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NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

JOSH STEIN • Governor
DEVDUTTA SANGVAI • Secretary
MELANIE BUSH • Deputy Secretary, NC Medicaid

SIGNATURE REQUEST MEMORANDUM

TO: Melanie Bush DS MB

FROM: Ashley Blango, SPA Manager

RE: State Plan Amendment

Title XIX, Social Security Act
Transmittal #2026-0010

Purpose
Attached for your review and signature is a Medicaid State Plan Amendment **(CHIP Health Services Initiatives (HSI))** summarized below, and submitted on November 4, 2026 with a due date of November 10, 2026.

Clearance
This amendment has been reviewed for both accuracy and completeness by:

Ashley Blango, Kathryn Horneffer, Todd Baustert, Tabitha Evans, Chris Gordon, Sarah Gregosky, Melanie Bush

Background and Summary of Request
It is recommended that you sign this State Plan Amendment submission per Centers for Medicare and Medicaid Services (CMS) protocol as head of the Single State Agency administering the Medicaid program.

The purpose of the revisions to the State Plan Amendment will allow for an additional two year extension to the Breastfeeding Hotline Health Service Initiative, as well as the SUD Parenting Health Service Initiative. It also removes the Reach Out and Read Health Service Initiative, as it is no longer active

The proposed effective date for the SPA is December 1, 2026.

Your approval of this State Plan Amendment is requested. If you have any questions or concerns, please contact me at 919-812-6145.

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

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

State/Territory:_____North Carolina_____
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))_____ Melanie Bush _____ (Signature of Governor, or designee, of State/Territory, Date Signed)

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

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

Name: Devdutta Sangvai — Position/Title: Secretary, NC DHHS
Name: Melanie Bush — Position/Title: Deputy Secretary for Division of Health Benefits
Name: Sarah Gregosky — Position/Title: Deputy Medicaid Director

Disclosure Statement This information is being collected to pursuant to 42 U.S.C. 1397aa, which requires states to submit a State Child Health Plan in order to receive federal funding. This mandatory information collection will be used to demonstrate compliance with all requirements of title XXI of the Act and implementing regulations at 42 CFR part 457. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). Public burden for all of the collection of information requirements under this control number is estimated to average 80 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.

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Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, further modified the program. The HEALTHY KIDS Act and The Bipartisan Budget Act of 2018 together resulted in an extension of funding for CHIP through federal fiscal year 2027.

This template outlines the information that must be included in the state plans and the State plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.
- Added new provisions related to delivery methods, including managed care, to section 3 (81 FR 27498, issued May 6, 2016)

States are not required to resubmit existing State plans using this current updated template. However, States must use this updated template when submitting a new State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A) In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP SPAs, that may be stopped by a request for additional information and restarted after a complete

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response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a "clean" copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements**- This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination**- This section should provide general information related to the special characteristics of each state's program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls**- This section requires the State to specify its proposed method of delivery. If the State proposes to use managed care, the State must describe and attest to certain requirements of a managed care delivery system, including contracting standards; enrollee enrollment processes; enrollee notification and grievance processes; and plans for enrolling providers, among others. (Section 2103); (42 CFR Part 457. Subpart L)
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42 CFR 457.90)
6. **Coverage Requirements for Children's Health Insurance**- Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of

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any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))

7. **Quality and Appropriateness of Care**- This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration**- The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations**- Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity**- In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections**- This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

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Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

  Medicaid Expansion- CHIP SPA Requirements
  In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:
  - 1 (General Description)
  - 2 (General Background)

  They will also be required to complete the appropriate program sections, including:
  - 4 (Eligibility Standards and Methodology)
  - 5 (Outreach)
  - 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
  - 10 (Annual Reports and Evaluations).

  Medicaid Expansion- Medicaid SPA Requirements
  States expanding through Medicaid-only will also be required to submit a Medicaid State plan amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:
  - 3 (Methods of Delivery and Utilization Controls)
  - 4 (Eligibility Standards and Methodology)
  - 6 (Coverage Requirements for Children's Health Insurance)
  - 7 (Quality and Appropriateness of Care)
  - 8 (Cost Sharing and Payment)
  - 11 (Program Integrity)
  - 12 (Applicant and Enrollee Protections)

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of

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poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in "Option to Create a Separate Program" would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 457 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Mail Stop - S2-01-16

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Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

1.1.1. ☐ Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State's Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

1.1.2. ☒ Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

a. Medicaid Expansion Group:

-Children ages 0 (newborn) through 1 year with family income greater than 194% and up to 211% of Federal Poverty Level;

-Children ages 1 year through 6 years with family income greater than 141% and up to 210% of the Federal Poverty Level;

-Children ages 6 through 19 years with family income greater than 107% and up to 211% of the Federal Poverty Level

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1.1. and 1.1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. ☐ A combination of both of the above. (Section 2101(a)(2))

1.1-DS ☐ The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

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

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

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

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.

Original Plan
Effective Date: October 1, 1998

Implementation Date: October 1, 1998

The chart below incorporates five Modified Adjusted Gross Income (MAGI) CHIP State Plans by reference. The MAGI State Plans are attached to this file as appendices in .PDF format.

SPA #15-0001
Purpose of SPA: The primary purpose of SPA #15-001 is to implement program eligibility changes to reflect Affordable Care Act and State legislative requirements. The North Carolina Legislature has not amended any legislation affecting program benefits or cost sharing since 2011. This SPA also documents the repeal of North Carolina's CHIP buy-in program effective October 1, 2015.

Proposed effective date: October 1, 2015

Proposed implementation date: October 1, 2015

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SPA #18-0007
Purpose of SPA: To implement provisions for temporary adjustments to enrollment and redetermination policies and cost sharing requirements for children in families living and/or working in Governor declared or federally declared disaster areas in North Carolina. In the event of a natural disaster, the State will notify CMS that it intends to provide temporary adjustments to its enrollment and/or redetermination policies and cost sharing requirements, the effective and duration date of such adjustments, and the applicable Governor or FEMA declared disaster areas.

Proposed effective date: September 13, 2018

Proposed implementation date: September 13, 2018

SPA #19-0007
Purpose of SPA: To comply with updated template as well as to demonstrate compliance with Mental Health parity. The North Carolina CHIP program, North Carolina Health Choice (NCHC), is the only North Carolina (NC) benefit plan to which the final rule applies. The North Carolina Division of Medical Assistance (DMA) has completed an analysis of the NCHC benefit package and has determined that NC is compliant with the final rule.

Title XXI (Health Choice) services authorized by this State Plan are reimbursed at the Medicaid established rate for the provided service. Unless otherwise authorized within this section of the State Plan, Title XXI services are prospectively reimbursed and not subject to cost settlement.

Proposed effective date: October 1, 2017

Proposed implementation date: October 1, 2017

SPA #20-0005
Purpose of SPA: To implement provisions for temporary adjustments to enrollment and redetermination policies and cost sharing requirements for children in families living and/or working in Governor or Federally-declared disaster areas in North Carolina. In the event of a natural disaster or public health emergency, the State will notify CMS that it intends to provide temporary adjustments to its enrollment and/or redetermination policies and cost sharing requirements, the effective and duration date of such adjustments, and the applicable Governor or Federally-declared disaster or public health emergency areas.

Proposed effective date: March 13, 2020

Proposed implementation date: March 13, 2020

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SPA # 20-20014
Purpose of SPA: To implement a Health Service Initiative (HSI) that will expand an early literacy program that encourages reading for children age 0-5 years old through the Reach Out and Read initiative.

Proposed effective date: July 01, 2020

Proposed implementation date: July 01, 2020

SPA # 20-0010
Purpose of SPA: To comply with updated template as well as to demonstrate Substance Use-Disorder prevention that promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) requirements for children in CHIP.

Proposed effective date: October 24, 2019

Proposed implementation date: October 24, 2019

SPA # 22-0014
Purpose of SPA: To implement 12-month postpartum option, and to comply with continuous eligibility exception regulations for children in CHIP.

Proposed effective date: April 1, 2022

Proposed implementation date: April 1, 2022

SPA # 22-0013
Purpose of SPA: To implement the Managed Care delivery system to the Children's Health Insurance Program (CHIP). North Carolina Division of Health Benefits has completed an analysis of the NCHC Managed Care Requirements and has determined that NC is compliant with the final rule.

Proposed Effective Date: July 1, 2021

Implementation date: July 1, 2021

SPA # 22-0034
Purpose of SPA: The purpose of this SPA is to demonstrate compliance with the American Rescue Plan Act provisions that require states to cover treatment (including treatment of a condition that may seriously complicate COVID-19 treatment), testing, and vaccinations for COVID-19 without cost sharing in CHIP.

Proposed effective date: March 11, 2021

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Proposed implementation date: March 11, 2021

SPA # 23-0008
Purpose of the SPA: The purpose of this SPA is to combine the Separate Children's Health Insurance Program with North Carolina Medicaid program.

Proposed effective date: April 1, 2023

Proposed Implementation Date: April 1, 2023

SPA # 23-0010
Purpose of the SPA: The purpose of this SPA is to combine the Separate Children's Health Insurance Program with North Carolina Medicaid program and outline the eligibility guidelines.

Proposed effective date: April 1, 2023

Proposed Implementation Date: April 1, 2023

SPA# 23-0017
Purpose of SPA: To implement Health Service Initiatives (HSI) that will create a Breastfeeding Hotline to provide support to all North Carolina families, and a Substance Use and Parenting Intervention Health Service Initiative, to address the social and health challenges that are associated with families and addiction.

Proposed Effective Date: July 1, 2023

Proposed Implementation date: December 1, 2023

SPA # 26-0010
Purpose of SPA: To request extension on Health Service Initiatives that will continue a Breastfeeding Hotline to provide support to all North Carolina families, and a expand and extend a Substance Use and Parenting Intervention Health Service Initiative, to address the social and health challenges that are associated with families and addiction. This State Plan Amendment also removes the Reach Out and Read Health Service Initiative as it has ended.

