separate CHIP Program and Policy Changes

Indicate any changes you've made to your Separate CHIP program and policies in the past federal fiscal year.

1. Have you made any changes to the eligibility determination process?

- ( ) Yes
- (●) No
- ( ) N/A

2. Have you made any changes to the eligibility redetermination process?

- ○ Yes
- ◉ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrolees?
For example: adding benefits or removing benefit limits.

- ○ Yes
- ◉ No
- ○ N/A

5. Have you made any changes to the single streamlined application?

- ○ Yes
- ◉ No
- ○ N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ○ Yes
- ◉ No
- ○ N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Separate CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- (●) Yes
- ( ) No
- ( ) N/A

9. Have you made any changes to substitution of coverage policies?
For example: removing a waiting period.

- ( ) Yes
- (●) No
- ( ) N/A

10. Have you made any changes to an enrollment freeze and/or enrollment cap?

- ( ) Yes
- (●) No
- ( ) N/A

11. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to your conception to birth expansion (as described in the October 2, 2002 final rule)?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made any changes to coverage for your CHIP pregnant individuals eligibility group?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ◉ No
- ○ N/A

17. Have you made any changes to eligibility for "lawfully residing" pregnant individuals?

- ○ Yes
- ◉ No
- ○ N/A

18. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

19. Have you made changes to any other policy or program areas?

- ◉ Yes
- ○ No
- ○ N/A

20. Briefly describe why you made these changes to your Separate CHIP program.

With the passage of the American Rescue Plan Act (ARPA), California opted to implement the extended postpartum coverage period from 60 days to a full 365 days for Medicaid populations. In addition, and in compliance with ARPA, DHCS also submitted SPA 22-0031 with an effective date of April 1, 2022 to extend the postpartum coverage period to the County Children's Health Insurance Program (CCHIP). With an effective date of July 1, 2022, SPA 22-0041 was submitted to CMS to reduce the dollar amount for monthly premiums to zero dollars for State Children's Health Insurance Program (S-CHIP) coverage groups. DHCS is awaiting CMS approval of SPA 22-0041. Additionally, the temporary policies allowed by SPA 20-0024 during the COVID-19 PHE are still in place. These flexibilities included expanding Presumptive Eligibility for ages 65 and over.

21. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- (●) Yes
- ( ) No

Part 1: Number of Children Enrolled in CHIP

This table is pre-filled with your SEDS data for the two most recent federal fiscal years (FFY). If the information is inaccurate, adjust your data in SEDS (go to line 7: "Unduplicated Number Ever Enrolled" in your fourth quarter SEDS report) and then refresh this page. If you're adjusting data in SEDS, allow one business day for the CARTS data below to update.

Program	Number of children enrolled in FFY 2021	Number of children enrolled in FFY 2022	Percent change
Medicaid Expansion CHIP	1,530,897	1,477,697	-3.475%
Separate CHIP	70,854	78,519	10.818%

1. If you had more than a 3% percent change from last year, what are some possible reasons why your enrollment numbers changed?

FFY 2022 counts are based on preliminary SEDS reports submitted on 10/28/2022. These counts are not considered complete and may change with additional months of retroactive eligibility and paid claims data. Decrease in Medicaid Children's Health Insurance Program (MCHIP) enrollment: California assumes the COVID-19 PHE is the reason this population has been declining. The federal legislation under the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act which provides temporary increased federal funding through increased Federal Medical Assistance Percentage (FMAP) includes a continuous coverage requirement wherein states must halt disenrollment of eligibles until the end of the PHE. The continuous coverage requirement has resulted in a change in what is referred to as caseload churn, where beneficiaries enroll and dis-enroll at a normal rate. As families lost income due to the stay - at - home order, and the decline in the economy, children shifted to the lower poverty level caseload categories. In summary, it is assumed that the decline in MCHIP population is due to children shifting to the lower percent of poverty caseload categories and remaining in those categories throughout the PHE. In addition, due to the continuous coverage requirement, children are not being re-determined and moving back to the higher income MCHIP category. Increase in S-CHIP enrollment: The increase in SCHIP enrollment between federal fiscal years affected two of the S-CHIP populations: 1) those enrolled in CCHIP, and 2) prenatal services for an unborn child for undocumented women and legal immigrants. California's SCHIP population is relatively small in comparison to the MCHIP population (approximately 5% of overall CHIP enrollment) resulting in the percent change calculation being significantly larger for a much smaller number of beneficiaries. • The year over year increase in the number of children enrolled in the CCHIP program is due to the PHE continuous coverage requirement described in the MCHIP section. Children are not being re-determined out of the CCHIP program resulting in higher enrollment. • Increased utilization has resulted in higher year over year user counts for the unborn child group based on Medi-Cal FFS paid claims data.

Part 2: Number of Uninsured Children in Your State

This table is pre-filled with data on uninsured children (age 18 and under) who are below 200% of the Federal Poverty Level (FPL) based on annual estimates from the

American Community Survey. Due to the impacts of the COVID-19 PHE on collection of ACS data, the Census Bureau did not release standard one-year ACS estimates in 2020 and that row is intentionally left blank.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
2013	Not Available	Not Available	Not Available	Not Available
2014	Not Available	Not Available	Not Available	Not Available
2015	193,000	12,000	2%	0.1%
2016	165,000	10,000	1.8%	0.1%
2017	147,000	9,000	1.6%	0.1%
2018	146,000	10,000	1.6%	0.1%
2019	149,000	11,000	1.6%	0.1%
2020	Not Available	Not Available	Not Available	Not Available
2021	146,000	9,000	1.6%	0.1%

Percent change between 2019 and 2021
0.00%

2. Are there any reasons why the American Community Survey estimates wouldn't be a precise representation of the actual number of uninsured children in your state?

- ○ Yes
- ◉ No

3. Do you have any alternate data source(s) or methodology for measuring the number and/or percent of uninsured children in your state?

- ○ Yes
- ◉ No

4. Is there anything else you'd like to add about your enrollment and uninsured data?

The percent of children who remained uninsured did not change; however, the actual number of uninsured children decreased from 2019 to 2021. This could be due to an increase in public coverage through the ongoing COVID-19 pandemic. California will use (California Health Interview Survey) CHIS data as an alternate source of data, whenever the ACS survey data is not available for CARTS reports.

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Program Outreach

1. Have you changed your outreach methods in the last federal fiscal year?

- ○ Yes
- ◉ No

2. Are you targeting specific populations in your outreach efforts?
For example: minorities, immigrants, or children living in rural areas.

(●) Yes

2a. Have these efforts been successful? How have you measured the effectiveness of your outreach efforts?

Only preliminary project data for individuals of all ages is available, with DHCS making efforts to validate all reported enrollment data from project partners. Presently, the data suggests that the Navigators Project has been successful in reaching a significant number of California residents (over one million) through the efforts stated above. There have been significant efforts in enrollment, application assistance, troubleshooting, and assistance with accessing and utilizing health care, totaling in the tens of thousands. DHCS anticipates that it will have more specific data for the under age 18 population available within state fiscal year 2022-23.

( ) No

3. What methods have been most effective in reaching low-income, uninsured children?

For example: TV, school outreach, or word of mouth.

Through the DHCS Health Enrollment Navigators program (Navigators Project), local, community-based organizations (CBOs) use various methods to reach uninsured, low-income children. The methods include embedding Health Enrollment Navigators at homeless shelters, emergency rooms, clinics, and other critical places where families seek any type of government assistance. In addition, some CBOs work closely with school districts to provide flyers and pamphlets regarding Medi-Cal enrollment to be disbursed with school-related information to all students. Other CBOs use language specific media such as radio and television advertisements, as well as social media campaigns and printed materials placed in strategic locations.

4. Is there anything else you'd like to add about your outreach efforts?

Not at this time.

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Substitution of Coverage

Substitution of coverage (also known as crowd-out) occurs when someone with private insurance drops their private coverage and substitutes it with publicly funded insurance such as CHIP.

1. Do you track the number of CHIP enrollees who have access to private insurance?

- ○ Yes
- ◉ No
- ○ N/A

2. Do you match prospective CHIP enrollees to a database that details private insurance status?

- ○ Yes
- ◉ No
- ○ N/A

3. What percent of applicants screened for CHIP eligibility cannot be enrolled because they have group health plan coverage?

%

4. If you have a Separate CHIP program, do you require individuals to be uninsured for a minimum amount of time before enrollment ("the waiting period")?

- ○ Yes
- ◉ No
- ○ N/A

5. Is there anything else you'd like to add about substitution of coverage that wasn't already covered? Did you run into any limitations when collecting these data?

For Question 3 above, California does not track the percent of applicants screened for CHIP eligibility that cannot be enrolled because they have group health plan coverage.

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Renewal, Denials, and Retention

Part 1: Eligibility Renewal and Retention

1. Does your state provide presumptive eligibility, allowing children to access CHIP services pending a final determination of eligibility?

- (●) Yes

  1a. What percent of children are presumptively enrolled in CHIP pending a full eligibility determination?

  %

  1b. Of the children who are presumptively enrolled, what percent are determined fully eligible and enrolled in the program (upon completion of the full eligibility determination)?

