State of California—Health and Human Services Agency
Department of Health Care Services

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TO: ALL COUNTY WELFARE DIRECTORS Letter No.: 22-18
ALL COUNTY WELFARE ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS
ALL COUNTY MEDS LIAISONS

SUBJECT: Case Processing Actions after the Conclusion of the Coronavirus (COVID-19) Public Health Emergency (PHE)
(Reference: Medi-Cal Eligibility Division Information Letters I 20-25, 21-04 and ACWDL 21-16 and 14-32)

The purpose of this All County Welfare Directors Letter (ACWDL) is to instruct counties on resuming normal case processing actions after the Novel Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE) concludes based on guidance issued by the Centers for Medicare and Medicaid Services (CMS).

Background
During the federal COVID-19 PHE, the Department of Health Care Services (DHCS) used various program flexibilities to respond to the pandemic and provide continuous access to care for millions of Californians. As a result of Governor Newsom's March 4, 2020, State of Emergency declaration and the President's subsequent Federal declaration on March 13, 2020, DHCS released policy guidance through multiple Medi-Cal Eligibility Division Informational Letters (MEDILs) and ACWDL 21-16 on modifying case processing during the federal COVID-19 PHE.

In order to prepare for the end of the federal COVID-19 PHE, DHCS has collaborated with various stakeholders to develop a comprehensive 12-month plan for reinstating regular Medi-Cal eligibility determinations to address the outstanding work that has accumulated during the federal COVID-19 PHE. As a first step in preparing for the end of the federal COVID-19 PHE, DHCS released ACWDL 21-16 that outlined allowable case processing activities during the federal COVID-19 PHE based on CMS guidance. The second step is releasing this ACWDL which contains instructions on reinstating

regular county operations and processing any outstanding work after the federal COVID-19 PHE is lifted.

CMS Guidance
CMS released State Health Official (SHO) letters 20-004 – "Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the federal COVID-19 Public Health Emergency" on December 22, 2020, and SHO 21-002 – "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" on August 13, 2021. SHO 21-002 provided guidance to states on planning for the eventual return to regular operations, including establishing a timeframe in which outstanding work must be completed, ending temporary processing procedures when the federal COVID-19 PHE concludes, making some temporary changes permanent, and addressing pending eligibility and enrollment actions that developed during the federal COVID-19 PHE.

SHO 21-002 highlighted the following two policy areas:

1. Extended the timeframe for states to complete pending eligibility and enrollment actions to up to 12 months after the month in which the PHE ends, and
2. Required states to complete an additional redetermination for individuals determined ineligible for Medicaid during the PHE prior to discontinuance.

On March 3, 2022, CMS provided states with clarification on the 12-month timeframe in SHO 22-001 – "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". This clarification provided that states must *initiate* outstanding renewals within the 12-month timeframe but states will also have two additional months to *complete* the renewals. This 12-month period is known as the "unwinding period".

In order to prepare for the return to normal operations, DHCS has created the Medi-Cal COVID-19 Public Health Emergency (PHE) Operational Unwinding Plan that aligns with CMS guidance. The two primary purposes of this document are to: 1) describe DHCS' approach to unwinding or making permanent the temporary flexibilities implemented across the Medi-Cal program during the PHE; and 2) describe DHCS' approach to resuming normal Medi-Cal eligibility operations following the end of the PHE.

Restoring Normal Business Processes
Once CMS informs states of the end date to the federal COVID-19 PHE, DHCS will publish a MEDIL that provides counties with important dates for counties to begin the resumption of normal business processes related to applications, annual redeterminations, and change in circumstances.

Applications
Counties shall follow normal application processing requirements, including the Second Contact process outlined in ACWDL 08-07 and ACWDL 22-12. As a reminder, counties shall follow the Medi-Cal hierarchy outlined in ACWDL 17-03 when processing new applications and evaluating applicants for Medi-Cal eligibility.