Proposed Effective Date: December 1, 2026

Proposed Implementation Date: December 31st, 2026

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1.4- TC **Tribal Consultation** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR section 431.408(b), State Medicaid Director Letter #01-024, and contained in the state's approved Medicaid State plan, when any program changes to the demonstration, either through amendment as set out in STC 6 or extension, are proposed by the state. The Division of Health Benefits is in constant and almost daily communication with the Eastern Band of Cherokee Indians. For this SPA submission, the Tribe reviewed this submission as submitted to them on September 23rd, 2026, and the Tribe agreed and approved the SPA as written, but proposed a few suggested updates.

Section 2. General Background and Description of Approach to Children's Health Insurance Coverage and Coordination

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified , by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

2.2. **Health Services Initiatives-** Describe if the State will use the health services initiative

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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)

Moving forward, North Carolina will expand and improve the delivery of services for maternal and child health by using a statewide breastfeeding hotline as well as a parenting intervention for caregivers with substance use disorder. These HSIs will help to improve the wellbeing of families within the state and support positive social and emotional development of infants and children.

North Carolina CHIP Health Services Initiative (HSI) for Statewide Breastfeeding Hotline
General Description and Purpose

North Carolina will implement and administer a centralized, statewide breastfeeding hotline to expand breastfeeding support to all families in our state. We anticipate that approximately 55% of the participants will be considered low income as we plan to focus our outreach efforts within this population. North Carolina defines low-income as individuals who are income-eligible for Medicaid. The 24-hour hotline and text line will provide accessible, consistent breastfeeding support and messaging, and facilitate referrals to local resources including, but not limited to, the North Carolina Women, Infants, and Children (WIC) Program and the Breastfeeding Peer Counselor Program. This HSI will directly support families in the first year of the baby's life, as well as supporting maternity centers by providing breastfeeding support after the family leaves the maternity center. The statewide breastfeeding hotline would allow parents to access professional lactation support regardless of their geographic location or financial means and at critical times when parents are vulnerable to misinformation and immediately when needed and useful, such as when struggling to breastfeed at home. North Carolina will engage with the Eastern Band of Cherokee Indians (EBCI), and other Tribal entities in the development of the Breastfeeding Hotline.

Over a two-year period ending in December 202~~6~~8, the initiative will create and implement the North Carolina Statewide Breastfeeding Hotline:

- Create a phone-based platform that the >1222~~1~~8,000 North Carolina families with new babies can call 24 hours per day to receive professional breastfeeding and infant feeding support.
- The Hotline will be available ~~to all North Carolina individuals who are pregnant, postpartum,~~ to pregnant and postpartum individuals living in North Carolina, as well as their partners, family members, support people, and providers. Outreach will be directed to low-income individuals who are Medicaid eligible or beneficiaries.
- Establish partnerships with the four (4) International Board-Certified Lactation Consultant (IBCLC) training programs in North Carolina (two of which are at Historically Black Colleges and Universities (HCBUs)) to utilize their recent graduates, or student/mentor pairs to field calls.
- Expand existing state referral resource lists so local referrals can be initiated ~~if needed~~ for the family, if needed.
- Train ~~maternity~~ hospital and birthing center staff about the availability of the Hotline so they can share information with families upon ~~maternity center~~ discharge.
- Train pediatric, family medicine, and obstetrician office physicians and staff about the availability of the Hotline, which is particularly important in rural counties of the state with no maternity care center or outpatient lactation consultants.
- Utilize the established breastfeednc.com website to create ~~Create~~ a public-facing webpage with breastfeeding

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resources for families in English and Spanish, and to advertise~~ment of~~ the Hotline. The webpage will provide links to assist the public with applying for healthcare coverage through Medicaid.

- ~~The webpage will provide links to assist the public with applying for health care coverage through Medicaid~~

The Project

Breastfeeding is widely accepted as an effective strategy to promote positive health outcomes for both mothers and their infants. Breastmilk is nutritionally superior to other forms of infant feeding and offers substantial immunological and health benefits for both the mother and infant. As Baby-Friendly USA states: "Breastfeeding is the single most powerful and well-documented preventative modality available to health care providers to reduce the risk of common causes of infant morbidity." [i] ~~1~~ Breastfeeding provides short- and long-term benefits to the mother and infant, and reduces disease burden and death in both populations by

~~1) CBC Breastfeeding Report Card: https://www.cdc.gov/breastfeeding/data/reportcard.htm~~
~~2) CDC report: https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6947a3_H.pdf~~
~~3) Vidant Hospital Lactation Short Falls: https://www.wnct.com/local-news/the-need-for-lactation-services-and-support-in-the-enc/~~
~~4) North Carolina Maternity Center Closures: https://www.northcarolinahealthnews.org/2020/02/24/when-rural-maternity-units-close-alternatives-are-hard-to-come-by/~~

significantly lowering rates of leukemia, diabetes, asthma, otitis media, necrotizing enterocolitis, and Sudden Infant Death Syndrome in infants, and Type 2 diabetes, breast and ovarian cancers, hypertension, and heart disease in mothers.[ii]

~~Infant Death Syndrome in infants, and Type 2 diabetes, breast and ovarian cancers, hypertension, and heart disease in mothers.~~ ~~2~~ Recent evidence has shown that mothers who have received the COVID-19 vaccine provide protection to their infant through the transfer of antibodies in breast milk. [iii] ~~3~~ There is ~~a proven link between~~ strong evidence linking breastfeeding and the reduction of food insecurity. The World Alliance for Breastfeeding Action notes that breastfeeding helps to prevent malnutrition, ensures food security for infants and young children, and thus helps to bring people out of the hunger and poverty cycle. [iv] ~~4~~ The benefits for families and babies last long after breastfeeding has stopped.

Despite growing data about these benefits, the rate of any breastfeeding in North Carolina decreases dramatically in the first few months of life, dropping from 8~~25~~% when infants leave the maternity center to 62~~56~~% at 6 months, according to North Carolina data from the Title V Office analysis of North Carolina Resident Live Birth Certificate Data report[v] and the CDC's ~~most recent National Immunization Survey/Breastfeeding Report Card.~~ ~~5~~ National Immunization Survey-Child Breastfeeding Rates.[vi] ~~And~~ Additionally, rates of exclusive breastfeeding at 3 months old in North Carolina are ~53 ~~38~~% and only 31 ~~20~~% at 6 months old [viii], well below the Healthy People 2030 goal of 42.~~45~~% exclusive breastfeeding at 6 months old. [vii] ~~6~~

Most North Carolina families are initiating breastfeeding immediately after the infant's birth, but upon discharge, ~~from the maternity center~~ families face many barriers in identifying or obtaining the skilled support needed to address their concerns about breastfeeding. Families encounter issues in accessing care due to limited or complete lack of lactation consultants in their county, barriers to insurance reimbursement of lactation professionals, high out-of-pocket costs for private lactation professionals, and limited lactation knowledge among their healthcare providers. [viii,ix]

[1] Annual Births in North Carolina in 2024. https://www.dph.ncdhhs.gov/programs/title-v-maternal-and-child-health-block-grant/nc-maternal-and-infant-health-data-dashboard/nc-birth-demographics Accessed 2/27/2026
[1] Baby-Friendly USA. "The Baby-Friendly Hospital Initiative: Interim Guidelines and Evaluation Criteria for Facilities Seeking and Sustaining Baby-Friendly Designation." https://www.babyfriendlyusa.org/wp-content/uploads/2019/12/US-Interim-GEC_191107_CLEAN.pdf Accessed 2/27/2026
[1] CDC: Breastfeeding Benefits Both Baby and Mom. https://www.cdc.gov/breastfeeding/features/breastfeeding-benefits.html#:~:text=Breastfeeding%20can%20help%20protect%20babies,ear%20infections%20and%20stomach%20bugs. Accessed 2/27/2026
[1] CDC: Implementation of Hospital Practices Supportive of Breastfeeding in the Context of COVID-19 — United States, July 15–August 20, 2020. Accessed 2/27/2026
[1] Tomori C (2023) Global lessons for strengthening breastfeeding as a key pillar of food security. Front. Public Health 11:1256390. doi: 10.3389/fpubh.2023.1256390. Accessed 2/27/2026
[1] World Alliance for Breastfeeding Action: WABA Activity Sheet 10 – Breastfeeding and Food Security. https://waba.org.my/resources/activitysheet/acsh10.htm. Accessed 2/27/2026
[1] NC DHHS, Division of Public Health, Title V Office analysis of NC Resident Live Birth Certificate Data, 10OCT2025. Breastfed at Delivery Discharge | Division of Public Health, Accessed 2/27/2026
[1] CDC NIS-Child Breastfeeding Rates by State 2022. NIS-Child Breastfeeding Rates by State: 2022 | Breastfeeding Data | CDC, Accessed 2/27/2026
[1] Increase the proportion of infants who are breastfed exclusively through age 6 months — MICH-15 - Healthy People 2030 | odphp.health.gov, Accessed 2/27/2026

In order to decrease these barriers and assist families with breastfeeding, we will create the North Carolina Breastfeeding Hotline, modeled after existing successful statewide breastfeeding hotlines in other states, including Tennessee, Ohio, Oklahoma, and Arizona. The North Carolina Breastfeeding Hotline will provide accurate, evidence-based breastfeeding information, counseling, and ~~encouragement~~ support during the prenatal and postpartum period by lactation professionals. The 24/7 accessibility of the Breastfeeding Hotline ~~24/7~~ permits families to receive unbiased information at critical time periods when pediatric and obstetric offices may not be available or lack the expertise to adequately support breastfeeding success. In addition to advertising widely and broadly, we will explore adding the Hotline as a resource on the NC Care 360 site, so the resource is easily accessible to all.

