DEPARTMENT OF HEALTH CARE SERVICES

MEDI-CAL COVID-19 PUBLIC HEALTH EMERGENCY AND CONTINUOUS COVERAGE OPERATIONAL UNWINDING PLAN

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DEPARTMENT OF
HEALTH CARE SERVICES

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Background and Overview

Since the initiation of the of the federal declaration of the COVID-19 Public Health Emergency (PHE), the Department of Health Care Services (DHCS) implemented over 100 programmatic flexibilities to help minimize the strain to the Medicaid (Medi-Cal in California) program and its beneficiaries, and California's (CA) health care providers and systems. These changes were implemented under a variety of federal and State authorities, and impact almost all aspects of Medi-Cal's delivery systems. While many of these programmatic flexibilities will terminate on or around the end of the PHE, some will continue due to the positive impact they have left on the Medi-Cal program. **In preparation for the end of the federal PHE declaration, and the continuous coverage requirements that were delinked from the PHE in the Consolidated Appropriations Act of 2023 (enacted December 29, 2022), DHCS developed this Unwinding Operational Plan to help inform Medi-Cal beneficiaries, providers, managed care plans, counties, and other valued stakeholders, of the changes to expect. The PHE was renewed on January 11, 2023, and is anticipated to continue at least until April 11, 2023.** The U.S. Department of Health and Human Services (HHS) has committed to providing at least a 60-day notice prior to the official end date. **Due to the ongoing progress DHCS continues to make to return to normal operations, this document will be updated on a frequent basis, with significant changes identified by bold blue font (e.g., PHE policies that have recently been formally extended through SPA authority).**

Most of the flexibilities implemented in Medi-Cal during the PHE were authorized through federal pathways in partnership with the Centers for Medicare and Medicaid Services (CMS). Examples of these pathways include the Disaster Relief State Plan Amendment (DR SPA), Disaster 1135 Waiver Authority (1135), section 1115 demonstration authority, and the Appendix K process for 1915(c) Home and Community-Based Services (HCBS) waivers. Each federal authority differs in terms of the applicable policy, approval process, and unwinding requirements, resulting in important implications for DHCS' approach to unwinding. These differences influence the Department's ability and timeline to make permanent changes to the Medi-Cal program, or revert back to policies in place before the PHE. The requests for federal flexibilities submitted by DHCS, and approvals granted by CMS, are available on the DHCS website located here.

In addition to these federal authority pathways, significant changes to Medicaid programs were authorized through federal legislation. The Families First Coronavirus Response Act (FFCRA), for instance, authorized enhanced federal funding for Medicaid programs conditioned upon Maintenance of Eligibility (MOE) requirements that prohibit disenrollment in most circumstances. This requirement is commonly referred to and throughout this document as the continuous coverage requirements under the FFCRA. It also authorized Medicaid coverage for an optional Medicaid coverage group specific for the receipt of COVID-19 testing and testing-related services, known in California as the COVID-19 Uninsured Group. Further, the American Rescue Plan Act (ARP) extended coverage of COVID-19

vaccines and treatment services to limited benefit populations at no cost to states, and also provided an enhanced funding opportunity for State Medicaid programs to spend on increasing access to HCBS. As with the flexibilities granted by CMS through the DR SPA and waiver pathways, the FFCRA and ARP also influenced DHCS' unwinding plan.

On December 29, 2022, Consolidated Appropriations Act of 2023 was enacted. The Consolidated Appropriations Act of 2023 included various Medicaid and Children Health Insurance Program (CHIP) provisions, including significant changes to the continuous coverage requirement, which would no longer be linked to the COVID-19 PHE as of April 1, 2023. In effect, the continuous coverage requirements will end on March 31, 2023 and the unwinding of the continuous coverage requirement will begin as of April 1, 2023. The Consolidated Appropriations Act also decouples enhanced Federal Medical Assistance Percentage (FMAP) from the PHE end date, reducing from 6.2% down in quarterly increments to normal levels at the beginning of 2024. Additionally, the act requires redeterminations to be conducted in accordance with all applicable federal requirements, with new additional conditions including using certain specified sources to maintain up-to-date contact information, and requires states to make good faith efforts to contact beneficiaries through multiple modalities prior to disenrollment on the basis of returned mail. The act also establishes new monthly data reporting requirements, which will be made publicly available, including elements such as: counts of redeterminations initiated, total renewals, number of ex parte renewals, terminations, number of procedural terminations, number of CHIP enrollments, Exchange metrics, and call center metrics. Non-compliance with these reporting requirements could result in Federal Medical Assistance Percentage (FMAP) penalties. Lastly, the Consolidated Appropriations Act of 2023 grants HHS additional corrective action plan enforcement authority over non-compliance with redetermination rules which could result in civil monetary penalties. Additional information on the Medicaid provisions of the Consolidated Appropriations Act of 2023 can be found in January 5, 2023 CMCS Informational Bulletin.

One of the Department's top priorities is to maximize continuity of coverage for Medi-Cal beneficiaries throughout the unwinding of the FFCRA continuous coverage requirement. Due to the critical nature of these activities, the Department has developed a detailed Unwinding Operational Plan, specific to the resumption of normal eligibility operations, described in greater detail in Part II of this document. The following sections are intended to provide a comprehensive view of the Department's plan to unwind the flexibilities implemented over the course of the PHE, including programmatic changes in many of Medi-Cal's delivery systems (Part I), and the resumption of normal Medi-Cal eligibility operations (Part II). The topics covered in Part I include future changes to telehealth, Medi-Cal benefit and reimbursement rates, behavioral health delivery systems, Home and Community Based Services, provider enrollment, and state fair hearings. Part II of this document describes the Department's plan to resume normal eligibility operations, including, but not limited to, DHCS' guiding principles, anticipated losses in coverage, and federal flexibilities specific to eligibility processes.

Medi-Cal's Global Unwinding Approach

To support States through this challenging transition, CMS issued a robust set of guidance to Medicaid programs, providing details and requirements for unwinding each type of federal flexibility. CMS published three State Health Official (SHO) Letters specifically on the topic of unwinding federal flexibilities authorized during the PHE—SHO# 20-004, SHO# 21-002, and SHO# 22-001—in addition to tool kits, presentation slide decks, and other materials. **CMS also published an Informational Bulletin on January 5, 2023 outlining the new requirements authorized in the Consolidated Appropriations Act of 2023.** CMS also hosted numerous all-state webinars, and made themselves available for individual technical assistance calls. Because of the significant impact it will have on the Medi-Cal program, DHCS has taken every opportunity to partner with CMS on the unwinding efforts. The latest guidance for unwinding the PHE can be found on CMS' website located here and in the Resources Section of this document.

SHO# 20-004, released on December 22, 2020, contains the majority of guidance related to unwinding Medicaid flexibilities through the Disaster Relief SPA, 1135, 1115, and Appendix K processes. The Department is following this guidance closely in order to ensure compliance with all applicable requirements. This SHO letter provides details regarding timeframes associated with each authority, and the requirements that must be followed when they expire, or if states choose to make eligible flexibilities permanent. Appendix B of SHO# 20-004 describes the specific circumstances in which the expiration of an 1135 flexibility requires advanced notice to affected beneficiaries. This letter also allows for streamlining beneficiary notices by issuing a combined notice for all changes that will occur at the end of the PHE. In addition to individual beneficiary notices, DHCS may leverage the *Jackson vs. Rank* (JvR) quarterly mailing process for the purposes of broad information sharing, as part of the unwinding process. These mailings are sent to each Medi-Cal beneficiary head of household reminding them of their rights and responsibilities. DHCS leverages these mailings to also include important information on major changes happening in the program and will similarly do as such for the unwinding activities, where appropriate. However, DHCS anticipates some beneficiary notices will need to be specifically targeted to only a subset of the Medi-Cal population and, therefore, will send "stand-alone" mailings to the extent warranted. Ultimately, the Department understands that excessive mailings can lose their effectiveness, and will work with stakeholders to find the right balance. The Department will ensure that JvR mailings, individual notices and any information included will be made accessible in the format or language that the beneficiary has selected.

It is important to keep in mind that, while Medi-Cal flexibilities were authorized in the form of DR SPAs and federal waiver approvals, DHCS often implemented these changes through policy letters, provider bulletins, and other forms of sub-regulatory guidance. As the Department unwinds the temporary flexibilities of the PHE, we will publish, revise, and/or rescind guidance to ensure that Medi-Cal beneficiaries, managed care plans (health, dental, and behavioral health), counties, providers, and stakeholders all understand the applicable Medi-Cal policies and procedures that are in effect, as appropriate. All DHCS policy guidance specific to the PHE can be

found on the Department's [COVID-19 Response webpage]. Further, the Department will utilize its existing stakeholder groups and forums to share unwinding information as it becomes available. As necessary, DHCS will also host new stakeholder events to discuss the unwinding process when existing forums are not sufficient.

Part I: Unwinding Medi-Cal Program Flexibilities

In addition to the significant effort to prepare for resumption of normal eligibility operations described in Part II of this document, there are many programmatic flexibilities that DHCS, Medi-Cal managed care plans (MCPs), counties, providers, and other partners and stakeholders must now take action to unwind. This section provides further detail on these specific flexibilities, including those that DHCS has already made permanent, seeks to make permanent, or will let expire at the end of the PHE.

Telehealth

While Medi-Cal had an existing expansive telehealth policy given the changes implemented in 2019, as a result of the COVID-19 PHE, DHCS implemented additional broad flexibilities relative to telehealth modalities via blanket waivers and DR SPAs. This enabled Medi-Cal's health care delivery systems to meet the health care needs of our beneficiaries in an environment where in-person encounters were not recommended and, at times, not available. The broad temporary telehealth flexibilities implemented during the PHE impacted many of Medi-Cal's delivery systems through the following policy changes:

- Expanding the ability for providers to render all applicable Medi-Cal services that can be appropriately provided via telehealth modalities including those historically not identified or regularly provided via telehealth, such as home and community-based services, Local Education Agency Billing Option Program (LEA BOP) and the Targeted Case Management Program (TCM) services.
- Allowing most telehealth modalities to be provided for new and established patients.
- Allowing many covered services to be provided via audio-only for the first time.
- Allowing payment parity between services provided in-person face-to-face, by video, and by audio-only when the services met the requirements of the billing codes by various provider types, including Federally Qualified Health Centers (FQHCs)/Rural Health Centers (RHCs), Tribal FQHCs, and Indian Health Services-Memorandum of Agreement providers in both fee-for-service (FFS) and managed care; and also Drug Medi-Cal, Drug Medi-Cal Organized Delivery System, and Specialty Mental Health Services providers consistent with [guidance] describing the use of billing code modifiers for services delivered via telehealth modalities.
- Waiving site limitations for both providers and patients for FQHC/RHCs, which allows providers and/or beneficiaries to be in locations outside of the clinic to render and/or receive care, respectively.
- Allowing for expanded access to telehealth through non-public technology platforms.

As DHCS looks to the future, the Department will continue many of the PHE polices that allow Medi-Cal covered benefits and services to be provided via telehealth across delivery systems when clinically appropriate. Pursuant to Section 380 of Assembly Bill 133 (AB 133) (Committee on Budget, Chapter 143, Statutes of 2021), DHCS convened a Telehealth Advisory Workgroup for the purposes of informing the fiscal year 2022–23 Governor's Budget and the development of post-PHE telehealth policies. Information regarding the workgroup report and deliberations from each workgroup session can be found on DHCS's Telehealth Advisory Workgroup Webpage.

DHCS's **updated** telehealth policies were guided by the following principles, which were also updated to reflect Advisory Workgroup input: equitable access to providers and addressing inequities and disparities; leveraging telehealth modalities as a means to expand access to care; quality and culturally responsive standards of care; patient choice in their service delivery model; protecting patient confidentiality; responsible stewardship of public resources; and payment appropriateness for services provided via telehealth modalities.

DHCS's final Medi-Cal telehealth policies are reflected in the December 2022 Telehealth Policy Paper, which describes each major telehealth policy area, the state during the PHE, and the approach after January 1, 2023 (the official effective date of our State Plan Amendments), and the policy rationale. DHCS has also published a Telehealth Research and Evaluation Plan, which describes DHCS's efforts to monitor the use and impact of telehealth in Medi-Cal in the coming years.

Medi-Cal Benefit and Reimbursement Rate Changes

DHCS implemented several changes to Medi-Cal benefits policy over the course of the PHE. Many of these changes were related to expanding coverage for COVID-19 testing, testing-related, treatment services, and vaccine administration. However, additional changes were implemented to allow flexibilities in Medi-Cal prescribing policy, prior authorization policy, and pharmacy benefits. These flexibilities were implemented through federal authority pathways including DR SPA, 1135 waiver, section 1115 demonstration, and Medicare Blanket Waivers, with other flexibilities coming in the form of now-expired CA Executive Orders (EOs).