Annual Redeterminations
Per CMS guidance, counties shall complete the beneficiary's redetermination in accordance with Title 42 Code of Federal Regulations (C.F.R.) section 435.916 prior to taking an adverse action after the end of the federal COVID-19 PHE. This includes all individuals who were identified as potentially ineligible or who failed to respond to a request for information during the federal COVID-19 PHE. This includes beneficiaries determined no longer eligible to Medi-Cal through Foster Care, Former Foster Youth, Adoption Assistance Program, Kin-GAP and Fair Hearing Decisions. This also applies to Medi-Cal beneficiaries who were granted eligibility based on a system or administrative error or a finding by the DHCS fraud investigator during the COVID-19 PHE. This is true even in instances when the county was able to continue processing a beneficiary's annual renewal through *ex parte* or manual processing during the federal COVID-19 PHE.

After the PHE is lifted, counties shall resume processing annual renewal redeterminations for all beneficiaries following the normal annual renewal schedule. Due to the COVID-19 PHE, CMS concurred that this emergency warranted the use of the exception described in 42 Code of Federal Regulations 435.912(e) with regards to the timeliness standards for completing annual renewals and change of circumstance in California. As such, counties **are not required to process** outstanding annual renewals or change in circumstances that occurred during the COVID-19 PHE, except where a change in circumstance would result in a positive change for one or more beneficiaries as set forth more fully on page 7 of this ACWDL.

> **Example:** For illustrative purposes, suppose the COVID-19 PHE ends October 31, 2022, and an individual has a renewal month of May. This beneficiary will not have their annual renewal conducted until May 2023 and the county does not need to process unprocessed renewals or change in circumstances received

during the federal COVID-19 PHE or before the beneficiary's annual renewal month, except where a change in circumstance would result in a positive change for one or more beneficiaries.

Note: Counties may update the case file with newly reported information by the beneficiary to assist with the *ex parte* review once the COVID-19 PHE has ended as long as the county maintains the same tier of coverage until the beneficiary's post-PHE annual renewal.

When processing annual renewal redeterminations, counties shall follow normal business processes including the processing of Income and Employment Verification System (IEVS) and Asset Verification Program (AVP) reports when appropriate. A full redetermination for PHE Unwinding purposes is defined as completing a renewal as outlined in ACWDLs 14-18, 14-32, 14-35, 14-38, and 20-21 which include the *ex parte* review and sending a prepopulated annual renewal form only to those beneficiaries whose eligibility cannot be determined through *ex parte* **or** if the *ex parte* review were to result in a discontinuance.

The notice of action (NOA) outlined in ACWDL 19-03 must be sent to beneficiaries who have no change in their Medi-Cal eligibility at annual renewal. This NOA provides the information that was used to determine eligibility and asks beneficiaries to inform the county if any information has changed.

As a reminder, in instances when a beneficiary is no longer eligible to their current Medi-Cal program, counties must assess for any other Medi-Cal programs within the hierarchy prior to discontinuance as outlined in ACWDL 17-03. Once the county has determined there is not eligibility under any other Medi-Cal program, the county must assess for eligibility for Covered California. DHCS will be releasing updated guidance on transitioning individuals from Medi-Cal to Covered California as part of the new auto-plan selection requirement.

In instances when the county initiates the annual renewal and a beneficiary fails to complete the redetermination or provide requested information, counties shall follow the requirements outlined in ACWDL 14-18 and 14-32 as well as guidance in MEDIL I 22-01. This may result in the beneficiary being discontinued from Medi-Cal.

Note: DHCS will be releasing additional guidance in the near future regarding processing redeterminations. Counties shall also follow the guidance including the future ACWDL when redetermining eligibility during the COVID-19 PHE unwinding period.

