Implementation Plan for New Eligibility and Enrollment Changes under H.R. 1

Thursday, February 5, 2026

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

California Department of Health Care Services

Agenda

- Purpose of Implementation Plan
- Work and Community Engagement Requirements
- Six-Month Renewals
- Member Use Case: Work Reporting Requirements at Renewal
- Non-Citizen Coverage

Background and Overview

H.R. 1 establishes new eligibility and enrollment (E&E) changes to Medicaid, including requirements that change eligibility criteria and establish new parameters for how to enroll in and maintain coverage.

DHCS has developed an implementation plan to outline its approach to mitigating the impact on members and minimizing coverage loss to the greatest extent possible. DHCS' implementation plan will be updated accordingly throughout the implementation process.

Today's discussion will focus on how DHCS will implement (1) new work reporting requirements, (2) six-month renewals, and (3) changes to immigrant coverage for certain Medi-Cal populations.

H.R. 1 Key Medi-Cal Eligibility Changes (1 of 2)

Change	Description	Effective Date
Streamlining Eligibility Final Rules Moratorium	Pauses implementation and enforcement of some provisions in eligibility and enrollment federal rules that were focused on further improving noticing and processing timeframes at application and renewal and streamlining eligibility processes for the Aged and Disabled eligibility groups.	Immediate (7/1/24)
Amended Eligibility for Federally-Funded Medicaid	Changes who counts as a "qualified" immigrant for federally funded full-scope Medi-Cal.	10/1/26
Work Reporting Requirements	Requires adult expansion enrollees eligible for federally-funded Medicaid under the Affordable Care Act, also called the "New Adult Group"* to work, study, or volunteer at least 80 hours per month unless exempt.	1/1/27
Six-Month Renewals	Requires the New Adult Group members to renew Medi-Cal every six months instead of once a year.	1/1/27

H.R. 1 Key Medi-Cal Eligibility Changes (2 of 2)

Change	Description	Effective Date
Reducing Duplicate Enrollment	Codifies requirement that all states update address information based on information received from other data sources such as the National Change of Address database and returned mail starting in 2027. Effective 2029, the federal government must establish a national database that will identify individuals who may be enrolled in Medicaid in more than one state.	1/1/27 and 10/1/29
Deceased Member Verification	Requires states to verify eligibility against the federal Death Master File on a quarterly basis, or a successor system, to identify deceased individuals who should no longer be enrolled in coverage.	1/1/27
Retroactive Medi-Cal Timeframes	Reduces retroactive coverage from three months to one month for New Adult Group members and two months for all other Medi-Cal members.	1/1/27
Cost-Sharing for New Adult Group	Requires states to implement copayments for certain New Adult Group members for some services while keeping essential care—like emergency, prenatal, and mental health visits—free.	10/1/28

DHCS Implementation Guiding Principles

- **Automate to Protect Coverage.** Maximize the use of data sources to confirm eligibility without burdening members and counties. Reduce paperwork, streamline verifications, and safeguard coverage stability.
- **Communicate with Clarity and Connection.** Implement an outreach and education campaign that is culturally relevant, linguistically accurate, and written in plain language to build trust and help members, their families, and caregivers understand the changes.
- **Simplify the Renewal Experience.** Modernize and streamline the Medi-Cal renewal process with clearer, member-friendly forms (first in the New Adult Group, and later for all members) and with six-month renewal steps that are easier to navigate.
- **Educate and Train Those Who Serve Medi-Cal Members.** Deliver comprehensive training on all H.R. 1 provisions for county eligibility workers. Provide clear policy guidance, practical tools, and ongoing technical assistance so counties, plans, providers and DHCS Coverage Ambassadors can confidently support members and avoid error on member cases.
- **Provide Timely and Transparent Communication to Members.** Share information on H.R. 1 changes early on and via multiple channels (mail, text, outbound phone calls, etc.) so members can build awareness, anticipate changes to their coverage, and have ample preparation time to meet new requirements.

Work and Community Engagement Requirements

Overview of Work and Community Engagement Requirements

Section 71119: Requires states to condition Medicaid eligibility on compliance with work rules (called “community engagement requirements”) for adults ages 19 through 64. The provision applies to adult expansion enrollees under the Affordable Care Act (ACA), also called the “MAGI New Adult Group."