  %

- ( ) No
- ( ) N/A

2. In an effort to retain children in CHIP, do you conduct follow-up communication with families through caseworkers and outreach workers?

- (●) Yes
- ( ) No

3. Do you send renewal reminder notices to families?

◉ Yes

3a. How many notices do you send to families before disenrolling a child from the program?

If eligibility cannot be redetermined via an ex parte review, California sends a pre-populated renewal form to the individual providing at least 60 days for response prior to disenrollment. In the State's separate CHIP, two notices are sent prior to disenrollment. In the same manner, the State's Medicaid expansion provides two notices prior to disenrollment.

3b. How many days before the end of the eligibility period did you send reminder notices to families?

At least 30 days prior to the end of the eligibility period, county contact is made to the individual through a notice of action (NOA) regarding the renewal form or missing information requirements. If information is not received, the individual is sent a reminder in their preferred language and method (phone, mail, etc.). To discontinue eligibility, a NOA must be sent ten days prior to the end of the renewal month. If it is not possible to issue a NOA that allows the ten day notice at the end of the renewal month, the individual retains eligibility the following month. For the State's separate CHIP, pending disenrollment, a notice is sent out 15 days before the end of the month, and a subsequent notice is sent at the end of the month prior to disenrolling.

○ No

4. What else have you done to simplify the eligibility renewal process for families?

California instituted many provisions as part of the ACA to simplify the renewal process including conducting an ex parte review of electronic data sources and current case information to complete the renewal without anything needed from the beneficiary and sending pre-populated renewal forms in threshold languages when additional information is required. Other improvements California has implemented include: 1) resetting the annual renewal date at change of circumstance redeterminations made between annual renewals, 2) partnering with community-based organizations to assist beneficiaries with renewal paperwork as needed, 3) use of self-attestations for household composition, 4) being pregnant, or 5) being an American Indian/Alaskan Native when documentary proof is not available, and 6) allowing telephonic or electronic signature for the renewal form.

5. Which retention strategies have you found to be most effective?

California reducing the premium amount to zero dollars, has been effective in retaining subscribers.

6. How do you measure the effectiveness of your retention strategies? What data sources and methodology do you use to track retention?

California has not evaluated the effectiveness of any strategies at this time.

7. Is there anything else you'd like to add that wasn't already covered?

For question 1a: California cannot provide the percentage of children Presumptively Enrolled (PE) in CHIP as California does not segregate CHIP applicants from other applications. For question 1b: California is currently developing a report to determine this percentage.

Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2022?
Don't include applicants being considered for redetermination - these data will be collected in Part 3.

202577

2. How many applicants were denied CHIP coverage for procedural reasons?
For example: They were denied because of an incomplete application, missing documentation, or a missing enrollment fee.

0

3. How many applicants were denied CHIP coverage for eligibility reasons?
For example: They were denied because their income was too high or too low, they were determined eligible for Medicaid instead, or they had other coverage available.

3a. How many applicants were denied CHIP (Title XXI) coverage and determined eligible for Medicaid (Title XIX) instead?

4. How many applicants were denied CHIP coverage for other reasons?

5. Did you have any limitations in collecting these data?

Data for application denial reasons is aggregate and not stratified by denial reason type. Additionally, DHCS does not collect data for the SCHIP population at this time.

Table: CHIP Eligibility Denials (Not Redetermination)
This table is auto-populated with the data you entered above.

	Percent
Total denials	100%
Denied for procedural reasons	0%
Denied for eligibility reasons	
Denials for other reasons	

Part 3: Redetermination in CHIP

Redetermination is the process of redetermining whether a child is eligible to renew in CHIP (Title XXI) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in CHIP in FFY 2022?

1207411

2. Of the eligible children, how many were then screened for redetermination?

309476

3. How many children were retained in CHIP after redetermination?

275030

4. How many children were disenrolled in CHIP after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

34446

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

4b. How many children were disenrolled for eligibility reasons?
This could be due to income that was too high or too low, eligibility in Medicaid (Title XIX) instead, or access to private coverage.

4c. How many children were disenrolled for other reasons?

5. Did you have any limitations in collecting these data?

Data for disenrollment is aggregate and not stratified by disenrollment reason type. Additionally, DHCS does not receive data on the separate CHIP (S-CHIP) population at this time.

Table: Redetermination in CHIP
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	100%
Children retained after redetermination	88.87%
Children disenrolled after redetermination	11.13%

Table: Disenrollment in CHIP after Redetermination

	Percent
Children disenrolled after redetermination	100%
Children disenrolled for procedural reasons	
Children disenrolled for eligibility reasons	
Children disenrolled for other reasons	

Part 4: Redetermination in Medicaid

Redetermination is the process of redetermining whether a child is eligible to renew in Medicaid (Title XIX) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in Medicaid in FFY 2022?

2. Of the eligible children, how many were then screened for redetermination?

3. How many children were retained in Medicaid after redetermination?

4. How many children were disenrolled in Medicaid after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

4b. How many children were disenrolled for eligibility reasons?
This could be due to an income that was too high and/or eligibility in CHIP instead.

4c. How many children were disenrolled for other reasons?

5. Did you have any limitations in collecting these data?

California's Medicaid reporting data for redeterminations is aggregated, combining adults and children. Additionally, the data does not segregate by age; therefore, this level of granularity is not reported.

Table: Redetermination in Medicaid
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	
Children retained after redetermination	
Children disenrolled after redetermination	

Table: Disenrollment in Medicaid after Redetermination

	Percent
Children disenrolled after redetermination	
Children disenrolled for procedural reasons	
Children disenrolled for eligibility reasons	
Children disenrolled for other reasons	

Part 5: Tracking a CHIP cohort over 18 months

Tracking a cohort of children enrolled in CHIP (Title XXI) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years who are newly enrolled in CHIP and/or Medicaid as of January through March 2022 (the second quarter of FFY 2022). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of

the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report on the number of children at the start of the cohort (Jan - Mar 2022) and six months later (July - Sept 2022). Next year you'll report numbers for the same cohort at 12 months (Jan - Mar 2023) and 18 months later (July - Sept 2023). If data are unknown or unavailable, leave it blank - don't enter a zero unless these data are known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2022. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2022 must be born after January 2006. Similarly, children who are newly enrolled in February 2022 must be born after February 2006, and children newly enrolled in March 2022 must be born after March 2006.

1. How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in CHIP: Children in this cohort weren't enrolled in CHIP (Title XXI) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP in December 2021.

◉ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP or Medicaid in December 2021.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

- (●) Yes
- ( ) No

January - March 2022 (start of the cohort)

3. How many children were newly enrolled in CHIP between January and March 2022?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
2145	9793	17050	4594

July - September 2022 (6 months later)

4. How many children were continuously enrolled in CHIP six months later?
Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
1485	7404	13689	3494

5. How many children had a break in CHIP coverage but were re-enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	23	25	0

6. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	12	15	0

7. How many children were no longer enrolled in CHIP six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
653	2366	3336	1093

8. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
376	1630	2157	490

9. Is there anything else you'd like to add about your data?

Not at this time.

January - March 2023 (12 months later): to be completed next year
Next year you'll report data about your cohort for this section.

10. How many children were continuously enrolled in CHIP 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in CHIP coverage but were re-enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in CHIP 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2023 (18 months later): to be completed next year
Next year you'll report data about your cohort for this section.

15. How many children were continuously enrolled in CHIP 18 months later? Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in CHIP coverage but were re-enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in CHIP 18 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Part 6: Tracking a Medicaid Cohort over 18 months

Tracking a cohort of children enrolled in Medicaid (Title XIX) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years, who are newly enrolled in Medicaid and/or CHIP as of January through March 2022 (the second quarter of FFY 2022). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report the number of

children identified at the start of the cohort (Jan-Mar 2022) and six months later (July-Sept 2022). Next year you'll report numbers for the same cohort at 12 months (Jan-Mar 2023) and 18 months later (July-Sept 2023). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2022. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2022 must be born after January 2006. Similarly, children who are newly enrolled in February 2022 must be born after February 2006, and children newly enrolled in March 2022 must be born after March 2006.

1. How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in Medicaid: Children in this cohort weren't enrolled in Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in Medicaid in December 2021.

◉ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP or Medicaid in December 2021.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

◉ Yes

○ No

January - March 2022 (start of the cohort)

3. How many children were newly enrolled in Medicaid between January and March 2022?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
57446	16430	14823	6846

July - September 2022 (6 months later)

4. How many children were continuously enrolled in Medicaid six months later? Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
43643	9989	7897	3626

5. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
705	207	190	72

6. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
	12	22	

7. How many children were no longer enrolled in Medicaid six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
13098	6234	6736	3148

8. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
370	676	838	389

9. Is there anything else you'd like to add about your data?

Not at this time.

January - March 2023 (12 months later): to be completed next year
Next year, you'll report data about your cohort for this section.

10. How many children were continuously enrolled in Medicaid 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in Medicaid 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2023 (18 months later): to be completed next year
Next year you'll report data about your cohort for this section.