The HSI will support North Carolina families to achieve optimal infant feeding by implementing the following project components and objectives:

- **Create a statewide Breastfeeding Hotline that is available for free to residents of all 100 North Carolina counties.** We will partner with a contractor with North Carolina experience providing on-demand, phone- and text-based ~~pregnancy~~ lactation support for North Carolina families. ~~Greater~~ More than 20 ~~50~~% of North Carolina's counties ~~do not have any outpatient lactation services[7]~~ are defined as maternity care deserts[x]; we will pay special attention to reaching families in those areas of high need. Medical providers may also use the hotline for professional assistance while helping a patient.
  - ***By ~~9 to 12 months after receiving funds~~ the end of FFY 26:*** The North Carolina Statewide Breastfeeding Hotline will be fully operational and available to all families in the state, with 24 hours a ~~per~~ day, seven days a week coverage.

~~5) North Carolina Breastfeeding Coalition Statewide breastfeeding support database: https://www.ncbfc.org/perinatal-region-map~~
~~6) ACOG's statement on COVID-19 health disparities: https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2020/addressing-health-equity-during-the-covid-19-pandemic~~
~~7) HRSA focus on breastfeeding: https://mchb.tvisdata.hrsa.gov/uploadedfiles/statesubmittedfiles/2021/NC/NC_stateActionplan_printversion_FY21.pdf~~
~~8) Black infant breastfeeding disparities: https://schs.dph.ncdhhs.gov/schs/pdf/SB_36_FIN_Oct_2010.pdf~~

  - ***By the end of FFY '2~~4~~7*** Based on numbers of calls from states with similar hotlines, our goal will be to assist 400 families per month by phone conversations by the end of FFY '27.

[1] The need for lactation services and support in the ENC | WNCT, Accessed 2/27/2026
[1] Addressing NC's rural maternity unit closures crisis - NC Health News, Accessed 2/27/2026
[1] March of Dimes. https://www.marchofdimes.org/peristats/reports/north-carolina/maternity-care-deserts. Accessed 2/27/2026.
[1] Breastfeeding Disparities. https://www.northcarolinahealthnews.org/2024/08/15/ncat-hosts-conference-on-importance-of-breastfeeding-to-black-brown-communities/, Accessed 2/27/2026
[1] North Carolina Breastfeeding Coalition Statewide breastfeeding support database: https://www.ncbfc.org/perinatal-region-map, Accessed 2/27/2026
[1] https://nccare360.org/, Accessed 2/27/2026

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- **Hire International Board-Certified Lactation Consultants (IBCLCs) and Certified Lactation Counselors (CLCs).** The contractor will hire IBCLCs and CLCs to field the calls and serve as an immediate source of evidence-based information and guidance, creating a rotating schedule for full-time coverage. Additionally, given the racial and socioeconomic disparities in breastfeeding initiation and continuation throughout North Carolina, [xi] ~~8~~ we plan to partner with the four North Carolina lactation training programs, including those administered by HBCUs (North Carolina A&T and Johnson C. Smith University). Students and recent graduates can gain the clinical hours needed to be eligible for the IBCLC exam with the guidance of their IBCLC preceptors. This will provide both coverage for the Hotline, and the much-needed opportunity for real-world ~~lactation support~~ experience for NC lactation consultants entering the workforce, allowing for more representation of ~~traditionally under-represented~~ historically marginalized groups within the field of lactation consulting.

  - ***By ~~9-12 months after receiving funds~~ the end of FFY 27:*** The North Carolina Statewide Breastfeeding Hotline will hire the needed number of IBCLCs and CLCs.
  - ***By the end of FFY '2~~4~~7***: We will partner with NC IBCLC training programs to involve at least ~~2~~ two student/preceptor pairs to provide Hotline support.
- **Expand and improve lactation resources referral list.** The contractor will collaborate with the North Carolina Breastfeeding Coalition to update and keep current the county-based lactation resource list. [xii]~~7~~ ~~This referral list can be used by the Hotline staff if follow-up is needed by a family.~~ Hotline staff can connect families with existing vetted resources in their local area. We will explore the potential of linking this resource list with NC Care 360, the state's SDOH referral platform.[9]
  - ***By the end of FFY '2~~4~~7:*** We will update and make more widely available the lactation resource list and have a system in place for continual updating.
- **Dissemination of opportunity.** The contractor will outreach to ~~maternity~~ hospital and birthing center staff, ~~and~~ as well as outpatient physician office providers and staff regarding the availability of the Hotline. As is the case in other states with successful statewide breastfeeding hotlines, we expect the majority of referrals and information distribution about the Hotline to come from maternity centers. The contractor will involve our WIC colleagues throughout the state to help disseminate information about the Hotline. We will develop a public-facing webpage with easy to access information about the Hotline.
  - ***Within 1 month of the contract being executed with the subcontractor:*** Webpage will be operational.
  - ***By the end of FFY '2~~4~~7:*** 100% of the maternity centers statewide (which includes hospitals with birthing centers, and free-standing birthing centers) will have information to distribute to families about the Hotline.
- **Data tracking and Impact Measurement.** The contractor will track incoming calls including number of calls/texts, type of issue/problem, number of mothers served, problem resolution using follow-up surveys, and qualitative participant data obtained by randomly choosing participants to receive satisfaction surveys. The contractor and state will also follow trends of statewide breastfeeding rates at various infant

~~9) North Carolina birth data: https://schs.dph.ncdhhs.gov/schs/births/babybook/2019/northcarolina.pdf~~
~~10) Tennessee birth data: https://www.marchofdimes.org/peristats/ViewSubtopic.aspx?reg=47&top=2&stop=1&lev=1&slev=4&obj=1~~
~~11) Breastfeeding Saves Lives Calculator, www.usbreastfeeding.org/saving-calc, accessed 4/8/2021~~
~~12) Stuebe AM, Jegier BJ, Schwarz EB, Green BD, Reinhold AG, Colaizy TT, Bogen DL, Schaefer AJ, Jegier JT, Green NS, Bartick MC. An Online Calculator to Estimate the Impact of Changes in Breastfeeding Rates on Population Health and Costs. Breastfeed Med. 2017 Dec;12(10):645–658. doi:~~

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~~10.1089/bfm.2017.0083~~

ages, although this data is reported by the CDC three years after collection, so there will be a delay in measuring this aspect of success.

- ***By the end of FFY '24~~7~~*** System developed for tracking use. 90% of incoming calls will have above data collected.

- **Quality measurement and assurance.** The Hotline staff will follow up with callers with automated surveys at 4, 8, and 12 weeks after the initial call. The follow-up touchpoints will monitor for problem resolution, current infant feeding practices (breastmilk, formula, or combination), and satisfaction with the Hotline service. Additionally, quality assurance will be monitored by a supervisor reviewing recordings of select calls or reading text message exchanges. More challenging cases will be referred back to the caller's primary provider.
  - ***By the end of FFY '2~~4~~7:*** We will collect responses from 20% of callers with responses to automated surveys, tracking data points noted above.

North Carolina provides assurances that funds under this HSI will not supplant or match CHIP Federal funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds.

Outcome and Evaluation

- We anticipate that approximately 55% of the callers will represent low-income families. The state will document the initiative's progress on performance and outcomes, reporting annually on the following metrics of success:
  - the number of families served (distinguishing first-time callers from repeat callers);
  - the number of infants in low-income families served;
  - questions/issues addressed, problem resolution using follow-up surveys;
  - the number of maternity centers that provide information about the Hotline to families prior to discharge;
  - statewide breastfeeding rates at various infant ages; and
  - qualitative participant data.
- These metrics will allow us to show the need for timely access to breastfeeding promotion and support during critical period, and its impact on breastfeeding success.

North Carolina CHIP Health Services Initiative (HSI) for Substance Use Disorder and Parenting Intervention

Purpose and Background

North Carolina will support ~~The North Carolina Perinatal and Maternal Substance Use, CASAWORKS for Families Initiatives (Initiatives) and the Eastern Band of Cherokee Indians Women's Residential program staff to receive Circle of Security Parenting (COSP) training to address the social and health challenges that are associated with families and addiction.~~ the implementation of an evidence-based parenting intervention for caregivers with substance use disorders (SUD) who are justice-involved or engaged in rural community-based SUD treatment programs. ~~Providing this program to women who receive SUD services through the Initiative will reduce the likelihood of child maltreatment and improve parent/child relationships. North Carolina will also fund the hiring of a mental health consultant to manage and oversee this program, including performing research analysis for quality metrics.~~ These caregivers may include mothers, fathers, kinship caregivers, and other primary caregivers of children ages 0-5. The initiative will support training in

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Circle of Security Parenting© (COSP) for reentry-focused staff and staff working within these systems, as well as the hiring of a mental health consultant and administrative manager to oversee implementation, fidelity, and evaluation. The initiative aims to reduce intergenerational trauma and child maltreatment risk while strengthening caregiver-child attachment during periods of incarceration, reentry, and recovery. Caregivers with SUDs who are justice-involved face compounding barriers, including separation from children, trauma exposure, and limited access to parenting education. Evidence demonstrates that attachment-focused parenting interventions delivered during incarceration, reentry, or treatment improve caregiver engagement, emotional regulation, reunification outcomes, and long-term recovery stability.