Effective Date: January 1, 2027

Impact:

An estimated up to 233K Medi-Cal members will lose coverage by June 2027, 1 million by Jan 2028, and 1.4 million by June 2028. This coverage loss will significantly drive up the uninsured rate and raise costs for hospitals and clinics treating uninsured patients.

All numbers are estimates and subject to change.

Overview of Work and Community Engagement Requirements

- **Requirement**: Individuals must complete one or more qualifying activities:
  - Have monthly income at least 80 times the federal hourly minimum wage ($580) or employment of 80 hours/month (Seasonal work will be averaged over the last six months)
  - Community service of 80 hours/month
  - Enrolled at least half-time in an educational program
  - Participation in a work program of 80 hours/month

- **Exemptions**. The law outlines mandatory and short-term hardship exemptions. Exemptions must be verified every 6 months.

- **All County Welfare Director's Letter (ACWDL) 25-30:** Work and Community Engagement Requirements for New Adult Group
  - *Note: This is preliminary DHCS guidance that is subject to change as federal guidance evolves.*

Work and Community Engagement Requirements: Mandatory Exemptions (1 of 2)

H.R. 1 provides individuals who meet the following criteria do not need to demonstrate compliance with work requirement's qualifying activities and are not subject to six-month renewals

Mandatory Exemptions

- Enrolled in one of the following Medi-Cal eligibility groups:
  - Pregnant or up to 12 months postpartum
  - Foster youth
  - Former foster care youth under age 26
  - Aged, Blind, or Disabled people (including individuals who receive SSI)
  - Children under age 19
- American Indian/Alaska Natives

Work and Community Engagement Requirements: Mandatory Exemptions (2 of 2)

Mandatory Exemptions

- Parents/guardians/caregivers of a dependent child age 13 and younger
- Parents/guardian/caregivers of a disabled individual
- Veterans with a disability rating of total
- Incarcerated or recently released from a correctional facility within the past 90 days
- Entitled to Medicare Part A or enrolled in Part B
- Meeting TANF (CalWORKs) work requirements or SNAP (CalFresh) work requirements
- Participating in drug/alcohol treatment programs
- Medically frail, per the statute, this includes individuals (1) with a substance-use disorder (SUD); (2) with a disabling mental disorder; (3) with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living; (4) with a serious or complex medical condition; or (5) who are blind or disabled (as defined in section 1614 of the Social Security Act)).

H.R. 1 provides that individuals who meet one of the following reasons for exemption do not have to demonstrate compliance with work requirement's qualifying activities at application and during their six-month renewal period

Work and Community Engagement Requirements: Optional Temporary Exemptions

DHCS will implement optional short-term hardship exemptions and automatically apply them as applicable to members and applicants to the maximum extent possible. Short term-hardship exemptions include:

- **Emergency declaration:** Living in a county impacted by a federally declared emergency or disaster.
- **Unemployment:** Living in a county or local jurisdiction (not yet defined by CMS) with a high unemployment rate (at or above the lesser of 8% or 150% of the national unemployment rate, which was 4.2% as of July 2025). Enrollees in approximately 22 counties (including Alpine, Colusa, Fresno, Glenn, Imperial, Kern, Kings, Madera, Merced, Sutter, and Tulare counties) could qualify for this exemption (approximately 15.6% of Medicaid expansion enrollees in California).[1]
- **Inpatient Care**: Receiving inpatient hospital care, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric care, or other services of similar acuity (including related outpatient care) determined by the U.S. HHS Secretary.*
- **Travel for Care**: Traveling for an extended period to access medically necessary care for a serious or complex medical condition that is not available in the individual/their dependent(s)' community.*

1. KFF, A Look at the Potential Impact of the High Unemployment Hardship Exemption to Medicaid Work Requirements, 2025

*Exemption only available if specifically requested by the individual.

DHCS Implementation Plan for Work Reporting Requirements

DHCS Actions for Work Requirements Implementation

To implement work reporting requirements, DHCS will:

- **Revise eligibility policies and procedures**—including the *ex parte* review process at renewal—to incorporate compliance and exemption verification processes.
- **Establish a streamlined process** that allows affected members to easily report their work activities or exemptions online and through other commonly used modalities.
- **Issue policy guidance and resources** for counties and update systems to maximize automation.
- **Launch extensive communication and outreach campaigns** to educate Medi-Cal members and applicants about the new eligibility requirements.