15. How many children were continuously enrolled in Medicaid 18 months later?
Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in Medicaid 18 months later?
Possible reasons for not being enrolled:
- Transferred to another health insurance program other than Medicaid
- Didn't meet eligibility criteria anymore
- Didn't complete documentation
- Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Cost Sharing (Out-of-Pocket Costs)

States can choose whether or not to require cost sharing in their CHIP program. Cost sharing includes payments such as enrollment fees, premiums, deductibles, coinsurance, and copayments.

1. Does your state require cost sharing?

- (●) Yes
- ( ) No

2. Who tracks cost sharing to ensure families don't pay more than the 5% aggregate household income in a year?

- ○ Families ("the shoebox method")
- ○ Health plans
- ○ States
- ◉ Third party administrator
- ○ Other

3. How are healthcare providers notified that they shouldn't charge families once families have reached the 5% cap?

While the State's premium processing vendor tracks the 5% cap amount to ensure that no family reaches the limit; the 5% cap is never exceeded and there is never a need to notify providers about non-enforceable cost sharing.

4. Approximately how many families exceeded the 5% cap in the last federal fiscal year?

The state's premium processing vendor tracks the 5% cap and no families have been identified.

5. Have you assessed the effects of charging premiums and enrollment fees on whether eligible families enroll in CHIP?

- ○ Yes
- ◉ No

6. Have you assessed the effects of charging copayments and other out-of-pocket fees on whether enrolled families use CHIP services?

- ○ Yes
- ◉ No

7. You indicated in Section 1 that you changed your cost sharing requirements in the past federal fiscal year. How are you monitoring the impact of these changes on whether families apply, enroll, disenroll, and use CHIP health services? What have you found when monitoring the impact?

DHCS is not monitoring the impact at this time.

8. Is there anything else you'd like to add that wasn't already covered?

With an effective date of July 1, 2022, SPA 22-0041 was submitted to CMS to reduce the dollar amount for monthly premiums to zero dollars for SCHIP coverage groups. This includes cost sharing for coverage groups with the 5% income cap (e.g. Medi-Cal Access Program (MCAP)). DHCS is awaiting CMS approval.

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Employer Sponsored Insurance and Premium Assistance

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and

parents.

1. Does your state offer ESI including a premium assistance program under the CHIP State Plan or a Section 1115 Title XXI demonstration?

- ○ Yes
- ◉ No

Program Integrity

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Do you have a written plan with safeguards and procedures in place for the prevention of fraud and abuse cases?

- ◉ Yes
- ○ No

2. Do you have a written plan with safeguards and procedures in place for the investigation of fraud and abuse cases?

- ◉ Yes
- ○ No

3. Do you have a written plan with safeguards and procedures in place for the referral of fraud and abuse cases?

- (●) Yes
- ( ) No

4. What safeguards and procedures are in place for the prevention, investigation, and referral of fraud and abuse cases?

DHCS has a comprehensive process to verify that providers applying for enrollment or reenrollment into the program meet program requirements. In addition, DHCS has a robust anti-fraud program that includes enhanced prescreening activities, provider education, and the investigation of suspect providers as early as possible to minimize any widespread damage to the program. In addition to receiving complaints and referrals, DHCS performs data mining and data analytics for case development and to detect fraudulent schemes, suspicious providers, and the identification of new fraud schemes. DHCS staff conduct on-site field reviews and audits of suspicious providers, which may lead to overpayment recoveries, administrative sanctions, utilization controls, or referrals to DHCS' Medi-Cal Fraud Investigations Branch for a preliminary criminal investigation, or directly to the Medicaid Fraud Control Unit (MFCU) when sufficient evidence has been gathered to establish a credible allegation of fraud, waste or abuse. Credible allegations of fraud associated with beneficiary cases are referred to local or federal law enforcement for criminal prosecution when warranted.

5. Do the Managed Care plans contracted by your Separate CHIP program have written plans with safeguards and procedures in place?

- (●) Yes

  5a. What safeguards and procedures do the Managed Care plans have in place?

  Managed care plans have compliance plans, policies, and procedures for the prevention, investigation, and referral of fraud and abuse cases. These provisions are outlined in the plans' DHCS approved contracts under Exhibit E, Attachment 2 Program Terms and Conditions, Fraud and Abuse.

- ( ) No

- ( ) N/A

6. How many eligibility denials have been appealed in a fair hearing in FFY 2022?

7. How many cases have been found in favor of the beneficiary in FFY 2022?

8. How many cases related to provider credentialing were investigated in FFY 2022?

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2022?

10. How many cases related to provider billing were investigated in FFY 2022?

212

11. How many cases were referred to appropriate law enforcement officials in FFY 2022?

10

12. How many cases related to beneficiary eligibility were investigated in FFY 2022?

338

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2022?

106

14. Does your data for Questions 8-13 include cases for CHIP only or for Medicaid and CHIP combined?

- ○ CHIP only
- ◉ Medicaid and CHIP combined

15. Do you rely on contractors for the prevention, investigation, and referral of fraud and abuse cases?

- ◉ Yes

  15a. How do you provide oversight of the contractors?

  > Oversight of contractors are performed through regularly scheduled meetings, where statuses of developing and established bodies of work are reviewed and feedback is provided.

- ○ No

16. Do you contract with Managed Care health plans and/or a third party contractor to provide this oversight?

(●) Yes

16a. What specifically are the contractors responsible for in terms of oversight?

The Medi-Cal managed care plans' responsibilities are outlined in the plans' approved contracts under Exhibit E, Attachment 2 Program Terms and Conditions, Fraud and Abuse. The mental health managed care plans' responsibilities are outlined in the plans' approved contracts under Exhibit A. The managed care dental plans' responsibilities are outlined in the plans' approved contracts under Exhibit E.

( ) No

17. Is there anything else you'd like to add that wasn't already covered?

Not at this time.

18. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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Browse...

PagesfromTwoplanCCIFinalRuleBoilerplate.pdf
DentalExhibitEFWA.pdf
BHFWAExhibitA.pdf

Dental Benefits

Tell us about the children receiving dental benefits in your Separate CHIP program. Include children who are receiving full benefits and those who are only receiving supplemental dental benefits. Include the unduplicated number of children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

Note on age groups
Children should be in age groups based on their age on September 30th, the end of the federal fiscal year (FFY). For example, if a child turns three years old on September 15th, the child should be included in the "ages 3-5' group. Even if the child received dental services on September 1st while they were still two years old, all dental services should be counted as their age at the end of the FFY.

1. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-18 years) instead.

- (●) Yes
- ( ) No

2. How many children were enrolled in Separate CHIP for at least 90 continuous days during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
710	1424	1083	1711	2522	2344

3. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one dental care service during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
21	232	264	582	788	604

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100-D9999 (or equivalent CDT codes D0100-D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

4. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one preventative dental care service during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
15	222	253	546	749	552

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.
All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

5. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received dental treatment services during FFY 2022?
This includes orthodontics, periodontics, implants, oral and maxillofacial surgery, and other treatments.

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
<11	51	107	309	312	225

Dental treatment service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D2000-D9999 (or equivalent CDT codes D2000-D9999 or equivalent CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

6. How many children in the "ages 6-9" group received a sealant on at least one permanent molar tooth during FFY 2022?

110

Sealant codes and definitions
The sealant on a permanent molar tooth is provided by a dental professional for whom placing a sealant is within their scope of practice. It's defined by HCPCS code D1351 (or equivalent CDT code D1351) based on an unduplicated paid, unpaid, or denied claim. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, and 31, and additionally - for states covering sealants on third molars ("wisdom teeth") - teeth numbered 1, 16, 17, and 32.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

7. Do you provide supplemental dental coverage?

- ○ Yes
- ◉ No

8. Is there anything else you'd like to add about your dental benefits? If you weren't able to provide data, let us know why.

9,794 children were enrolled in Separate CHIP for at least 90 continuous days during FFY 2022. California initiated the California Advancing and Innovating Medi-Cal (CalAIM) Oral Health Initiatives, on January 1, 2022, which aims to improve the quality of life and health outcomes of the Medi-Cal population. CalAIM expanded Pay-for-Performance payments that reward increasing the use of preventive services and establishing/maintaining continuity of care through a dental home, and added two new benefits, Silver Diamine Fluoride for young children and specific high risk and institutional populations, and a Caries Risk Assessment Bundle for young children. DHCS and its partners continued the Smile, California Campaign, which launched in October 2018 to build positive momentum and drive increased utilization of dental services for Medi-Cal beneficiaries. DHCS continued promoting teledentistry as an alternative modality for the provision of select dental services, particularly during the COVID-19PHE. DHCS continues to look at opportunities to appropriately utilize teledentistry for the dental delivery systems including virtual dental homes as a way to effectively serve the Medi-Cal population. Dental Transformation Initiative (DTI), and subsequently CalAIM, Smile, CA, and teledentistry have contributed to increased utilization of any dental service, preventive services, treatments, and sealants.

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

CAHPS Survey Results

Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that all CHIP programs submit survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey assesses your CHIP program quality and customer satisfaction. For the 2022 CARTS report, the only option for reporting CAHPS results will be through the submission of raw data to the Agency for

Healthcare Research and Quality (AHRQ) CAHPS Database.