Annual Redetermination Sequencing of Activities

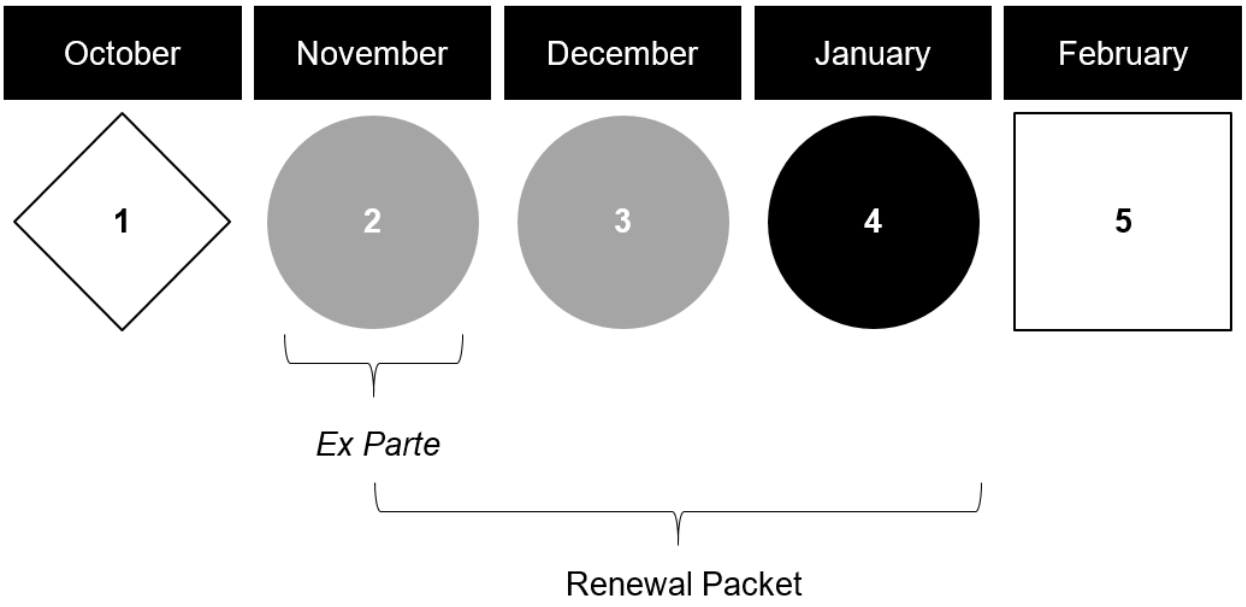
The unwinding period, as described above, will begin with the month following the end of the federal COVID-19 PHE. The annual renewal process occurs in several steps, spanning multiple months. Once the PHE ends, counties will begin initiating renewal activities starting with the following case actions in the below sequence that occur prior to the last day of the renewal period. The dates listed below may vary slightly within each SAWS system.

- 85 Days Prior: *Ex parte* Review Completed
- 60-75 Days Prior: Annual Renewal Packet Mailed (when applicable)
- 10 Days Prior: Notice of Action Sent
- Last Day of Eligibility: Final Day of Eligibility for Discontinued Beneficiaries

This means that for the first and second months after the PHE ends, renewal activities will focus on completing *ex parte* review and sending annual renewal packets. The third month following the end of the PHE is when the first redeterminations will be processed.

> **Example:** For illustrative purposes, suppose the COVID-19 PHE ends October 31, 2022. The county will complete *ex parte* review and send the annual renewal packet (when applicable) for beneficiaries with a renewal month of January 2023. The first month that beneficiaries would be redetermined will be January 2023 with the first beneficiaries potentially without coverage on February 1.
> **Note:** In this example, where the PHE has concluded at the end of October 2022, individuals with a renewal month of November will not have their annual renewal conducted until November 2023, as time is needed to complete the pre-renewal activities.

Figure 1: Annual Renewal Timeline for January 2023 Renewal Month



The following describes each section of Figure 1. This figure does not describe all renewal activities or timing. A more detailed eligibility sequencing map can be found in the *DHCS Medi-Cal COVID-19 Public Health Emergency Operational Unwinding Plan, Appendix A.*

1. October: For illustrative purposes, the PHE ends October 31, 2022
2. November: The 12-month PHE unwinding period begins November 2022. Renewal activities begin for individuals with a January 2023 renewal month in the month of November 2022. The *Ex Parte* review will be initiated and completed. A renewal packet will be sent, if applicable.
3. December: January 2023 renewal activities continue.
4. January: January 2023 renewal activities are completed and eligibility is determined.
5. February: February 1, 2023, would be the first date the individual would no longer be enrolled in Medi-Cal if found ineligible.