~~The North Carolina Perinatal and Maternal Substance Use and CASAWORKS for Families Initiatives represent a nationally recognized state-wide approach to the many social and health challenges associated with families and addiction. The Initiatives are comprised of 27 programs, utilizing evidence-based treatment models, located in 13 counties across the state. One program, UNC Horizons will receive HSI funding and will coordinate training and provide TA/consultation activities for all program sites.~~

~~Women with substance use disorders and associated co-morbidities in the programs are supported to engage with family-centered, gender-responsive, trauma informed substance use disorder treatment with their children. Research and clinical experience show that women are motivated to engage with treatment and recovery based on concern for their children or pregnancy but that they are often unwilling to seek treatment if it means leaving their children. All the programs in the Initiatives are considered cross-area services, and this helps to meet the need of pregnant and parenting women who do not have gender- or family-responsive treatment in their home communities. Women and their families in need of services can access these programs through a toll-free hotline, which also maintains bed availability for the residential programs statewide. Through this capacity management system health care providers, Department of Social Services social workers, treatment providers and others can consult with a Licensed Clinical Addiction Specialist and refer women and their children to the services they need in any of the programs statewide (https://ncpoep.org/guidance-document/treatment-matters/nc-perinatal-and-maternal-substance-abuse-and-the-casaworks-for-families-residential-initiatives/).~~

North Carolina has one of the largest rural populations in the United States, second only to Texas, with nearly 3 million of its residents living in rural counties, and 85 out of 100 counties classified as rural. For the purposes of this initiative, North Carolina defines “rural” using the Rural Health Grants Eligibility Analyzer and Federal Office of Rural Health Policy designations implemented by the Health Resources and Services Administration which includes counties with at least one census tract designated as rural. Addressing accessibility and availability to evidence-based interventions, including COSP in rural counties, is essential to improving recovery, attachment, and family outcomes in communities that have historically lacked such support.

~~Programs provide family-centered, trauma informed services that include, but are not limited to:~~

- ~~Evidence-based substance use and mental health disorder treatment services for pregnant and parenting women;~~
- ~~Parenting education & support;~~
- ~~Provide or arrange for treatment and prevention services for children;~~
- ~~Referral for and coordination with medical care for women;~~
- ~~Referral for and coordination with pediatric and developmental services for children;~~
- ~~Case management; and~~

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- ~~Access to childcare and transportation.~~

The initiative will target the following populations:

- Justice-involved caregivers with a history of SUD
- Caregivers enrolled in rural community-based SUD programs including outpatient, residential, opioid treatment programs where access to family-centered and trauma-informed parenting interventions may be limited

~~**Key Benefits of the Initiatives**~~

~~With the support of a gender responsive and trauma informed system of care, women receiving treatment through the Initiatives report:~~

- ~~High engagement in prenatal care among pregnant women;~~
- ~~Healthy newborn birth weights for pregnant women who enter treatment prior to delivery;~~
- ~~Lower recidivism with child welfare among families engaging with treatment services;~~
- ~~Fewer number of days in out-of-home foster care placement for children of parents involved with child welfare as compared to parents with substance use problems not engaged in the services;~~
- ~~Successful engagement with pediatric care for families involved with services;~~
- ~~Increased affectional bonds and reduced conflict among families engaged in parenting programs;~~
- ~~Successful engagement in the work force. The families served by the Initiatives and the EBCI's women's program are some of those with the highest needs in our state system. Intergenerational substance use, trauma and child welfare involvement are all common. Successful intervention with evidence-based parenting programs can break the cycle of addiction and trauma in families and reduce suffering and loss for children and their parents, reducing future costs to the state, and improving child health and welfare outcomes. In SFY 21, there were 642 new and continuing women receiving services across the Initiatives. Upon admission, 28% of the women were pregnant and they had 646 children in their physical custody.~~

~~The following is an overview of some demographics of the client population:~~

- ~~**History of SUD**: Had a Moderate or Severe Substance Use Disorder 96%~~
- ~~**Trauma History**: Experienced Incest/Sexual Abuse (prior year) 13%; Experienced Physical Abuse (within 3 mo. prior to admission) 23%~~
- ~~**Pregnancy Status At admission**: Pregnant 28%~~
- ~~**Insurance Coverage:** Medicaid 82%; No Insurance 8%; Private Insurance 1%; Other 5%; Unknown 4%~~
- ~~**Client Education Status:** < High School Education 35%; High School or GED 33%; > High School Education 32%~~
- ~~**Treatment Mandate:** Mandated to Treatment 50% (By CJ System 16%; By DSS 297 34% - some are mandated by both systems)~~
- ~~**Support Needs At Admission:** Housing Services 71%; Needed Transportation To Access Services 69%; Had food insecurity 63%; Unemployed 48%~~

~~We propose two connected approaches to directly address the physical, social and emotional health of children ages 0-5 whose mothers are receiving treatment for substance use disorders (SUDs) in these programs.~~

Program Description

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1.) **Training in Circle of Security-Parenting© for ~~Clinical~~ Program Staff**:

~~We are requesting funding to allow 35 staff members from the women's SUD treatment programs in the Initiatives and EBCI women's program, to receive training in Circle of Security Parenting. Written and designed by Kent Hoffman, Glen Cooper, and Bert Powell, the Circle of Security- Parenting (COSP) program is based in attachment theory and utilizes simple diagrams and videos to make the program's concepts easy for caregivers to understand. The attachment process is a biological process in humans and applies to all cultures; however, it is important to consider the attachment process within a cultural context. The COSP staff will work with the NC pilot to ensure that the trainings and interventions address the culturally diverse populations served by the programs statewide. The HSI funding will be used for training, materials and staff time for evaluation support and to support the FTE working with the UNC Day Care.~~

~~COSP is both an intervention and a framework to help caregivers understand their child's relationship needs for a secure base from which to venture out to explore the world, and to which to return in times of distress - called the "circle of security".[10,11] COSP increases parents' skills around recognizing and responding appropriately to children's needs and reflecting on their interactions with their children. The body of literature to support its use continues to grow and includes over 40 publications in 2020. Please see https://www.circleofsecurityinternational.com/wp-content/uploads/COS-Bibliography-1.20.pdf for all publications.~~

HSI funding is requested to train approximately 35 multidisciplinary staff working across justice-involved reentry, community-based, and rural SUD programs in COSP. Written and designed by Kent Hoffman, Glen Cooper, and Bert Powell, the Circle of Security- Parenting (COSP) program is grounded in attachment theory and utilizes simple diagrams and videos to make the program's concepts easy for caregivers to understand. COSP is both an intervention and a framework to help caregivers understand their child's relationship needs for a secure base from which to venture out to explore the world, and a safe haven to return to in times of distress- called the "Circle of Security" (Cooper, Hoffman, & Powell, 2009). COSP increases parents' skills around recognizing and responding appropriately to children's needs and reflecting on their interactions with their children. The body of literature to support the COSP program continues to grow and includes over 50 publications. (Please see https://www.circleofsecurityinternational.com/pages/research for more information.)

The attachment process is a biological process in humans and applies to all cultures; however, it is important to consider the attachment process within a caregiver's cultural context. The COSP intervention is utilized around the world and has been translated into over 25 languages. Staff from Circle of Security International, the parent company for COSP, will work with the Mental Health Consultant to ensure that the training and intervention address our culturally diverse populations statewide. The HSI funding will be used for training, materials, hiring a Mental Health Consultant who is a subject matter expert who can provide technical assistance, supervision and evaluation support and an administrative assistant.

COSP is primarily a group-based parenting intervention, with content that applies to parents of children of any age, but it can also be used with caregivers and/or caregiver/child dyads individually. COSP is an eight-session manualized program which uses handouts and an eight-chapter DVD that contains key concepts about healthy caregiver-child attachment and includes examples of effective and ineffective parent-child interactions.[12] Each weekly chapter on the DVD contains approximately 15 minutes of recorded content and

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has four to six recommended pauses during which the facilitator stops the recording and leads a discussion using process questions (supplied by the program) or reviews included handouts. The suggested time for each session is approximately 1.5 hours.

Dr. Evette Horton, the Director of Child Clinical Services at UNC Horizons, ~~completed training in COSP and then, recognizing that COSP had not been widely used with women in treatment for substance use disorders, tested the program with women at UNC Horizons for her doctoral dissertation in 2013.~~ is the Mental Health Consultant and context expert on the currently funded HSI project. She and other researchers have utilized COSP with caregivers with substance use disorders and found reductions in caregiver stress, depression, anxiety, and substance use in an outpatient program serving clients with opioid use disorders (Coleman, 2014) and improvements in in parent discipline practices, emotion regulation, and parental attributions in a residential program serving pregnant and parenting mothers (Horton & Murray, 2015). COSP is also being utilized with justice-involved caregivers around the world (See two examples in the U.S., https://www.emergect.net/programs; https://fortycarrots.com/parenting-program/circle-security/). ~~She analyzed data for a cohort of clients who received the full COSP curriculum using Parenting Scale scores.[13] The Parenting Scale (PS) has two factors related to discipline, lax and over-reactive, and a total score. The participants' mean scores on the Parenting Scale's total, lax, and over-reactive factors showed significant improvement from pretest to posttest, indicating a *reduction* in harsh parenting practices such as spanking, yelling, and threatening and an *increase* in the mother's ability to consistently respond to her child's misbehavior. The mothers in the COSP study **reduced** their harsh parenting practices and **increased** their parental consistency after taking the COSP program while in residential treatment, as measured on the Parenting Scale pre- and post-tests.~~ COSP is well-suited for justice-involved populations, because it is trauma-informed and non-punitive, can be delivered in group or individual formats, is adaptable for incarceration, re-entry, and community-based settings, and supports caregivers who are physically separated from their children, focusing on emotional connection, repair, and reunification.

Training in COSP is now offered online, with various schedules for trainees around the world~~., but totaling four full days of training.~~ Training includes five two-hour live training sessions, prerecorded video content, and some independent reading over a two-week period. In total, the entire training is an approximate 35-hour time commitment. Completion of online ~~the 4-day~~ Circle of Security Parenting Training© is required in order to use the copyrighted content ~~DVD-based parent education program~~. After completing the training, facilitators are given a license to use the COSP manual, a DVD, and handouts for caregivers ~~with parents~~. These materials are included in the price of the training. The program developers indicate that COSP training is appropriate for both professionals and paraprofessionals who work with parents. For more information, please refer to the website: https://www.circleofsecurityinternational.com/.

