



California CARTS FY2021 Report

Welcome!

We already have some information about your state from our records. If any information is incorrect, please contact the mdct_help@cms.hhs.gov.

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

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Saralyn.Ang-Olson@dhcs.ca.gov

7. Full mailing address:

Include city, state, and zip code.

Department of Health Care Services, Office of Compliance - Internal Audits; 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 the 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

160



FPL ends at

266

Premium starts at

\$ 13



Premium ends at

\$ 39

☐ 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

160



FPL ends at

266

Premium starts at

\$ 156



Premium ends at

\$ 468

☐ 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.

\$13 per child with maximum family contribution of \$39. Families receive fourth month premium free, if three months paid in advance, use Electronic Funds Transfer or reoccurring credit card payments. This results in a 25% savings on the annual premiums.

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. Children enrolled into Presumptive Eligibility receive fee-for-service Medi-Cal until they have finalized their enrollment. Children eligible for CCS receive primary care through their managed care plan, while CCS services are delivered on a fee-for-service basis. In some counties, the plan is responsible for CCS services. CHIP eligible children receive specialty mental health services and Substance Use Disorder (SUDs) 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

266



FPL ends at

322

Premium starts at

\$ 21



Premium ends at

\$ 63

☐ 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

266



FPL ends at

322

Premium starts at

\$ 252



Premium ends at

\$ 756

☐ 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. Children enrolled into Presumptive Eligibility receive fee-for-service Medi-Cal until they have finalized their enrollment. Children eligible for CCS receive primary care through their managed care plan, while CCS services are delivered on a fee-for-service basis. In some counties, the Medi-Cal managed care plan is responsible for CCS services. CHIP eligible children receive specialty mental health services and SUDs 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. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

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 women?

- ☐ 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

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. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

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 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 your Pregnant Women State Plan expansion?
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 women?

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

- ☒ Yes
- ☐ No

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

On March 11, 2021, President Joe Biden signed the American Rescue Plan Act of 2021 (ARPA) into law. This allowed states to extend its postpartum coverage from 60 days to 12 months. This extension is to be provided to Medicaid pregnancy groups and CHIP pregnancy groups. To cover a larger population, California utilizes the CHIP unborn option covering targeted low-income children from conception to birth. California opted to implement this expansion of benefits to its Medicaid populations, and DHCS submitted a Health Services Initiative (HSI) as CHIP SPA 21-0032 to prevent disparity between the pregnancy populations and the targeted low-income children from conception to birth. On September 14, 2021, CHIP SPA 21-0032 was approved expanding the postpartum period from 60 days to 12 months (365 days). This SPA became effective July 1, 2020.

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 2020	Number of children enrolled in FFY 2021	Percent change
Medicaid Expansion CHIP	1,750,138	1,530,897	-12.527%
Separate CHIP	61,617	70,854	14.991%

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

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 2020 children's uninsurance rates are currently unavailable. Please skip to Question 3.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
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

Percent change between 2019 and 2020
Not Available

1. What are some reasons why the number and/or percent of uninsured children has changed?

California did not use American Community Survey data as from previous years.

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

2a. What are some reasons why the American Community Survey estimates might not reflect the number of uninsured children in your state?

Due to the impact of the COVID-19 pandemic, the Census Bureau is changing the 2020 American Community Survey (ACS) release schedule. Further, the ACS is providing 1-yr experimental estimated data, using experimental weights not comparable with prior ACS 1-yr estimates.

☐ 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

3a. What is the alternate data source or methodology?

California utilized a state specific data source the California Health Interview Survey (CHIS) conducted by the University of California in Los Angeles (UCLA) Center for Health Policy Research. It is a population-based, geographically stratified, multi-modality survey.

3b. Tell us the date range for your data

Start

mm/yyyy

 /

End

mm/yyyy

 /

3c. Define the population you're measuring, including ages and federal poverty levels.

This CHIS estimate is provided by age (0-18 years old) and FPL (0-199%).

3d. Give numbers and/or the percent of uninsured children for at least two points in time.

For 2018: The percent of children currently uninsured was 3%. The 95% confidence interval (CI) of percent was 1.0 - 5.1. The weighted population count was 129,000. The standard error of weighted frequency was 44,888. The 95% CI of weighted frequency was 39,625 - 218,285. For 2019: The percent of children currently uninsured was 4%. The 95% confidence interval (CI) of percent was 2.4 - 5.6. The weighted population count was 139,000. The standard error of weighted frequency was 28,458. The 95% CI of weighted frequency was 82,696 - 195,961. For 2020: The percent of children currently uninsured was 2.1%. The 95% confidence interval (CI) of percent was 1.1 - 3.0. The weighted population count was 63,000. The standard error of weighted frequency was 14,592. The 95% CI of weighted frequency was 33,681 - 91,758.

3e. Why did your state choose to adopt this alternate data source?