- ***Testing, treatment, and vaccine coverage - Continuing:*** Under the ARP, Medi-Cal will continue to cover COVID-19 testing, and vaccines and their administration, without cost-sharing, for nearly all Medicaid beneficiaries, including most groups receiving limited-benefit packages under the state plan or a section 1115 demonstration. The ARP also requires Medicaid coverage without cost sharing for COVID-19-related treatment, and treatment for conditions that may seriously complicate the treatment of COVID-19. This coverage period generally continues through end of the first calendar quarter that starts one year after the end of the PHE. These coverage policies also apply to the COVID-19 Uninsured Group, however, only through the end of the PHE

for this specific population[1]. For the remaining Medi-Cal populations who are not coverable under the ARP coverage period, Medi-Cal will cover these COVID-19 services with state funds.

DHCS also received approval under section 1115 demonstration authority to carve out coverage of COVID-19 testing in school settings, and COVID-19 vaccine administration, from Medi-Cal's managed care delivery system, with reimbursement limited exclusively to Medi-Cal Fee-for-Service (FFS). DHCS intends to continue this policy in perpetuity. **In addition, as part of SPA 22-0004, effective January 1, 2023 through the end of the ARP coverage period, DHCS is extending the policy initially authorized under SPA 20-0040,** which allows pharmacies to be qualified providers of COVID-19 vaccinations, and permits pharmacy technicians and pharmacy interns to administer the vaccine when supervised by an immunizing pharmacist, when the COVID-19 vaccine becomes recommended by Advisory Committee on Immunization Practices (ACIP).

DHCS is requesting approval for a number of other COVID-19 coverage policies under the ARP through SPA 22-0004, which will also be extended effective January 1, 2023 through the end of the ARP coverage period, upon approval by CMS. This SPA adds COVID-19 and pediatric vaccine counseling-only visits for children under 21 years of age as an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, and adults when covered within the scope of practice of the provider. Additionally, this SPA would authorize reimbursement of COVID-19 testing as a pharmacy service for pharmacies that possess a Clinical Laboratory Improvement Amendment (CLIA) Waiver. SPA 22-0004 also requests coverage for home COVID-19 test kits without cost sharing for all Medicaid/CHIP coverage groups effective retroactively to March 11, 2021, acknowledging that these currently can be billed and reimbursed as a pharmacy medical supply benefit through Medi-Cal Rx since February 1, 2022.

- ***Federally Qualified Health Clinics (FQHCs), Tribal FQHCs, Rural Health Clinics (RHCs), and Indian Health Services-Memorandum of Agreement Clinics (IHS/MOAs) - Continuing:*** Due to increased costs associated with administration of COVID-19 vaccine administration, DHCS intends to extend beyond the PHE the flexibility authorized in SPA 21-0020 which allows for reimbursement to FQHC, Tribal FQHC, and RHC providers a supplemental amount of $67.00 for COVID-19 vaccine only visits. This alternative payment methodology (APM) is in addition to reimbursement above the applicable Prospective Payment Systems (PPS)/APM approved in the State Plan. This additional reimbursement is necessary to account for the significant increase in vaccine only visits and costs due to COVID-19 vaccine administration that were not considered in the PPS calculation. **Effective January 1, 2023, SPA 22-0067 makes permanent reimbursement for COVID-19 vaccine administration provided by an**

[1] RE: Mandatory Medicaid and CHIP Coverage of COVID-19- Related Treatment under the American Rescue Plan Act of 2021: https://www.medicaid.gov/federal-policy-guidance/downloads/sho102221.pdf

IHS/MOA clinic provider that would not otherwise have qualified for an All-Inclusive Rate. Reimbursement will be at 100% of the Medicare rate. Also effective January 1, 2023, SPA 22-0014 makes permanent the inclusion of services provided by Associate Clinical Social Workers (ACSWs) and Associate Marriage and Family Therapists (AMFT) in FQHCs, RHCs, and Tribal FQHCs, which was initially authorized in DR SPA 20-0024. However, the services rendered by these provider types must be billed by the supervising licensed professional. To the extent the clinic does not currently have the supervising licensed professional on staff who is a billable provider, the clinic would need a scope change to add the licensed professional as required by current policy.

- ***Additional PHE benefits policy DHCS intends to extend - Continuing:*** As part of SPA 20-0024, DHCS received approval from CMS to waive limitations on who can prescribe certain covered Medi-Cal benefits. These benefits included: non-emergency medical transportation; home health services such as Durable Medical Equipment (DME), medical supplies, and enteral nutrition services; physical, occupational, and speech therapies; and prosthetics. **DHCS does not intend to continue this policy for allowing all of the identified prescribers to continue to order the listed services included in this SPA, but has made permanent policies allowing select provider types to prescribe within their scope of practice for medical supplies (nurse practitioner, clinical nurse specialist, physician assistant) through SPA 20-0035, and physical therapy (physical therapists) through SPA 22-0044.** During the PHE, DHCS also received temporary approval to cover adult acetaminophen-containing cough and cold products under SPA 20-0024, but this has already been made permanent in Medi-Cal as part of AB 133.

- ***Medi-Cal reimbursement rates - Continuing:*** During the PHE, DHCS implemented several changes to Medi-Cal reimbursement rates under DR SPA authority. SPAs 20-0024, 20-0040, and 21-0016 authorized reimbursement rates to 100 percent of Medicare rates for clinical laboratory services, COVID-19 vaccine administration, and oxygen and respiratory DME, respectively. **The Department has made these increases to 100 percent of Medicare rates permanent through SPA 22-0053 (clinical laboratory services), SPA 22-0004 (vaccine administration through the end of the ARP period), and 22-0073 (respiratory DME).** Additionally, a 10% payment rate increase was authorized in SPA 20-0024 for certain long-term care facility types, including Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), ICF/DD Habilitative, ICF/DD Nursing, Freestanding Skilled Nursing Facilities (SNF) Level B, and Adult Freestanding Subacute Facilities Level B. **The Department is making these higher payment rates for ICF/DD facilities permanent through SPA 22-0061,** and will include any SNF rate increases within the SNF payment reform budget proposal. In the Targeted Case Management (TCM) program, prior to the PHE, DHCS required a physical paper invoice with original signatures to authorize payment of TCM services. During the PHE, DHCS

provided additional flexibility to Local Governmental Agencies (LGA) for temporary acceptance of electronic submission of invoices. Post-PHE, DHCS intends to continue this flexibility to accept electronic submission of invoices from LGAs permanently.

Expiring flexibilities: DHCS obtained several flexibilities associated with prior authorization requirements in the early stages of the PHE. However, as these were all approved under the federal 1135 waiver authority, they terminate with the end of the PHE and are not eligible to be extended. These flexibilities allowed for waivers of prior authorization pre-approval requirements under the State Plan, extended pre-existing authorizations through the end of the PHE, and allowed for services already authorized to continue without a new or renewed prior authorization. SPA 20-0024 also permitted a waiver of State Plan requirements that limit dispensing of a covered drug up to a 100-day supply without a Treatment Authorization Request (TAR) or Service Authorization Request (SAR). DHCS has decided not to pursue this policy beyond the end date of the PHE. The Medi-Cal State Plan allows the program to reimburse for up to 100 day supply without prior authorization; and, Title 22 California Code of Regulations 51313 (b) codifies the authority for Medi-Cal to reimburse quantities not to exceed a 100 calendar day supply. These standards of the program will not change. However, the federal drug review and utilization requirements of HR 6 -Section 1902 of the Social Security Act (42 U.S.C. 1396a), will resume and opioid products with quantity limitations less than 100-day supplies will once again require prior authorization to obtain larger quantities.

Some temporary prior authorization flexibilities were driven by pandemic exigencies that severely impacted California's hospitals. Due to major impediments in placing or repatriating patients having been hospitalized for severe COVID-19 infections, criteria were eased for acute administrative day (AAD) reimbursement in Medi-Cal fee-for-service (FFS). Similarly, as the pandemic limited facility access and availability of occupational, physical, and speech therapists (those central to provision of acute inpatient intensive rehabilitation or AIIR), the prior requirement for weekly hours of combined inpatient therapy was reduced in FFS. Lastly, medical necessity criteria in FFS for supplemental oxygen provision were temporarily made less stringent in order to facilitate expeditious yet safe hospital discharges, both benefitting patients in need of oxygen and helping hospitals maintain bed capacity under dire pandemic conditions. In all three circumstances (AAD, AIIR, oxygen), the flexibilities are retroactive to March 18, 2020 and will terminate (return to pre-PHE criteria) when the PHE ends.

As permitted by CMS, the Department implemented several Medicare blanket waivers in the Medi-Cal program, many which are not eligible to be extended beyond the PHE. **However, the Acute Hospital at Home Program was extended through December 31, 2024, as part of the $1.7 trillion omnibus spending bill that passed in December 2022.** This program was designed to allow patients who required an acute inpatient admission and at least daily rounding by a physician and medical team to be seen outside of a traditional hospital setting. Additional blanket waiver policies affected hospitalization requirements prior to a Skilled Nursing Facility (SNF) stay, bed limitations at Critical Access Hospitals (CAHs), and limitations regarding

relocating patients to specific hospital units, and allowable destinations for ambulance transports. Additional details regarding the Medicare blanket waivers implemented in Medi-Cal can be found here. Another flexibility obtained under 1135 authority temporarily allows facilities, including nursing facilities (NFs), intermediate care facilities for individuals with intellectual and developmental disabilities (ICF/IDDs), psychiatric residential treatment facilities (PRTFs), and hospital NFs, to be fully reimbursed for services rendered to an unlicensed facility under specific circumstances and conditions. Although this flexibility was initially expected to expire at the end of the PHE, CMS recently informed states that it would terminate on June 6, 2022.

Continuing Eligibility PHE Policies

SPA 20-0024 expanded Hospital Presumptive Eligibility (PE) to the aged (65 years of age and older), disabled, and blind population, and also expanded the PE period limitations for all coverage groups to two periods within a 12-month timeframe, with the exception of children who already have the ability to have two PE periods within a 12-month timeframe. **The Department is making permanent the aged, blind, and disabled coverage group effective January 1, 2023 as part of SPA 22-0055,** but does not intend to continue the allowance for two periods per year. **SPA 20-0024 also approved a waiver of premiums and cost-sharing for Medicaid and CHIP, and the Department has made this permanent through SPA 22-0042 and SPA 22-0045.** DHCS has already made permanent certain changes to eligibility policy for the Minor Consent program. Prior to the PHE, counties were instructed to only accept Minor Consent applications or renewals from minors in person. Medi-Cal Eligibility Division Information Letter (MEDIL) 2109, issued on June 24, 2021, now makes telephone applications a permanent policy of the Minor Consent program. Similarly, DHCS intends to make permanent remote enrollment of clients into the Family PACT program beyond the PHE.

Behavioral Health Delivery Systems

Over the course of the PHE, the Department implemented a wide array of temporary changes to Medi-Cal's behavioral health delivery systems through the same federal authorities that were leveraged for other programmatic flexibilities. The behavioral health flexibilities impacted service delivery across the Specialty Mental Health Services (SMHS) program, Drug Medi-Cal State Plan services, and Drug Medi-Cal Organized Delivery Systems (DMC-ODS). Many of the temporary policies adopted during the PHE will become permanent fixtures in Medi-Cal, either as part of the Telehealth Policy Proposal, or as part of the new CalAIM 1915(b) waiver and section 1115 demonstration.

- ***Drug Medi-Cal State Plan, DMC-ODS, and SMHS - Continuing:*** SPA 20-0024 temporarily modified the rehabilitative services benefit in the Drug Medi-Cal State Plan to expand individual counseling visits to focus on short-term personal, family, professional, educational, or other problems and their relationship to substance use, in addition to the currently allowable visits for the purpose of intake, crisis intervention, collateral services, and treatment and discharge planning. This SPA also authorized the use of telehealth for Drug Medi-Cal State Plan individual and group counseling services. These policies were made

permanent through the approval of SPA 20-0006-A on December 20, 2021. Temporary changes were authorized for the DMC-ODS delivery system through section 1115 demonstration authorities approved on July 27, 2020, and October 9, 2020. These flexibilities allowed residential treatment services to exceed existing stay and day limitations, and suspended minimal clinical service hour and disallowance requirements for intensive outpatient and residential SUD treatment. As part of the transition to the CalAIM 1915(b) waiver, the CalAIM section 1115 demonstration, the State Plan, and as implemented in DHCS guidance, these policies are now permanent as well. Paragraph 11 of CA Executive Order (EO) N-55-20, signed on April 20, 2020, suspended California Code of Regulations, Title 9, Section 852 which normally prevents a patient from receiving psychiatric medication without the patient's physical signature. Although this flexibility expired on September 30, 2021, as part of EO N-08-21, DHCS intends to pursue this as a permanent change to the Medi-Cal program through State legislative action.