2.) **Expert Support for Statewide COSP Implementation ~~and for UNC Horizons' Child Development Center~~:**

We are proposing to ~~support the Horizons Program~~ to hire (time-limited for 2 years to end December 202~~6~~) a mental health consultant focused on early childhood (minimum of master's level, preference for doctoral level) with expertise in attachment, ~~and~~ child development and caregivers with substance use history who would spend three-quarters of their time as the lead for the Circle of Security Parenting©project proposed above~~., and one quarter of their time in the UNC Horizons' Child Development Center providing trainings and consultations in the center and/or virtually, as needed due to COVID restrictions..~~ As the lead for the

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COSP project, this person would:

- Schedule the COSP trainings, act as the liaison between all the ~~clinicians~~ program staff being trained and the Circle of Security International team, ~~COSP trainers~~ and troubleshoot any issues with the virtual training sessions, and support the trainees across the state with implementation of the COSP intervention.
- Design and implement the data collection system to evaluate the project, including distributing evaluation instruments ~~(likely the Parenting Scale)~~ to all programs participating in the project, maintaining contact and providing reminders regarding data collection, and following up regarding any missing data.
- ~~Work with a database designer to develop a database to collect the outcome data.~~
- Data will be collected using Qualtrics and the Mental Health Consultant utilizes that for compliance with reporting
- Input and analyze data from the project.
- Facilitate monthly virtual supervision sessions with trainees ~~of the existing Perinatal Learning Collaborative~~ focused on attachment, implementation of the COSP curriculum, and fidelity to the curriculum, and answer question or address issues ~~clinicians~~ program staff may be confronting with the COSP curriculum ~~in the parenting groups~~.

- Facilitate a virtual pre-launch session as well as a live, in-person session to build trainee cohesion, provide technical assistance, and offer continued implementation support.

- Provide fidelity coaching and troubleshooting to programs throughout the two-year initiative period.

- Support adaptations of COSP delivery specific to incarceration and reentry contexts, including strategies for caregivers who are separated from children due to incarceration.
- Serve as the main contact for the project with the Division of MH/DD/SAS Women's Services Team Lead ~~Special Populations Team Lead~~.
- Create and disseminate reports to the Division of MH/DD/SUAS Women's Services Team Lead ~~Special Populations Team Lead~~
- Lead both quarterly metrics and evaluation ~~and~~ as needed regarding program implementation and outcomes.

- ~~Provide individual fidelity coaching and troubleshooting to programs throughout the two-year initiative period. The remaining 25% of the mental health consultant's time would be spent at the UNC Horizons' Child Development Center (HCDC). The HCDC is onsite at the UNC Horizons SUD treatment program in Carrboro, NC, and is a 5-star, licensed center with the capacity to serve 41 children ages 6 weeks to 5 years. All of the children in the center have mothers who are receiving SUD treatment services at Horizons. The HCDC serves approximately 65-70 children per year. While the race/ethnicity data varies slightly from year to year, in general the population served is approximately 20% African American, 25% bi-racial, 45% Caucasian, 5% Hispanic and 5% Native American. All families have incomes that place them below the federal poverty line. As a group, the children in the center have faced significant adversity prior to coming to Horizons due to a combination of poverty, early traumatic experiences, prenatal drug exposure, lack of stable housing and daily routines, and disrupted attachments in early life. Dr. Horton has collected scores for a cohort of the residential children (unpublished data) at Horizons using the TESI (Traumatic Events Screening Inventory) and has found that over 80% have experienced one or more serious traumatic events. They bring a wide range of emotional, developmental, and health concerns. Common issues include developmental delays,~~

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anxiety disorders, attachment disorders, PTSD, ADHD, behavior problems, difficulty regulating emotion, poor social skills, adjustment disorders, and somatic illnesses. Each year approximately 80% of the families coming into Horizons have had a history involvement with Child Protective Services.

During the COVID pandemic the HCDC closed only briefly (March 23-May 11, 2020) and then resumed operations for families in the Horizons' residential programs only. This change resulted in a lower census for the HCDC but freed up staff to allow for the addition of school-age children. The HCDC extended its license to cover school-age children, and then those children in the residential programs were invited onsite to attend their Zoom classes while being supervised by teachers in the HCDC. One of the group treatment rooms was converted into a classroom for the children, and each child had their own carol to use for Zoom sessions and classwork. The HCDC provided breakfast and lunch for all of the children, and transportation to and from the residential programs. The school-age program lasted from August 2020 to March 2021, when public school resumed in-person operations. The HCDC then resumed allowing children of outpatient women to attend if their caregivers are vaccinated. The census in the HCDC has been lower this past year than normal given staffing challenges in both the center and the residential programs that have resulted in lower-than-normal patient populations. The number of students in the HCDC is increasing, however, and we anticipate a return to normal operations within the next year.

In order to further support the teachers in the HCDC in meeting the day to day needs of the children, the mental health consultant would work with the teachers on professional development, including a two-tier training (virtual if needed due to COVID restrictions) in Circle of Security Parenting for Classrooms.[14,15] See https://www.circleofsecurityinternational.com/wp-content/uploads/An-Overview-of-COSP-Classroom-Approach-V20.9.pdf for more information) which is similar to the model described above for the providers and includes training in the Circle of Security Parenting for Classrooms model and 6 – 8 months of follow up support via a virtual learning collaborative at the center. The consultant would also be available to work one-on- one with teachers dealing with challenging behaviors in the classroom. The consultant will assess the impact of this two-tiered program with pre/post assessments, such as the Teacher Opinion Survey-Revised and the Goal-Achievement Scale, which assess the teachers' perceived efficacy in managing children's challenging behaviors and ability to meet children's social and emotional needs.[16,17] The consultant will share lessons learned from this work with other programs in the state.

Population Impacted

We estimate that approximately 650 women in treatment for substance use disorders will receive education through the COSP curriculum over the two-year project period, and 650 children ages 0-5 will benefit from their mothers' participation in the program. Over the two years, approximately 120 unduplicated children ages six weeks to five years will benefit from enhanced training and support for their teachers in the UNC Horizons' Child Development Center.

Over the two-year project period, it is estimated that 400 justice-involved and/or rural community-based caregivers with SUDS will receive COSP-informed parenting education, 500 children ages 0-17 will benefit indirectly through improved caregiver attachment behaviors, emotional regulation, and reunification readiness, and a minimum of three rural counties offering SUD treatment programming will gain capacity to deliver attachment-focused parenting interventions.

Outcome Measures

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We will track the outcomes of this program with the following measures:

- ~~Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment~~
  ~~These are HEDIS measures that are measured in the full population, ensuring that we are able to monitor for changes between counties that have implemented the program and those that have not.~~
- Total number of caregivers with a history of a SUD that will benefit from participation in COSP
- Total number of children ages 0-17 whose caregiver is participating in COSP
- Well-Child Visits in First 15 Months of Life
- Total number of staff trained in COSP as part of this initiative
- Total number of counties that had at least one staff trained in COSP
- Total number of rural counties with at least one staff receiving training in COSP as part of the initiative

References

Coleman, M. (2014). An attachment-based parenting training program for opiate dependent carers. J Addict Res Ther, 5(201.10), 4172.

Cooper, G., Hoffman, K., & Powell, B. (2009). Circle of Security: COS-P facilitator DVD manual 5.0. Spokane: Marycliff Institute.

Horton, E., & Murray, C. (2015). A quantitative exploratory evaluation of the circle of security-parenting program with mothers in residential substance-abuse treatment. Infant mental health journal, 36(3), 320-336.

~~North Carolina CHIP Health Services Initiative (HSI) for Children- Reach out and Read~~

~~Description and Purpose~~

~~North Carolina will expand and improve the delivery of an AAP-endorsed, evidence-based model to promote early literacy, early learning and school readiness as part of routine pediatric primary care visits for children, birth to age 5. This HSI will contribute to transforming the standard of pediatric care for young children in North Carolina to sharpen the focus on activities that support social and emotional development.~~

~~Over a three-year period, the initiative will support Reach Out and Read in North Carolina to:~~

- ~~Expand to about 40 new clinic sites in targeted North Carolina counties, reaching approximately 30,000 children who are currently unserved;~~
- ~~Increase the number of infants, birth to 6 months, served;~~
- ~~Train roughly 120 new pediatric primary care providers to deliver the Reach Out and Read model;~~
- ~~Prepare all providers (new and existing) in the "Back to Birth" component of the intervention, so all clinics can begin at birth, rather than 6 months of age; and~~
- ~~Boost the percentage of clinics meeting the highest quality standards by providing training and technical assistance.~~

~~The state will document the initiative's progress on performance and outcomes, reporting semi-annually on the following metrics: the number of children served; the number of children in low-income families served; the number of providers completing core training on the Reach Out and Read model; the number of providers trained to deliver the Reach Out and Read model from birth to 6 months of age; the number of new clinic sites launched; and the percentage of clinics achieving the highest quality rating (12/14~~

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quality standards met.)

We project the total cost of the 3-year initiative to be $3,013,000, of which $2,400,432.30 will come from the state's federal CHIP allotment. The state's share of the cost will amount to $643,056; the source of the non-federal share will be funding from the NC General Assembly. The state's preferred effective date for program launch is July 1, 2020.

The Project

In the earliest stages of a child's life, brain development is occurring at an unprecedented rapid pace, mediated by the nurturing, language-rich interactions that strengthen the parent-child bond and support social and emotional development. Such early responsive caregiving sets the stage for early literacy, early learning, and school readiness. In addition, reading aloud with children eases family stress and fosters feelings of safety and security, building resilience and enabling families and children to cope with social and emotional challenges.

Parents play a vital role in fostering healthy child development and they rely on supportive anticipatory guidance delivered by their child's health care provider during routine well-child visits. Recognizing these important factors, in 2014 the American Academy of Pediatrics (AAP) issued a policy statement making clear that literacy promotion is an essential component of pediatric primary care practice.1

Starting in infancy, the AAP recommends that pediatric providers advise parents about the importance of reading aloud with their children and counseling them on developmentally appropriate shared-reading activities and the value of providing developmentally appropriate books at health supervision visits for children in low-income families.