The experimental nature and delayed release date of the ACS-1 year data provided California an opportunity to seek out an alternative.

3f. How reliable are these estimates? Provide standard errors, confidence intervals, and/or p-values if available.

See 3d above.

3g. What are the limitations of this alternate data source or methodology?

Based on the CHIS 2019-2020 methodology report, CHIS has low screener response rate (16.2%) but high conditional response rate (72% for adult interviews and 85.7% for child interviews). 2020 and 2019 data may not be comparable. Per CHIS weighted estimates: The number of children living below 200% FPL who were uninsured dropped by 55% in 2020 compared with 2019. This significant variation is due to increased sample size in 2020 during COVID-19 related disruptions and potential improvement in survey responses. Additionally, even if the parameters were consistent across years, it is possible that more 0-18 year olds were insured because of the pandemic.

3h. How do you use this alternate data source in CHIP program planning?

California will continue to use CHIS data as an alternate source of data, if the ACS survey data is not available for CARTS reports.

☐ No

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

No.

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 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 2021-22.

☐ No

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

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

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 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).

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?

This question should only be answered in respect to Separate CHIP.

☒ Yes

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

0 %

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)?

0 %

☐ 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, there is county contact made to the individual through a notice of action (NOA) regarding the renewal form or missing information requirements. If information is not received, a reminder is sent in the individual's preferred language and method (phone, mail, etc.), to discontinue, and it must be sent ten days prior to the end of renewal due 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 will be eligible 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 a pre-populated renewal forms in threshold languages when additional information is required. Other improvements California has implemented include resetting the annual renewal date at change of circumstance redeterminations made between annual renewals, partnering with community based organizations to assist beneficiaries with renewal paperwork as needed, use of self-attestations for household composition, being pregnant, or being an American Indian/Alaskan Native when documentary proof is not available, and allowing telephonic or electronic signature for the renewal form.

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

California providing premium relief to individuals affected by natural disasters and authorizing county flexibilities with renewals during these emergencies, 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?

No.

Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2021?

Don't include applicants being considered for redetermination - this data will be collected in Part 3.

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.

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 this data?

Data for application denial reasons is aggregate and not separated out by denial reason type. Additionally, DHCS does not collect data for the separate CHIP (SCHIP) population at this time. For Questions 1-4, above, further information on limitations are described below. For Question 1: DHCS does not receive data on the S-CHIP population at this time. DHCS is able to report partial CHIP data. 86,280 Medicaid Children's Health Insurance Program (MCHIP) applicants were denied CHIP coverage in FFY 2021. For Question 2: DHCS receives aggregate data on CHIP coverage denials. The aggregate data is not separated out by denial reason type such as denials for procedural reasons. For Question 3: DHCS receives aggregate data on CHIP coverage denials. The aggregate data is not separated out by denial reason type such as denials for eligibility reasons. For Question 3a: DHCS's hierarchy of eligibility determinations at application evaluates for Medicaid eligibility first, then if not potentially Medicaid eligible, evaluate for CHIP eligibility. Therefore, DHCS would not expect an applicant denied for CHIP coverage to be determined eligible for Medicaid. If an applicant is determined eligible. For Question 4: DHCS receives aggregate CHIP data for coverage denials. The aggregate data is not separated out by denial reason type such as denials for other reasons.

Table: CHIP Eligibility Denials (Not Redetermination)

This table is auto-populated with the data you entered above.

	Percent
Total denials	
Denied for procedural reasons	
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 2021?

1029069

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

394465

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

342950

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.

51515

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 this data?

Data for disenrollment is aggregate and not stratified by disenrollment reason type. DHCS does not receive data on separate CHIP (SCHIP) population at this time. For Questions 1 - 4, above, data reflects Medicaid Children's Health Insurance Program (MCHIP) applications. As stated above, DHCS does not receive data on the SCHIP 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	86.94%
Children disenrolled after redetermination	13.06%

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 2021?

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 this data?

California's Medicaid reporting data for redeterminations is aggregated, combining adults and children. Additionally, the data does not segregate by age or by disenrollment reason; 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 (Title XXI) 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 2020 (the second quarter of FFY 2020). 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 last year you reported on the number of children at the start of the cohort (Jan - Mar 2020) and six months later (July - Sept 2020). This year you'll report on the same cohort at 12 months (Jan - Mar 2021) and 18 months later (July - Sept 2021). 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 2020. 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 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

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 2020 weren't enrolled in CHIP in December 2019.

☒ 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 2020 weren't enrolled in CHIP or Medicaid in December 2019.

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 2020 (start of the cohort): included in 2020 report.

You completed this section in your 2020 CARTS Report. Please refer to that report to assist in filling out this section if needed.

3. How many children were newly enrolled in CHIP between January and March 2020?

Ages 0-1

2429

Ages 1-5

28386

Ages 6-12

30193

Ages 13-16

8570

July - September 2020 (6 months later): included in 2020 report.