Note: To maintain parity across all New Adult Group populations receiving full-scope Medi-Cal benefits, DHCS plans to implement work reporting requirements for all expansion New Adult Group enrollees receiving full-scope Medi-Cal.

DHCS Stakeholder Engagement Activities for Work Reporting Requirements

DHCS collaborates with a wide range of stakeholders to prepare for and implement work reporting requirements.

Through a multi-phased approach, DHCS and stakeholders will ensure that members are properly equipped to respond to work reporting requirements while helping them maintain access to care.

- **Phase 1: Awareness and Preparation.** DHCS will raise awareness of upcoming changes and prepare members for specific actions they must take to maintain their Medi-Cal coverage ahead of programmatic changes. Stakeholders will leverage DHCS materials for outreach and education efforts (e.g., earned media, social media, and toolkits).
- **Phase 2: Support and Action.** As the implementation date gets closer, DHCS will shift communication to focus on the specific actions members must take, such as responding to notices or completing renewal packets. Messaging will reinforce this through direct outreach, reminders, and targeted assistance to help members retain coverage (e.g., public notices and toolkits).

Anticipated Stakeholder Engagement Activities:

Impacted Partners	Topics to Discuss
» Counties » Managed care plans (MCPs) » Eligibility systems » Members » Community Partners/ Advocates » Health Care Providers » CoveredCA	**Phase 1: Awareness and Preparation** » Meet with impacted partners to solicit input on ways to implement, and provide effective outreach for new work reporting requirements and implications for: eligibility determinations at application and renewal; notices; training materials; education; and outreach » Provide opportunity for input on process design for verifying applicant/member compliance with/exemptions for work reporting requirements **Phase 2: Support and Action** » Distribute ongoing outreach communication and notices to all impacted partners and members in advance of renewal to promote awareness » Collaborate with impacted partners on guidance, training, updating systems and technical assistance (TA) to counties, CalSAWS, MCPs, and CoveredCA to support implementation

Member Communication and Outreach

DHCS will lead a coordinated communication and outreach strategy to ensure stakeholders and members have the information they need as the H.R. 1 provisions take effect.

DHCS' goal is to deliver clear, consistent, and culturally responsive messaging that helps members understand changes, identify actions they may need to take, and find the support available to them.

- **Member communication channels include, but are not limited to:**
  - **Toolkits**: Messaging guides, flyers, and FAQs in all 19 Medi-Cal threshold languages and accessible formats to post on the DHCS website and disseminate to stakeholders.
  - **Texting**: A limited, targeted texting strategy to raise awareness about work reporting requirements in early 2026.
  - **DHCS Coverage Ambassadors and Navigators**: DHCS will rely on Coverage Ambassadors and navigators to distribute resources and messaging at the local level.
- **Timeframe for outreach:**
  - Feb – Jul 2026 to develop member awareness (Phase 1)
  - Oct – Jan 2027 to support members taking action to respond to new requirements (Phase 2)

Stakeholder Roles

Providers

- Ensure patients have up-to-date information on program changes
- Assist patients in gathering exemption documentation
- ECM providers may conduct outreach and support members in navigating work reporting requirements and increased eligibility renewals

Community Health Workers and Navigators

- Support outreach and retention efforts
- Assist members with completing paperwork related to work reporting requirements

Managed Care Plans

- Conduct outreach and retention efforts
- DHCS is exploring MCP role in supporting verification efforts, pending CMS guidance

Work Reporting Requirements Verification Process

Work Reporting Requirements: High-Level Process Overview

1

At application/renewal, DHCS will gather exemption or work reporting requirement information.

- Exemption and work reporting questions will be added to the CalHEERS and BenefitsCal consumer portals.
- DHCS will create an exemption and work reporting form to use at application and renewal.1

2

DHCS will conduct *ex parte* review at renewal to determine if someone is compliant with or exempt from work reporting requirements.

- DHCS is leveraging current data sources and building bridges to new data sources to support verifying work activities and exemptions.
- Data received from CalFresh, CalWorks, General Assistance/General Relief, and other income information available in CalSAWS will be incorporated into the *ex parte* process at application and renewal.

3

If DHCS is unable to verify work activities or exemptions *ex parte*, it will manually request documentation. Applicants and members will have 30 days to demonstrate compliance or that they meet an exemption.

Verification Lookback Periods

H.R. 1 mandates that individuals comply with or demonstrate work reporting requirements during specific timeframes depending on whether the individual is applying for or renewing coverage.