Reach Out and Read2, a clinic-based pediatric primary care intervention, operating in all 50 states and D.C., delivers on the benefits contemplated in the 2014 AAP Policy Statement. Pediatric care providers are trained to recognize and reinforce the strengths parents bring to the relationship with their infants and young children. The provider enters the exam room with a new, developmentally appropriate book which is used as a tool for observing the parent-child relationship and the child's developmental stage, modeling effective dialogic reading techniques, and providing anticipatory guidance to parents, as referenced in the AAP policy statement.

Reach Out and Read works with a National Book Committee and a variety of large publishing partners, like Scholastic and All About Books, to develop a curated selected of high-quality books to serve the developmental needs of Reach Out and Read's children/families and providers. They also work to make books available in a variety of languages to serve the cultural needs of families. Publishers create specific catalogs for Reach Out and Read and providers are able to select from the hundreds of vetted titles the books that they would like to utilize with the children/families in their community.

1 Literacy Promotion: An Essential Component of Primary Care Pediatric Practice, American Academy of Pediatrics Policy

In North Carolina, Reach Out and Read currently operates in 340 clinic locations in 88 counties. It is delivered by 1,700 pediatric care providers to roughly 263,000 young children, an estimated 75 percent

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of whom are in low-income families, and are covered under Medicaid or CHIP. This intervention can be implemented at a cost of $15/child/year, which covers basic expenses including provider training, technical assistance, books, and evaluation. A component of Reach Out and Read's engagement with providers also involves connecting providers to community resources such as libraries to train providers on how to connect children with programs and instructions to complete library card applications. NCDHHS considers books to be essential materials to the program. The documented benefits that Reach Out and Read delivers aligns with the goals of the North Carolina Early Childhood Action Plan and NCDHHS' interests in assuring a robust medical home that not only attends to the medical needs of children and families, but also addresses health-related social needs.

The HSI will enable more of North Carolina's children and families to benefit from Reach Out and Read by implementing the following project components and objectives:

- **Expand to all 100 North Carolina Counties.** In addition to establishing Reach Out and Read in the 12 North Carolina counties that are unserved3, we will focus expanding to "hard to reach" locations in counties that already host Reach Out and Read. Such counties may include those with rural areas, those with fewer available health care options, or with limited capacity to explore opportunities like Reach Out and Read. We also will focus attention on counties where well-child visit compliance is low.

By the end of FFY '24, Reach Out and Read will operate in 100% of NC counties, up from 88%. About 40 new clinic sites, will bring the total to 380 clinics statewide. An additional 120 pediatric primary care providers will be trained to deliver the Reach Out and Read model to 30,000 additional children from birth to age 5.

- **Begin at birth in all clinics.** While Reach Out and Read historically launched at the child's 6-month visit, research supports starting Reach Out and Read at the earliest well-child visit after a child is born (generally, the 2-week visit.) Doing so helps to take advantage of every opportunity to influence early brain development and establish nurturing family routines.

By the end of FFY '24, Reach Out and Read will have put in place a plan to increase the number of clinics that implement the intervention from birth from 85 (25%) to 380 clinics (100%), the effort will be complete after three to five years.

Statement, 2014 https://pediatrics.aappublications.org/content/pediatrics/134/2/404.full.pdf

2 Find information about Reach Out and Read and the evidence supporting its effectiveness. https://www.reachoutandread.org/about/ ; https://www.reachoutandread.org/why-we-matter/the-evidence/

3 Yancey, Mitchell, Avery, Watauga, Alleghany, Harnett, Sampson, Bladen, Greene, Halifax, Martin, and Tyrrell

- **Improve quality so more clinics attain the highest Reach Out and Read quality rating.** We aim to ensure quality and fidelity to the evidence-based Reach Out and Read model by providing training and technical assistance. Clinics that meet 12 out of 14

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quality standards earn the highest quality designation.

By the end of FFY '24, 90% of clinics will have attained the highest quality rating, an increase from 58% of clinics that currently meet that goal.

- **Increase support for robust Medical Engagement and Training.** Activities will focus on facilitating continuous learning and aligning research that supports the pediatric primary care providers' role with children and families. Other activities include developing CME-certified coursework available on the ROR-Carolinas Online Learning Community, partnering with providers on Quality Improvement work and supporting education and training for medical residents. This work is intended to connect with the needs of specific sites and also advance the field of primary care, in general.

By the end of FFY '24, at least one research project launched to evaluate the impact of Reach Out and Read on well-child visit compliance.

Over a three-year period, the HSI will be implemented according to a phased-in approach, as shown in Table 1. A supporting budget for each phase is presented in Table 2. Site quality standards are described in Figure 1. The state intends to use these HSI funds for three years.

- North Carolina provides assurances that the HSI program will only target children under the age of 19.
- North Carolina provides further assurances that funds under this HSI will not supplant or match CHIP Federal funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds.

Budget

We project the total cost of these initiatives to be $899,158, of which $695,948 will come from the state's federal CHIP allotment. The state's share of the cost will amount to $203,210 the source of the non- federal share will be funding from the NC General Assembly. The state's preferred effective date for program launch is July 1, 2023.

North Carolina will be requesting an extension the previous HSI, Reach out and Read, effective until June 2024. Planned activities could not be completed in the original timeline due to contracting delays. Additional time allows the state to complete the activities.

The funds used through the CHIP HSI allowed the organization to expand services to all counties in the state, to extend the number of practices participating in the program and to further activities in research to improve care for social emotional wellbeing for children. The program continues to operate in the state using existing funds and these funds helped the program expand services beyond current operations.

2.3-TC **Tribal Consultation Requirements**- (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian

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Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

The North Carolina Department of Health and Human Services, Division of Health Benefits, follows the same Tribal consultation process for the CHIP Program as it does for the State Medicaid Program. North Carolina received CMS approval on SPA 10-038 on March 17, 2011 to establish the Tribal consultation process which consists of a representative of the Eastern Band of Cherokee Indians sitting on the Medical Care Advisory Committee. The Advisory Committee meets at least quarterly to review activities of the Division of Health Benefits and provide recommendations and advice on current and future policy initiatives and pending changes to the Medicaid and CHIP programs. During the development of this SPA and prior to submission to CMS:

- The State sought the Tribe's advice and input on matters related to the changes to Medicaid and CHIP programs through the MCAC quarterly meeting.
- The State Medicaid Agency also notified the Tribe in writing of these pending CHIP SPA changes via e-mail on September 23rd, 2026 ~~April 6, 2015~~ providing details of the changes.
- The tribe notified the Agency on October 26th, 2026 ~~April 6, 2015~~ that they were in agreement with the changes.
- Please see attached in the SPA submission packet the CMS standard tribal questions/responses, the notification to the tribes, and the tribal notification back to the State.

TN No: ~~10-038~~ Approval Date: 10/26/2026 ~~03/17/2011~~ Effective Date: 12/1/2026 ~~01/01/2011~~

Section 3. Methods of Delivery and Utilization Controls

☒ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 4 (Eligibility Standards and

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North Carolina does not implement the Express Lane eligibility option

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

North Carolina anticipates a notable impact on the budget.

- **CHIP Budget**

STATE: North Carolina	**FFY Budget**
Federal Fiscal Year	**2026, 2027**
State's enhanced FMAP rate	**75.23% FFY2026 Q4; 74.91% FFY2027 Q1-Q3;**
Benefit Costs	

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STATE: North Carolina	FFY Budget
Insurance payments	
Managed care	$1,252,490,019
per member/per month rate	$311.14
Fee for Service	$7,055,302
Total Benefit Costs	**$1,259,545,321**
(Offsetting beneficiary cost sharing payments)	0
Net Benefit Costs	**$1,259,545,321**
Cost of Proposed SPA Changes – Benefit	**0**
Administration Costs	
Personnel	$6,063,607
General administration	$36,343,273
Contractors/Brokers	0
Claims Processing	$981,309
Outreach/marketing costs	0
Health Services Initiatives	$1,770,345
Reach Out and Read	$
Breastfeeding Hotline	$703,434
Substance Use Disorder & Parenting Intervention	$245,920
Other	0
Total Administration Costs	**$46,107,888**
10% Administrative Cap	$152,143,108
Cost of Proposed SPA Changes	$1,652,788
Federal Share	$982,242,909
State Share	$323,410,299
Total Costs of Approved CHIP Plan	**$1,305,653,209**

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds: Appropriations

~~**Substance Use Disorder & Parenting Intervention Line Item Budget:**~~

~~**Item**~~			~~**Total Cost**~~
~~Circle of Security Parenting Online Training~~	~~$1000 per person~~	~~35 staff members~~	~~$35,000~~
~~Mental Health Consultant - year one~~	~~Salary: $70,000~~	~~Fringe: $29,941~~	~~$99,941~~
~~Mental Health Consultant - year two~~	~~Salary: $72,100~~	~~Fringe: $31,264~~	~~$103,364~~

Technology and supplies			$3,646
		Total budget:	$241,951

*Plus 10% indirect if approved

Breastfeeding Hotline Line Item Budget:

Startup costs/Development

Birth Compass team	$60-80k of tech development
-	$40k of program support
-	$10k of licensing, setting up website, graphic
	$100,000

Ongoing costs	**Per month**	**12 months**	**18 months**	**24 months**
Coordinator/ Client Survey (50% FTE)	$3,000	$36,000	$54,000	$72,000
Medical director (consult)	$3,600	$43,200	$64,800	$86,400
IBCLC personnel (consult)	-	$64,128	$96,192	$128,256
Quality Assurance specialist / IBCLC training (consult)	$3,000	$36,000	$54,000	$72,000
Tech platform support	$2,500	$30,000	$45,000	$60,000
Liability insurance	annual ~$10,000	$10,000	$20,000	$20,000
Quarterly operational reports	Part of the platform	-	-	-
On-demand phone interpretation	Per call as needed	$3,500	$5,250	$7,000
		$222,828	**$339,242**	**$445,656**