- ***Narcotic Treatment Programs (NTPs) – Continuing:*** During the PHE, NTPs are not required to submit exceptions through the SAMHSA Opioid Treatment Program extranet website for take-home medication exceptions, blanket urinalysis exceptions, and blanket counseling exceptions related to COVID-19. NTPs must, however, submit a letter of need to DHCS for review and approval per licensed location. DHCS intends to continue this policy to allow blanket take-home medication exception requests beyond the PHE, to the extent consistent with SAMHSA extension of the federal methadone take-home flexibilities policy; however, DHCS does not intend to continue the policy for blanket urinalysis and counseling exception requests beyond the PHE. NTPs must submit a letter of need to DHCS for review and approval to align with SAMHSA's extension of the federal methadone take-home flexibilities when the end of the State PHE is declared.

- ***Expiring flexibilities:*** DR SPA 20-0024 also included temporary policy changes that will expire at the conclusion of the PHE. The Department does not intend to permanently waive the State Plan requirement for a face-to-face contact between a Medi-Cal beneficiary and treatment staff person at the facility on the day of service for Specialty Mental Health Service providers delivering Adult Residential Treatment Services and Crisis Residential Treatment Services. However, permanent changes in the use of telehealth modalities in these settings will be a component of DHCS' proposed telehealth policy. DHCS will also not extend the flexibility authorized in DR SPA 20-0025, which allows the provision of Drug Medi-Cal State Plan and DMC-ODS crisis stabilization services, crisis residential treatment services, adult residential treatment services, day treatment intensive services, day rehabilitative services, psychiatric health facility services and perinatal SUD services in locations recognized by the State as temporary extensions of qualified settings.

DHCS received approval in DR SPA 20-0024 for several temporary changes to behavioral health financing policies. These flexibilities adjusted reimbursement methodologies for the SMHS program, and Drug Medi-Cal non-Narcotic Treatment Program (non-NTP) services. CMS also authorized modifications to the rate-setting methodology of the DMC-ODS Certified Public Expenditure protocol in the July 27, 2020 section 1115 demonstration approval. These temporary financing policies will expire on their currently scheduled termination dates.

Home and Community Based Services (HCBS)

The pandemic emphasized the significant importance of HCBS, in part due to the heightened risk of COVID-19 transmission in institutional and congregate settings. In Medi-Cal's HCBS waiver programs, flexibilities were necessary in order to reduce unnecessary face-to face interactions, expand options for locations in which services could be provided, and support the providers who are essential to HCBS delivery systems. As such the Department implemented many changes through 1915(c) Appendix K amendments, DR SPAs, 1135 waivers, and section 1115 demonstration authorities. It is important to note that the flexibilities approved through the 1915(c) Appendix K and the 1115 Attachment K processes are currently set to expire six months after the end of the PHE.

- ***Assisted Living Waiver (ALW):*** DHCS intends to continue several programmatic changes authorized through the Appendix K process, beyond the current end date which is six months following the end of the PHE. The ALW Appendix K approved on April 2, 2020 authorized changes to service delivery methods, including telephonic assessments or video conferencing in lieu of face-to-face visits, and allowance for digital signatures. As part of the Department's larger Medi-Cal telehealth policy proposal, DHCS intends to make these temporary features of the ALW permanent.

  The April 2, 2020 Appendix K approval also included other provisions that DHCS does not intend to continue beyond the six-month period following the PHE. These flexibilities include the modification of incident reporting requirements, suspension of the 60-day enrollment period of impacted applicants, and the extension of the 31 through 60-day reenrollment period for waiver participants to retain their enrollment slot in the waiver. Other flexibilities set to expire in the ALW include the May 27, 2020 approval to not comply with HCBS settings requirements for visitation at any time, and allowance for case management entities to provide direct services. Additionally, the flexibility that pauses waiver enrollment policy in designated "hot spots" as approved on September 17, 2020 will expire following the end of the PHE.

- ***Community Based Adult Services (CBAS):*** The Department implemented the CBAS Temporary Alternative Services (TAS) flexibility using 1115 Waiver Attachment K authority approved by CMS in October 2020 for a one-year period (March 2020 – March 2021). The State received CMS approval in June 2021 to extend the Attachment K CBAS TAS flexibility for up to six months

past the end of the PHE. The intent of the CBAS TAS flexibility was to provide beneficiaries continued access to CBAS services during the PHE through alternative service delivery options to traditional congregate settings, and to preserve the CBAS provider network. Although DHCS intends to end the TAS flexibility, permanent changes to the CBAS program will be implemented as part of the Emergency Remote Services (ERS) delivery option, which was approved under the CalAIM section 1115 Demonstration[2]. CBAS ERS may be provided in response to the individual's person-centered needs, in instances of qualified emergencies such as state or local disasters, or personal emergencies such as time-limited illness/injury or crises. DHCS intends to transition to CBAS ERS prior to the Appendix K end date so long as it does not violate the MOE requirements of the American Rescue Plan Section 9817. CBAS All Center Letters (ACLs) issued during the PHE are available on the California Department of Aging's webpage, here.

- ***HIV/AIDS Waiver:*** As part of DHCS' telehealth policy proposal, the Department intends to implement permanent changes to current HIV/AIDS waiver service delivery methods, including: face-to-face re/assessments, monthly service plan monitoring, and care management activities to be completed through telephonic or live virtual video conferencing; and allow digital signatures. However, DHCS does not intend to make permanent the flexibility approved on November 23, 2020, which extends the time in which waiver agencies can complete Level of Care (LOC) re-evaluations and reassessments beyond the current 180-day requirement. The May 27, 2020 flexibility that waives the HCBS settings requirements for visitation at any time, and allowance for case management entities to provide direct services will not be extended as well.

- ***Home and Community Based Alternatives (HCBA) Waiver:*** The April 2, 2020 Appendix K approval included several temporary flexibilities for the HCBA Waiver, some of which the Department intends to make permanent. These include authorization for payment for personal care services rendered by legally responsible adults, telehealth as an alternative to face-to-face interactions and a means to conduct LOC re/evaluations, and acceptance of digital signatures. Additionally, an amendment to State law temporarily allows for paid sick leave for Waiver Personal Care Services (WPCS) providers until September 30, 2022, in alignment with the FFCRA.

  Not all of the flexibilities authorized in the April 2, 2020 Appendix K will be made permanent beyond the PHE. The flexibilities that will end on the Appendix K expiration date include modifications to provider qualifications that permit unlicensed Waiver Personal Care Services (WPCS) providers to participate when the provider is not enrolled as an IHSS provider, modifications to

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[2] CalAIM Section 1115 Demonstration Approval Letter and Special Terms and Conditions (STCs): https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-Approval-Letter-and-STCs.pdf

provider types that allow for Certified Nurse Assistants to provide Private Duty Nursing, and the pausing of disenrollments of participants who are re-institutionalized beyond the 30-day limit. Additional flexibilities set to expire in the HCBA Waiver include the May 27, 2020 approval to not comply with HCBS settings requirements for visitation at any time, and allowance for case management entities to provide direct services. Also the temporary approval for WPCS providers to exceed the maximum workday limit of 12 hours per day without penalty, approved on August 10, 2020, will not continue. Last, the flexibility that pauses waiver enrollment policy in designated "hot spots" as approved on September 17, 2020 will expire following the end of the PHE.

- ***Home and Community Based Services Development Disabilities (HCBS-DD) Waiver and Self Determination Program Waiver:*** The HCBS-DD waiver received flexibilities through Appendix K approvals which will be made permanent beyond the PHE. These flexibilities include modification and expansion of participant directed services, rate increases for specified providers, the provision of specific services in alternate locations including remote electronic communications to meet the consumer's individual needs, and Assistive Technology. Approved flexibilities not continuing beyond the PHE period include the allowance for up to three episodes of no more than 30 days of retainer payments, the provision of specific services in alternate locations, and the delay of level-of-care evaluations and re-evaluations. As with other HCBS waiver programs, the flexibility to not comply with HCBS settings requirements for visitation at any time will also not continue.

- ***1915(i) State Plan for Home and Community-Based Services (HCBS) for Individuals with Developmental Disabilities:*** The state received federal approval of various Disaster Relief SPAs which allowed for temporary flexibilities, **which are now permanent policies as part of SPA 21-0002 and SPA 22-0048 (pending approval).** Flexibilities to be made permanent include the provision of specific services in alternate locations including remote electronic communications to meet the consumer's individual needs, modification and expansion of participant directed services, rate increases for specified providers, the addition of State-Operated Mobile Crisis Teams and Speech-Language Pathology Assistants as new providers, Intensive Transition Services as a new service, and rate methodologies for existing services such as state-operated Enhanced Behavioral Supports Homes and Community Crisis Homes. The approved flexibilities regarding remote provision of service plan development and monitoring meetings are proposed to continue for one year in statute until June 30, 2023 as part of the 2022-23 Governor's Budget. The flexibility to not comply with HCBS settings requirements will not continue.

- ***Multipurpose Senior Services Program (MSSP):*** The virtual and telephonic flexibilities approved under MSSP will continue beyond the PHE Appendix K period as part of Medi-Cal's telehealth policy proposal. These flexibilities allow for certain services

to be provided in absence of face-to-face visits. Guidance for the Multipurpose Senior Services Program (MSSP) for Reopening Sites after Coronavirus Disease 2019 (COVID-19), was released on April 21, 2021 and is available here.

- ***Additional HCBS Program Changes:*** Additional flexibilities implemented in Medi-Cal include a waiver of requirements for 1915(c) waiver programs, 1915(i) HCBS State Plan programs, and 1915(k) Community First Choice programs, that person-centered service plans receive written consent from beneficiaries, and be signed by beneficiaries and all providers, allowing documented verbal consent as an alternative. The Department does not intend to make these policies permanent beyond the end date of the PHE. **DHCS also obtained approval to waive in-home face-to-face requirements for conducting initial assessments and reassessments in the In-Home Supportive Services (IHSS) program, and will seek to make these changes permanent beyond the end date of the PHE.**

- ***Program of All-Inclusive Care for the Elderly (PACE):*** DHCS intends to permanently continue some of the flexibilities authorized through the July 1, 2020, PACE Policy Guidance program, including telehealth as an alternative to face-to-face interactions, the flexibility for PACE Organizations (POs) to place participants in facilities that are outside the approved service area of a PO, the flexibility to use brokers for marketing purposes as provided by the PACE Final Rule, replacement of the requirement for PO staff to take the DHCS marketing exam with a DHCS-approved marketing training program, and the flexibility to receive direct referrals from hospital and facility discharge planners. DHCS will not be continuing other flexibilities identified in the letter, including the flexibility to accept verbal acceptance in lieu of signature to complete the Enrollment Agreement, Adult Day Healthcare Center (ADHC) licensure flexibilities authorized through Executive Order N-04-22, and the flexibility to discontinue involuntary disenrollments for participants that moved out of the approved PO service area during the PHE due to COVID-19 concerns.

Provider Enrollment

On March 23, 2020, CMS approved an 1135 waiver of federal provider screening requirements, allowing DHCS to provisionally and temporarily enroll providers, to the extent necessary, for the duration of the PHE. Specifically, this waiver relaxed requirements in federal regulations for States to collect payment of application fees, conduct fingerprinting and criminal background checks, conduct site visits, and verify licensure requirements. As a result, DHCS implemented the regulatory provider bulletin titled "Requirements and Procedures for Emergency Medi-Cal Provider Enrollment," which established Medi-Cal provider enrollment requirements and procedures for emergency enrollment. Providers seeking to enroll as a Medi-Cal provider through the emergency enrollment process are required to meet the following modified requirements:

- The applicant or provider must have treated a Medi-Cal beneficiary who has been affected by the current COVID-19 public health emergency and attest to the following statement, "I, (name of applicant or provider) understand that approval of my application is dependent upon the treatment that I provided to a Medi-Cal beneficiary who has been affected by the COVID-19 national public health emergency. By submitting this application, I acknowledge that this attestation is incorporated into my application by reference."
- The applicant or provider must submit a Crossover Only application using the PAVE portal.
- The applicant or provider is required to attach a copy of their Driver's License or state-issued identification card in their PAVE Crossover Only application.