1. Did you collect the CAHPS survey?

- (●) Yes

  1a. Did you submit your CAHPS raw data to the AHRQ CAHPS database? Please note this is a requirement for FFY 2022.

  - ( ) Yes
  - (●) No

- ( ) No

Part 2: You didn't collect the CAHPS survey

Health Services Initiative (HSI) Programs

All states with approved HSI program(s) should complete this section.
States can use up to 10% of the total computable amount of their fiscal year allotment to develop Health Services Initiatives (HSI) that provide direct services and other public health initiatives for low-income children. [See Section 2105(a)(1)(D)(ii) of the Social Security Act, 42 CFR 457.10 and 457.618.] States may only claim HSI expenditures after funding other costs to administer their CHIP State Plan.

1. Does your state operate Health Services Initiatives using CHIP (Title XXI) funds? Even if you're not currently operating the HSI program, if it's in your current approved CHIP State Plan, please answer "yes."

- (●) Yes
- ( ) No

Tell us about your HSI program(s).

1. What is the name of your HSI program?

California Poison Control System

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

The targeted populations are children who are Latino, African American, or in the lowest income families.

4. How many children do you estimate are being served by the HSI program?

220000

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

DHCS does not utilize a metric to measure the outcomes; however, increased access to consumer-based educational materials have been developed in Spanish using research findings with target audiences. Materials are culturally relevant, take into consideration health literacy levels and clearly illustrate and describe poison center services. Chinese, Korean, Vietnamese, Tagalog, Hmong, Russian, and Armenian brochures have also been developed. Materials are customized and culturally relevant to each group.

7. What outcomes have you found when measuring the impact?

DHCS does not utilize a metric to measure the outcomes; however, California Poison Control provides public awareness to facilitate a reduction in the number of children ingesting poisonous and other hazardous substances.

8. Is there anything else you'd like to add about this HSI program?

Not at this time.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Postpartum Care Extension

2. Are you currently operating the HSI program, or plan to in the future?

(●) Yes

( ) No

3. Which populations does the HSI program serve?

This extension includes the lower income unborn population with incomes from 0-213 percent of the Federal Poverty Level (FPL). It also includes the upper income unborn option with incomes from 213-322 percent of the FPL, known as the Medi-Cal Access Program (MCAP).

4. How many children do you estimate are being served by the HSI program?

12000

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

The state measures the impact of this HSI using three of the CMS Maternal and Child Health or Adult Core Set measures: • Prenatal and Postpartum Care: Postpartum Care (PPC-AD) • Contraceptive Care- Postpartum Women Ages 21-44 (CCP-AD) • Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)

7. What outcomes have you found when measuring the impact?

The State has been providing 12 months of continuous postpartum coverage since July 2020, during the time of the pandemic. During that time, these measures have been relevant to the covered populations and have been tied back to promoting the health of the child. For example, timely postpartum visits have been used to screen mothers for postpartum depression and support breastfeeding, which both have shown to influence health outcomes for the children. Additionally, providing treatment and counseling for individuals with SUDs has shown to continue to also influence health outcomes for children.

8. Is there anything else you'd like to add about this HSI program?

None at this time.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another HSI Program in this list?

Optional

Part 1: Tell us about your goals and objectives

Tell us about the progress you've made on your performance goals in the past year. The objectives and goals you add to this section should match those reflected in your CHIP State Plan, Section 9. Submit a CHIP State Plan Amendment (SPA) if any of them are different.
Objective 1 is required. We've provided examples for other objectives, but you can edit them so they match the objectives in your CHIP State Plan. You can add additional objectives and goals to fit what's in your CHIP State Plan.

1. Briefly describe your goal.

For example: In an effort to reduce the number of uninsured children, our goal is to increase enrollment by 1.5% annually until the state achieves 90% enrollment of all eligible children in the CHIP program.

Through its culture of care, California's effort to continually reduce the number of uninsured children and to maintain coverage for eligible children remains as the state's primary goal.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

The numerator is defined as the number of uninsured children in 2019 minus the number of uninsured children in 2021.

4. Numerator (total number)

13000

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total estimated number of children eligible for CHIP within the state in the last federal fiscal year.

The denominator is defined as the number of uninsured children in the state in 2019.

6. Denominator (total number)

334000

Computed: 3.89%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

10 / 2022

8. Which data source did you use?

- ( ) Eligibility or enrollment data
- (•) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Yes, even though there was no data from the ACS for 2020, the state still demonstrated a 4% decrease in the uninsured children's population in the state.

10. What are you doing to continually make progress towards your goal?

California continues to take steps to implement the "Infant Initiative" into California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). The "Infant Initiative" will allow mothers covered under the CHIP higher income unborn option to enroll their newborns via the online portal, as well as allow CalHEERS to retain enrollment data for this program.

11. Anything else you'd like to tell us about this goal?

California will continue efforts to reduce the number of uninsured children in California up through 2025.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective so it matches what's in your CHIP State Plan.

Increasing access to care

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase access to care for underserved populations, our goal is to increase the number of children of Hispanic ethnicity who have visited a primary care physician by 5% annually over the next five years (ending in 2028).

The goal is to improve performance of the HEDIS well-child visit measure: two or more well-child visits between ages 15 to 30 months - so that California meets/exceeds the NCQA National Medicaid 50th percentile.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children of Hispanic ethnicity enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

Children who turned 30 months old during 2021 measurement year who had two or more well-child visits between ages 15-30 months.

4. Numerator (total number)

112443

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children of Hispanic ethnicity enrolled in CHIP in the last federal fiscal year.

Children who turned age 30 months during 2021 measurement year and were continuously enrolled between 15 months plus 1 day-30 months of age with no more than a one-month gap.

6. Denominator (total number)

186539

Computed: 60.28%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

For this continuing goal, the managed care plan-reported performance rate of 60.28% for 2021 measurement year (MY) is slightly below MY2020 performance (66.4%) and fell short of the Medicaid national 50th percentile of 65.83%.

10. What are you doing to continually make progress towards your goal?

DHCS is collaborating with Managed Care Plans (MCPs) on a variety of quality improvement projects focusing on improving well-infant visits through data-driven approaches and regional deconstruction of barriers around access difficulties. Additionally, DHCS is collaborating with CMS in the Affinity Well-Infant Workgroup along with a few other MCPs. The State is also stratifying well-infant measures by race/ethnicity to better assess potential disparities that are evident so that we can improve and create better, equitable services.

11. Anything else you'd like to tell us about this goal?

The goal may evolve depending on how our data is shaping with the current efforts underway. Additionally, DHCS may want to incorporate a more disparity focus.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective to match what's in your CHIP State Plan.

Increase the use of preventative care

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase the use of preventive care in rural communities, our goal is to increase the number of rural children who receive one or more well child visits by 5% annually until relative utilization is equivalent to all other CHIP populations within the state.

Maintain performance at or above the NCQA's 50th National Medicaid percentile for the HEDIS® immunization Status - Combination 10.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of rural children who received one or more well child visits in the last federal fiscal year.

Children who are two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. Including CHIP and Medicaid managed care populations.

4. Numerator (total number)

70024

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of rural children enrolled in CHIP.

Children who turned two years of age during the 2021 measurement year and were continuously enrolled prior to their second birthday with no more than 1-month gap.

6. Denominator (total number)

191169

Computed: 36.63%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

For this continuing goal, the managed care plan-reported performance rate of 36.63% for the 2021 measurement year (MY) is slightly below the MY2020 performance, (37.95%), but is slightly higher than Medicaid national 50th percentile of 34.79%.

10. What are you doing to continually make progress towards your goal?

As DHCS works together with MCPs in improving access to well-infant/child visits, we will leverage these efforts in creating a more holistic approach to our measure improvement around immunization status, developmental screenings, lead screening, and other important preventive service. If the State can increase well-visits, there is potential other important services that occur in those visits can also be achieved. Additionally, we are holding MCPs to a defined benchmark and have created incentive programs to encourage achievement of these benchmarks.

11. Anything else you'd like to tell us about this goal?

For now DHCS will keep these goals; however it may be updated or altered for a more disparity focus depending on how current efforts impact the measure rate.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

Outreach and education activities

1. Briefly describe your goal as it relates to this objective.

DHCS' goal is to provide opportunities to obtain or retain coverage for as many low-income Medi-Cal individuals as possible throughout the state, including children under 18 years of age. DHCS has focused its outreach and education efforts on the Navigators Project in counties where local agencies need assistance in reaching this population, as well as, in counties that have expressed a desire to partner with one or more CBOs, to ensure this population is best served. The DHCS Navigators Project currently partners with 23 counties and 12 CBOs to assist with outreach, enrollment, and retention efforts to meet this objective in 44 counties. DHCS recognizes that local CBOs are integral to the success of this project, as they work and live in the areas they serve.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

The Navigators Project targets 11 different populations including children under the age 18.

4. Numerator (total number)

14908

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

The total number of individuals (all ages) that were enrolled and/or retained Medi-Cal benefits through the Navigators Project.