Processing Annual Renewals for Beneficiaries No Longer in the Household

During the federal COVID-19 PHE, the primary applicant may have reported a beneficiary is no longer in the household or tax household but the individual remained on Medi-Cal in the existing case due to the continuous coverage requirement. CMS guidance requires that beneficiaries remain eligible until states complete an additional full redetermination prior to discontinuance for individuals who may have been determined ineligible for Medicaid during the federal COVID-19 PHE. To the extent that

counties did not process the change in circumstance redetermination for all MAGI and Non-MAGI beneficiaries required by Welfare and Institutions (W&I) Code Section 14005.37 (including but not limited to, a change in tax dependency or a spouse or adult child moving out of the home) during the federal COVID-19 PHE, counties are required to process this change during the beneficiary's next scheduled annual renewal process after the PHE ends.

- If the primary household member has reported that the individual is no longer in the household and has requested to discontinue benefits for that individual, then the county shall:
    - Discontinue benefits for the individual no longer in the household and send appropriate notices to the last known address on file, prior to starting the annual renewal process for the remaining household members. An annual renewal is not required for the individual no longer in the household because the primary household member requested discontinuance.
    - Complete the annual renewal for the original case and remaining household members following the guidance within this letter
- If the primary household member has reported that the individual is no longer in the household and has not requested to discontinue benefits for that individual, then the county shall:
    - Move the beneficiary who is reported out of the household into their own case, utilizing any information known to the SAWS and can be found in MEDS, prior to starting the annual renewal process for the remaining household members.
    - Contact the beneficiary to request any missing information by means of the MC 355. As all beneficiaries must have a full eligibility redetermination after the end of the federal COVID-19 PHE, counties must request all information or verification needed from the beneficiary.
        - Counties shall use the most recent contact information for the beneficiary to request this information.
    - If the county has all necessary information or the beneficiary provides all necessary information, then the county can move forward with the eligibility determination as outlined in this letter.
        - If the county does not have all necessary information and the beneficiary does not respond timely, the county may discontinue the individual for failure to provide.
    - Complete the eligibility review for the original case and household following the guidance within this letter.

Reported Change in Circumstances

Beneficiaries have been reporting and will continue to report changes in their households, such as a new job, during the PHE and through the PHE Unwinding Period. However, any changes in circumstance reported during the PHE and the 12-month PHE Unwinding Period that could lead to a negative action shall be paused, in accordance with the continuous coverage requirement until the beneficiary's annual redetermination is initiated at the end of the PHE, as determined by their redetermination date on their Medi-Cal case record. The process below outlines the various change in circumstance procedures counties must follow depending on the scenario.

Change in Circumstances reported during the federal COVID-19 PHE

Any change in circumstance reported during the federal COVID-19 PHE that was not processed will not be addressed until the beneficiary's next annual renewal after the end of the federal COVID-19 PHE. As a reminder, counties must only use the current information received when processing the beneficiary's first regular annual renewal. This may mean that changes reported during the federal COVID-19 PHE are no longer applicable and require no action by the county.

Change in Circumstances reported During the PHE Unwinding Period

Reported Change Results in No Change or Negative Change

Counties shall document the reported change in the Statewide Automated Welfare System (SAWS) case file and not process the reported change. Counties may update the case file with newly reported information by the beneficiary to assist with the ex parte review once the COVID-19 PHE has ended as long as the county maintains the same tier of coverage until the beneficiary's post-PHE annual renewal. Additionally, in instances when a beneficiary has been placed in Soft Pause in CalHEERS, the county may maintain the Soft Pause status until the beneficiary's annual renewal. As a reminder, once it is time for the beneficiary's post-PHE annual renewal, the county must use current information to complete the annual renewal. Counties shall use the following language to journal this action: *Delayed change in circumstances processing for Medi-Cal benefits approved due to federally declared public health emergency*.

