DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

September 14, 2021

Jacey Cooper
Chief Deputy Director
Health Care Programs
Department of Health Care Services
1501 Capitol Avenue, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cooper:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) CA-21-0032, submitted on June 28, 2021, has been approved. This SPA establishes a Health Services Initiative (HSI) to provide comprehensive coverage during the 12-month postpartum period for women whose newborns had been covered as targeted low-income children from conception to birth. The benefits provided during this postpartum period are identical to the benefits provided to Medicaid pregnant women. The SPA has an effective date of July 1, 2020.

Section 2105(a)(l)(D)(ii) of the Social Security Act (the Act) and 42 CFR §457.10 authorize use of title XXI administrative funding for expenditures for HSIs under the plan for improving the health of children, including targeted low-income children and other low-income children. Consistent with section 2105(c)(6)(B) of the Act and 42 CFR §457.626, title XXI funds used to support an HSI cannot supplant Medicaid or other sources of federal funding.

The state shall ensure that the remaining title XXI administrative funding, within the state's 10 percent limit, is sufficient to continue the proper administration of the CHIP program. If such funds become less than sufficient, the state agrees to redirect title XXI funds from the support of this HSI to the administration of the CHIP program. The state shall report annually to CMS the expenditures funded by the HSI for each federal fiscal year.

Additionally, the state has informed us that it intends to submit subsequent SPAs to adopt the option described in sections 9812 and 9822 of the American Rescue Plan Act of 2021 (ARP), to provide comprehensive coverage during an extended 12-month postpartum period under the Medicaid and CHIP state plans, effective April 1, 2022. Please inform CMS if the state anticipates implementing this ARP provision later than April 1, 2022.

Your title XXI project officer is Ms. Joyce Jordan. She is available to answer questions concerning this amendment and other CHIP-related issues. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-3413
E-mail: Joyce.Jordan@cms.hhs.gov

If you have any questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,

[redacted]

Amy Lutzky
Deputy Director

1.4. Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

CA RESPONSE:

Date Original Plan Submitted: November 19, 1997
Date Plan Approved: March 24, 1998
Date Plan Effective/Implemented: July 1, 1998

Date Amendment#1 Purpose: Changed its income eligibility for the Healthy Families Program to be in compliance with the State enabling legislation. This amendment lowered income eligibility from 200 percent of the FPL net income to 200 percent of the FPL gross income. This amendment was initiated at the start of the program's implementation on July 1, 1998.
Date Amendment #1 Submitted: April 14, 1998
Date Amendment #1 Approved: June 29, 1998
Date Amendment #1 Effective/Implemented: July 1, 1998

Date Amendment#2 Purpose: Increased the enrollment broker fees from $25 to $50 per successful applicant.
Date Amendment #2 Submitted: January 8, 1999
Date Amendment #2 Approved: December 21, 1999
Date Amendment #2 Effective/Implemented: October 1, 1998

Date Amendment#3 Purpose: Expanded income eligibility for the Healthy Families Program by disregarding income between 200 to 250 percent of the FPL. Income eligibility for the Healthy Families Program is further expanded by applying
Medi-Cal income deductions when determining eligibility for the Healthy Families Program. The Child Health and Disability Prevention (CHDP) provider-claiming period for services received prior to enrollment is also lengthened from 30 to 90 days.
Date Amendment #3 Submitted: August 3, 1999
Date Amendment #3 Approved: November 23, 1999
Date Amendment #3 Effective/Implemented: July 22, 1999

Date Amendment#4 Purpose: Allowed a Family Contribution Sponsor to pay a specific child's HFP) premiums for the first year of enrollment.
Date Amendment #4 Submitted: December 9, 1999
Date Amendment #4 Approved: March 6, 2000
Date Amendment #4 Effective/Implemented: March 1, 2000

Date Amendment#5 Purpose: Exempted cost sharing for American Indians (AI) and Alaskan Native (AN) children who meet the eligibility criteria for

the Healthy Families Program (HFP) and provide acceptable documentation of their status as AI or AN children.
Date Amendment #5 Submitted: April 17, 2000
Date Amendment #5 Approved: July 7, 2000
Date Amendment #5 Effective Date: October 6, 1999