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

1607

Ages 1-5

20852

Ages 6-12

23479

Ages 13-16

6588

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

14

117

123

38

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

<11

92

95

32

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

808

7417

6591

1944

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

525

5818

4590

1146

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

In March 2020, DHCS issued Medi-Cal Eligibility Division Information Letter (MEDIL) 20-06 instructing counties to delay the processing of Medi-Cal annual redeterminations and delay discontinuances and negative actions for Medi-Cal, Medi-Cal Access Program (MCAP), Medi-Cal Access Infant Program (MCAIP), and County Children's Health Initiative Program (CCHIP) based on the declared State and National Emergency due to COVID-19. With the exception of CMS approved negative action (i.e. death, moved out of state, request to be discontinued) counties were instructed to continue to process new applications and maintain beneficiary's Medicaid/CHIP coverage during the PHE (March 2020 to January 2022-latest guidance from CMS).

January - March 2021 (12 months later): to be completed this year.

This year, please 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

1384

17229

19800

5619

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

Ages 0-1

13

Ages 1-5

137

Ages 6-12

135

Ages 13-16

28

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

11

Ages 1-5

124

Ages 6-12

119

Ages 13-16

23

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

1032

Ages 1-5

11020

Ages 6-12

10258

Ages 13-16

2923

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

713

9170

7942

2026

July - September of 2021 (18 months later): to be completed this year
This year, please 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

1216

15143

17334

4941

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

13

122

167

35

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

11

115

156

34

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

1200

13121

12692

3594

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

1272

13821

11628

2680

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

In March 2020, DHCS issued Medi-Cal Eligibility Division Information Letter (MEDIL) 20-06 instructing counties to delay the processing of Medi-Cal annual redeterminations and delay discontinuances and negative actions for Medi-Cal, Medi-Cal Access Program (MCAP), Medi-Cal Access Infant Program (MCAIP), and County Children's Health Initiative Program (CCHIP) based on the declared State and National Emergency due to COVID-19. With the exception of CMS approved negative action (i.e. death, moved out of state, request to be discontinued) counties were instructed to continue to process new applications and maintain beneficiary's Medicaid/CHIP coverage during the PHE (March 2020 to January 2022-latest guidance from CMS).

Part 6: Tracking a Medicaid (Title XIX) 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 2020 (the second quarter of FFY 2020). 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 last year you reported the number of children identified at the start of the cohort (Jan-Mar 2020) and six months later (July-Sept 2020). This year you'll report numbers for the same cohort at 12 months (Jan-Mar 2021) and 18 months later (July-Sept 2021). 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 2021. 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 2021 must be born after January 2004. Similarly, children who are newly enrolled in February 2021 must be born after February 2004, and children newly enrolled in March 2021 must be born after March 2004.

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 2020 weren't enrolled in Medicaid in December 2019.

☒ 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 2020 weren't enrolled in CHIP or Medicaid in December 2019.

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 2020 (start of the cohort): included in 2020 report

You completed this section in your 2020 CARTS Report. Please refer to that report to assist in filling out this section if needed.

3. How many children were newly enrolled in Medicaid between January and March 2020?

Ages 0-1

57601

Ages 1-5

18438

Ages 6-12

20866

Ages 13-16

8954

July - September 2020 (6 months later): included in 2020 report

You completed this section in your 2020 CARTS report. Please refer to that report to assist in filling out this section if needed.

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

44169

Ages 1-5

10435

Ages 6-12

11949

Ages 13-16

5220

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

Ages 0-1

735

Ages 1-5

223

Ages 6-12

208

Ages 13-16

87

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

18

18

47

13

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

12697

7780

8709

3647

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

483

903

1507

652

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

N/A

January - March 2021 (12 months later): to be completed this year
This year, please 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

41036

Ages 1-5

9075

Ages 6-12

10521

Ages 13-16

4651

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

Ages 0-1

371

Ages 1-5

126

Ages 6-12

117

Ages 13-16

45

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

76

Ages 1-5

29

Ages 6-12

27

Ages 13-16

17

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

16194

9237

10228

4258

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

964

1335

2224

975

July - September of 2021 (18 months later): to be completed next year
This year, please 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

37426

8395

9726

4340

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

372

145

116

48

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

51

30

41

14

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

19803

9898

11024

4566

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

3365

1943

3191

1397

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

In March 2020, DHCS issued Medi-Cal Eligibility Division Information Letter (MEDIL) 20-06 instructing counties to delay the processing of Medi-Cal annual redeterminations and delay discontinuances and negative actions for Medi-Cal, Medi-Cal Access Program (MCAP), Medi-Cal Access Infant Program (MCAIP), and County Children's Health Initiative Program (CCHIP) based on the declared State and National Emergency due to COVID-19. With the exception of CMS approved negative action (i.e. death, moved out of state, request to be discontinued) counties were instructed to continue to process new applications and maintain beneficiary's Medicaid/CHIP coverage during the PHE (March 2020 to January 2022-latest guidance from CMS).