> **Example**: For this example, assume the PHE ends in October 2022. A beneficiary reports increased income in November 2022 that would make them ineligible for Medi-Cal and their annual renewal is scheduled in April 2023. The CEW shall not process the change in circumstance and redetermine eligibility as the reported increase in income will result in a negative action. The county will wait to process the renewal at the scheduled annual renewal date of April 2023.

Reported Change Results in Positive Change
Counties will first need to determine if an annual renewal was completed in the last 12 months either through the automated *ex parte* process or through manual case processing.

- If an annual renewal was completed in the last 12 months, counties should follow the normal change in circumstances processing outlined in ACWDL 14-18.
- If an annual renewal was not completed, counties will need to complete a full redetermination as outlined in the "Annual Redeterminations" section of this ACWDL when the positive change is reported and not delay processing until the beneficiary's scheduled annual renewal.

  Example: For this example, assume the PHE ends in October 2022. A beneficiary has a renewal month of May 2023 and reports a decrease in income in December 2022 that would result in a positive eligibility change. The beneficiary has not had a renewal completed since December 2020. The county shall complete a full redetermination and advance the renewal date with a new 12-month eligibility period and a new renewal month of December 2023.

Mixed actions for households
There may be instances when a reported change is positive for some household members and cause a negative action for other household members. Counties should follow the "Reported Change Results in Positive Change" process above when there is at least one beneficiary in the household that would be positively impacted by the redetermination. This means that a full redetermination for each member of the household would take place at this time and some individuals may no longer be eligible for Medi-Cal. As a reminder, counties must assess for consumer protection programs and all other Medi-Cal eligibility as outlined in ACWDL 14-18.

Individuals who aged out of their aid code
During the federal COVID-19 PHE unwind period, counties shall follow the "Reported Change in Circumstances" policy found in this letter when a beneficiary has a change in age which normally requires a redetermination such as a child turning 19 or an adult turning 65.

Reported Change after Post-PHE Annual Renewal is Processed
Counties shall return to normal change in circumstances processing procedures outlined in ACWDL 14-18 once a post-PHE redetermination is completed. This includes resuming the processing of Medi-Cal Eligibility Data System (MEDS) Alerts, Public Assistance Reporting Information System (PARIS) reports, and IEVS reports. Normal

change in circumstances processing may result in continued eligibility or a discontinuance, depending on the beneficiary's circumstances.

> **Example**: For this example, assume the PHE ends in October 2022. A beneficiary has their annual renewal in June 2023 and is found eligible for continued coverage. If the beneficiary reports a change in circumstance in December 2023, the county shall process the change in circumstance utilizing current business practices. If the beneficiary is determined to be eligible based on the change in circumstance, then a new 12-month eligibility period is set in compliance with W&I Code section 14005.37.

MEDS Alerts

Once the COVID-19 PHE has lifted, counties must resume processing MEDS Alerts as outlined in ACWDL 16-23 and 17-30. If processing the MEDS Alert would result in a change to coverage, the county must follow the change in circumstance guidance found in this letter to determine when the MEDS Alert should be processed.

Counties are reminded that critical MEDS alerts and MEDS alerts related to outdated address information should continue to be worked during the COVID-19 PHE and the unwinding period to avoid access to care issues or loss of coverage.

Craig v Bonta Cases

Counties shall resume normal processing of the exception eligibles lists related to Craig v Bonta cases received once the COVID-19 PHE has ended, including working the associated MEDS alerts. For Craig vs Bonta cases received during the COVID-19 PHE that were unprocessed, cases shall be redetermined at the next annual renewal post-PHE using existing processing guidelines outlined in ACWDL 07-24, including using the existing notice process once the eligibility determination is complete. The first annual renewal month after the PHE shall be based on the month the beneficiary was placed on the exceptions eligible list. For example, if placed on the list in January 2021 the first annual renewal month must be January 2023. If the individual was placed on an active case with their family members, then the county shall use the existing case's annual renewal month.