Date Amendment#6 Purpose: Indicated the State's partial compliance with the final SCHIP regulations.
Date Amendment #6 Submitted: July 2, 2002
Date Amendment #6 Approved: September 19, 2002
Date Amendment #6 Effective Date: August 24, 2001
Date Amendment#7 Purpose: Expanded coverage levels to 300 percent of the FPL for children residing in selected counties (Alameda, San Francisco, San Mateo and Santa Clara) through the CCHIP). This amendment also expands coverage to children up to age 2 born to mothers enrolled in the AIM program with family incomes up to 300 percent of the FPL.
Date Amendment #7 Submitted: April 1, 2003
Date Amendment #7 Approved: June 10, 2004
Date Amendment #7 Effective: January 1, 2003 – CCHIP Expanded Coverage levels; and July 1, 2004 – AIM Program

Date Amendment #8 Purpose: Implemented oral health services initiative, including case management, oral health education, preventative services, and mobile dental vans.
Date Amendment #8 Submitted: July 24, 2003
Date Amendment #8 Approved: January 16, 2004
Date Amendment #8 Effective: January 1, 2004

Date Amendment #9 Purpose: Allowed the State to provide presumptive eligibility to children with family incomes from 100 to 200 percent of the FPL through the CHDP program.
Date Amendment #9 Submitted: September 9, 2003
Date Amendment #9 Approved: December 8, 2003
Date Amendment #9 Effective: July 1, 2003

Date Amendment #10 Purpose: Allowed the State to claim for the State's rural health demonstration projects as a health services initiative under the SCHIP 10 percent administrative cap. The rural health demonstration projects, which were previously approved under the California SCHIP State plan, aim to improve access to health care services for low-income medically underserved and uninsured populations in rural areas and special populations who have rural occupations. By claiming for the rural health demonstrations under the 10 percent cap, the State has the flexibility to provide services for all low-income children, thereby benefiting all low-income children, not just SCHIP enrollees. The amendment also allows the State to use tobacco taxes as a new source of State funding.

Date Amendment #10 Submitted: December 15, 2003
Date Amendment #10 Approved: March 11, 2004
Date Amendment #10 Effective: February 1, 2004

Date Amendment #11 Purpose: Increased premiums for children with family incomes from above 200 percent of the FPL up to and including 250 percent of the FPL. The amendment also provides for school-based outreach for the Healthy Families Program through a partnership between the State and the David and Lucile Packard Foundation.
Date Amendment #11 Submitted: March 23, 2005
Date Amendment #11 Approved: March 15, 2007
Date Amendment #11 Effective: March 22, 2005 (School-based Outreach) July 1, 2005 (Premium Increase)

Date Amendment #12 Purpose: Extend health care coverage to unborn children with family income up to 300 percent of the Federal poverty level (FPL).
Date Amendment #12 Submitted: June 30, 2005
Date Amendment #12 Approved: March 28, 2006
Date Amendment #12 Effective: July 1, 2004

Date Amendment #13 Purpose: Added a fifth county (Santa Cruz) to their County Program allowing children to be enrolled from 250 percent to 300 percent of the FPL. However, it was subsequently withdrawn by the State on 11/6/08.
Date Amendment #13 Submitted: July 12, 2007
Date Amendment #13 Approved: Withdrawn (November 6, 2008)

Date Amendment #14 Purpose: Responded to program changes enacted by the Legislature to increase premiums, place a cap on dental benefits, limit 5 certain vision benefits, apply a wait list, and remove the 6-month residency requirement for pregnant women in the Access for Infants and Mothers program.
Date Amendment #14 Submitted: April 2, 2009
Date Amendment #14 Approved: January 14, 2010
Date Amendment #14 Effective: January 31, 2009 Wait List /Disenrollment Infrastructure January 6, 2009 AIM 6-Month Residency Requirement Elimination February 1, 2009 HFP Family Contribution Increase, & Vision Benefit Modification
July 1, 2009 Dental Benefit Cap

Date Amendment #15 Purpose: CHIPRA Shifting of Presumptive Eligibility Cost to Title XIX Funds; CHIPRA Option of Lawfully Residing Children; CHIPRA Shifting of Accelerated Enrollment Cost to Title XIX Funds; Presumptive Eligibility at Initial Application under Title XXI Funds.
Date Amendment #15 Submitted: June 30, 2009

Date Amendment #15 Approved: December 29, 2009
Date Amendment #15 Effective: April 1, 2009

Date Amendment #16 Purpose: Implemented a health services initiative to support the California Poison Control System (CPSC).
Date Amendment #16 Submitted: October 16, 2009
Date Amendment #16 Approved: December 3, 2009
Date Amendment #16 Effective: July 1, 2009

Date Amendment #17 Purpose: Increased premiums and co-payments for children with a family income above 150 percent up to and including 250 percent of the FPL. The amendment also proposes to limit dental plan choices for new subscribers. These changes are based on changes in State law.
Date Amendment #17 Submitted: December 24, 2009
Date Amendment #17 Approved: July 29, 2010
Date Amendment #17 Effective: November 1, 2009

Date Amendment #18 Purpose: Premium Increases
Date Amendment #18 Submitted: June 1, 2011
Date Amendment #18 Approved: Withdrawn July 3, 2012
Date Amendment #18 Effective: Not applicable.