- **At application:** Individuals must meet work reporting requirements in the month before they apply.
- **At renewal:** Individuals must meet work reporting requirements in at least one of the months since their last renewal.

Verification Hierarchy for Medicaid Work Reporting Requirements

- The following slides outline a proposed stepwise process for verifying whether an individual is subject to work reporting requirements or qualifies for an exemption. The steps prioritize data sources that aim to minimize member burden and only request documentation from individuals when necessary.
- The estimated number of enrollees that can be captured in each verification step is also displayed in the subsequent slides.

Verification Steps

1	Assess if the individual meets an exemption based on being eligible for a non-expansion eligibility category or based on other eligibility information
2	Assess if the individual meets a hardship exemption that can be verified electronically
3	Identify individuals who meet exemptions using data sources or cross-system information data sharing
4	Conduct data verification to identify compliance with qualifying activities based on income and/or hours
5	Request information from the consumer to verify compliance with qualifying activities or an exemption

Verification Steps (1 of 3)

1	**Assess if the individual meets an exemption based on being eligible for a non-expansion eligibility category or based on other eligibility information** (*Note: All data below reflects August 2025 Medi-Cal enrollment numbers)	
	Identify Medicaid Expansion Adults/New Adult Group Individuals aged 19 to 64	**~4,633,636** Individuals
	Identify eligibility group exemptions: Exempts individuals identified by aid code based on their eligibility category, including: children under 19; parents and other caretaker relatives; aged/blind/disabled non-Modified Adjusted Gross Income (MAGI) eligibility; pregnant and postpartum individuals; foster youth and former foster youth under age 26; those receiving Supplemental Security Income; and inmates.	**Already exempted based on aid code**
	Identify individuals who can be coded as exempt based on their eligibility group plus a systems modification: Exempts individuals including parents/guardians/caregivers of dependent child age 13 and younger; individuals recently released from incarceration within the past 90 days.	**~619,711** Individuals
	Identify individuals who can be coded as exempt based on information provided on the application/renewal form: Exempts individuals including AI/AN; individuals entitled to or enrolled in Medicare Part A or Part B.	**~14,385** Individuals

Verification Steps (2 of 3)

2 Assess if the individual meets a hardship exemption that can be verified electronically

Determine individuals who meet a short-term hardship exemption:
Exempts individuals living in a county impacted by a federally declared emergency or disaster; living in a county with high unemployment rate.

~373,389
Individuals

3 Identify individuals who meet exemptions using data sources or cross-system information data sharing

Determine if individuals meet other exemption criteria using new data sources or reports
Verifies that individuals:

- Meet TANF work requirements;
- Have a member of a household receiving SNAP or meets a SNAP exemption that is aligned with a Medicaid exemption;
- Are parents or guardians of a disabled individual;
- Are veterans with a disability rated as total by Veterans Affairs (VA);
- Are medically frail; or
- Are at least half-time enrolled in educational program

TBD
Individuals

Verification Steps (3 of 3)

4 Conduct data verification to identify compliance with qualifying activities based on income and/or hours.

Verify individuals complying with income/work hours qualifying activities:
Verifies individuals who have an income of at least $580/month;
who have an average monthly income of $580/month;
who work 80 hours/month.

~672,831
Individuals

~1,842,155 individuals determined exempt or income compliant via an automated source (Steps 1-4)

5 Request information from the consumer to verify compliance with qualifying activities or an exemption

Individuals unable to verify compliance with qualifying activities or receive an exemption using sources above
May vary by individual.

~2,791,481
Individuals who could not be determined exempt or income compliant via an automated data source

~1,395,741
assume 50% of 2,791,481 will disenroll due to failure to return verifications/comply

Examples of State and Federal Data Sources For Verifying Compliance (Income or Hours)

Compliance/Exemption Category	Potential Data Source	Status
Income of at least $580/month and/or 80 hours of work	State Quarterly Wage Data (EDD) and IRS Data	Currently in use
	Equifax Work Number (provides timely income data and hours of work)	DHCS executed a one-year contract to access database
	Gig Economy Data	California is assessing several options
	CalFresh, CalWORKs, GA/GR, and other income information in CalSAWS	Currently in use
Veteran with disability rated as total	Veteran Service History and Eligibility Application Programming Interface (API)	DHCS currently receives this data and will use for exemption purposes