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, as we indicated above it is not possible for families to reach the 5% cap. Therefore, the 5% cap is never exceeded and there is never a need to notify providers about non-enforceable cost sharing. • The 5% ceiling of a three child household with the Annual Income at 261% of the FPL is \$3,210. For a CCHIP family with three children, the annual premium cost would be \$756, well below the 5% ceiling of \$3,210. • MCAP has a lower income range for eligibility at 208% of the FPL. MCAP premiums are set as 1.5% of the families Annual Income. For a three person family that would be in the amount of \$767, well below the 5% Ceiling of \$2,558.

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

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

The 5% cap is provided on the monthly premium statement sent to beneficiaries to inform them of the maximum monthly dollar amount incurred before the family is no longer subject to premium or cost sharing provisions. Currently, California only charges premiums for children in families with family income above 160% FPL. There are no enforceable copayments for these children but if their family members are subject to cost sharing, those charges will be counted towards the aggregate family limit. Premiums cannot exceed \$39 per family per month in the Medicaid expansion program and \$63 per family per month in the separate CHIP.

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?

Audits & Investigations (A&I) Division works collaboratively with the DHCS Provider Enrollment Division towards fraud prevention via a comprehensive and analytics-based approach to screening and eliminating problem providers from the program. Activities include enhanced prescreening activities, provider education and the investigation of suspect providers as early as possible to minimize any widespread damage to the program. A&I also performs data mining and data analytics for case development and to detect fraudulent schemes, suspicious providers, and the identification of new fraud schemes. A&I staff conduct on-site field reviews and audits of suspicious providers, which may lead to overpayment recoveries, administrative sanctions, utilization controls, or referrals to A&I's 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. A&I works closely with all local, state and federal law enforcement partners and also has a presence on various local and national fraud task forces.

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 2021?

0

7. How many cases have been found in favor of the beneficiary in FFY 2021?

0

8. How many cases related to provider credentialing were investigated in FFY 2021?

0

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2021?

0

10. How many cases related to provider billing were investigated in FFY 2021?

55

11. How many cases were referred to appropriate law enforcement officials in FFY 2021?

36

12. How many cases related to beneficiary eligibility were investigated in FFY 2021?

313

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2021?

58

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 medical 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?

For Question 6, above: This information is not tracked by DHCS. For Questions 7-9, above: N/A.

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.

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

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 2021?

Ages 0-1

696

Ages 1-2

1290

Ages 3-5

1130

Ages 6-9

1847

Ages
10-14

2926

Ages
15-18

2627

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 2021?

Ages 0-1

19

Ages 1-2

161

Ages 3-5

274

Ages 6-9

611

Ages
10-14

868

Ages
15-18

593

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 2021?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
14	140	250	579	819	538

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 2021?

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	67	143	340	347	276

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 2021?

116

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.

California continued Dental Transformation Initiative (DTI) payments, which aimed to improve dental health for Medi-Cal children by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform. DHCS promoted teledentistry as an alternative modality for the provision of select dental services, particularly during the Coronavirus Disease (COVID-19) Public Health Emergency. 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.

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).

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 2021 CARTS report, we highly encourage states to report all raw CAHPS data to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database instead of reporting a summary of the data via CARTS. For 2022, the only option for reporting CAHPS results will be through the submission of raw data to AHRQ.

1. Did you collect the CAHPS survey?

☒ Yes

1a. Did you submit your CAHPS raw data to the AHRQ CAHPS database?

☐ Yes

☒ No

☐ No

Part 2: You collected the CAHPS survey

Since you collected the CAHPS survey, please complete Part 2.

1. Upload a summary report of your CAHPS survey results.

This is optional if you already submitted CAHPS raw data to the AHRQ CAHPS database. Submit results only for the CHIP population, not for both Medicaid (Title XIX) and CHIP (Title XXI) together. Your data should represent children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

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...

2. Which CHIP population did you survey?

- ☐ Medicaid Expansion CHIP
- ☐ Separate CHIP
- ☒ Both Separate CHIP and Medicaid Expansion CHIP
- ☐ Other

3. Which version of the CAHPS survey did you use?

- ☐ CAHPS 5.0
- ☒ CAHPS 5.0H
- ☐ Other

4. Which supplemental item sets did you include in your survey?

Select all that apply.

- ☐ None
- ☒ Children with Chronic Conditions
- ☐ Other

5. Which administrative protocol did you use to administer the survey?

Select all that apply.



NCQA HEDIS CAHPS 5.0H



HRQ CAHPS



Other

6. Is there anything else you'd like to add about your CAHPS survey results?

See attachment: 2021 CHIP CAHPS Survey Results

Part 3: 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 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.] States can only develop HSI programs after funding other costs to administer their CHIP State Plan, as defined in regulations at 42 CFR 457.10.