As of December 5, 2021, there were 722 providers approved through the emergency enrollment process, a majority of which were physicians and physician groups. For dental providers, this emergency enrollment process expired on June 30, 2020, and all normal processes resumed for dental provider enrollment requirements.

Although 1135 flexibilities typically end upon the termination of the PHE, DHCS has decided to terminate this streamlined provider enrollment process on March 17, 2023. The approved 1135 waiver further clarifies that DHCS has six months beyond the end of the PHE to cease payments to providers who are not fully screened and enrolled, and must provide CMS assurance that it has taken the necessary steps to complete the screening of provisional enrollments. In order to comply with federal unwinding requirements, while also minimizing risks to access to care, DHCS has developed the following plan for resuming normal provider enrollment activities.

Proposed Plan for Resuming Normal FFS Screening and Enrollment

As set forth in the emergency provider bulletin, emergency enrollment is granted for 60 days retroactive to March 1, 2020, and will be extended in 60-day increments in accordance with the 1135 waiver. On March 17, 2023, DHCS is ending the provider enrollment flexibilities granted during the waiver period through a regulatory provider bulletin. DHCS will notify all providers enrolled pursuant to the bulletin that in order to continue to participate as Medi-Cal program providers, they are required to submit a complete application by June 15, which is 90 days from the effective date of the March provider bulletin and meet all Medi-Cal enrollment requirements. If an enrolled emergency provider submits a full application, DHCS will not deactivate the emergency enrollment until review and screening of the full application have taken place. Granting providers 90 days to submit their full application will allow DHCS sufficient time to screen and process these incoming applications, and if necessary, allow providers to remediate any deficiencies prior to the federally required six-month deadline to cease payments to these providers.

State Fair Hearings and Member Rights

The Department obtained approval of important flexibilities related to State Fair Hearings under the 1135 waiver authority during the PHE. These flexibilities granted additional time for Medi-Cal beneficiaries to request hearings, and for DHCS, other State Departments, and Medi-Cal managed care plans to take action to either continue or reinstate benefits. Specifically, the 1135 waiver approval received on March 23, 2020, provided beneficiaries an additional 120 days for an eligibility or FFS appeal to request a fair hearing. Although this approval also relaxed requirements on managed care appeal timelines so that Medi-Cal managed care members could proceed to a State Fair Hearing almost immediately, DHCS did not exercise this authority due to concerns of disruption to the current appeals system and potential confusion for members. However, in its policy guidance to MCPs, DHCS reminded MCPs of their obligations to resolve expedited appeals for any service within 72 hours from the request. DHCS further advised that if MCPs are found to be systemically denying medically necessary services that DHCS will invoke the one day appeal allowance to ensure members have access to all medically necessary services during this emergency. The 1135 waiver approval, received on March 12, 2021, permitted the State, and managed care plans to reinstate benefits to individuals who requested a fair hearing beyond the standard timeframes. **These flexibilities will expire at the end of the PHE, with the exception of the State Fair Hearing flexibilities requested from CMS under the 1902(e)(14)(A) authority as described in Part II of this document.**

CA Executive Orders

In addition to the temporary changes authorized under federal authorities, State-level flexibilities were implemented in Medi-Cal through State Executive Orders. Although most changes to Medi-Cal were included in EO N-55-20, EO N-29-20 and EO N-43-20 also impacted the program and DHCS operations, to a lesser degree. In particular, EO N-55-20 permitted several temporary changes to Medi-Cal requirements that stem from State statute or regulations. EO N-55-20 included temporary changes to Medi-Cal's managed care, behavioral health, and FFS delivery systems; and also broad flexibility to prevent conflict between State and federal laws due to the rapidly evolving federal flexibilities during the PHE. As part of EOs N-08-21 and N-04-22, which primarily terminated provisions of earlier orders, all provisions of E0 N-55-20 have now expired. With the exception of Paragraph 11 of EO N-55-20, which waived physical signature requirements for psychiatric medication, DHCS does not intend to make permanent the flexibilities authorized under State EOs.

Part II: Resumption of Normal Medi-Cal Eligibility Operations

Under the continuous coverage requirement in the FFCRA states are required to maintain enrollment of nearly all Medi-Cal enrollees through end of the month in which the PHE ends. **On December 29, 2022 Consolidated Appropriations Act of 2023 was enacted and delinked the continuous coverage requirement from the PHE. With the passage of the bill, the continuous coverage requirements will end on March 31, 2023 and the unwinding of the continuous coverage requirement will begin as of April 1,**

2023. When continuous coverage requirements expire, states will need to conduct a full redetermination for all beneficiaries who would have otherwise been subject to redetermination.

CMS has released guidance to support state Medicaid and CHIP agencies in returning to normal operations through a series of SHO letters. SHO guidance released in December 2020, August 2021, and March 2022 sets out federal expectations and requirements related to case processing timelines and beneficiary communications for redetermining Medicaid coverage for those who had their coverage continuously maintained. The March 2022 guidance builds upon the August 2021 SHO letter, where CMS clarifies that it will consider a state in compliance with resuming normal eligibility operations if it has: (1) initiated all renewals for the state's entire Medicaid (Medi-Cal) and CHIP caseload by the last month of the 12-month unwinding period; and (2) completed all such actions by the end of the 14th month after the end of the PHE. CMS also clarifies that states may use information gathered during a renewal that was initiated up to two months prior to the end of the PHE to take final action in the month after the month in which the PHE ends. The PHE Unwinding Period would be 12-months, with an additional two months, totaling 14 months, to complete all outstanding eligibility and enrollment actions from the PHE.

With the enactment of the Consolidated Appropriations Act of 2023, CMS released updated guidance in the form of a Centers for Medicaid and CHIP Services (CMCS) Informational Bulletin on January 5, 2023 that maintains the applicability of the unwinding rules set forth in previous SHO guidance (December 2020, August 2021, and March 2022) as it relates to the resumption of Medicaid redeterminations. States will continue to have the flexibility of applying an unwinding period of 12 months, with an additional two months, totaling 14 months, to complete all outstanding eligibility and enrollment actions that were paused as a result of the COVID-19 PHE. The previous term of "PHE Unwinding Period" will now be referred to as the "Continuous Coverage Unwinding Period," as redefined by the Consolidated Appropriations Act of 2023.

In support of the Continuous Coverage Unwinding Period and beyond, the DHCS has developed this Continuous Coverage Unwinding Operational Plan that overviews the DHCS guiding principles and implementation approach in preparing for the resumption of normal eligibility operations, specifically in the areas of Medi-Cal redeterminations, eligibility coverage retention strategies, beneficiary communications and outreach, county and system readiness, and data reporting. This Continuous Coverage Unwinding Operational Plan, in part, reflects the federal requirement of an operational plan that describes how states will address outstanding eligibility and enrollment actions in a way that reduces erroneous loss of coverage and enables a sustainable distribution of renewals in future years.

DHCS Guiding Principle: Maximizing Continuity of Coverage for Medi-Cal Beneficiaries

DHCS is committed to maximizing continuity of coverage for Medi-Cal beneficiaries through the course of the Continuous Coverage

Unwinding Period as the Department works with local county offices to resume normal eligibility operations. A key goal is to keep the Continuous Coverage Unwinding process **as simple as possible.** When the continuous coverage requirement expires, CMS guidance provides that states will generally have up to 14 months to return to normal eligibility and enrollment operations. This means California has a total of 14 months to initiate and complete redeterminations for nearly all of California's beneficiaries. This will include local county offices conducting a full renewal for all individuals enrolled in Medi-Cal and CHIP, through auto-renewals and requests for information where necessary. This is in addition to regular, ongoing operational requirements such as, processing any outstanding applications that were received prior to the end of the continuous coverage requirement, conducting routine verifications, and processing changes in circumstances.

California Approach for Prioritizing Pending Redeterminations: Maintain Current Renewal Month

To simplify the complexity of the Continuous Coverage Unwinding process, DHCS will maintain the Medi-Cal beneficiaries' current renewal month in their case records and conduct a full redetermination at the next scheduled renewal month following the end of the **continuous coverage requirement with the exception of the populations discussed in "Population Priorities" below.**

This approach achieves the following:

1) Least disruptive to county workloads on both an initial and ongoing basis
2) Aligns, to the greatest extent possible, on when Medi-Cal and CHIP beneficiaries usually expect to receive their auto-renewal letters or packets requesting additional information if auto-renewal is not successful, prior to the PHE. This familiarity is critical as DHCS rolls out the communication and outreach campaign discussed below.
3) Retains a similar pre-COVID-19 redetermination caseload distribution across the state, adjusting for the growth factor of individuals who enrolled into coverage and were protected through the continuous coverage requirements.

How this works. Per federal and state guidelines that have existed since before the PHE, the annual redetermination process occurs in several steps, spanning across multiple months. Local county offices and the Statewide Automated Welfare Systems (SAWS) will initiate redetermination activities starting approximately 85 days prior to last day of the individual's redetermination month (*See Appendix A "Eligibility Sequencing Map" for a full mapping of the 14-months of expected begin and end dates of renewal activities."):*

When the continuous coverage requirement ends in March 2023, the Continuous Coverage Unwinding period would begin in April 2023. As Medi-Cal has full month eligibility, this means that normal renewal processing resumes in **April 2023** for individuals with a **June 2023** renewal month.

- **April 2023** - Initiate ex-parte review (approximately 85 days prior to) for renewals due June 2023 and mail annual renewal packet (approximately 60-75 days prior to, if applicable because the ex parte process was not successful)
- **June 2023** - Notice of action sent (10 days prior to adverse action, i.e. received no later than June 20, 2023) if the annual renewal remains incomplete or the beneficiary is no longer eligible to Medi-Cal
- **June 30, 2023** - Final day of Medi-Cal eligibility for discontinued beneficiaries

For individuals with an October renewal month:

- **August 2023** - Initiate ex-parte review (approximately 85 days prior to) and mail annual renewal packet (approximately 60-75 days prior to, if applicable because the ex parte process was not successful)
- **October 2023** - Notice of action sent (10 days prior to adverse action, i.e. received no later than October 21, 2023) if the annual renewal remains incomplete or the beneficiary is no longer eligible to Medi-Cal
- **October 31, 2023** - Final day of Medi-Cal eligibility for discontinued beneficiaries

Per current renewal processing procedures, discontinuances will not start immediately after the continuous coverage requirement terminates. Rather, in the first and second months after the continuous coverage requirement ends, renewal activities will focus on completing ex-parte review and sending annual renewal packets when ex-parte is unsuccessful. Thus, the third month following the end of the continuous coverage requirement is when the first redeterminations will be processed, and the fourth month when individuals may potentially be discontinued.

Acting on Changes in Circumstance. As a reminder, beneficiaries have been reporting and will continue to report changes in their households, such as a new job during the PHE and through the Continuous Coverage Unwinding period. However, any changes in circumstance reported prior to the end of the continuous coverage requirement and during the 12-month Continuous Coverage Unwinding Period that could lead to a negative action shall be paused until the beneficiary's annual redetermination is initiated at the end of the continuous coverage requirement as determined by their redetermination date on their Medi-Cal case record. Once a beneficiary's annual redetermination is completed post-continuous coverage requirement (the 12-Month Continuous Coverage Unwinding Period plus two additional months), the county will process reported changes using traditional case processing procedures. During and after the continuous coverage requirement, changes that result in a positive change will be processed upon receipt of the change.

- *Example 1*: The continuous coverage requirement expires in March 2023, and a beneficiary has a renewal month of September 2023. In January 2023 the beneficiary reports new employment that could potentially lead to losing Medi-Cal coverage. Although

the continuous coverage requirement has concluded in March 2023, the change in circumstance will not be processed until the beneficiary's annual renewal in September 2023 when a full redetermination using current information can be completed.

- *Example 2:* When the continuous coverage requirement expires in March 2023, and a beneficiary has a renewal month of June, and the annual renewal is completed in June 2023. In July 2023, the beneficiary reports new employment. The county would process the change in circumstance using existing case processing rules because a full post-continuous coverage requirement annual renewal has been completed.

Population Priorities. Aligned with the goal of keeping the Continuous Coverage Unwinding process as simple as possible, DHCS is not requiring the prioritization of most populations. Individuals will be redetermined using their current renewal month. However, DHCS has identified two small subset of the renewal population who may have their Medi-Cal eligibility redetermined outside of their normal renewal period.