Examples of DHCS Data Sources for Identifying Eligibility Group Exemptions

Compliance/Exemption Category	Potential Data Source	Current Status
• Child under 19 • Pregnant or postpartum • Foster youth and former foster care youth • Aged/disabled • Parents/caretaker relatives • Inmates of a public institution or released from incarceration	Medi-Cal Eligibility Aid Codes	System to be configured to exempt individuals from work reporting requirements

Examples of DHCS Data Sources for Identifying Medical Frailty Exemptions

Compliance/ Exemption Category	Potential Data Source	Current Status
Medically Frail	All Claims and Encounters (e.g., submitted through PACES, CA-MMIS, Medi-Cal Rx)	• DHCS will exempt individuals who are eligible for certain programs (e.g., HCBS, HCBA waiver, MCWP formerly AIDS Waiver, ALW, CBAS, CCS, PACE, Enhanced Care Management, Community Supports) to extent program eligibility aligns with Medically Frail criteria. • In addition, DHCS is evaluating which International Classification of Diseases (ICD)-10 and Current Procedural Terminology (CPT) Codes could be used to identify diagnosis and utilization data to establish medical frailty, alcohol/drug treatment, pregnancy, and more. • DHCS is also exploring other potential data sources (e.g., MCP care management systems), for timely sources of exemption data.
	Short Doyle Medi-Cal System	System to be configured to pull in data for identifying exemption

Examples of Cross-State Data Sources for Identifying Compliance/Exemptions

Compliance/Exemption Category	Data System	Current Status
Compliance with Temporary Assistance for Needy Families (TANF)/CalFresh (SNAP) Work Requirements	California Statewide Welfare Automated Systems (CalSAWS)	System to be configured to pull in DSS data for identifying exemption
Part-Time Education	California Student Aid Commission (CSAC) and University of California (UC) data/ California State University (CSU) data / CA Department of Education (DOE) data	DHCS exploring potential for data matching
80 hours of work program participation	Department of Rehabilitation or other state agencies	DHCS exploring potential for data matching

Six-Month Renewals

Overview of Six-Month Renewals

Section 71107: Requires that as of January 1, 2027, states must conduct eligibility redeterminations for adult expansion enrollees under the Affordable Care Act (ACA), also called the "MAGI New Adult Group," once every six months instead of once every 12 months per current policy. Tribal members, pregnant and postpartum members, foster care youth and former foster care youth under age 26, disabled or aged members, and children are not subject to this requirement. This population is also subject to work and community engagement. The six-month redetermination process will largely mirror existing annual renewal processes for automated and manual *ex parte* efforts, verification requests, and other existing processes.

Effective Date: January 1, 2027

Impact:

An estimated up to 289K Medi-Cal members may lose coverage by June 2026, and increasing to approximately 400K by 2029-30, which will significantly drive up the uninsured rate and raise costs for hospitals and clinics treating uninsured patients.

All numbers are estimates and subject to change.

Six-Month Renewal Process

- Six-month renewals will follow the same process as the 12-month renewal, including *ex parte*, renewal timeline, and reminder notices.
- Only the individuals on the case who are subject to a six-month renewal will be required to complete and return the renewal.
- DHCS is updating and streamlining the MAGI renewal form to reduce member burden in completing the form.
- Tribal members and individuals that are pregnant or 12 months postpartum are not subject to six-month eligibility checks, even when enrolled through the MAGI New Adult Group.
- **All County Welfare Director's Letter (ACWDL) 25-31:** Six-Month Renewals for New Adult Group Requirements
  - *Note: This is preliminary DHCS guidance that is subject to change as federal guidance evolves.*

Anticipated Stakeholder Engagement Activities: Six-Month Renewals

Impacted Partners	Topics to Discuss
» Counties » MCPs » Eligibility systems » Members » Community Partners/ Advocates » Health Care Providers » CoveredCA	**Phase 1: Awareness and Preparation** » Provide education to all impacted partners to promote awareness and understanding of process/timing for more frequent renewals » Solicit input from implementation partners on design for streamlining renewals and conducting *ex parte* to the maximum extent possible **Phase 2: Support and Action** » Collaborate with impacted partners on the development and provision of guidance, training, updating systems, and TA to counties, MCPs, and Covered CA on implementing more frequent renewals

Member Use Case: Work Reporting Requirements at Renewal

Example Member Journey: Work Reporting Requirements at Renewal (1 of 2)

1. Christopher is a Medi-Cal member subject to the new work reporting requirements that go into effect January 2027. His renewal date is July 2027.