1. Does your state operate Health Service 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.

Increase access to consumer-based educational materials has 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?

Reduce the number of children ingesting poisonous and other hazardous substances.

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

For Question 5, above: The program serves children regardless of income range. It is based on service from poison control system centers; however, the HSI serves children in the lowest income families.

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 Medical Access Program (MCAP).

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

6700

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.

To ensure that the state can measure the impact of this HSI, CMS proposes to report on 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?

With an effective date, 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 has 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?

For Question 5, above: All of the children born to these mothers are below the state's FPL threshold.

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 this objective.

For example: In an effort to reduce the number of uninsured children, our goal is to enroll 90% of 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 2020.

4. Numerator (total number)

15473

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children 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: 4.63%

7. What is the date range of your data?

Start

mm/yyyy

01

/

2020

End

mm/yyyy

10

/

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, there was a 5% 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 CalHEERS. The "Infant Initiative" will allow mothers covered under the CHIP higher income unborn option to enroll their newborns into MCAIP 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 2022.

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.

Maintain HEDIS® at or above the NCQA 50th National Medicaid percentile.

1. Briefly describe your goal for this objective.

For example: In an effort to increase access to care, our goal is to increase the number of children who have visited a primary care physician by 5%.

The goal is to maintain performance at or above National Committee for Quality Assurance (NCQA) National Medicaid 50th percentile for the HEDIS measure and for Children to have at least 2 times of Well-Child Visits in the First 30 Months of Life.

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 who visited a primary care physician in the last federal fiscal year.

Well-Child Visits for Age 15 Months-30 Months. Children who turned 30 months old during the measurement year: Two or more Well-Child visits.

4. Numerator (total number)

114382

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

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

The eligible population: Children 15-30 Months as of December 31 of the measurement year. Includes all children who are at least 15 months old but younger than 30 months old during the measurement year.

6. Denominator (total number)

172267

Computed: 66.4%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 2020

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?

The goal is a new goal. In the measurement year of 2020, DHCS increased its requirement for MCPs on minimum performance level (MPL) from the 25th percentile to 50th percentile of National Medicaid Benchmarks.

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

Reporting year 2021 is the first year of the new goal.

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

DHCS will keep the goal in future years. DHCS will maintain the same goal.

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.

The objective is to maintain HEDIS® performance at or above the NCQA's 50th National Medicaid percentile.

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Maintain performance at or above the NCQA's 50th National Medicaid percentile for the HEDIS® measure immunizations 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 children who received one or more well child visits in the last federal fiscal year.

Children 2 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 population.

4. Numerator (total number)

67538

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

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

Children 2 years of age. Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

177960

Computed: 37.95%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 2020

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?

The goal is a new goal for reporting year 2021 (RY 2021) due to data collection in RY 2020 was interrupted by COVID pandemics. In RY 2020, DHCS switched from CIS-combination 3 to CIS-combination 10, and also increased its requirement for MCPs on minimum performance level (MPL) from the 25th percentile to 50th percentile of National Medicaid Benchmarks.

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

Reporting year 2021 is the first year of the new goal.

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

DHCS will keep these goals in future years. DHCS will maintain the same goals.

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).

Do you have another Goal in this list?

Optional

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

Ensure the participation of community-based organizations (CBOs) in outreach and education activities.

1. Briefly describe your goal for this objective.

DHCS' goal is to ensure that there is coverage in all 58 counties to reach as many, low-income Medi-Cal people, including children under 18 years of age as, possible. DHCS has focused its outreach and education efforts 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 that all this population is best served. The DHCS Navigators Project partners with 32 Counties and 13 CBOs to assist with outreach, enrollment, and retention efforts to meet this objective. 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. At this time, the numerator is unquantifiable due to the fact the data is in the validation process.

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

The total number of potentially eligible Medi-Cal applicants in each County. At this time, the denominator is unquantifiable due to the fact the data is in the validation process.

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

06 / 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 in the process of implementing an automated process to validate enrollment data submitted by our Navigator Project partners with a manual data validation implemented where needed.

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

Continuing monthly meetings with CBO 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 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.

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 2022).

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?

None at this time.

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 this data become available?

None at this time.

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

None at this time.

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 2021, and how much you anticipate spending in FFY 2022 and 2023.

Part 1: Benefit Costs

Please type your answers in only. Do not copy and paste your answers.

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 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

\$ 2,745,360,943

2022

\$ 2,347,240,891

2023

\$ 2,235,493,682

2. How much did you spend on Fee for Service in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

\$ 1,257,389,839

2022

\$ 1,724,917,471

2023

\$ 1,853,588,376

3. How much did you spend on anything else related to benefit costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

\$ 0

2022

\$ 0

2023

\$ 0

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 49,538,034

\$ 48,232,000

\$ 48,232,000

Table 1: Benefits Costs

This table is auto-populated with the data you entered above.