6. Denominator (total number)

53878

Computed: 27.67%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Yes, DHCS is still in the process of implementing an automated process to validate enrollment data submitted by our Navigator Project partners; however, the figures provided were obtained via manual data validation.

10. What are you doing to continually make progress towards your goal?

Continuing Navigators Project monthly meetings with CBOs and county partners, as well as one-on-one check-ins between the CBO and their assigned DHCS staff to provide technical assistance, support, performance, and project updates. DHCS also requires all project partners to submit a progress report along with monthly data reports on enrollment and retention activities and quarterly data. Ad-hoc sessions are conducted to share best practices, and a quarterly meeting series with project partners and stakeholders has been added to the Navigators Project activities, to further understanding of the needs of the community.

11. Anything else you'd like to tell us about this goal?

There are plans to maintain this goal through the end of the project implementation period (June 2026).

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?
Optional

Do you have another objective in your State Plan?
Optional

Part 2: Additional questions

1. Do you have other strategies for measuring and reporting on your performance goals? What are these strategies, and what information have you found through this research?

2. Do you plan to add new strategies for measuring and reporting on your goals and objectives? What do you plan to do, and when will these data become available?

3. Have you conducted any focused studies on your CHIP population? (For example: studies on adolescents, attention deficit disorder, substance use, behavioral health services access, health care equity, special health care needs, or other emerging health care needs.) What have you discovered through this research?

4. Optional: Attach any additional documents here.
For example: studies, analyses, or any other documents that address your performance goals.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Tell us how much you spent on your CHIP program in FFY 2022, and how much you anticipate spending in FFY 2023 and 2024.

Part 1: Benefit Costs

Combine your costs for both Medicaid Expansion CHIP and Separate CHIP programs into one budget.

1. How much did you spend on Managed Care in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 2,664,181,078	**$** 2,061,545,729	**$** 2,222,999,896

2. How much did you spend on Fee for Service in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 1,537,010,881	**$** 1,951,667,313	**$** 1,890,554,100

3. How much did you spend on anything else related to benefit costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 25,552,817	**$** 0	**$** 0

Table 1: Benefits Costs
This table is auto-populated with the data you entered above.

	FFY 2022	FFY 2023	FFY 2024
Managed Care	2664181078	2061545729	2222999896
Fee for Service	1537010881	1951667313	1890554100
Other benefit costs	0	0	0
Cost sharing payments from beneficiaries	25552817	0	0
Total benefit costs	4226744776	4013213042	4113553996

Part 2: Administrative Costs

1. How much did you spend on personnel in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?
This includes wages, salaries, and other employee costs.

2022	2023	2024
$ 8,903,027	**$** 9,766,115	**$** 9,948,690

2. How much did you spend on general administration in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

4. How much did you spend on claims processing in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 81,313,036	**$** 82,268,035	**$** 83,935,631

5. How much did you spend on outreach and marketing in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

7. How much did you spend on anything else related to administrative costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

Table 2: Administrative Costs
This table is auto-populated with the data you entered above.
Your total administrative costs cannot be more than 10% of your total CHIP program costs (the sum of your benefit and administrative costs). The 10% administrative cap is calculated by dividing the total benefit costs by 9.

	FFY 2022	FFY 2023	FFY 2024
Personnel	8903027	9766115	9948690
General administration	0	0	0
Contractors and brokers	0	0	0
Claims processing	81313036	82268035	83935631
Outreach and marketing	0	0	0
Health Services Initiatives (HSI)	0	0	0
Other administrative costs	0	0	0
Total administrative costs	90216063	92034150	93884321
10% administrative cap	463959904.67	445912560.22	457061555.11

Table 3: Federal and State Shares

CHIP is funded by federal and state budgets. The federal share of funding is calculated by multiplying your state's Federal Medical Assistance Percentage (eFMAP) by your total program costs (the sum of your benefit and administrative costs). The remaining amount of your total program costs is covered by your state share of funding.

This table is auto-calculated using the data you entered above. The federal and state shares for FFY 2022 will be calculated once the eFMAP rate for 2022 becomes available. In the meantime, these values will be blank.

	FFY 2022	**FFY 2023**	**FFY 2024**
Total program costs	4265855205	4105247192	4207438317
eFMAP	65	65	65
Federal share	2772805883.25	2668410674.8	2734834906.05
State share	1493049321.75	1436836517.2	1472603410.95

8. What were your state funding sources in FFY 2022?
Select all that apply.

- [x] State appropriations
- [x] County/local funds
- [ ] Employer contributions
- [ ] Foundation grants
- [ ] Private donations
- [x] Tobacco settlement
- [x] Other

8a. What other type of funding did you receive?

Healthcare Treatment Fund Prop 56

9. Did you experience a shortfall in federal CHIP funds this year?

- ( ) Yes
- (•) No

Part 3: Managed Care Costs

Complete this section only if you have a managed care delivery system.

1. How many children were eligible for managed care in FFY 2022? How many do you anticipate will be eligible in FFY 2023 and 2024?

2022	2023	2024
$ 1,431,980	**$** 1,436,779	**$** 1,402,175

2. What was your per member per month (PMPM) cost based on the number of children eligible for managed care in FFY 2022? What is your projected PMPM cost for FFY 2023 and 2024?
Round to the nearest whole number.

2022	2023	2024
$ 186	**$** 144	**$** 159

	FFY 2022	FFY 2023	FFY 2024
PMPM cost	186	144	159

Part 4: Fee for Service Costs

Complete this section only if you have a fee for service delivery system.

1. How many children were eligible for fee for service in FFY 2022? How many do you anticipate will be eligible in FFY 2023 and 2024?

2022	2023	2024
$ 112,462	**$** 112,839	**$** 110,121

2. What was your per member per month (PMPM) cost based on the number of children eligible for fee for service in FFY 2022? What is your projected PMPM cost for FFY 2023 and 2024?
Round to the nearest whole number.

2022	2023	2024
$ 2,635	**$** 3,334	**$** 3,310

	FFY 2022	FFY 2023	FFY 2024
PMPM cost	2635	3334	3310

1. Is there anything else you'd like to add about your program finances that wasn't already covered?

2. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...
FederalandStateExpenditures.pdf

1. How has your state's political and fiscal environment affected your ability to provide healthcare to low-income children and families?

Generally, California's political and fiscal environment has been supportive of efforts to maintain health care coverage for low-income, uninsured children under the Affordable Care Act (ACA). This environment has allowed the state to support health coverage for low income, uninsured children, and the increase in federal financial participation for CHIP, in October 2015, helped strengthen those efforts to reach uninsured children within the state. Assistance Through Increased FMAP On March 18, 2020, President Biden signed into law H.R. 6021, the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127). Section 6008 of the FFCRA provides a temporary, 6.2 percentage point increase to each qualifying state and territory's Federal Medical Assistance Percentage (FMAP) under section 1905(b) of the Social Security Act (the Act), effective beginning January 1, 2020, and extending through the last day of the calendar quarter in which the public health emergency was declared by the Secretary of Health and Human Services for COVID-19. By accepting this FMAP increase, California also agreed to the Maintenance of Effort requirement in the FFCRA to not impose eligibility standards, methodologies, or procedures that are more restrictive than those that were in place on January 1, 2020. Overall State Fiscal Evolution Through COVID-19 Pandemic California's fiscal situation has continued to rapidly evolve since the beginning of the coronavirus disease 2019 (COVID-19) pandemic. Although the state economy abruptly ground to a halt in the spring of 2020 with the emergence of COVID-19, it has since experienced a quicker rebound than expected. While negative economic consequences of the pandemic have been severe, they do not appear to have been as catastrophic from a fiscal standpoint as previously anticipated budgetarily. Overall, the economic recovery has been uneven, as many low-income Californians remain out of work, while most high-income workers have been spared. As a part of the California's 2020-21 budget, the Governor reintroduced Medi-Cal reforms totaling approximately $342.9 million. Many Medi-Cal reforms are collectively known as California Advancing and Innovating Medi-Cal (CalAIM). The Governor also proposed to address behavioral health needs statewide, including providing incentives for student behavioral health. Additionally, the governor's budget included spending to expand and make permanent certain flexibilities, such as telehealth services. While there were funds carved out in the State's budget for Medi-Cal, it is important to note that the State also faces an operating deficit that began in 2021-22. General Fund spending on Medi-Cal increased by $8.6 million,

representing 31 percent of the total cost increase. There are several major drivers of this increase including: (1) lower federal funding for Medi-Cal when the enhanced federal match for Medicaid programs expired at the end of 2021; (2) the expiration (without reauthorization) of the managed care organization tax, which occurs midway through 2022-23 under current law; and (3) underlying cost growth from caseload changes and per capita cost increases. While the operating deficit is relatively small in 2021-22, it is projected to grow to around $17 billion by 2024-25.