Date Amendment #19 Purpose: Expanded eligibility in CCHIP from 300 percent of the FPL to 400 percent of the FPL in San Mateo County; Eliminated the dental benefit cap; Implemented an electronic data match with the Social Security Administration for citizen verification; Required CHIP payments to FQHCs and RHCs comply with Medicaid payment requirements.
Date Amendment #19 Submitted: June 29, 2012
Date Amendment #19 Approved: September 7, 2012
Date Amendment #19 Effective:
October 1, 2011: Dental Benefit Cap Elimination
January 1, 2012: County Children's Health Initiative Program (CCHIP)
October 1, 2009: Prospective Payment System for FQHC's and RHC's
January 1, 2010: Citizenship Verification Requirement

SPA # 20. Purpose of SPA: To eliminate the "Healthy Families" program, and transition the majority of children from a separate program to a Medicaid expansion under the Medi-Cal program in California. This SPA reflects changes previously effectuated through section 1115 demonstration authority.
Proposed effective date: December 31, 2013
Proposed implementation date: January 1, 2013 through December 31, 2014

SPA #17-0043. Purpose of SPA: To implement provisions for temporary adjustments to enrollment, eligibility determination and redetermination policies, and premium and cost-sharing requirements for children in families living and/or working in Governor or FEMA declared disaster areas. In the event of a declared disaster, the State will notify CMS that it intends to provide temporary adjustments to its enrollment, eligibility determination and/or redetermination policies, and premium and/or cost-sharing requirements, the effective and duration date of such adjustments, and the applicable Governor or FEMA declared disaster areas.

Some or all of the temporary adjustments would apply to the following populations:
Population 1 (County Children's Health Initiative Program - CCHIP)
Population 2 (Unborn Option)
Population 3 (Medi-Cal Access Program - MCAP)
Population 4 (Medi-Cal Access Infant Program - MCAIP)
Proposed effective date: October 1, 2017
Proposed implementation date: October 1, 2017

SPA #18-0028. Purpose of SPA: To implement the transition of MCAP (Population 3) services provided by public-private-partnership to services provided by California's Medi-Cal Managed Care delivery system.
Proposed effective date: July 1, 2017
Proposed implementation date: July 1, 2017

SPA # 19-0036 Purpose of SPA: To demonstrate compliance with 42 CFR section 457 et al., the Managed Care Final Rule FR 81 27497.
Proposed effective date: July 1, 2018
Proposed implementation date: July 1, 2018

SPA # 21-0032 Purpose of SPA: To extend postpartum care period to 365 days for unborn populations. California is choosing to implement the American Rescue Plan Act for its Medicaid population, this Health Services Initiative is to prevent disparity between the state's pregnancy groups and its unborn groups.
Proposed effective date: July 1, 2020
Proposed implementation date: July 1, 2020

2.2. **Health Services Initiatives (HSI) -** Describe if the State will use the health services initiative option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

CA RESPONSE:

Postpartum Care Extension
California will use CHIP funds, within the 10 percent federal administrative expenditures cap allowed for states, to support the extension of the postpartum period from the existing 60-day period to a full 12-month period. This extension includes Population 2, the lower income unborn population with incomes from 0-208 percent of the Federal Poverty Level (FPL). It also includes Population 3, the upper income unborn option with incomes from 208-322 percent of the FPL, known as the Medi-Cal Access Program (MCAP).

On March 11, 2021, President Joe Biden signed the American Rescue Plan Act of 2021 (ARPA) into law. This allows states to extend its postpartum coverage from 60 days to 12 months, effective April 1, 2022. 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 children from conception to birth.

Because the ARPA does not address the unborn group (only pregnancy groups), California is proposing this HSI to prevent disparity among the groups, and provide the 12-month postpartum period to its unborn CHIP population.