As enacted by Senate Bill 184 (Chapter 47, Statutes of 2022), California will implement state-funded full scope Medi-Cal to individuals age 26 through 49, regardless of immigration status if otherwise eligible beginning on January 1, 2024. This Medi-Cal expansion is another important step to help close health equity gaps in California, and will improve access to care to the some of the state's most vulnerable populations. As part of the federal continuous coverage requirements, DHCS maintained ongoing Medi-Cal coverage for young adults who were conferred state-only full scope Medi-Cal under the Young Adult Expansion, and who would have otherwise lost their Medi-Cal eligibility due to aging out at 26 years of age. Under federal requirements outlined by the CMS, DHCS must redetermine all individuals in Medi-Cal once the continuous coverage requirement ends. As such, this population will most likely be determined ineligible for state-funded full scope Medi-Cal due to their age once the post-PHE renewals begin. In an effort to maintain continuity of coverage for these individuals who would have aged out during the PHE until the 26 through 49 expansion takes effect on January 1, 2024, DHCS will continue existing state-funded full scope Medi-Cal coverage for this population, and will issue policy guidance instructing counties to deprioritize the post-continuous coverage requirement renewal towards the end of the Continuous Coverage Unwinding period.

During the continuous coverage requirement, DHCS continued to protect individuals who were inadvertently moved from a Medi-Cal program without a share of cost into a program with a share of cost by correcting the record in the Medi-Cal Eligibility Data System (MEDS). Due to the complexity of maintaining correct eligibility for these beneficiaries in MEDS, counties may conduct a full redetermination on these beneficiaries prior to the scheduled annual renewal date. Additionally, DHCS will provide one-to-one technical assistance for any counties requesting guidance related to prioritization.

Medicare Enrollment Period. Individuals have three opportunities to apply for Medicare: their initial enrollment period, open enrollment, and a Special Enrollment Period. Individuals who have turned 65 and are not enrolled in Social Security or Railroad Retirement Board benefits are not automatically enrolled in Medicare and must apply. During the continuous coverage requirement, individuals may have not known they needed to, or may have chosen not to apply for Medicare during their initial enrollment period because they understood that they would not lose their Medi-Cal during the continuous coverage period. Per California Code of Regulations (CCR) § 50763 and CCR § 50777, Medi-Cal applicants/beneficiaries are required to apply for Medicare. Normally, this does not pose a problem as the requirement only goes into effect when an individual could apply for Medicare (during their initial enrollment period or during a Special Enrollment Period). However, for individuals who have not applied for Medicare at all during the PHE, and whose initial enrollment period has passed, they will not have an opportunity to apply for Medicare until the open enrollment period (January – March). This creates a risk for individuals who should have signed up for Medicare but did not. For example, if the individual's Medi-Cal renewal occurs between October 2022 and December 2022, the individual could lose their Medi-Cal coverage and also not have Medicare, causing the person to become completely uninsured. The individual would have to wait until January to apply for Medicare and may go without health coverage until then.

On October 28, 2022, CMS issued a final rule to implement sections of the Consolidated Appropriations Act of 2021 that simplifies Medicare enrollment rules. Section 120 of the Consolidated Appropriations Act of 2021 makes changes to Traditional Medicare by revising the effective dates of coverage and giving the Secretary of the federal Department of Health and Human Services (the Secretary) the authority to establish new special enrollment periods (SEPs) for individuals who meet exceptional conditions. Two SEPs to help to mitigate any gaps in coverage for this population:

- **An SEP for Individuals Impacted by an Emergency or Disaster that would allow CMS to provide relief to those beneficiaries who missed an enrollment opportunity because they were impacted by a disaster or other emergency as declared by a Federal, state, or local government entity.**
- **An SEP to Coordinate with Termination of Medicaid Coverage that would allow individuals to enroll after termination of Medicaid eligibility.**

Anticipated Coverage Loss with Continuous Coverage Requirement Termination

Loss of Contact and Procedural Discontinuances. California's Medi-Cal population is at an unprecedented level of **15.2** million beneficiaries or a 16 percent increase in total enrollment since March 2020, largely due to the continuous coverage requirements put in place during the PHE. DHCS recognizes that during the PHE, there has been minimal or no contact with many beneficiaries for an

extended period, as many have not had a completed renewal of eligibility due to the pause on all statewide discontinuances for failure to complete renewals. As such, there is an inherent risk that eligible individuals may lose coverage once the continuous coverage requirement expires because they have a new address or other contact information, that may not have been updated since their last completed renewal (in most cases prior to the PHE). Currently, the returned mail rate of 12% from the most recent DHCS PHE Outreach Mailer to all Medi-Cal households in December 2021 suggests that approximately two million individuals could lose coverage: e.g., due to loss of contact if auto-renewal activities are unsuccessful for a large group compared with the same prior to the PHE, and if the subsequent renewal packets are not returned to local county offices for beneficiaries to continue receiving coverage. Individuals may also lose Medi-Cal coverage because they were maintained in the Medi-Cal program but would otherwise have been discontinued if not for the continuous enrollment requirements. Finally, the possibility of procedural discontinuances, such as those for failure to complete renewals, will not be fully known until annual renewals are processed during the Continuous Coverage Unwinding period.

Ex-Parte Rates and Redeterminations Caseload. Prior to March 2020, California had an average 41% auto ex-parte rate statewide. Ex-parte is one of the most critical components of the Medi-Cal determination process, as it allows redeterminations to process automatically once all information passes through the Federal and State databases for verification and counties check all other available information. Beneficiaries going through the auto ex-parte and who are successfully renewed, would have no contact with the county and have their case renewed for another year. The ex-parte process becomes even more critical during and after the continuous coverage requirement ends, as it would prevent delays in eligibility determinations, reduce the administrative burden, and alleviate Medi-Cal applicants and beneficiaries from having to provide unnecessary information. **However, after March 2020 through the present time, the auto ex-parte success rate has been approximately 25% statewide.** This drop in the success rate is to be expected as circumstances of individuals have changed dramatically during the PHE and available state-level data has become increasingly inconsistent with the verification sources in the Federal and State databases. This means that counties will have to review the cases that have failed auto ex-parte (estimated **75%** of their monthly renewal caseload) and reach out to beneficiaries for additional information via the use of renewal packets to a greater number of beneficiaries than would have been necessary prior to the PHE – due to both the caseload growth during the PHE, as well as the reduced success rate of ex-parte processing.

Anticipated Total Disenrollments. DHCS anticipates that the sheer volume of redeterminations, compounded by the beneficiary loss of contact, and other normal churn of individuals moving to the State marketplace (Covered California), would potentially lead to **an estimated total of 2-3 million Medi-Cal disenrollments** as the normal redetermination processing resumes. Note that any disenrollments will take place through the course of the Continuous Coverage Unwinding period, not immediately upon expiration of the continuous coverage requirement, and this estimate would bring the Medi-Cal total enrollment closer to the pre-continuous coverage requirement caseload levels.

Federal Eligibility-Related Flexibilities

With the complexity of the Continuous Coverage Unwinding, DHCS has submitted various federal flexibilities to CMS in efforts to prepare for the significant volume of disenrollment related actions that were not acted upon due to the continuous coverage requirements, and to mitigate coverage loss to the greatest extent possible.

Timeliness Flexibilities due to PHE via State Concurrence Letter. During the PHE, DHCS instructed counties to delay processing received annual renewals to allow counties to dedicate resources to processing increased applications and access to care issues. On February 23, 2022, DHCS requested concurrence from CMS with DHCS' plan to temporarily waive the timeliness standards for processing annual renewals to Medicaid and CHIP policies on a statewide basis through the end of the PHE. These flexibilities are authorized in unusual circumstances including emergencies beyond the state's control under 42 Code of Federal Regulations (CFR) § 435.912(e)(2) and articulated in the CMS Inventory of Medicaid and CHIP Flexibilities and Authorities in the Event of a Disaster.

Adjusting Reasonable Compatibility Income Threshold to 20 percent for Modified Adjusted Gross Income (MAGI) Medi-Cal. California uses a standard to determine whether or not the income in federal data sources is compatible with the information an individual reports. When the income is reasonably compatible with federal data sources, the beneficiary does not need to provide proof of their income. On March 11, 2022, DHCS submitted the MAGI Verification Plan to increase the reasonable compatibility threshold to 20 percent. DHCS plans for this flexibility to be in place through May 2024. The reasonable compatibility threshold will be reduced to 10 percent beginning June 1, 2024, assuming the 12-month resumption to normal operations has concluded at that time. This flexibility is anticipated to help increase the percentage of automated ex-parte renewals completed for MAGI Medi-Cal.

Reasonable Explanation. CMS allows states to permit an applicant or beneficiary to provide a reasonable explanation why their self-attested information did not align with electronic verification sources in order to complete the Medi-Cal eligibility determination per 42 CFR §435.952(c)(2). Currently, when the electronic data source is not available or the electronic verification could not be reasonably compatible with the self-attestation, California requires the applicant or beneficiary to provide documentation prior to the approval or redetermination for Medi-Cal eligibility. However, with the implementation of "reasonable explanation" into the verification process, a Medi-Cal applicant or beneficiary could explain the discrepancy found between self-attested information and data received from electronic data sources, in lieu of providing further documentation. To elect this flexibility, DHCS submitted an updated MAGI Verification Plan to CMS to include reasonable explanation in the verification process. DHCS developed a short-term process that allows local county offices to begin using reasonable explanation as an allowable source to resolve income discrepancies during the 12-month

unwinding period and has begun work on a long-term automated processes for future implementation. The addition of the reasonable explanation policy will greatly reduce manual burdens on Medi-Cal applicants or beneficiaries, administrative workload on the county, and streamline the eligibility determination process for both MAGI and Non-MAGI Medi-Cal.

Expanded Use of Asset Verification Reports during Application and Renewal for Non-MAGI Medi-Cal. On July 1, 2022, and coinciding with the asset limit increase, the Medi-Cal program will expand the use of the asset verification reports required for those non-Supplemental Security Income (SSI) individuals subject to the asset test to facilitate increasing the number of new applications and annual renewals approved on an ex-parte basis. Counties may use the asset report as a verification source and approve initial or ongoing eligibility without the need to collect beneficiary provided paper verifications.

Section 1902(e)(14)(A) Flexibilities. SHO 22-001 also outlined additional targeted strategies under Section 1902(e)(14)(A) authority of the Social Security Act for states to leverage in efforts to mitigate churn and ensure eligible individuals remain in coverage. Specifically, Section 1902(e)(14)(A) of the Social Security Act allows for waivers "as are necessary to ensure that states establish income and eligibility determinations systems that protect beneficiaries." Under this waiver authority, CMS lays out five potential targeted enrollment strategies that can be used to facilitate renewals that lead to fewer discontinuances during the 12-month unwinding period. DHCS has pursued four of these targeted enrollment strategies, which temporarily permits the following:

- Ex-parte renewals for households whose attestation of zero-dollar income was verified within the last 12 months (at application or renewal) when no information is returned through data sources which will allow more beneficiaries without income such as those experiencing homelessness to have the annual renewal completed through ex-parte and without the need to complete an annual renewal packet
- Renewals on an ex-parte basis for individuals for whom no information was returned by the Asset Verification System Data within a reasonable timeframe. DHCS is defining this reasonable timeframe to be 20 calendar days for new applications, renewals as a result of reported change of circumstance and responsible relative reports, and 30 calendar days for annual renewal reports. Implementing a reasonable timeframe will allow counties to process annual renewals during the Continuous Coverage Unwinding without delay
- The acceptance of updated individual contact information provided by Medicaid managed care plans without additional confirmation from an individual which removes administrative barriers and allows timely updating of the case file so beneficiaries can receive important mail from the county at the correct address.
- An extension of the timeframe to take final administrative action on fair hearing requests, on the condition that states provide benefits pending the outcome of the fair hearing and without recoupment if the final decision is adverse to the individual. DHCS

anticipates the volume of fair hearing request to increase significantly. Allowing additional administrative time to complete the fair hearing process ensures beneficiaries remain in coverage pending a decision and the state remains in compliance with the fair hearing processing time frames.

- An extension of the timeframe for beneficiaries to request a fair hearing. This would allow beneficiaries to go beyond the current 90 day timeframe and provide them the ability to request a fair hearing that does not exceed 210 days from the date when the adverse notice of action was mailed to them.

On May 4, 2022, CMS approved the three flexibility requests unrelated to fair hearings with a May 1, 2022 effective date. At this time, the fair hearing flexibilities are still being considered by the federal government.

On October 18, 2022, DHCS submitted two additional flexibility requests to CMS seeking an effective date of October 18, 2022, through the end of the Continuous Coverage Unwinding period. These additional flexibilities will further reduce the administrative burden on beneficiaries, MCPs, and local county offices in assisting with updating beneficiary contact information, which is critical prior to and during the Continuous Coverage Unwinding period. These two flexibilities are:

- ***Partnering with the National Change of Address (NCOA) Database and United States Postal Service (USPS) In-State Forwarding Address to Update Beneficiary Contact Information.*** DHCS requests to temporarily permit the acceptance of updated in-state enrollee contact information from the NCOA database and USPS in-state forwarding address without additional confirmation from the individual. Under this authority, the state would treat updated in-state contact information confirmed by and received from the NCOA database or USPS returned mail with a forwarding address as reliable, and update the beneficiary record with the new contact information without first sending a notice to the beneficiary address on file with the state.