	FFY 2021	FFY 2022	FFY 2023
Managed Care	2745360943	2347240891	2235493682
Fee for Service	1257389839	1724917471	1853588376
Other benefit costs	0	0	0
Cost sharing payments from beneficiaries	49538034	48232000	48232000
Total benefit costs	4052288816	4120390362	4137314058

Part 2: Administrative Costs

Please type your answers in only. Do not copy and paste your answers.

1. How much did you spend on personnel in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

This includes wages, salaries, and other employee costs.

2021

2022

2023

\$ 9,458,847

\$ 9,660,215

\$ 9,155,523

2. How much did you spend on general administration in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 0

\$ 0

\$ 0

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 0

\$ 0

\$ 0

4. How much did you spend on claims processing in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 84,433,596

\$ 86,231,089

\$ 81,725,999

5. How much did you spend on outreach and marketing in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 0

\$ 0

\$ 0

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 0

\$ 0

\$ 0

7. How much did you spend on anything else related to administrative costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 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 2021	FFY 2022	FFY 2023
Personnel	9458847	9660215	9155523
General administration	0	0	0
Contractors and brokers	0	0	0
Claims processing	84433596	86231089	81725999
Outreach and marketing	0	0	0
Health Services Initiatives (HSI)	0	0	0
Other administrative costs	0	0	0
Total administrative costs	93892443	95891304	90881522
10% administrative cap	439245860.89	447102929.11	448983339.78

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 2023 will be calculated once the eFMAP rate for 2023 becomes available. In the meantime, these values will be blank.

FMAP Table	FFY 2021	FFY 2022	FFY 2023
Total program costs	4146181259	4216281666	4228195580
eFMAP	65	65	65
Federal share	2695017818.35	2740583082.9	2748327127
State share	1451163440.65	1475698583.1	1479868453

8. What were your state funding sources in FFY 2021?
Select all that apply.

- ☒ State appropriations
- ☒ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations
- ☒ Tobacco settlement
- ☒ 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 2021? How many do you anticipate will be eligible in FFY 2022 and 2023?

2021

1455101

2022

1500500

2023

1413321

2. What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2021? What is your projected PMPM cost for FFY 2022 and 2023?

Round to the nearest whole number.

2021

\$ 190

2022

\$ 157

2023

\$ 159

	FFY 2021	FFY 2022	FFY 2023
PMPM cost	190	157	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 2021? How many do you anticipate will be eligible in FFY 2022 and 2023?

2021

109151

2022

112556

2023

106017

2. What was your per member per month (PMPM) cost based on the number of children eligible for Fee For Service in FFY 2021? What is your projected PMPM cost for FFY 2022 and 2023?

The per member per month cost will be the average cost per month to provide services to these enrollees. Round to the nearest whole number.

2021

\$ 1,647

2022

\$ 2,191

2023

\$ 2,499

	FFY 2021	FFY 2022	FFY 2023
PMPM cost	1647	2191	2499

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

See attachment" Federal and State Shares Expenditures Summary Table.

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).

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

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 also allowed the state to support health coverage for low income, uninsured children. Additionally, the increase in federal financial participation for CHIP, in October 2015, helped strengthen those efforts to reach uninsured children within the state. 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.

2. What's the greatest challenge your CHIP program has faced in FFY 2021?

The COVID-19 public health emergency (PHE) was the greatest challenge our CHIP program faced in FFY 2021, due to the impact on delayed preventive services for children, remote learning, increased stress and mental health needs of parents and children, and the disruption of the state's health care delivery system, including through individual providers, clinics, hospitals, and managed care plans. DHCS has worked closely with our program partners and state and federal officials to address key challenges, in order to ensure that Medicaid and CHIP children continue to have access to all necessary care, including COVID-19 testing and care. As an example of these challenges, the state public hospitals described some specific impacts, including: the Delta variant surge with redirection of staff for COVID-19 inpatient treatment; large COVID-19 vaccination campaigns also leading to redirection of quality staff towards these efforts, including supplementing county public health vaccination efforts by some county hospital staff; large staffing shortages due to nurses and physicians leaving clinical care and competition from traveling nurse companies paying far more than most hospitals can afford; an onslaught of patients presenting to ambulatory care with urgent medical, behavioral, and social needs requiring immediate attention and necessitating delaying preventive care; and patient hesitancy in returning to the clinic for preventive and non urgent chronic care. Per informal data shared with the Department, 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 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 admissions load as last year. For ICU occupancy, in 2020 (Mar - Dec), in aggregate, 10.7% of days were over capacity. In 2021 (Jan-Sep), 14.8% of days were over capacity in aggregate. So, ICU occupancy was above capacity more frequently in 2021 compared to 2020. In FFY 2021, California also continued its ongoing efforts to increase utilization of children's preventive services, including immunizations and children's dental preventive care.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2021?