All pregnant individuals should receive comprehensive care during the postpartum period to assess their physical recovery from pregnancy and childbirth, address chronic conditions (such as diabetes or hypertension), address mental health issues (including postpartum depression), discuss reproductive health (including contraception and birth spacing), and ensure continuity of care. In spite of having a higher prevalence of medical conditions such as diabetes and hypertension, pregnant Medicaid and CHIP individuals have lower postpartum care visit rates than do individuals with private insurance. More than half of pregnancy-related deaths occur in the postpartum period, with 12 percent occurring after six weeks postpartum.

The American College of Obstetricians and Gynecologists (ACOG) recommends:

- All women have contact with their health care providers within the first three weeks' postpartum
- Initial visit followed by individualized ongoing care as needed, including a comprehensive postpartum visit no later than 12 weeks after birth
- Timely follow-up care with obstetrician-gynecologists or primary care doctors for women who had pregnancy complications or who have chronic medical conditions
- Scope of care that includes a full assessment of:
    1) Physical, social, and psychological wellbeing;
    2) Infant care and feeding;
    3) Sexuality, contraception, and birth spacing;
    4) Sleep and fatigue;
    5) Physical recovery from birth;

6) Chronic disease management; and
7) Health maintenance

The Pregnancy Mortality Surveillance System (PMSS) defines a pregnancy-related death as the death of a woman while pregnant or within 1 year of the end of pregnancy from any cause related to or aggravated by the pregnancy. Over one half of maternal deaths occur between the first day of the postpartum period up through the 365th day during postpartum period. Causes can include cardiovascular issues, hypertension, infection, and other non-cardiovascular conditions. Identifying the causes of maternal mortality and morbidity is complex and coverage is only one factor. Research strongly indicates that access to health care throughout a woman's reproductive years is essential for prevention, early detection, and treatment of some of the conditions that place women at higher risk for pregnancy-related complications, including cardiovascular disease, diabetes, and chronic hypertension.

As defined by the Center for Disease Control and Prevention, infant mortality is the death of an infant before the first birthday. The infant mortality rate is the number of infant deaths for every 1,000 live births. In addition to giving us key information about maternal and infant health, the infant mortality rate is an important marker of the overall health of a society. In 2018, the infant mortality rate in the United States was 5.7 deaths per 1,000 live births.

A major cause of infant mortality is Sudden Unexpected Infant Death (SUID). The term SUID is used to describe the sudden and unexpected death of a baby less than 1 year old in which the cause was not obvious before investigation. About 3,600 babies in the United States die suddenly and unexpectedly each year. Sudden unexpected infant deaths include sudden infant death syndrome (SIDS), accidental suffocation in a sleeping environment, and other deaths from unknown causes. Although the SUID rate has declined since the 1990s, significant racial and ethnic differences continue.

These studies suggest that changing the concept of postpartum care and the emphasis on risk reduction for maternal health, both in the immediate postpartum period and in the extended postpartum period up to one year after delivery, is essential to maintain the health of the child. 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)

These measures are relevant to the covered populations and can be tied back to promoting the health of the child. For example, timely postpartum visits can be used to screen mothers for postpartum depression and support breastfeeding,

which both have been shown to influence health outcomes for children.

Population 2, unborn children (pregnant women) with income from 0 up to 208 percent of the FPL, receive prenatal care, prescriptions, labor and delivery, dental care, and services for other conditions that may complicate the pregnancy. Postpartum coverage is also included and lasts until the end of the month of the 365th day following the end of the pregnancy. There are approximately 3,100individuals enrolled in California's Unborn Option with income from 0 up to 138 percent of the FPL There are also approximately 3,500 individuals enrolled with incomes from 138 up to 208 percent of the FPL. Of this population,75 percent identify as Hispanic. This coverage is available throughout the state.

Population 3 (MCAP), unborn children (pregnant women) with income from 208 up to 317 percent of the FPL, receive comprehensive healthcare from the effective date of coverage in MCAP until the last day of the month in which the 365th day following the end of the pregnancy occurs. There are approximately 3,548 individuals enrolled in MCAP, and is available throughout the state.

The postpartum care provided to the state's CHIP populations is identical to the care provided to the state's Medicaid population, and by providing 12 months of postpartum care to these CHIP populations, California prevents disparity between the populations benefitted by the ARPA provisions and the California CHIP populations that are not included in the ARPA postpartum provisions. MCAP subscribers will still continue to receive their services through the managed care delivery system, and individuals in Population 2 will still continue to receive services through the fee-for-service delivery system. To further align with ARPA provisions in the state, for both populations, this postpartum care extension will be provided for 365 days, including the remaining days of the month in which the 365th day falls.