- ***Partnering with Program of All-Inclusive Care for the Elderly (PACE) Organizations to Update Beneficiary Contact Information.*** California requests to temporarily permit the acceptance of updated in-state enrollee contact information from PACE organizations without additional confirmation from the individual. Under this authority, the state would treat updated in-state contact information confirmed by and received from PACE organizations contracting with the state Medicaid agency as reliable, and update the beneficiary record with the new contact information without first sending a notice to the beneficiary address on file with the state.

On October 24, 2022, CMS approved the two additional flexibility requests for partnering with NCOA and PACE, with an effective date of October 18, 2022.

Payment Error Rate Measurement (PERM) or Medicaid Eligibility Quality Control (MEQC) Programs. Eligibility and enrollment actions that were delayed as a result of the continuous coverage requirement will **not be considered untimely** for the purposes of PERM or MEQC programs if a state complies with the timelines outlined in SHO 22-001. SHO 22-001 also clarifies that states with approved 1902(e)(14)(A) waivers will be considered in compliance with Medicaid statute and regulation for the purposes of PERM and MEQC reviews.

Program Operations: Medi-Cal/CHIP Program Policies during Continuous Coverage Unwind

The breadth of California's Medi-Cal and CHIP programs and the number of lives we support, dictate a simple process for the unwinding of the continuous coverage requirement to minimize the risk of inappropriate coverage loss. Recognizing the varied program rules, this section of the Continuous Coverage Unwinding Operational Plan overviews how the Medi-Cal and CHIP programs would be handled through the course of the PHE Unwinding Period. As a reminder, DHCS is not looking to change any current Medi-Cal and CHIP policies, and instead is looking to utilize existing procedures to process all redeterminations.

Modified Adjusted Gross Income (MAGI). MAGI Medi-Cal method uses federal tax rules to determine if individuals qualify based on how taxes are filed and countable income. Most individuals in MAGI Medi-Cal will go through an automatic ex-parte process at the time of their annual renewal in order to receive a full redetermination at the end of the continuous coverage requirement. Beneficiaries that are unable to be redetermined through the automated ex-parte process will be sent a pre-populated annual renewal form. MAGI redeterminations will occur during the beneficiary's next post-continuous coverage requirement annual renewal.

Non-MAGI. Non-MAGI Medi-Cal uses rules to count property, household income, and size to determine if individuals qualify. Individuals in Non-MAGI Medi-Cal will go through a manual ex-parte process at the time of their annual renewal in order to receive a full redetermination at the end of the continuous coverage requirement. DHCS has expanded the use of various electronic data sources to increase the use of ex parte during the Non-MAGI Medi-Cal annual renewal. Non-MAGI redeterminations will occur during the beneficiary's next post- continuous coverage requirement annual renewal.

Medi-Cal Access Program (MCAP). MCAP provides pregnant individuals with comprehensive coverage for a low cost and with no copayments or deductibles for its covered services. Throughout the continuous coverage period, DHCS continued coverage for MCAP members after the end of their postpartum period. MCAP individuals that have reported a pregnancy or were in a postpartum period on

or after July 1, 2020, will receive 365 days of postpartum benefits prior to the redetermination for continued Medi-Cal coverage or a transition to coverage through Covered California. MCAP members do not have a renewal process and will complete a full redetermination at the end of the continuous coverage requirement with timely noticing on a flow basis based on pregnancy end date.

County Children's Health Initiative Program (CCHIP) and Medi-Cal Access Infant Program (MCAIP). CCHIP provides affordable comprehensive medical, dental, mental health, and vision benefits to children under the age of 19 in San Francisco, San Mateo, and Santa Clara counties. MCAIP provides Medi-Cal to newborns of an individual in MCAP. Beneficiaries in CCHIP and MCAIP were continued in coverage during the continuous coverage requirement. Renewals and reported changes in circumstances continued to be processed during the continuous coverage period except in instances when processing the change would result in a negative action. At the conclusion of the continuous coverage requirement, normal processing will resume related to annual redeterminations, and change in circumstances. CCHIP and MCAIP redeterminations will occur during the beneficiary's next post-continuous coverage requirement annual renewal and will follow the normal annual redetermination guidelines prior to removing members out of continuous coverage requirement protected coverage.

Breast & Cervical Cancer Treatment Program (BCCTP). BCCTP provides cancer treatment benefits to eligible low-income California residents diagnosed with breast and/or cervical cancer. Beneficiaries in BCCTP were continued in coverage during the continuous coverage requirement. Renewals and reported changes in circumstances continued to be processed during the continuous coverage period except in instances when processing the change would result in a negative action. At the conclusion of the continuous coverage requirement, normal processing will resume related to annual redeterminations and change in circumstances. BCCTP redeterminations will occur during the beneficiary's next post-continuous coverage requirement annual renewal and will follow the normal annual redetermination guidelines prior to removing members out of continuous coverage requirement protected coverage.

Medi-Cal Inmate Eligibility Program (MCIEP). MCIEP provides Medi-Cal covered acute inpatient hospital services to eligible inmates if those services are provided off the grounds of the correctional facility. Beneficiaries in MCIEP were continued in coverage during the continuous coverage requirement. Renewals and reported changes in circumstances continued to be processed during the continuous coverage period except in instances when processing the change would result in a negative action. At the conclusion of the continuous coverage requirement, normal processing will resume related to annual redeterminations and change in circumstances. MCIEP redeterminations will occur during the beneficiary's next post-continuous coverage requirement annual renewal and will follow the normal annual redetermination guidelines prior to removing members out of continuous coverage requirement protected coverage.

COVID-19 Uninsured Group (UIG). On March 18, 2020, the FFCRA authorized Medicaid programs the ability to provide access to coverage for medically necessary COVID-19 diagnostic testing and testing-related services for individuals without access to such services. California started the COVID-19 Uninsured Group Program which is a temporary Medi-Cal program that only covers medically necessary COVID-19 testing, testing-related services, and COVID-19 related treatment services. At the end of the PHE, individuals will receive a notice informing them of the end of the PHE and the end of their coverage in the COVID-19 Uninsured Group. The notice will encourage individuals to apply for ongoing Medi-Cal and Covered California coverage through any application method. Individuals will be eligible for a Covered California Special Enrollment Period. Individuals enrolled in the COVID-19 Uninsured Group will be discontinued at the end of the month in which the PHE ends. To support the unwinding actions needed for the COVID-19 UIG, DHCS has developed a visual flow of the critical dates and activities for this coverage group. *(See Appendix "COVID-19 Uninsured Group – Unwinding Activities).* **The Consolidated Appropriations Act of 2023 does not modify the termination date of the COVID-19 Uninsured Group, which is still tied to the termination of the COVID-19 PHE**.

Transitions to Covered California

Once the continuous coverage requirement ends, many Medi-Cal and CHIP beneficiaries may become ineligible and move to Covered California. DHCS and Covered California collaborated to implement Senate Bill (SB) 260 (Chapter 845, Statutes of 2019) which authorizes Covered California to enroll individuals in a qualified health plan when they lose coverage in Medi-Cal, MCAP, and CCHIP and gain eligibility for financial assistance through Covered California. The auto-plan selection program was launched in July 2022 and will seamlessly transition individuals into Covered California once Medi-Cal discontinuances resume at the conclusion of the continuous coverage requirement. The provisions of SB 260 will ensure that individuals losing Medi-Cal will not experience a gap in coverage if they confirm their selection of the qualified health plan and pay a premium (only if required) for Covered California coverage within a month of their disenrollment from Medi-Cal. **As part of the Consolidated Appropriations Act of 2023, DHCS will report to CMS the number of individuals that transition to Covered California and, of those, the number who enrolled into a Qualified Health Plan.**

Continuous Coverage Unwind Communication and Outreach Campaign: Become a DHCS Coverage Ambassador

The end of the Medi-Cal continuous coverage requirements necessitates a coordinated, phased communication campaign to reach beneficiaries with messages across multiple channels using trusted partners called **DHCS Coverage Ambassadors.** As California plans

to resume normal Medi-Cal eligibility operations, beneficiaries will need to know what to expect and what they need to do to keep their health coverage. Most beneficiaries will either remain eligible for Medi-Cal or qualify for tax subsidies that allow them to buy affordable Covered California coverage.

DHCS Coverage Ambassadors. Anybody can be a Coverage Ambassador, so please sign up today! DHCS will engage community partners to serve as DHCS Coverage Ambassadors to deliver important messages to Medi-Cal beneficiaries about maintaining Medi-Cal coverage after the continuous coverage requirement ends. The DHCS Coverage Ambassadors will be trusted messengers made up of diverse organizations that can reach beneficiaries in culturally and linguistically appropriate ways. Additionally, DHCS Coverage Ambassadors will connect Medi-Cal beneficiaries at the local level with targeted and impactful communication. Ambassadors may include, but are not limited to:

- Local County Offices
- Health Navigators
- Managed Care Plans
- Community Organizations
- Advocates
- Stakeholders
- Providers
- Clinics/Healthcare Facilities
- Legislative Offices/Other State Agencies
- Schools

DHCS Continuous Coverage Unwind Resources Webpage and Communications Outreach Toolkits. The toolkits serve as communication guides and provides resources to support ongoing preparations for the upcoming end of the continuous coverage requirement. DHCS Coverage Ambassadors can download the updated Medi-Cal continuous coverage resources (including language translations) from the website and start educating beneficiaries. The latest information and updated toolkits will be added to the website as they become available, and ambassadors will be notified when there are new resources. DHCS Coverage Ambassadors can locate communication toolkits here.

Health Navigators. DHCS will utilize the Health Navigators and direct partners to serve as DHCS Coverage Ambassadors during the unwinding of the continuous coverage requirement. The Health Navigators will focus on proactively engaging beneficiaries leveraging the DHCS communication and outreach toolkits and modifying materials to provide a localized outreach campaign message. The Health

Navigators will leverage existing outreach events for other social service programs (i.e., CalFresh, Women, Infants, and Children, and CalWORKs) and provide materials and contact information at community clinics and hospitals, state unemployment offices, grocery stores, and places of worship where members of the community congregate. Additionally, Health Navigators will leverage targeted outreach campaign materials that community organizations can use to connect beneficiaries with Health Navigators for assistance with completing annual renewal packets and responding to local county offices requests in order to maintain coverage.

Two-Phased Approach. A Continuous Coverage Unwind Communication and Outreach Campaign is currently rolling out in two phases to prioritize and sequence strategies, tactics, and messages across the state to prepare for the resumption of normal eligibility operations.

- **Phase 1.0** – This phase is designed to encourage beneficiaries to provide their local county office with any updated contact information such as: name, address, phone number, and email so the local county office can contact beneficiaries with important information about keeping their Medi-Cal. This phase is underway.
- **Phase 2.0** – This phase is designed to encourage beneficiaries to continue to update their contact information, with their local county office if it changes, to report any change in circumstances, as well as check for upcoming renewal packets for beneficiaries whose cases have not auto-renewed. Phase 2.0 will begin 60 days prior to the end of the continuous coverage requirement. A Phase 2.0 Outreach Toolkit will be released in the future.