In some instances, the county may have "pended" the case in SAWS during the federal COVID-19 PHE in an attempt to redetermine eligibility but were unable to proceed due to the continuous coverage requirement. Counties may make the necessary adjustments in SAWS to process ongoing eligibility based on the month of the annual renewal. If counties had requested information from the beneficiary by means of an MC

355 during the PHE, the county must request this information again to ensure the county has the beneficiary's current information.

> **Example**: A beneficiary was reported on the exceptions eligible list and placed in a Craig vs Bonta aid code starting in August 2020. Due to the continuous coverage requirement, counties have not processed a redetermination of this case. Counties shall process this case the first August following the end of the federal COVID-19 PHE.

Batch Processes

SAWS batch eligibility processes will continue to be disabled through the duration of the unwinding period, with the exception of the process to automatically discontinue for failure to complete redetermination and the Failure to Provide Former Foster Youth turning age 26 packet process.

MEDS Restoration Cases

DHCS has engaged in two separate processes to ensure maintenance of eligibility requirements outlined in the Families First Coronavirus Relief Act were met during the COVID-19 PHE. The first process involved DHCS restoring eligibility to individuals who had been discontinued during the federal COVID-19 PHE. The second involved DHCS adjusting the share of cost for individuals who either were granted a share of cost or had an increase of share of cost during the federal COVID-19 PHE.

In order for DHCS to restore the cases that were discontinued, DHCS took over management of the case and corrected the eligibility directly in MEDS. These cases need to be transitioned back under county control and the following procedures provide direction on how counties will do so.

- DHCS will provide counties with a list of cases that DHCS has restored, including the month in which DHCS began restoring the eligibility.
- Counties will process these cases based upon the last known redetermination month. If no redetermination month is known, counties shall utilize the month in which DHCS restored the case. For example, if the last known renewal month was March in any year, the first annual renewal month must be March 2023. If the county cannot find a last known renewal month, then if DHCS restored the case in July 2021 then July 2023 is the first annual renewal month.
    - Counties may utilize the same process for completing the annual renewal for the restoration population that was outlined in ACWDL 18-06 for the cleanup effort for the Low Income Health Program beneficiaries.

- Counties shall utilize any available information to process the redetermination utilizing normal redetermination processes, including *ex parte*, requests for information, and noticing.
- Counties shall report back to DHCS the actions taken for these cases on a monthly basis

The following procedures apply for cases which DHCS made an adjustment of the share of cost:

- DHCS will provide counties with a list of all cases that have had an adjustment to the share of cost
- Due to the ongoing adjustments to these cases, counties may complete a full redetermination for these cases prior to the scheduled annual renewal date at their discretion, but no later than the renewal month found within SAWS.
- Counties must report to DHCS which cases they have conducted a renewal for so that DHCS will no longer adjust the case.

DHCS will provide additional instructions to the counties on the location of these files and the location where counties can upload the monthly reports prior to the end of the COVID-19 PHE.

Returned Mail and Updated Contact Info
W&I Code section 14005.37 requires that counties take certain steps when mail sent to a beneficiary is returned as undeliverable. Counties shall follow the updated undeliverable mail process outlined in ACWDL 22-09. Counties shall also continue updating the beneficiary's contact information that was received by Medi-Cal Managed Health Care Plans (MHCP) as outlined in ACWDL 15-30. This includes updating the case if sufficient information was provided to the county.

CMS has approved a Section 1902(e)(14)(A) temporary waiver request to assist in the unwinding of the COVID-19 PHE. This waiver allows CEWs to treat updated contact information confirmed by and received from MHCPs as reliable. CEWs are temporarily allowed to update the beneficiary record with the new contact information without having to first send a notice to the beneficiary address on file. In implementing this option, MHCPs will continue to:

- Provide updated contact information that was received directly from or verified with the beneficiary, an adult who is in the beneficiary's household or family, or the beneficiary's authorized representative recognized by the health plan
- Not accept contact information provided to them by a third party or other source if not independently verified with the beneficiary, an adult who is in the

beneficiary's household or family, or the beneficiary's authorized representative recognized by the MCP, and
- Assure that the beneficiary contact information provided is more recent than the information on file with the county.

DHCS will provide further guidance on each this policy in an upcoming ACWDL.