2. What's the greatest challenge your CHIP program has faced in FFY 2022?

The COVID-19 public health emergency (PHE) has once again been a significant challenge our CHIP program faced in FFY 2022. Specifically, the impact of the PHE has delayed preventive services for children, increased stress and mental health needs of parents and children, and led to the disruption of the state's health care delivery system, including through individual providers, clinics, hospitals, and managed care plans. Rising to these challenges, DHCS has worked closely with our program partners and state and federal officials to address key challenges, to ensure that Medicaid and CHIP children continue to have access to all necessary care, including COVID-19 testing and care. Challenges in State Public Hospitals As an example of these challenges, the state public hospitals described some specific impacts, including: large backlogs of care that are taking time to reduce; shortages of staff and providers alike; difficulty filling open positions due to other industries offering higher salaries; historic levels of staff and provider burnout leading to resignations and further staffing shortages; impact of suspended redetermination inflating denominators; and significantly reduced staff of analytic employees struggling to manage the data analytics required to drive quality improvement. Informal data shared with DHCS indicated, in aggregate, there was an average of 2,118 admissions with a COVID-19 diagnosis per month in 2020 (Mar - Dec 2020), compared to an average of 2,109 COVID-19 admissions per month in 2021 (Jan - Sep 2021). The percentage difference is less than 1%, so COVID-19 admissions did not decrease in 2021, and systems were still dealing with a similar COVID-19 admissions load as that of last year. For ICU occupancy, in 2020 (Mar - Dec), in aggregate, 10.7% of days were over-capacity. In 2021 (Jan- Sep), in aggregate, 14.8% of days were over-capacity. So, ICU occupancy was above capacity more frequently in 2021 compared to 2020. Challenges in the Behavioral Health Workforce Another challenge is that the behavioral health workforce does not always mirror the people it serves. While it is a requirement that every service must be available in a threshold language, it can still be challenging for patients in a counseling visit to engage and build trust with a provider who is not a fluent speaker of their language, does not look like them, or may not have the same lived experiences as they. We need those who serve a community to come from that community, whenever possible. We are committed to looking at the workforce and making necessary investments, so that in five years our workforce will more closely resemble the communities it serves. Challenges of Access to Behavioral Health Care Due to Lack of Equity Lastly, DHCS' focus on improving the state's behavioral

health system is driven by the stark inequities in access to health care by race, ethnicity, and income. There are certain populations, especially Black, Indigenous, and People of Color, who have historically been underserved in the health care system. They have worse outcomes and a shorter life expectancy on almost every measure. We are taking the first step in a long journey to ensure that Medi-Cal is an agent of change with a focus on health equity. DHCS is also looking at data to identify inequities and use the best quality improvement techniques to ensure health care is better, fair, and equitable.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2022?

• COVID-19 Related Flexibilities • Enrollment Expansion • Vaccine Outreach for Children • Children's Oral Health • Smile, California Dental Campaign • Postpartum Extension • Hearing Aid Coverage for Children Program (HACCP) • ACEs Aware Initiative • California Advancing and Innovating Medi-Cal (CalAIM) Access Criteria for Specialty Mental Health Services • CalAIM Behavioral Health Adult and Youth Screening and Transition Tools Informational Webinar • No Wrong Door • Streamlined Documentation Requirements • Standardized Screening and Transition Tools • California Behavioral Health Community-Based Continuum Demonstration • CalAIM Oral Health Initiatives • Children and Youth Behavioral Health Initiative (CYBHI) • Children and Youth Behavioral Health Initiative (CYBHI) Monthly Webinar • Behavioral Health Continuum Infrastructure Program (BHCIP) • Expansion of School-Based Health Care • Family First Prevention Services Act (FFPSA) • Premiums and Eligibility Waived for Displaced Families • 2016 Final Rule Compliance COVID-19-Related Flexibilities Since the initiation of the of the federal declaration of the COVID-19 Public Health Emergency (PHE), the Department of Health Care Services (DHCS) implemented over 100 programmatic flexibilities to help minimize the strain to the Medicaid (Medi-Cal in California) program and its beneficiaries, and California's (CA) health care providers and systems. These changes were implemented under a variety of federal and state authorities, and impact almost all aspects of Medi-Cal's delivery systems. While many of these programmatic flexibilities will terminate on or around the end of the PHE, some will continue due to the positive impact they have left on the Medi-Cal program. In preparation for the end of the federal PHE declaration, DHCS has developed this Unwinding Operational Plan to help inform Medi-Cal beneficiaries, providers, managed care plans, counties, and other valued stakeholders, of the changes to expect. DHCS continues to cover both COVID-19 viral and serologic (antibody) tests, at no cost to Medi-Cal beneficiaries. Further, DHCS continued to implement the COVID-19 Uninsured Group Program, which provides free COVID-19 diagnostic testing and treatment services and is available to uninsured individuals determined eligible for up to 12 months or the end of the PHE, whichever comes first. Enrollment Expansion Given the unique health challenges of the COVID-19 health crisis, Medi-Cal is an even more critical resource for Californians who need help meeting their health care needs. As such, DHCS is continuing efforts to inform these Californians about the availability of Medi-Cal. Effective July 1, 2019,

Assembly Bill (AB) 74 (Chapter 23, Statutes of 2019) appropriated $59.7 million for DHCS to partner with counties and/or community-based organizations (CBOs) for Medi-Cal outreach, enrollment, retention, and navigation services, including for uninsured children and youth formerly enrolled in Medi-Cal. On July 1, 2022, Senate Bill (SB) 154 (Chapter 43, Statutes of 2022) appropriated an additional $60.0 million to continue the efforts authorized by AB 74. Beginning June 2022, the Navigators Project provided a one-quarter extension (through September 30, 2022) of remaining AB 74 funding to current partners, enabling current efforts to continue while DHCS engaged in the bid process for new SB 154 agreements. As of September 2022, the Navigators Project provided new agreements to selected partners, effective October 1, 2022, through June 30, 2026. DHCS has also developed and continues to update (as necessary) a social media toolkit with a set of targeted messages for providers to reach various groups of Californians, many of whom do not know they may qualify for Medi-Cal. As an example, in FFY 2022 and 2023, California has continued its ongoing efforts to increase utilization of children's preventive services, including immunizations and preventive dental care services. Vaccine Outreach for Children DHCS allocated up to $350 million to incentivize COVID-19 vaccination efforts in the Medi-Cal managed care delivery system from September 1, 2021, through February 28, 2022. Medi-Cal managed care plans (MCPs) were eligible to earn incentive payments for activities designed to close vaccination gaps with their enrolled members, and to address vaccine uptake disparities for specific age and race/ethnicity groups. The third outcome ascertainment period for the program ended on March 6, 2022. Between January 3 and March 6, the total vaccination rates showed improvement in all reported measures. On March 6, the target goals for all vaccine outcome measures increased to closing 100 percent of the gap between Medi-Cal and county rates, which was a challenge for plans to meet. Three beneficiary sub-groups (those of 12-25 years of age, African Americans, and American Indian/Alaska Natives) were within 5 percent of closing two-thirds of the gap. For the high-performance pool measures, preliminary data demonstrate that eight MCPs achieved targets of at least one dose for members ages 5 11 years, and two MCPs achieved targets for fully vaccinated and boosted members ages 12 years and older. For more information, please refer to All Plan Letter (APL) 21 0010, Attachment A. In regard to the Monkey Pox (MPox) vaccines, DHCS will reimburse the administration of MPox vaccines and the orthopoxvirus laboratory test as Family Planning, Access, Care, and Treatment (Family PACT) program benefits, effective for dates of service on or after August 17, 2022, through the end of the federal MPox public health

emergency. MPox vaccine administration and the orthopoxvirus laboratory test are Family PACT benefits only when provided during a family planning visit as a family planning-related service. Children's Oral Health Due to COVID-19 impacts and the delay of the California Advancing and Innovating Medi-Cal (CalAIM) initiatives, DHCS submitted a request to the Centers for Medicare & Medicaid Services (CMS) for federal approval to extend the Medi-Cal 2020 Waiver for 12 months ending on December 31, 2021. On December 29, 2020, CMS approved DHCS' request for an extension of the Medi-Cal 2020 Waiver, which only included DTI Domains 1, 2, and 3. Domain 1 aimed to increase statewide proportion of children ages 1 through 20 enrolled in Medi-Cal who receive a preventive dental service by 10 percentage points over a five-year period. However, Domain 1 was only able to increase the preventive service utilization by 5.94 percentage points (including the SNC encounters) from PY 1 to PY 4. PY 5 was severely impacted by the COVID-19 PHE and PY 6 had shown some progress when compared to PY 5. DHCS issued a total of approximately $307.5M as incentive payments for Domain 1 as of July 2022. Domain 2 assessed Medi-Cal children ages six (6) and under for caries risk assessment (CRA) to manage the disease of caries using preventive services and non-invasive treatment approaches instead of more invasive and costly restorative procedures. Over the course of the DTI period, children who received a CRA showed an increased use in preventive services versus their restorative services which is a desired outcome for the Domain. DHCS issued a total of approximately $236M in incentive payments for Domain 2 as of October 2022. In addition, DHCS observed a steady growth in dental exams continuity for children ages 20 and under as a part of the Domain 3 objective; specifically, the continuity of care increased on an average by 1.80 and 1.36 percentage points in the initial and expansion counties respectively. DHCS issued a total of approximately $269M in incentive payments for Domain 3 as of July 2022. Smile, California Dental Campaign Smile, California is a campaign DHCS launched with its partners to make Medi-Cal members aware of their dental benefit. In partnership with the California Department of Public Health, the Smile, California Campaign launched the Back-Tooth-School activation campaign, which encouraged parents and caregivers to schedule a dental check-up before the beginning of the 2021-2022 school year. Smile, California also launched new downloadable marketing material (available in English and Spanish), and continued its Smile Alerts, to alert partners and providers of campaign updates via email. By the end of June, SmileCalifornia.org had 101,833 new visitors with 142,587 visits to the "Find a Dentist." Postpartum Extension California opted to implement the