The State assures that the HSI programs will not supplant or match CHIP federal funds with other federal funds, or allow other federal funds to supplant or match CHIP federal funds.

Poison Treatment Advice and Prevention.
California uses CHIP funds, within the 10 percent federal administrative expenditures cap allowed for states, to support the California Poison Control System (CPCS). CPCS provides daily, 24-hour emergency telephone treatment advice, referral assistance, and information to manage exposure to poisonous and hazardous substances. The CPCS answers poisoning emergency calls from the general public 24 hours a day, 365 days each year at no charge. At all times, a Specialist in Poison Information (SPI) is available to manage cases and Certified Specialists in Poison Information (CSPI) manage cases and direct Poison Information Providers. The service is provided to all communities, including underserved and indigent populations, in over 150 languages and via telecommunications devices for the deaf and hearing impaired (TDD).

The call center receives approximately 220,000 calls per year involving someone ingesting poison and other hazardous substances. Nearly 40 percent of all calls relate to children age 0-18 with annual household incomes of $55,000 or less (250 percent FPL for a family of 4). Another 10 percent of calls are for children 0-18 with incomes up to $65,000 (250 percent FPL for a family of 5). Children under the age of five account for the majority of poison exposures. In addition to calls regarding exposure, another 90,000 calls are for information and are considered preventive. Of these calls, 64 percent are for children age 0- 18 in families with incomes at $55,000 or less, and another 12 percent for families with incomes up to $65,000. Only children below the age of 19 are served through this HSI.

Poison center public education programs direct attention and resources to "identified at-risk populations". In California, the targeted at-risk populations are Latinos, African Americans, and children born to low income parents. Of California's 2.5 million children under the age of five (2016 U.S. Census), approximately 525,000 live in poverty. African-Americans and Latinos are California's largest at-risk groups.

A line of 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.

A Community Health Worker Initiative directs efforts to the "hardest to reach" and "at highest risk" populations. Community health workers deliver the CPCS message through group education sessions, community health fairs, and local events, as well as informally, though one-on-one outreach in their neighborhoods, churches, and community gatherings

CPCS advertises the national public toll free number and its own TTY toll free number in both the white pages and the "customer guide" (usually appearing on page 2) of all California telephone directories. Listings placed with the major local phone companies (SBC, Verizon) are applied to each directory they publish in California. CPCS also places these listings in the smaller rural phone company, as well as independent community directories.

The State assures that the HSI programs will not supplant or match CHIP federal funds with other federal funds, or allow other federal funds to supplant or match CHIP federal funds.

9.10 Provide a 1-year projected budget. A suggested financial form for the budget is below. The

budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
  - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:

  - Total 1-year cost of adding prenatal coverage
  - Estimate of unborn children covered in year 1

The Source of State Share Funds: State General Fund
Based on January 2021 CARTS Submission

HSI SPA Changes	TF	GF	FF
FFY 2020-2021	$97,333,000	$34,067,000	$63,266,000
FFY 2021	$77,866,000	$27,253,000	$50,613,000

CHIP Budget Projections

STATE: CA	**FFY Budget**	**FFY Budget**

Federal Fiscal Year	2020-2021	2022
State's enhanced FMAP rate	**65.00%**	**65.00%**
Benefit Costs		
Insurance payments		
Managed care	$2,540,049,031	$2,499,029,459
per member/per month rate	$2,162.00	$2,340.00
Fee for Service	$2,097,154,725	$2,166,141,625
Total Benefit Costs	**$4,637,203,756**	**$4,665,171,084**
(Offsetting beneficiary cost sharing payments)	($66,347,407)	($64,270,000)
Net Benefit Costs	**$4,570,856,349**	**$4,600,901,084**
Cost of Proposed SPA Changes – Benefit		
Administration Costs		
Personnel	21,916,238	20,861,313
General administration		
Contractors/Brokers		
Claims Processing	86,190,890	82,042,142
Outreach/marketing costs		
Health Services Initiatives (postpartum)	$97,333,000	$77,866,000
Health Services Initiatives (Poison)	$2,950,000	$2,950,000
Other		
Total Administration Costs	**$208,390,128**	**$183,719,455**
10% Administrative Cap	$507,872,928	$511,211,231
Cost of Proposed SPA Changes (postpartum)	**$97,333,000**	**$77,866,000**
Federal Share	$3,406,550,899	$3,245,225,066
State Share	$1,372,695,580	$1,539,395,472
Total Costs of Approved CHIP Plan	**$4,779,246,479**	**$4,784,620,538**