Notes: IBCLCs $32-36/hr

Tech support and ongoing tech hosting/licensing fees
If needed
Generated by the tech platform without additional cost
Language Line Services, per minute fee for languages other than Spanish (see note on Staffing Costs page about bilingual Spanish/English IBCLCs)

Breastfeeding Hotline Staffing Costs:

Table 1.Retainer staffing cost to have providers be on call for 24/7 coverage

Total hours of coverage per month (24/7 access)	Provider hourly rate for on-call availability: hourly rate	Fixed cost for on-call coverage per month	Fixed cost for on-call coverage per year per provider	Number of providers on call	Total fixed cost for on-call coverage
672	$2	$1,344	$16,128	1	$16,128

Table 2.Variable staffing costs based on population size and call volume

Avg calls/client	# calls/month	Provider hours per call	Provider hourly rate for calls	Call Cost /visit	Call cost /month	Call cost/ year	**Total annual cost**	Total hours per month for active calls	FTE providers
1	400	0.25	$32	$8	$3,200	$38,400	**$54,528**	100	0.600
1	500	0.25	$32	$8	$4,000	$48,000	**$64,128**	125	0.750
1	600	0.25	$32	$8	$4,800	$57,600	**$73,728**	150	0.900

Table 3. Call volume estimates based on population size

Calls/birth/year*	NC births/ year**	NC births/year**	**Calls/month**
0.06	118725	9,893.75	**615**
0.05	118725	9,893.75	**492**

***Assuming a similar rate of calls per birthing person to Tennessee's Breastfeeding Hotline (4000-5000 calls/year with annual births ~ 80500)**

****March of Dimes data**

TN

Calls/year	**Calls/month**	**# Births annually***	**# Births/month***	**Rate of calls/birth/month**
5000	417	80450	6,704.17	0.06
4000	333			0.05

Note: Every effort will be made to hire/retain bilingual (Spanish/English) IBCLCs

Reach Out and Read Line Item Budget:

Table 1: HSI Implementation in Three Phases

	Phase 1 (July 2020- September 2020)	**Phase 2 (October 2020 – September 2021)**	**Phase 3 (October 2021 – September 2022)**	**Notes**
Expansion	New clinics identified in 5 counties	Clinic identification in other 7 counties and applications submitted	Expansion in underserved counties in NC, working towards scale	

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~~**Back to Birth**~~	~~Plan phase 1 of expansion~~	~~Roll out in 25% of clinics, identified for readiness~~	~~Roll out in 25% of clinics, as identified for readiness~~	~~This project will take 3-5 years to scale in NC~~
~~**Quality/Implementation**~~	~~Continued TA and quality focus in all RORC sites in NC~~	~~Continued TA and quality focus in all RORC sites in NC~~	~~Continued TA and quality focus in all RORC sites in NC~~	~~This work in ongoing~~
~~**Medical Engagement and Training**~~	~~Needs assessment for continued learning content and research tools~~	~~Implementation of needs assessment data to create new learning channels and evaluation tools, including well-visit compliance research~~	~~Implementation of needs assessment data to create new learning channels and evaluation tools, including well-visit compliance research~~	~~This work will build and be ongoing to support engaged providers across the network.~~

Breastfeeding Hotline Line Item Budget:

Ongoing Costs

	Per month	12 months
Hotline Coordinator (1.0 FTE) (a)	$10,235	$122,825
IBCLC personnel (4 x 1.0 FTE) (b)	$37,457	$449,484
Tech platform support (c)	$5,000	$60,000
Liability Insurance (d)		$1,125
On-demand phone interpretation (e)	Per call as needed	$10,000
Call & text support services (f)	$5,000	$60,000
Total annual cost		**$703,434**

In the original document (NC-23-0017), there is no description of the following positions or where the compensation estimates came from (p12-16): Coordinator/Client Survey (0.50 FTE); Medical Director (consult); Quality Assurance Specialist/IBCLC Training.

(a) The Hotline Coordinator (1.00 FTE) would be a position held by an International Board Certified Lactation Consultant (IBCLC) in a supervisory role; duties would include general program coordinator, liaison with the State, client survey coordinator, quality assurance specialist, operator (IBCLC and Certified Lactation Counselor (CLC)) coordinator (train, schedule, manager, etc).

(b) IBCLC personnel: in the original document, this is shown as $64,128 annually, which refers to a

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0.75 FTE IBCLC hotline operator who is paid only for active time and who also provides on-call coverage (Table 2) and appears to be the only funding budgeted for hotline staffing. A 24/7 hotline would require a bare minimum of one operator and one on-call operator per shift, who could theoretically cover for each other, but this would not be logistically feasible. We are budgeting for 4 x 1.0 FTE IBCLC/CLC positions, which would likely be divided into part-time positions.

(c) Tech platform support – this is an estimate

(d) Liability insurance – IBCLCs pay ~$150-300 annually for individual coverage, and cost depends on how much coverage is desired and if the provider has other credentials (like LCSW or doula, etc). We are budgeting for five IBCLCs at $225 each, totaling $1,125 annually.

(e) Interpreter services: in the original document, $3,500/annually was budgeted for interpreter services, but it is unclear how this was determined and I strongly suspect this will not be sufficient. Using 2024 data, the total population of NC is estimated to be 11,046,024 with 5.6% under the age of 5 = 10,427,447 are over age 5. Per 2020-2024 census data, 13.5% of NC residents over age 5 speak a language other than English. 13.5% of 10,247,447 = 1,407,705 NC residents over age 5 speak a language other than English, and 64% of those residents speak Spanish. The intention is to hire a Spanish-speaking IBCLC and utilize language services only for languages other than Spanish. 36% of 1,407,705 = 506,774 NC residents over age 5 that speak a language other than English or Spanish. 506,774 is ~5% of 10,247,447. Let's say 5% of calls require interpreter services. Based on Table 3, our average monthly call volume is expected to be ~563. 5% of 563 = 28 calls. Table 2 estimates that each call will last 15 minutes. 28 calls x 15 minutes each = 420 minutes monthly at $3.95/minute for interpreter services = $1,695/month x 12 months = $19,908 annually. This does not take into account that a vendor contracted with an interpreter service may pay a lower per-minute rate than what is advertised by Language Line Solutions' on-demand service. If we estimate the actual per-minute cost is 50% less with a service contract, the monthly cost would be $2 x 420 minutes = $840/month or $840 x 12 months = $10,080/year (this figure is included in the budget). Even at $1/minute, the annual cost would be $5,040. See simplified table below.

Calculating annual cost of phone-based interpreter services

2024 Population of NC total	11,046,024
2024 Population of NC over age 5 (5.6%)	10,427,447
2024 Population of NC over age 5 who speak a language other than English (13.5%)	1,407,705
2024 Population of NC over age 5 who speak a language other than English or Spanish (36%)	506,774
Percentage of total population over age 5 who speak a language other than English or Spanish	~5%
Average estimated monthly hotline call volume (Table 3)	563 calls

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Estimated number of calls monthly requiring interpreter services for language other than Spanish (5%)	28 calls
Estimated hotline call length	15 minutes
Estimated number of minutes needed for interpreter services monthly	420 minutes
Cost per minute using Language Line Solutions	$3.95
Estimated discounted cost per minute with an interpreter services contract	$2.00
Estimated monthly cost of interpreter services ($4/min vs $2/min)	$1,695 / $840
Estimated yearly cost of interpreter services ($4/min vs $2/min)	$19,908 / $10,080

This does not take into account the fact that calls/conversations made using an interpreter require more time.

(f) Call and text handling cost is based on the Tier 2 call and Tier 2 text support services cost outlined in vendor proposals. We are unsure if this expense is part of their operating system or call/text platform budget and/or part of operator compensation, so this may be above and beyond what is needed.

SUD Parenting Health Service Initiative Line Item Budget:

Budget Categories	TOTAL
Human Resources	
Mental Health consultant 75%	
Admin support 25% 8 hours per week	
Total Human Resources	**$ 100,000**
Other (includes Office Supplies) - Technology and Supplies	$ 1,500
Total Supplies and Materials	**$ 1,500**
Travel	$ 9,000
Food	$ 2,220
Total Travel	**$ 11,220**
Rent	
Office Space	$ 1,000
Total Rent	**$ 1,000**
Total Operational Expenses\Capital Outlays	**$ 13,720**

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Subcontracting and Grants (provide breakdown on Subcontracting sheet)	$ 31,500
Sub Total	**$ 145,220**
Total Budgeted Expenditures	**$ 145,220**

Total Budgeted Expenditures (Year 1): $ 145,220.00

#NAME?	TOTAL
Human Resources	
Mental Health consultant 75%	
Admin support 25% 8 hours per week	
HR/Other	
Total Human Resources	**$ 100,000**
Supplies and Materials	
Furniture	
Other (includes Office Supplies)	$ 200
Total Supplies and Materials	**$ 200**
Travel	
Grantee Staff Travel	$ 500
Board Member Travel	
Total Travel	**$ 500**
Total Operational Expenses\Capital Outlays	**$ 700**
Subcontracting and Grants (provide breakdown on Subcontracting sheet)	$ -
Sub Total	**$ 100,700**
Total Budgeted Expenditures	**$ 100,700**

Total Health Service Projected Budget (Year 2): $100,700
Total Budget for 2 years: $245,920

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TABLE 2: Proposed Budget for Each Phase of the HSI Implementation

Reach Out and Read North Carolinas HSI Project			
-	***Phase 1***	***Phase 2***	***Phase 3***
-	***July 2020 September 30, 20202***	***October 2020* September 2021***	***October 2021 September 2022***
EXPENSES	-	-	-
Leadership Support (non-programs related expenses)	$ 25,000.00	75,000	75,000
Staff and Board Professional Development and Convening	-	-	-
Accounting/HR expenses	-	-	-
-	-	-	-
Programmatic Costs	-	-	-
Communications	$ 500.00	5,000	5,000
Books	$ 300,000.00	650,000	800,000
Medical Engagement and Training	$ 5,000.00	25,000	25,000
Program technical assistance and outreach	$ 50,000.00	250,000	250,000
Program Materials	$ 500.00	1000	1000
Evaluation and Research	$ —	20,000	20,000
Expansion	$ —	50,000	65,000
Back to Birth	$ 15,000.00	150,000	150,000
-	-	-	-
Total Expenses:	$ 396,000.00	1,226,000	1,391,000
Non-Federal match	$ 28,670.40	$ 266,471.10	$ 319,930.00
Federal Share	$ 367,329.60	$ 959,528.90	$ 1,073,573.80

*Assumes increased FMAP from FFCRA through CY 2020.