Phase	Core Messaging	Partners/*DHCS Coverage Ambassadors!*	Communication Channels
Phase 1 **Launch Immediately**	*Update your contact information now if it has changed. Make sure <county> has the correct mailing address, phone, and email contacts to reach you with important updates about your Medi-Cal.*	▪ Local County offices ▪ Medi-Cal managed care plans ▪ Provider associations ▪ Clinics ▪ Health enrollment navigators ▪ Consumer Advocates ▪ Community Organizations ▪ Other State Agencies (CDPH, CDDS) ▪ Legislative Offices ▪ Schools	▪ DHCS Outreach Toolkit 1.0 – Includes all 19 Medi-Cal Threshold Languages ▪ Websites ▪ Plan newsletters, emails ▪ Digital outreach – social media ▪ Flyers ▪ Call center scripts for local county offices managed care plans, and state call centers

Phase	Core Messaging	Partners/*DHCS Coverage Ambassadors!*	Communication Channels
Phase 2 **Launch 60-days prior to COVID-19 PHE Termination**	*Update your contact information now if it has changed. Make sure <county> has the correct mailing address, phone, and email contacts to reach you with important updates about your Medi-Cal.* *The continuous coverage protections are ending. You may need to take action to keep your Medi-Cal. Please make sure you are updating your contact information with <county> to get ready for your renewals.*	▪ Local County offices ▪ Medi-Cal managed care plans ▪ Provider associations ▪ Clinics ▪ Health enrollment navigators ▪ Consumer Advocates ▪ Community Organizations ▪ Other State Agencies (CDPH, CDDS) ▪ Legislative Offices ▪ Schools	▪ DHCS Outreach Toolkit 2.0 – Includes all 19 Medi-Cal Threshold Languages ▪ Websites ▪ Plan newsletters, emails ▪ Digital outreach – social media ▪ Flyers ▪ Call center scripts for local county offices, managed care plans, and state call centers

Returned Mail. DHCS has developed multiple strategies to assist with obtaining updated contact information for beneficiaries who may have changed their address during the continuous coverage requirement. Key strategies include:

- Updated policy guidance to the counties to ensure individuals retain coverage when mail is returned with an in-state forwarding address
- Requiring counties to request updated contact information at all points of contact
- Ongoing outreach campaigns to relay the importance of sharing updated contact information with the county
- DHCS has engaged counties and managed care plans to improve the process by which they communicate updated beneficiary contact information
- Adding key messaging to state websites reminding consumers to update their contact information (DHCS, Covered CA)

Role of Medi-Cal Managed Care Plans (MCPs)

MCPs are another trusted source that will serve as *DHCS Coverage Ambassadors* to communicate important outreach messages to beneficiaries. To underscore the importance of MCPs during the PHE Unwind, CMS released guidance in December 2021, and updated in March 2022 ("Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations)," to highlight four key strategies to maximize continuity of coverage at the end of the continuous coverage requirement. In March 2022 and updated in August 2022, DHCS issued All Plan Letter 22-004 - Strategic Approaches for Use by Managed Care Plans to Maximize Continuity of Coverage as Normal Eligibility and Enrollment Operations Resume which mandates the use of these four strategies in both phases of the PHE Unwind Communication and Outreach Campaign (see section above). These key strategies include:

1. Obtain and update (through communication with the local county offices) beneficiary contact information
2. Conduct outreach and provide support to individuals enrolled in Medi-Cal during their renewal period
3. Conduct outreach to individuals who have recently lost coverage for procedural reasons (i.e., failure to provide information to complete renewal)
4. Assist individuals to transition to and enroll in Covered California if ineligible for Medi-Cal.

The APL instructs MCPs to use all modalities available to outreach and update beneficiary contact information.

County Readiness

Funding for County Continuous Coverage Redeterminations Workload. The local county offices play a significant role in the Continuous Coverage Unwinding as they administer the Medi-Cal eligibility and manage Medi-Cal cases on behalf of DHCS. Counties are expected to redetermine the full Medi-Cal population during the 14-month period after the continuous coverage requirement ends. Recognizing that the significant volume of redeterminations, in addition to the existing workload of application adjudication and ongoing case management, the Budget Act of 2021-2022 (Senate Bill 170, Chapter 240, Statutes of 2021) has appropriated a one-time augmentation of $146 million to counties to prepare for the resumption of Medi-Cal redeterminations.

Criticality of Counties. Under the administrative guidance and supervision of DHCS, the 58 local county offices are responsible for completing Medi-Cal determinations of eligibility, distributing notices, managing ongoing activities for active Medi-Cal cases, and renewing eligibility at least annually. DHCS issues guidance to counties to perform these activities. Preparing counties for the end of the continuous coverage requirement is vital to the success of the unwinding efforts. DHCS will provide counties with the following

guidance, resources, and support to ensure counties have the tools necessary to resume normal operations at the end of the continuous coverage requirement.

Regular Policy Guidance. DHCS issued regular guidance instructions on maintaining continuous coverage for beneficiaries (see "Resource" section). DHCS will continuously issue written policy guidance on post- continuous coverage requirement enrollment activities, processing undeliverable mail, use of electronic verifications for Non-MAGI eligibility, and several other important policies that will assist counties in processing redeterminations after the continuous coverage requirement has ended. The updated written policy guidance related to the unwinding of the continuous coverage requirement will also serve as the foundation to DHCS' statewide Medi-Cal training series for counties.

County Survey. In order to provide appropriate technical assistance and to gauge high impact areas to Counties in advance of the continuous coverage requirement termination, DHCS issued a county survey in early April 2022 to local county directors. The survey requests county input on current county operational capacity (county lobby closures or at reduced capacity due to COVID-19), staffing levels, case management models and any operational impacts, and current outreach strategies. The survey helps inform DHCS in providing tailored guidance and technical assistance to counties as the Department continues with the continuous coverage unwinding preparation.

County Readiness Toolkit. To assist counties with readiness for the Continuous Coverage Unwind, and to provide the appropriate technical assistance, DHCS created a County Readiness Toolkit, similar to what CMS provided for states, as outlined in Medi-Cal Eligibility Division Letter (MEDIL) 22-33, later superseded by **MEDIL 23-03**, for counties to develop and document a county-level plan for the unwinding of the continuous coverage requirement that considers local business processes and needs. **Counties are required to use the County Continuous Coverage Unwinding Readiness Plan Template to document their Continuous Coverage Unwinding operations plan which includes staffing levels, assignment of outstanding work, and staff training. Creation of the county level readiness plan will ensure the counties' success in performing federal and state mandated Continuous Coverage Unwinding activities, and a seamless transition to normal business operations. The County Continuous Coverage Unwinding Readiness Plan is due no later than February 21, 2023 to DHCS.**

Visuals. Visual flow-charts of the steps for processing various scenarios of outstanding work that resulted from the continuous coverage requirement have been provided to counties by means of MEDIL I 22-28. The annual redeterminations and reported change in circumstances during the continuous coverage requirement flow charts include each step the county must take to complete the redetermination of eligibility.

Statewide Medi-Cal Training. Statewide webinar training on the post-COVID-19 policy guidance and refresher trainings on important policy topics relating to the PHE. See below for training topics, summary of each training and dates trainings were conducted:

Training	Training Objective	Date
Renewals Refresher Training	This refresher training will focus on the required steps for processing annual renewals, including handling special case scenarios resulting from the PHE.	May 18 and 19, 2022
Income Refresher Training	This refresher training is designed to provide important reminders about income counting rules for MAGI and Non-MAGI Medi-Cal and the verification process for income.	June 16, 2022
Post-PHE Enrollment Activities	This training will review policy guidance issued in the "Post-PHE Enrollment Activities" ACWDL published by DHCS.	July 12 and 14, 2022
Covered California Transitions	This training will introduce the implementation of SB 260 and the role county eligibility workers have in transitioning beneficiaries to Covered California.	July 28 and 29, 2022
Processing Undeliverable Mail	The training will outline the updated procedures for addressing in-state- and out-of-state returned mail.	August 9 and 11, 2022
Property Refresher Training	This refresher training is designed to provide important reminders about property for Non-MAGI Medi-Cal.	August 23 and 25, 2022
Resumption of Normal Business Practices during PHE Unwinding for County Fair Hearing Representatives	This training will review policy guidance for county fair hearings representatives.	September 30, 2022

Eligibility System Readiness

Statewide Automated Welfare System (SAWS). In response to the continuous coverage requirement, the California Statewide Automated Welfare Systems (CalSAWS) and the California Work Opportunity and Responsibility to Kids Information Network (CalWIN) implemented special protections to allow continuous coverage. Currently, DHCS is working in close collaboration with the SAWS to review system functionality and to design the appropriate system changes to resume normal renewal actions, while ensuring individuals are maintained in coverage awaiting their annual renewal. **SAWS conducted testing of the updated functionality in October 2022 to**

ensure it aligns with the continuous coverage requirement unwinding policies outlined by DHCS. The updated functionality will be deployed to align with redetermination processing to begin with the first redeterminations due June 2023.

California Healthcare Eligibility, Enrollment and Retention System (CalHEERS). During the continuous coverage requirement, changes to CalHEERS functionality were not needed beyond portal messaging that encouraged beneficiaries to update their contact information in the portal. As part of the continuous coverage requirement unwind efforts, CalHEERS implemented a 20 percent reasonable compatibility threshold to its processing of electronic verifications for MAGI Medi-Cal, MCAP, and CCHIP programs. Additionally, CalHEERS will continue to be leveraged to communicate Phase 2.0 banner messaging and will be available for system testing to support any required SAWS changes.

Stakeholder Engagement

DHCS collaborates with a variety of stakeholders including counties, MCPs, advocates, and community organizations to diligently prepare for the resumption of normal Medi-Cal eligibility operations and maintain health care coverage for beneficiaries once the continuous coverage requirement ends. The experience and expertise of workgroup participants assists DHCS with the following aspects:

- Developing policy guidance on resuming normal business activities once the continuous coverage requirement ends.
- Creating trainings, flowcharts, and other tools specific to county operational planning and staff development.
- Enhancing existing policies and business processes to increase efficiencies in case processing and to reduce barriers to continued coverage. This includes updating policy guidance, exploring other federal eligibility flexibilities, and incorporating Medi-Cal retention strategies developed by CMS.
- Identifying innovative solutions to obtain updated beneficiary contact information. Including utilizing MCPs to outreach to beneficiaries and provide counties with reported address changes.

DHCS facilitates the following engagement efforts throughout the month to elicit feedback and share important information related to the unwinding of the PHE.

	Members	Purpose
DHCS/County Workgroup	Counties SAWS County Welfare Directors Association (CWDA)	• Identify key policy, system, and operational components essential to the unwinding of the continuous coverage requirement.

		• Any issues identified with the current unwinding plan are identified and reconciled as a group.
DHCS/Community Stakeholder Workgroup	Community advocates Health plans Health plan associations CWDA	• Discuss unwinding plans and gain an understanding of the impacts these plans would have on beneficiaries. • Identify areas of improvement in the planning and eventual operation of returning to normal business practices.
California Department of Social Services (CDSS) State Hearings Division/DHCS Monthly Touch Point	CDSS State Hearings Division	• Collaborate on policy related to the unwinding of the continuous coverage requirement and its impacts on hearings and hearing requests.
DHCS Medi-Cal Consumer-Focused Stakeholder Workgroup	Open to the public	• Provide stakeholders an opportunity to review and offer feedback on a variety of consumer messaging materials.
CWDA Medi-Cal Care Committee	Counties SAWS CWDA DHCS	• Update committee with potential unwinding strategies and policies related to the end of the continuous coverage requirement. • Provide counties an opportunity to give feedback on proposed activities and policy and identify gaps or potential barriers.
DHCS Stakeholder Advisory Committee & DHCS Behavioral Health Advisory Committee	CA Health Care Foundation Hospital/Physician Associations Health Plans Community advocates CWDA Tribal Associations Behavioral Health Associations General public	• Provide updates to Committee members and general public on DHCS unwinding plans • Provide Committee members an opportunity to give feedback on proposed activities and policy and identify gaps or potential barriers.

Tracking Medi-Cal/CHIP Coverage Trends during Continuous Coverage Unwinding Period and Beyond

Enrollment Trends. The PHE has had a profound impact on the Medi-Cal program and the nearly **15.2** million average monthly individuals receiving Medi-Cal and CHIP benefits. State and federal policies placed important beneficiary protections during the PHE and allowed individuals to maintain Medi-Cal coverage. Prior to the PHE, the Medi-Cal program experienced a steady but gradual decline in total enrollment. Between March 2017 and March 2020, total Medi-Cal enrollment declined by approximately one million enrollees or 7.4 percent. Between April 2020 and December 2021, the Medi-Cal program experienced a 16 percent increase in total enrollment due to the continuous coverage requirements.

COVID-19 Impacts to Enrollment. Two primary factors influenced Medi-Cal caseloads during the PHE: the continuous coverage requirement and a volatile labor market. The federal FFCRA requirement implemented a continuous coverage requirement, under which Medi-Cal beneficiaries may be disenrolled only under very limited circumstances. Without Medi-Cal's naturally occurring disenrollment and attrition, the Medi-Cal caseload continued to grow. Difficult labor market conditions related to COVID-19 resulted in individuals experiencing the loss of income, employment, and health coverage, which led to more individuals qualifying for and enrolling into Medi-Cal program. As the continuous enrollment requirements established during the PHE begin to unwind, and normal operations resume, it is likely that Medi-Cal caseload will begin to level off and start to trend downward toward pre-PHE levels.