2. In September 2026, Christopher (and all expansion enrollees) will receive a notice from DHCS informing him of forthcoming work reporting requirements.

3. In April 2027, DHCS will attempt to conduct *ex parte* renewal for Christopher based on information he provided at his last application/renewal and available data sources. If DHCS can verify compliance/exemption *ex parte*, Christopher will be automatically renewed for coverage.

Example Member Journey: Work Reporting Requirements at Renewal (2 of 2)

5

If DHCS is unable to verify Christopher *ex parte*:

6

In May 2027, DHCS (via counties) will issue Christopher a manual renewal packet to request documentation from him to verify compliance/exemption.

7

In June/July/August 2027, DHCS will process Christopher's returned renewal form and issue a notice of renewed coverage or a notice of non-compliance based on the information he provides.

- *If Christopher is approved for renewal,* his notice will include language informing him of the forthcoming 6-month redetermination.
- *If Christopher's response shows he is not meeting work requirements,* he will receive a notice providing 30 days to comply with work reporting requirements.
- *If Christopher does not comply within 30 days,* his coverage is terminated. His notice will include options he can pursue if he disagrees with the decision, information on appeal rights.

8

Christopher will receive 6-months of renewed coverage, from July-December 2027, if approved.

Non-Citizen Coverage

Non-Citizen Coverage

Section 71109: Ends the availability of full-scope federal Medicaid and CHIP funding for most refugees, asylees, victims of human trafficking, certain individuals whose deportation is being withheld or who were granted conditional entry, or individuals who received humanitarian parole, such as certain Afghans who aided U.S. operations in Afghanistan or people fleeing violence in the Ukrainian war.

Effective Date: October 1, 2026

Impact:

An estimated up to 200,000 Medi-Cal members will no longer qualify for federal full-scope Medicaid, which will significantly change the medical services these individuals can access. Per Governor's Budget 2026-27, this group will transition to restricted scope Medi-Cal.

All numbers are estimates and subject to change.

Restricted Federal Funding for Certain Qualified Non-Citizens

- H.R. 1 narrows eligibility for who counts as a "qualified" immigrant for federally funded Medi-Cal. Under the proposed Governor's Budget 2026-2027, only the following immigration statuses will be eligible for federally funded Medi-Cal Coverage:
  - Lawful Permanent Resident (LPR), who are subject to and have met their five-year bar
  - Cuban or Haitian Entrants
  - Migrants legally residing in the United States and its territories under the Compact of Free Association (COFA), who are citizens of Micronesia, the Marshall Islands, or Palau.

- Per proposed Governor's Budget 2026-27, individuals whose immigration status previously qualified them for federal full-scope Medi-Cal will be transitioned to restricted scope (emergency and pregnancy-related services only) effective October 1, 2026.

Restricted Federal Funding for Certain Qualified Non-Citizens

- Lawfully present immigration statuses affected by this change include:
  - Refugee status (T-Visa holders are treated as refugees)
  - Granted asylee status
  - Amerasian immigrants
  - Individuals granted withholding of deportation or removal
  - Conditional entrants granted before April 1980
  - Individuals paroled into the United States for one year or more
  - Battered non-citizens, or the parent or child of a battered non-citizen
  - Victims of human trafficking
  - Individuals granted humanitarian parole, such as certain Afghans who aided U.S. operations in Afghanistan or people fleeing violence in the Ukrainian war
- Lawfully present children under the age of 21 and lawfully present pregnant or postpartum individuals, if otherwise eligible, will continue to receive federally-funded full scope Medi-Cal.

Anticipated Stakeholder Engagement Activities: Immigrant Coverage

Impacted Partners	Topics to Discuss
» Counties » Managed care plans (MCPs) » Eligibility systems » Members » Community Partners/ Advocates » Health Care Providers » CoveredCA	**Phase 1: Awareness and Preparation** » Meet with impacted partners for input on approaches for amended rules on who qualifies for federally-funded Medi-Cal Coverage **Phase 2: Support and Action** » Training and technical assistance (TA) to counties, MCPs, and CoveredCA to support implementation » Education to immigrant populations to improve understanding and awareness of upcoming changes

Questions?

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