For the reporting period of October 2020 through September 2021, DHCS accomplishments include: COVID-19 Related Flexibilities In response to the COVID-19 pandemic, DHCS continued to implement over 100 programmatic flexibilities for providers, counties, beneficiaries, and health plans to address the delivery system disruption of health care needs and services available to meet the needs of beneficiaries. These flexibilities impact Medi-Cal eligibility, health care service delivery (e.g., telehealth), provider reimbursement, and many other aspects of the program. DHCS covers 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. Vaccine Outreach for Children DHCS is allocating \$350 million in incentive payments to encourage COVID-19 vaccinations among Medi-Cal's 14 million beneficiaries. The vaccination incentive program also encourages significantly expanded outreach in underserved communities, to include children and adults. As of February 14, 2022, 51 percent of Medi-Cal beneficiaries aged 5 and over have received at least one vaccine shot compared to more than 81.6 percent of Californians as a whole. The new program to boost vaccination rates will allow Medi-Cal managed care plans (MCPs) to earn incentive payments for activities that are designed to close vaccination gaps with their members, based upon lessons learned thus far in the pandemic. Funding will incentivize outreach programs and activities by MCPs and their providers. Enrollment Expansion Given the unique health challenges of the COVID-19 emergency, Medi-Cal is an even more critical resource for Californians who need help meeting their health care needs. As such, DHCS is expanding 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 uninsured children and youth formerly enrolled in Medi-Cal. In Phases I & II, DHCS approved 32 counties and 9 CBOs (serving an additional 20 counties) to provide navigation services to those 52 counties. DHCS has also developed 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. Postpartum Extension California opted to implement the postpartum extension related to the American Rescue Plan and its expansion of benefits to its Medicaid populations, and DHCS submitted a Health Services Initiative (HSI) as CHIP SPA 21-0032 to prevent disparity between the pregnancy populations and the targeted low-income children from conception to birth. On September 14, 2021, CHIP SPA 21-0032 was approved, expanding the postpartum period from 60 days to 12 months (365 days). Hearing Aid Coverage for Children Program (HACCP) In FFY 2021, DHCS introduced a new California state-only benefit for children, ages 0-17, who are otherwise not eligible for Medi-Cal, and with a household income up to 600 percent of the federal poverty level, effective July 1, 2021. The HACCP benefit is available to children with no health insurance or whose existing health insurance does not cover hearing aids and related services. Phase 1 of the program launched and began accepting paper-based applications on July 1, 2021. DHCS is working with pediatric audiology stakeholders to optimize the program application and other materials for a web-based Phase 2, and to develop HACCP educational resources. Children's Oral Health California continued the Dental Transformation Initiative (DTI), to improve dental health for Medi-Cal children by focusing on improved access and utilization of performance measures to drive delivery system reform. Domain 1 aims 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. As of August 2021, a \$2M payment was disbursed for Domain 1, which brings the total payment to \$249.7M. Domain 2 assesses Medi-Cal children ages six (6) and under for caries risk and to manage the disease of caries using preventive services and non-invasive treatment approaches instead of more invasive and costly restorative procedures. As of September 2021, 3,433 Medi-Cal dental providers have opted to participate in Domain 2. In July 2021, Domain 3 incentive payments were released, which included the final payment for Program Year (PY) 4 (calendar year (CY) 2019) and the first payment for PY 5 (CY 2020), totaling \$73,570,100. Compared to the baseline year (CY 2014), preventive dental service utilization for children ages 1-20 increased in PY 1 by 4.64 percentage points; PY 2 by 7.48 percentage points; PY 3 by 8.06 percentage points; PY 4 by 10.58 percentage points; and PY 5 by 1.20 percentage points. Increases in the first four PYs demonstrate the program's effectiveness in meeting the DTI goals. Unfortunately, utilization decreased in PY 5, to the lowest in any program year, due to impacts from the COVID-19 PHE. Increases in the first four PYs demonstrate the program's effectiveness in meeting the DTI goals. Unfortunately, utilization decreased in PY 5, to the lowest in any