1. Programmatic Materials refer to outreach materials or collateral materials, such as bookmarks, posters, and flyers.

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2. Leadership Support refers to strategic activities that further the HSI program goals but occur prior to program implementation. This work would include, for example, staff time associated with establishing cross-system opportunities to boost early literacy through pediatric primary care. Examples of such activities could include staff time, materials, and training costs associated with educating providers on services provided by local libraries and forming connections between beneficiaries and local libraries.

Figure 1: CHIP HSI Quality Measures:
The Reach Out and Read Program assesses a list of 14 quality standards for each clinic site:

1. Medical providers complete the Reach Out and Read online CME training course.
2. Site implements the Reach Out and Read model with fidelity during appropriate well-child visits, giving the book early in the visit along with age-appropriate guidance about incorporating reading into daily routines.
3. New providers who join the practice complete the Reach Out and Read provider training, as indicated on my ROR, within 3 months.
4. The ROR Medical Consultant actively champions Reach Out and Read in the clinic and helps keep providers engaged.
5. Books are prescribed during at least 85% of Reach Out and Read well-child visits.
6. Books are easily accessible, and there is a defined, efficient system for ensuring that books consistently get to the exam rooms and into the hands of children.
7. High-quality, age, language, and culturally appropriate books are readily available for Reach Out and Read visits.
8. Site utilizes an effective tracking system for books prescribed during Reach Out and Read visits.
9. Site consistently submits Progress Reports on time, and with accurate data about well-child visits, books distributed, and patient demographics.
10. A sustainability plan to ensure ongoing Reach Out and Read book funding is in place.
11. Site has an active, engaged program coordinator who is responsive and communicative with Reach Out and Read staff.
12. Clinic leadership is engaged and supportive of ROR and fidelity to the program model.
13. Site takes advantage of feasible opportunities to include a literacy-rich environment in the waiting room and/or exam rooms to further promote reading. This can include pieces like a bookshelf with gently used books, literacy themed posters or artwork, resource materials, and story times with volunteer readers.
14. Site provide information about community resources, such as local libraries, museums, adult reading programs, PreK, early childhood education initiatives, or other community resources to help connect families with opportunities and services.

NC Medicaid plans to look at key child health indicators that align with NC Medicaid's Quality Strategy and CMS' Medicaid and CHIP Child Core Measure Set in practices that offer Reach Out and Read, and practices that do not. Metrics to be measured include:

1. Well-child visits (Phase 1-3),
2. Pediatric immunization rates (Phase 3), and
3. Depression screenings (Phase 3).

Section 10. Annual Reports and Evaluations

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Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed 7745framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at http://www.nashp.org. Per the title XXI statute at Section 2108(a), states must submit reports by January 1st to be compliant with requirements.

10.1. **Annual Reports.** The State assures that it will assess the operation of the State plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. ☒ The progress made in reducing the number of uninsured low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The State assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. ☒ The State assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting

10.3-DC ☒ The State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

Section 11. Program Integrity (Section 2101(a))

☒ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue to Section 12.

11.1. ☐ The State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) (The items below were moved from section 9.8. Previously 9.8.6. - 9.8.9.)

11.2.1. ☐ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and

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fiscal agents)

11.2.2. ☐ Section 1124 (relating to disclosure of ownership and related information)

11.2.3. ☐ Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4. ☐ Section 1128A (relating to civil monetary penalties)

11.2.5. ☐ Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. ☐ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

☒ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan.

12.1. **Eligibility and Enrollment Matters-** Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.

Guidance: "Health services matters" refers to grievances relating to the provision of health care.

12.2. **Health Services Matters-** Describe the review process for health services matters that complies with 42 CFR 457.1120.

12.3. **Premium Assistance Programs-** If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, describe how the State will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

North Carolina does not implement a Premium Assistance Program

Key for Newly Incorporated Templates

The newly incorporated templates are indicated with the following letters after the numerical section throughout the template.

- PC- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- PW- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- TC- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- DC- Dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- DS- Supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- PA- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- EL- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- LR- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)

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CMS Regional Offices				
CMS Regional Offices	**States**		**Associate Regional Administrator**	**Regional Office Address**
Region 1-Boston	Connecticut Massachusetts Maine	New Hampshire Rhode Island Vermont	Richard R. McGreal richard.mcgreal@cms.hhs.gov	John F. Kennedy Federal Bldg. Room 2275 Boston, MA 02203-0003
Region 2-New York	New York Virgin Islands	New Jersey Puerto Rico	Michael Melendez michael.melendez@cms.hhs.gov	26 Federal Plaza Room 3811 New York, NY 10278-0063
Region 3-Philadelphia	Delaware District of Columbia Maryland	Pennsylvania Virginia West Virginia	Ted Gallagher ted.gallagher@cms.hhs.gov	The Public Ledger Building 150 South Independence Mall West Suite 216 Philadelphia, PA 19106
Region 4-Atlanta	Alabama Florida Georgia Kentucky	Mississippi North Carolina South Carolina Tennessee	Jackie Glaze jackie.glaze@cms.hhs.gov	Atlanta Federal Center 4th Floor 61 Forsyth Street, S.W. Suite 4T20 Atlanta, GA 30303-8909
Region 5-Chicago	Illinois Indiana Michigan	Minnesota Ohio Wisconsin	Verlon Johnson verlon.johnson@cms.hhs.gov	233 North Michigan Avenue, Suite 600 Chicago, IL 60601
Region 6-Dallas	Arkansas Louisiana New Mexico	Oklahoma Texas	Bill Brooks bill.brooks@cms.hhs.gov	1301 Young Street, 8th Floor Dallas, TX 75202
Region 7-Kansas City	Iowa Kansas	Missouri Nebraska	James G. Scott james.scott1@cms.hhs.gov	Richard Bulling Federal Bldg. 601 East 12 Street, Room 235 Kansas City, MO 64106-2808
Region 8-Denver	Colorado Montana North Dakota	South Dakota Utah Wyoming	Richard Allen richard.allen@cms.hhs.gov	Federal Office Building, Room 522 1961 Stout Street Denver, CO 80294-3538
Region 9-San Francisco	Arizona California Hawaii Nevada	American Samoa Guam Northern Mariana Islands	Gloria Nagle gloria.nagle@cms.hhs.gov	90 Seventh Street Suite 5-300 San Francisco Federal Building San Francisco, CA 94103
Region 10-Seattle	Idaho Washington	Alaska Oregon	Carol Peverly carol.peverly@cms.hhs.gov	2001 Sixth Avenue MS RX-43 Seattle, WA 98121

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GLOSSARY

Adapted directly from Sec. 2110. DEFINITIONS.

CHILD HEALTH ASSISTANCE- For purposes of this title, the term 'child health assistance' means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in Section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

1. Inpatient hospital services.
2. Outpatient hospital services.
3. Physician services.
4. Surgical services.
5. Clinic services (including health center services) and other ambulatory health care services.
6. Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
7. Over-the-counter medications.
8. Laboratory and radiological services.
9. Prenatal care and prepregnancy family planning services and supplies.
10. Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
11. Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.
12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).
13. Disposable medical supplies.
14. Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).
15. Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.
16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
17. Dental services.
18. Inpatient substance abuse treatment services and residential substance abuse treatment services.
19. Outpatient substance abuse treatment services.
20. Case management services.
21. Care coordination services.
22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

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23. Hospice care.
24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--
    a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
    b. performed under the general supervision or at the direction of a physician, or
    c. furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.
25. Premiums for private health care insurance coverage.
26. Medical transportation.
27. Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
28. Any other health care services or items specified by the Secretary and not excluded under this section.

TARGETED LOW-INCOME CHILD DEFINED- For purposes of this title--

1. IN GENERAL- Subject to paragraph (2), the term ‘targeted low-income child’ means a child--
    a. who has been determined eligible by the State for child health assistance under the State plan;
    b. (i) who is a low-income child, or
    (ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
    c. who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in Section 2791 of the Public Health Service Act).
2. CHILDREN EXCLUDED- Such term does not include--
    a. a child who is a resident of a public institution or a patient in an institution for mental diseases; or
    b. a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.
3. SPECIAL RULE- A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.
4. MEDICAID APPLICABLE INCOME LEVEL- The term ‘Medicaid applicable income level’ means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under Section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical

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assistance under Section 1902(l)(2) for the age of such child.

5. TARGETED LOW-INCOME PREGNANT WOMAN.—The term 'targeted low-income pregnant woman' means an individual— (A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends; (B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and (C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of Section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

ADDITIONAL DEFINITIONS- For purposes of this title:

1. CHILD- The term 'child' means an individual under 19 years of age.
2. CREDITABLE HEALTH COVERAGE- The term 'creditable health coverage' has the meaning given the term 'creditable coverage' under Section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).
3. GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC- The terms 'group health plan', 'group health insurance coverage', and 'health insurance coverage' have the meanings given such terms in Section 2191 of the Public Health Service Act.
4. LOW-INCOME CHILD - The term 'low-income child' means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.
5. POVERTY LINE DEFINED- The term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.
6. PREEXISTING CONDITION EXCLUSION- The term 'preexisting condition exclusion' has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).
7. STATE CHILD HEALTH PLAN; PLAN- Unless the context otherwise requires, the terms 'State child health plan' and 'plan' mean a State child health plan approved under Section 2106.
8. UNINSURED CHILD- The term 'uninsured child' means a child that does not have creditable health coverage.

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