DHCS Continuous Coverage Unwinding Eligibility Data Dashboard. A DHCS Continuous Coverage Unwinding Eligibility Data Dashboard will be released publicly on the DHCS webpage that reports monthly application, enrollment, and renewal measures from the SAWS throughout the 12-month Continuous Coverage Unwinding Period. Dashboard measures will be updated monthly. The monthly dashboard will report total enrollment, newly enrolled, total applications received, applications in process, determination outcomes, and the following renewal measures: total renewals due for the redetermination month being reported, renewed via ex-parte, maintained in coverage due to COVID-19 Continuous Coverage continuous coverage requirements, and renewals resulting in discontinuance due to failure to respond, over income, and other common discontinuance reasons. To the extent possible, this dashboard with stratify data at the statewide and county level. **Per the January 5, 2023's CMCS Informational Bulletin, DHCS is still pending CMS guidance on additional data specifications included in the Consolidated Appropriations Act of 2023 for federal and state reporting. This includes Call Center volumes, average abandonment rates, and average wait times, and metrics for transitions to Covered California and individuals who have selected a Qualified Health Plan.**

Federal Monitoring through Continuous Coverage Unwind Period and Beyond. Per SHO 22-001, all states will be required to submit monthly data for a minimum of 14 months through a CMS-developed reporting template. CMS will require all states to report on

specific metrics described in this "Unwinding Eligibility and Enrollment Data Reporting Template" (Unwinding Data Report). These metrics are designed to demonstrate states' progress towards restoring timely application processing and initiating and completing renewals of eligibility for all Medicaid and CHIP enrollees consistent with the guidance outlined in SHO 22-001. Subsequent CMS guidance requires states to complete a baseline and subsequent monthly Unwinding Data Report and submit these reports to CMS per the Medicaid and CHIP Eligibility and Enrollment Data Specifications for Reporting During Unwinding. In addition, states will complete and submit to CMS a summary of the state's plans for initiating renewals for its total caseload within the state's 12-month unwinding period (Statewide Renewal Distribution Plan). **Per the January 5, 2023's CMCS Informational Bulletin, DHCS is still pending CMS guidance on additional data specifications included in the Consolidated Appropriations Act of 2023 for federal and state reporting. This includes Call Center volumes, average abandonment rates, and average wait times, and metrics for transitions to Covered California and individuals who have selected a Qualified Health Plan.**

For states that are out of compliance, CMS will require the submission of a corrective action plan that details strategies and timelines for coming into compliance.

Appendix

Appendix A: Eligibility Sequencing Map

Appendix A.pdf

Appendix B: COVID-19 Uninsured Group – Unwinding Activities

Appendix B.pdf

Resources

State Guidance

DHCS has released multiple guidance letters throughout the duration of the PHE in order to assist counties with frequently asked questions, policy changes, policy clarifications and other useful information. The guidance can be found at the following links:

ACWDL 22-23	October 17, 2022	American Rescue Plan Act Postpartum Care Extension Ref: ACWDL 21-15, MEDIL 21-13 and 21-13E, MEDIL 22-21
ACWDL 22-22	August 8, 2022	Introduction of Reasonable Explanation for Medi-Cal Eligibility Determinations
ACWDL 22-18	June 24, 2022	Case Processing Actions after the Conclusion of the Coronavirus (COVID-19) Public Health Emergency (PHE)
ACWDL 22-04	February 11, 2022	Treatment of Certain Public Health Emergency Assistance Payments for Medi-Cal Eligibility
ACWDL 21-22	October 28, 2021	Implementation of the “Support Act” - Suspension of Medi-Cal Benefits For “Eligible Juveniles”, Under Age 21 or Former Foster Youth under Age 26, And Other Suspension Requirements
ACWDL 21-16	September 14, 2021	Case Processing Actions Allowed during the Coronavirus (COVID-19) Public Health Emergency (PHE)
ACWDL 21-15	August 6, 2021	Postpartum Care Extension
ACWDL 21-14	July 29, 2021	Golden State Stimulus and Golden State Grant Payments
ACWDL 22-17	June 17, 2022	Increase to the Reasonable Compatibility Threshold in the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS)
ACWDL 21-10	May 18, 2021	Provisions from the American Rescue Plan Act of 2021
ACWDL 21-03	February 17, 2021	Provisions from the Coronavirus Response and Relief Supplemental Appropriations Act, 2021
ACWDL 20-16	September 17, 2020	Information Regarding the Lost Wages Assistance Program

ACWDL 20-14	July 31, 2020	Provisional Postpartum Care Extension
ACWDL 20-09	April 27, 2020	Provisions from the Federal Coronavirus Aid, Relief, and Economic Security Act
MEDIL I 23-03	January 10, 2023	Updates to the County Readiness Toolkit for the Preparation of novel Coronavirus (COVID-19) Public Health Emergency (PHE) End of Continuous Coverage Requirement (REF: Medi-Cal Eligibility Division Information Letter (MEDIL) I 22-33)
MEDIL I 23-02	January 10, 2023	Updated Guidance for Counties on Resuming Medi-Cal Redeterminations (REF: MEDIL 20-25, ACWDL 21-16, ACWDL 22-18, MEDIL 22-20E)
MEDIL I 22-48	November 22, 2022	Instructions for the Request for Additional Income Information For Medi-Cal Form to Obtain a Reasonable Explanation
MEDIL I 22-45	November 09, 2022	Updates Regarding The Processing Of Returned Mail With In-State Forwarding Address
MEDIL I 22-43	November 01, 2022	COVID-19 Public Health Emergency Unwinding Period: Adding a Person to an Existing Case
MEDIL I 22-34	August 22, 2022	COVID-19 Public Health Emergency (PHE) Unwinding for Individuals who Aged out of the Young Adult Expansion during the PHE
MEDIL I 22-33	August 26, 2022	County Readiness Toolkit for the Preparation of the novel Coronavirus (COVID-19) Public Health Emergency (PHE) Unwinding and Resumption of Normal Medi-Cal Operations
MEDIL I 22-28	July 11, 2022	COVID-19 Public Health Emergency (PHE) Unwinding Flow Charts
MEDIL I 22-20E	June 24, 2022	Errata To The Medi-Cal Eligibility Division Information Letter No. I 22-20 For Updates Regarding The Approval Of Temporary Waiver Requests As A Result Of The Covid-19 Public Health Emergency
MEDIL I 22-19	May 13, 2022	The Coronavirus (COVID-19) Uninsured Group Program Continues to Process COVID-19 Testing, Testing-related, Vaccination and Treatment Claims
MEDIL I 22-11	March 18, 2022	County Support for Managed Care Plans Regarding All Plan Letter 22-004
MEDIL I 22-10	March 21, 2022	Additional And Updated Frequently Asked Questions Due To The Covid-19 Public Health Emergency
MEDIL I 22-01	January 14, 2022	Federal Covid-19 Public Health Emergency Additional Contact Requirement

MEDIL I 21-39	November 23, 2021	Global Outreach Language Translations
MEDIL I 21-37	November 17, 2021	Federal Stimulus Payments
MEDIL I 21-21	September 20, 2021	COVID-19 Global Outreach Language
MEDIL I 21-19	September 16, 2021	Expiration of Pandemic Unemployment Benefits from the American Rescue Plan Act and Coronavirus Aid, Relief, and Economic Security Act
MEDIL I 21-13	August 31, 2021	Postpartum Care Extension Implementation
MEDIL I 21-09	June 24, 2021	Continuing Telephonic Flexibilities for the Minor Consent Program beyond the COVID-19 Public Health Emergency
MEDIL I 21-04	March 4, 2021	Additional and Updated Frequently Asked Questions due to the COVID-19 Public Health Emergency
MEDIL I 20-37	December 7, 2020	Coronavirus (COVID-19) Uninsured Group Program
MEDIL I 20-30	October 5, 2020	Mixed Household Renewals Guidance During The COVID-19 Public Health Emergency
MEDIL I 20-26	August 14, 2020	Additional Frequently Asked Questions Due to the COVID-19 Public Health Emergency
MEDIL I 20-25	August 13, 2020	Updated Guidance Due to the COVID-19 Public Health Emergency Superseding MEDIL I 20-07 and MEDIL I 20-08
MEDIL I 20-20E	February 22, 2021	Extend Eligibility for Refugee Medical Assistance Applicants and Beneficiaries Due to the Covid-19 Public Health Emergency Errata
MEDIL I 20-20	July 30, 2020	Extend Eligibility for Refugee Medical Assistance Applicants and Beneficiaries Due to the COVID-19 Public Health Emergency
MEDIL I 20-19	June 18, 2020	Outreach Letters to Two Populations Regarding the Spousal Impoverishment Provisions
MEDIL I 20-18	June 2, 2020	Frequently Asked Questions Due to the Covid-19 Public Health Emergency
MEDIL I 20-16	May 15, 2020	Companion to MEDIL I 20-12 - Applications Received Through SAWS Portal

MEDIL I 20-15	May 13, 2020	Prioritizing Case Processing Activities Through the Duration of the Covid-19 Public Health Emergency
MEDIL I 20-14	May 29, 2020	Extension of Delaying Annual Redeterminations, Discontinuances, and Negative Actions Due to Covid-19 Public Health Emergency
MEDIL I 20-12	April 27, 2020	Applications Received Without Applicant Signature
MEDIL I 20-11	April 23, 2020	Follow-up Guidance to MEDIL I 20-07 and I20-08 on Medi-Cal Inmate Eligibility Programs & Medi-Cal Beneficiaries Who Become Incarcerated
MEDIL I 20-08	April 10, 2020	Follow-up Guidance to MEDIL I 20-07
MEDIL I 20-07	March 16, 2020	Access to Care During Public Health Crisis or Disaster for Medi-Cal
MEDIL I 20-06	March 12, 2020	Public Health Crisis or Disaster Reminders for Medi-Cal

Federal Guidance

DHCS developed the COVID-19 PHE and Continuous Coverage Requirement Unwinding Operational Plan utilizing the guidance and tools released by CMS. The guidance can be found at the following links:

SHO 20-004	December 22, 2020	State Health Office Letter: Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency
All State Call Presentation	June 16, 2020	Additional information on federal requirements for retaining Medicaid state plan flexibilities
CIB	December 4, 2020	Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements
All State Call Presentation	January 7, 2021	Overview of December 2020 State Health Official Letter
All State Call Presentation	January 19, 2021	Overview of eligibility and enrollment provisions in December 2020 State Health Official Letter
Presentation	July 29, 2021	Ensuring Continuity of Coverage and Preventing Inappropriate Terminations – Part 1

Presentation	August 3, 2021	Ensuring Continuity of Coverage and Preventing Inappropriate Terminations – Part 2
SHO 21-002	August 13, 2021	Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency
All State Call Presentation	August 19, 2021	Overview of August 2021 State Health Official Letter
Issue Brief	November 24, 2021	Connecting Kids to Coverage: State Outreach, Enrollment and Retention Strategies issue brief
Issue Brief	November 24, 2021	Strategies States and U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as they Return to Normal Operations
All State Call Presentation	November 30, 2021	Strategies for retaining eligible individuals and engaging managed care plans
Presentation	December 8, 2021 Updated- March 3, 2022	Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations
All State Call Presentation	February 15, 2022	Sunsetting Medicaid and CHIP disaster relief SPAs and section 1135 waivers and options for disaster relief SPA provisions
All State Call Presentation	February 22, 2022	CMS Office of Communications consumer research on preventing churn during unwinding
SHO 22-001	March 3, 2022	Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency
All State Call Presentation	March 8, 2022	CMS Unwinding Resources
Proposed Rule	April 22, 2022	Implementing Certain Provisions of the Consolidated Appropriates Act, 2021 and other Revisions to Medicare Enrollment and Eligibility Rules (CMS-4199 – P)
Presentation	May 17, 2022	Eligibility & Enrollment Processing for Medicaid, CHIP, and BHP During COVID-19 Public Health Emergency Unwinding Key Requirements for Compliance
FAQ	October 17, 2022	COVID-19 Public Health Emergency Unwinding FAQs

All State Call Presentation	October 17, 2022	Ending Coverage in the Optional COVID-19 Group: Preparing States for the End of the Public Health Emergency
Presentation		Ex Parte Renewal: Strategies to Maximize Automation, Increase Renewal Rates, and Support Unwinding Efforts
Presentation	November 3, 2022	Preparing for the End of the COVID-19 Public Health Emergency: Opportunities to Support Medicaid and SNAP Unwinding Efforts
Presentation	December 3, 2022	Improving Efficiency and Beneficiary/Staff Experience Through Improved Renewal Automation for Unwinding
All State Call Presentation	December 12, 2022	Supporting Seamless Coverage Transitions for Children Moving Between Medicaid and CHIP in Separate CHIP States
CMCS Informational Bulletin	January 5, 2023	Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the Consolidated Appropriations Act, 2023
General Guidance	January 6, 2023	System Readiness Artifacts: A Refresher on Medicaid Enterprise Systems Artifacts for Unwinding