program year, due to impacts from the COVID-19 PHE. Additionally, DHCS continued to allow teledentistry as an alternative modality for the provision of select dental services, as the COVID-19 PHE continued. 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 61,914 new visitors, of which 51,603 checked the "Find a Dentist." 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 January 27, DHCS and CA OSG announced the awarding of grant funding to 35 organizations across California to build and strengthen a robust network of care to effectively respond to ACEs and toxic stress with community-based health and social supports. As of March 31, 2021, 17,100 individuals completed a core ACEs training, and 9,700 providers became ACEs Aware certified as of March 31, 2021. Based on Medi-Cal claims data, Medi-Cal providers conducted nearly 315,000 ACE screenings of more than 264,000 unique Medi-Cal beneficiaries, including children and adults, across California in the first nine months of 2020. California Advancing and Innovating Medi-Cal (CalAIM) Over the course of 2021, DHCS made significant progress in developing and implementing CalAIM, while concurrently preparing for the 1115 Demonstration and 1915(b) waiver renewals, effective January 2022. Although not specific to CHIP, CalAIM will transform Medi-Cal into a system that is standardized, simplified, and focused on helping enrollees live healthier lives. Success requires the investment and sustained commitment of a broad network of health partners, including plans, providers, and community-based organizations, with incentives to achieve high quality of service. When CalAIM is fully implemented, Medi-Cal will better serve and benefit enrollees because it will be a seamless and streamlined health care system. CalAIM includes major changes across the entire Medi-Cal program such as a Population Health Management Program in managed care that offers an Enhanced Care Management benefit and new Community Supports, statewide standardized managed care enrollment and benefits, new dental benefits and dental pay for performance initiatives,

behavioral health delivery system transformation, new services and supports for justice-involved adults and youth, and transition to statewide Dual Eligible Special Needs Plans and managed long-term services and supports. Additional information regarding CalAIM can be found here: <https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx>. CalAIM Behavioral Health Through DHCS' CalAIM initiative, effective January 1, 2022, DHCS is expanding 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)) 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. Implementation of the CalAIM "no wrong door" policy will ensure beneficiaries receive medically necessary treatment regardless of the delivery system where they seek care. This policy will allow 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 the other 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. CalAIM Foster Care Model of Care Workgroup DHCS and the California Department of Social Services convened the CalAIM Foster Care Model of Care Workgroup to develop policy recommendation and operationally achievable timelines for implementing a new, and/or transitioning to a slightly different, model of care for children and youth in foster care, including Former Foster Youth programs and transitioning out of foster care programs and services at age 26. In FFY 2021, the workgroup convened on: October 16, 2020; December 17, 2020; February 26, 2021; and April 23, 2021. 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 will be statewide, evidence-based, culturally competent, and equity-focused. This initiative includes funding of \$4 billion over five years, including \$2.3 billion one-time and \$300 million General Fund and certain federal matching funds ongoing starting in 2022-23. Behavioral Health Continuum Infrastructure Program (BHCIP) BHCIP provides DHCS with \$2.2 billion in 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. A portion of the funding is available for increased infrastructure targeted to children and youth 25 years of age and younger (approximately \$480 million). Expansion of School-Based Health Care In August 2021, DHCS released the Request for Proposals (RPAs) to solicit firms that are able to 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 in order 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. 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 placed in a 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. Family Urgent Response System (FURS) Effective July 1, 2021, FURS is a coordinated statewide, regional, and county-level system designed to provide current and former foster youth and their caregivers with immediate, trauma-informed support during moments of instability or crisis to preserve the relationship between the caregiver and the child or youth. FURS operates through a statewide phone based response system that is available 24 hours per day, 7 days per week, with counselors trained in conflict resolution and de-escalation techniques for children and youth impacted by trauma. If necessary, the statewide hotline will initiate an in-home, in person mobile response provided through county-level partners available 24 hours per day, 7 days per week, to render stabilization and ongoing support services. FURS primarily serves to prevent foster youth replacement, functions as an effective alternative to law enforcement contacts, reduces hospitalizations, and promotes stability for youth and caregivers.

Proposition 56 Funding In 2016 California voters approved the California Healthcare, Research and Prevention Tobacco Tax Act (also known as "Proposition 56"). This Act authorized supplemental payments to providers, including those that serve children. Proposition funding was being used to support developmental screenings for children ages 0-3 and trauma screenings for children and adults. Pursuant to the 2020 Budget Act these payments, with the exception of Family Planning services, were suspended effective July 1, 2021, depending upon the budget outlook for fiscal year 2021-22. However, supplemental payments continued through December 31, 2021, due to improved budget conditions.

Premiums and Eligibility Waived for Displaced Families Due to the unfortunate wildfires from 2017 through 2021 that displaced so many families, California has maintained authority through State Plan amendments to waive premiums and certain eligibility-verification requirements on a temporary basis, in order to assist beneficiaries who were 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 2021 or plan to make in FFY 2022? Why have you decided to make these changes?

In FFY 2022, DHCS will continue to respond to the COVID-19 pandemic. Given the unprecedented 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 2022, 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 2022, targeted at providers, public hospital systems, and managed care and behavioral 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 will also launch the CalAIM initiative, with a start date of 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 disparity 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. 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. California also continues working with CMS, seeking SPA approval to demonstrate parity between mental health services and medical services as it relates to CHIP. California is also introducing additional contract amendments for county behavioral health plans to further ensure parity compliance.

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

California has nothing further 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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