postpartum extension related to the American Rescue Plan and its expansion of benefits to its CHIP populations, specifically CCHIP. DHCS submitted CHIP State Plan Amendment (SPA) 22-0031 to provide a continuous 365-day postpartum coverage period for CCHIP. On May 25, 2022, CHIP SPA 22-0031 was approved by CMS. Hearing Aid Coverage for Children Program (HACCP) On September 6, the Governor signed Assembly Bill 179 (Chapter 249, Statutes of 2022), which extends the HACCP eligible age limit to those under 21 years of age and allows other health coverage to be accepted when there is a coverage limit of $1,500 or less per year for hearing aids. The HACCP offers hearing aid coverage to children who do not qualify for Medi-Cal or have insufficient health insurance coverage for hearing aids and related services. ACEs Aware Initiative ACEs Aware is a first-in-the-nation initiative led by DHCS and the Office of the California Surgeon General (CA-OSG), which gives Medi-Cal providers training, clinical protocols, and payment for screening children and adults for ACEs. On September 16, 2022, DHCS and CA OSG announced the awarding of grant funding to 25 organizations across California to increase the workforce and services needed for primary care clinics to expand and sustain screening and response to ACEs and toxic stress in local communities. As of August 31, 2022, 26,900 individuals completed a core ACEs training, and 12,100 providers became ACEs Aware certified as of August 31, 2022. Based on Medi-Cal claims data, Medi-Cal providers conducted nearly 1,153,000 ACE screenings of more than 899,000 unique Medi-Cal beneficiaries, including children and adults, across California between January 1, 2020, and December 31, 2021. California Advancing and Innovating Medi-Cal (CalAIM) Access Criteria for Specialty Mental Health Services Effective January 1, 2022, DHCS implemented CalAIM policy that expands access to Specialty Mental Health Services (SMHS) to children and youth in the child welfare system by requiring county Mental Health Plans (MHPs) to provide SMHS to beneficiaries who have a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the Department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness. (See Welf. & Inst. Code section 14194.402(d)). CalAIM Behavioral Health Adult and Youth Screening and Transition Tools Informational Webinar On November 3, DHCS held a webinar to provide an opportunity for stakeholders to learn about the Screening and Transition of Care Tools, which will go live on January 1, 2023, as part of CalAIM. This initiative is focused on developing statewide screening and transition of care tools for both youth and adults for use by county mental health plans and Medi-Cal managed

care plans to address beneficiary service needs across Medi-Cal mental health delivery systems, ensure all Medi-Cal beneficiaries receive coordinated services, and improve health outcomes. No Wrong Door Through CalAIM, DHCS aims to streamline policies to improve access to behavioral health services, simplify how these services are funded, and support administrative integration of mental illness and substance use disorders treatment, which will also impact foster care youth. DHCS implemented the CalAIM "no wrong door" policy effective July 1, 2022, to ensure beneficiaries receive medically necessary treatment regardless of the delivery system through which they seek care. This policy allows beneficiaries who directly access a treatment provider to receive an assessment and mental health services, and to have that provider reimbursed for those services, even if the beneficiary is ultimately transferred to a different delivery system due to the level of impairment and mental health needs. In certain situations, beneficiaries may receive non-duplicative services in multiple delivery systems, such as when a beneficiary has an ongoing therapeutic relationship with a therapist or psychiatrist in one delivery system while requiring medically necessary services in the other. Streamlined Documentation Requirements As part of CalAIM, DHCS made significant changes to behavioral health documentation requirements to improve the beneficiary experience; effectively document treatment goals and outcomes; promote efficiency to focus on delivering person-centered care; promote safe, appropriate, and effective beneficiary care; address equity and disparities; and ensure quality and program integrity. To achieve this, DHCS implemented CalAIM policy, effective July 1, 2022, that streamlines and standardizes clinical documentation requirements across Medi-Cal SMHS, Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) services. These updated documentation requirements align with Centers for Medicare and Medicaid Services' national coding standards and physical health care documentation practices. Standardized Screening and Transition Tools Currently, multiple behavioral health screening and transition of care tools are in use for Medi-Cal beneficiaries across the state, leading to inconsistencies for when beneficiaries are referred to mental health plan networks versus managed care networks. CalAIM seeks to streamline this process and improve patient care by creating standardized statewide tools. During this reporting period, DHCS undertook a robust stakeholder process to develop statewide Screening and Transition of Care Tools for both adults and individuals under 21 years of age for use by County Mental Health Plans (MHPs) and Medi-Cal Managed Care Plans (MCPs). DHCS is developing standardized Adult and Youth Screening Tools to determine the most appropriate

Medi-Cal mental health delivery system referral (i.e., MHP or MCP) for beneficiaries who are not currently receiving mental health services when they contact the MHP or MCP seeking mental health services. In addition, DHCS is developing a standardized Transition of Care Tool to ensure that Medi-Cal beneficiaries receive timely and coordinated care when completing a transition of services to the other delivery system or when adding a service from the other delivery system to their existing mental health treatment. DHCS will require MHPs and MCPs to use the Screening and Transition of Care Tools effective January 1, 2023. California Behavioral Health Community-Based Continuum Demonstration During this reporting period, DHCS planned, prepared for, and engaged stakeholders on a new Medicaid Section 1115 waiver, which DHCS will apply for in 2023. The new Medicaid Section 1115 Demonstration will increase access to and improve mental health services for Medi-Cal Members statewide. The demonstration, known as the California Behavioral Health Community-Based Continuum Demonstration (CalBH-CBC), takes advantage of the Centers for Medicare & Medicaid Services' (CMS) guidance and associated federal funding aimed at improving care for people living with serious mental illness (SMI) and serious emotional disturbance (SED). This demonstration opportunity is similar to California's historic commitment to creating a full continuum of care for substance use disorder treatment and recovery services; in 2015, California launched the Drug Medi-Cal Organized Delivery System (DMC-ODS), a first-in-the-nation model that has been emulated in many other states. Like DMC-ODS, this opportunity allows California to make historic investments in building out the full continuum of care for behavioral health, with a special focus on the populations most at risk. DHCS' central goal of the CalBH-CBC Demonstration is to leverage this opportunity to expand a robust continuum of community-based behavioral health care services for Medi-Cal members living with SMI or SED. It would also amplify California's ongoing behavioral health initiatives and be informed by findings from DHCS' 2022 Assessing the Continuum of Care for Behavioral Health Services in California. CalAIM Oral Health Initiatives On January 1, 2022, the CalAIM Oral Health Initiatives went into effect, as approved by SPA 21-0019 on December 15, 2021. CalAIM is a multi-year initiative to improve the quality of life and health outcomes of our Medi-Cal population by implementing broad delivery system, program, and payment reform across the Medi-Cal program. The major components of CalAIM for dental specifically were built on the successful outcomes of various pilots (including DTI) from the previous federal waivers and will result in a better quality of life for Medi-Cal members as well as long-term cost savings/avoidance. The Department is

committed to improving the accessibility of Medi-Cal dental services and improving oral health outcomes for Medi-Cal members. The Department set a goal to achieve at least a 60 percent dental utilization rate for Medi-Cal eligible children and increase preventive service utilization for children and adults. To progress toward achieving these goals and based on lessons learned from DTI, CalAIM expanded Pay for-Performance payments that reward increasing the use of preventive services and establishing/maintaining continuity of care through a dental home and added two new benefits - namely, Silver Diamine Fluoride (SDF) for young children and specific high risk and institutional populations, and a Caries Risk Assessment (CRA) Bundle for young children. SDF and CRA can be performed by dentists and allied dental professionals. Children and Youth Behavioral Health Initiative (CYBHI) Pursuant to Assembly Bill (AB) 133 (Committee on Budget, Chaptered 143, Statutes of 2021), California established the CYBHI Initiative, which is administered by the California Health and Human Services Agency (CalHHS) and its departments, as applicable, including DHCS. Effective January 1, 2022, through the CYBHI, California will work towards transforming the state's behavioral health system into a world-class, innovative, upstream-focused ecosystem in which children and youth 25 years of age and younger, regardless of payer, are routinely screened, supported, and served for emerging and existing behavioral health needs. Services are statewide, evidence-based, culturally competent, and equity-focused. The CYBHI is a multi-year, multi-department package of investments that reimagines the systems that support behavioral health for all California's children, youth, and their families. Efforts focus on promoting social and emotional well-being, preventing behavioral health challenges, and providing equitable, appropriate, timely, and accessible services for emerging and existing behavioral health needs for children and youth ages 0 to 25. The $4.7 billion investment of state General Funds for CYBHI will improve access to behavioral health services for all children and youth in California, regardless of payer. Moreover, it will have significant implications for the Medi-Cal program since 5.4 million (approximately 54 percent) children and youth are enrolled in Medi-Cal. CYBHI will improve and change the way Medi-Cal's children and youth access behavioral health service-virtually, through their communities and schools, and through their existing relationships with Medi-Cal managed care plans (MCP) and county behavioral health plans. As a component of CYBHI, DHCS will build and drive adoption of the Behavioral Health Virtual Services Platform for all children, youth, and families in California, regardless of payer. The platform will support the delivery of equitable, appropriate, and timely behavioral health services from prevention to treatment to

recovery and provide an e Consult platform for pediatric and primary care providers to connect with BH providers. CYBHI also includes statewide efforts that will make it easier for children, youth, and young adults to access behavioral health services in California's schools. On October 3, 2021, DHCS, in collaboration with the Department of Managed Health Care (DMHC), virtually hosted the webinar to inform the development of the statewide all-payer fee schedule for school-based behavioral health services under the CYBHI. DHCS and DMHC will engage workgroup members on a variety of policy and operational topics to inform the development and refinement of the program design. On October 6, 2021, DHCS virtually hosted the fourth public workgroup meeting to identify evidence-based and community-defined evidence practices for CYBHI. The Evidence-Based Practice and Community-Defined Evidence Practice (EBP/CDEP) Workgroup is tasked with providing input and guidance to DHCS on the selection of EBPs and CDEPs to improve outcomes for children and youth with or at high risk for behavioral health conditions. The EBP/CDEP Workgroup will be one of multiple sources of input used to inform program design and implementation. Children and Youth Behavioral Health Initiative (CYBHI) Monthly Webinar On September 26, 2022, DHCS hosted a webinar to keep stakeholders apprised of its progress in implementing various work streams for the CYBHI. Key attendees include youth, parents, family members, behavioral health providers, Medi-Cal managed care plans, county behavioral health departments, commercial health plans, education and other cross-sector partners, and all interested Californians. Behavioral Health Continuum Infrastructure Program (BHCIP) The Behavioral Health Continuum Infrastructure Program (BHCIP) provides the DHCS funding to award competitive grants to qualified entities to construct, acquire and rehabilitate real estate assets or to invest in mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources. In Fiscal Year 2021-22, DHCS was awarded a total of $2.2 billion under the BHCIP to provide competitive grants to counties, cities, non-profit, Tribal entities, and for-profit organizations to increase the number of behavioral health (mental health and substance use disorder) facilities in California. DHCS released BHCIP Round 4: Children and Youth Request for Application for $480.5 million on June 1, 2022. Funding will be awarded by late 2022 to qualified entities expanding behavioral health service capacity. This round of funding is specific to children and youth ages 25 and younger, including pregnant and postpartum women and their children, and transition-age youth, along with their families. Applicants must demonstrate how their infrastructure project will expand behavioral health services for this population exclusively.

Eligible facilities include, but are not limited to, psychiatric acute care hospitals and psychiatric health facilities. Other BHCIP rounds of funding will also increase the number of behavioral health facilities for children and youth. Expansion of School-Based Health Care DHCS released the Request for Proposals (RPAs) to solicit firms that can research, design, develop, implement, and manage a strategic plan focusing on outreach and engagement methodologies. This would be done in consultation with the California Department of Education (CDE), the executive director of the State Board of Education (SBE), and other stakeholders to successfully meet the needs of the Local Education Agencies (LEAs) that participate in the LEA Billing Options Program (BOP). The LEA BOP reimburses LEAs (school districts, county offices of education, charter schools, community colleges, and university campuses) for health-related services already provided by qualified health service practitioners to Medi-Cal enrolled students. The goal of this contract is to bring awareness to the over 1,039 LEAs in California to the changes and opportunities in the LEA BOP. A contract was awarded to WestEd in March 2022, who has begun training material development along with outreach and engagement efforts. Family First Prevention Services Act (FFPSA) FFPSA has several provisions to enhance support services for families to help children remain at home, reduce the unnecessary use of congregate care, and build the capacity of communities to support children and families. DHCS is collaborating with the California Department of Social Services for areas impacting Medi-Cal, including FFPSA Part I evidence-based programs and Part IV requirements effective October 1, 2021, that an assessment by a Qualified Individual (QI) be completed any time a child is considered for placement in a Qualified Residential Treatment Program (QRTP) to determine if a child's needs can instead be met with family members, in a family home, or in one of the other approved settings and to make other specified determinations. In addition, FFPSA Part IV requires six months of family-based aftercare support be provided to a child exiting QRTP placement. These services may be covered under the Medi-Cal program as a medically necessary specialty mental service if all requirements are met. Premiums and Eligibility Waived for Displaced Families Due to the unfortunate wildfires from 2017 through 2022, which displaced so many families, California has retained its authority through State Plan Amendments to waive premiums and certain eligibility-verification requirements on a temporary basis, in order to assist beneficiaries who have been affected by the natural disasters. 2016 Final Rule Compliance In this reporting period California has demonstrated continued compliance with the Medicaid and CHIP Managed Care Final Rule (2016 Final Rule) in the delivery of

CHIP services and benefits covered under the state's separate child health plan.

4. What changes have you made to your CHIP program in FFY 2022 or plan to make in FFY 2023? Why have you decided to make these changes?

In FFY 2022-23, DHCS has and will continue to respond to the COVID-19 pandemic. Given the unpreceded nature of the COVID-19 PHE, DHCS will continue to seek federal approval related to program flexibilities as needed. California continues efforts to reduce health disparities in the Medi-Cal program in order to help achieve high quality health care for all beneficiaries, including children and families. As part of those efforts, DHCS publishes an annual report on health disparities in Medi-Cal managed care, which includes differences in quality measures for children by race and ethnicity. DHCS also regularly publishes a variety of data on the Medi-Cal program and includes a number of demographic identifiers in that data. In FFY 2023, DHCS will continue to develop a performance and outcomes system for children and youth in Medi Cal mental health services in an effort to improve health outcomes. Further, California will continue to provide incentive payments in FFY 2023, targeted at providers, public hospital systems, and managed care and mental health plans to maximize health care and payment reform, including efforts to address health disparities. As part of the ACEs Aware initiative, eligible Medi-Cal providers will continue to receive training, clinical protocols, and payment for conducting qualifying ACEs screenings for children and adults (through age 64) with full-scope Medi-Cal benefits. DHCS also relaunched the CalAIM initiative, on January 1, 2022, to improve the entire continuum of care from birth to end of life. Finally, as a part of its 2022 Comprehensive Quality Strategy, DHCS has identified improving children's preventive services as a key clinical focus area. In 2022, it will be launching its Bold Goals: 50x2025 initiative which has the following goals-many of which will directly improve the health outcomes of children enrolled in Medi-Cal: • Close racial/ethnic disparities in well-child visits and immunizations by 50% (state level • Close maternity care disparities for Black and Native American persons by 50% (state level) • Improve maternal and adolescent depression screening by 50% (state level) • Improve follow up after emergency department visit for mental health or substance use disorder by 50% (state level) • Ensure all health plans exceed the 50th percentile for all children's preventive care measures California continues to expand and extend efforts to enroll hard-to-reach people through the Medi-Cal Health Enrollment Navigators Project. Due to the community health impacts of COVID-19, navigator services are more important than ever before. Project partners have implemented innovative and creative approaches to contact and enroll the eligible, hard to reach

populations in their local communities. DHCS will continue working closely with counties and CBOs to enhance DHCS' efforts to achieve a successful implementation in reaching out to California residents who are potentially or actually eligible for Medi-Cal but who are not currently enrolled. Moreover, DHCS believes that monthly premiums can create barriers in access to care and unnecessary breaks in coverage for eligible individuals. The state made this change, because Medi-Cal premiums can add additional financial hardships for families that in turn have lasting impacts on the health and well-being of children. In addition, California continues the CMS Child Core Set as the basis for the performance measures that all Medi-Cal MCPs are required to report on. While DHCS' prior set of required managed care performance metrics had numerous measures devoted to access and quality of care for children, DHCS believes that adopting the CMS Child Core Set provides a more robust measurement of access and quality of care for children and provide a better lever for driving improvement. The following SPAs will impact the CHIP 2023. With an effective date of July 1, 2022, SPA 22-0042 was approved by CMS to reduce the dollar amount to $0 for monthly premiums for the Medicaid Expansion coverage group. Additionally, with an effective date of July 1, 2022, SPA 22-0041 was submitted to CMS to reduce the dollar amount to $0 for monthly premiums for SCHIP coverage groups. This includes cost sharing for coverage groups with the 5% income cap (e.g., MCAP). DHCS is awaiting CMS approval for SPA 22-0041.

5. Is there anything else you'd like to add about your state's challenges and accomplishments?

DHCS has nothing additional to add.

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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