Tracking Categories
ACWDL 21-16 recommended that counties utilize tracking categories to help organize county work for the end of the federal COVID-19 PHE. Based on the updated guidance provided in SHO 21-002 and 22-001, counties must not utilize these tracking categories to prioritize cases and should follow the procedures described within this letter. Additionally, counties may clear any tracking tasks or records that will not assist counties with case processing based on the procedures outlined in this letter.

Other Policy Updates
Due to the declared federal COVID-19 PHE, DHCS released MEDIL I 20-25 that instructed counties to delay the processing of Medi-Cal annual redeterminations, discontinuances, and negative actions for Medi-Cal, Medi-Cal Inmate Program (MCIEP), Medi-Cal Access Program (MCAP), Medi-Cal Access Infant Program, and County Children's Health Initiative Program (CCHIP) throughout the federal COVID-19 PHE. The following sections provide information on resuming normal business processes for the programs when the federal COVID-19 PHE is lifted. Please note that the programs listed below will follow the same annual renewal requirements outlined above prior to any discontinuances or negative actions.

Medi-Cal Inmate Eligibility Program (MCIEP)
The guidance provided in this ACWDL applies to MCIEP applicants and beneficiaries. As directed, counties are expected to resume normal business processes related to MCIEP applications, annual redeterminations and change in circumstances, as described within this letter.

Medi-Cal Suspension Process
As a reminder, ACWDL 21-22 provides information and directives on implementation of the SUPPORT Act which requires CEWs to suspend Medi-Cal benefits for "eligible juveniles" for the duration of their incarceration, activate Medi-Cal benefits upon release and to process eligible juvenile pre-release applications for those not receiving Medi-Cal prior to their incarceration.

Pursuant to the suspension policy provided in ACWDL 21-22, if an adult inmate reaches their one year of incarceration and remains incarcerated, then their Medi-Cal must be discontinued at the end of the month, with proper notice, which ends their suspension. In circumstances that the one year of incarceration occurred during the PHE, and the adult remains incarcerated post-PHE, DHCS recommends that counties wait to process the Medi-Cal discontinuance and resume the end of suspension process at the next scheduled annual renewal date.

Medi-Cal Access Program

Case management for MCAP does not occur within the county but instead by a DHCS contracted Administrative Vendor (AV). At the conclusion of the federal COVID-19 PHE, the AV will resume normal business processes related to applications, reported change in circumstances related to income, household size, and end of pregnancy. MCAP cases for individuals held in coverage during the COVID-19 PHE that are still protected under their postpartum period will be updated to reflect the remainder of their postpartum period and follow normal processing after 365 days of postpartum. Individuals no longer in COVID-19 PHE protection and their postpartum period has ended will be redetermined for continued health coverage and other Insurance Affordability Programs through Covered California. If the member's postpartum period has ended during the PHE, the AV will redetermine eligibility for the member the month following the end of the PHE. Otherwise, the member's eligibility will be redetermined based upon normal business processes. The AV will coordinate with the counties to transition back into normal business processes.

County Children's Health Initiative Program

Case management for CCHIP does not occur within the county but instead by a DHCS contracted AV. Throughout the federal COVID-19 PHE, the AV continued to process reported changes in circumstances that resulted in no-change or positive changes for a child in CCHIP. Changes that resulted in a negative action placed the child in protection until their next annual renewal. At the conclusion of the PHE, the AV will resume normal business processes related to applications, annual redeterminations and change in circumstances. The AV will be directed to follow the restoring of normal business processes and annual redeterminations, as described above.

Medi-Cal Eligibility Procedure Manual Article 4V

During the PHE, Medi-Cal eligibility received under Article 4V of the Medi-Cal Eligibility Procedure Manual was to be maintained by the county continuously without requiring the minor to contact the county each month. Following the official end of the PHE, coverage returns to a month-by-month basis. Minors who have been held in coverage continuously through the PHE must be discontinued once the PHE lifts, unless the

minor recertifies that month. Minors must contact the county in person or via telephone to continue their coverage, unless they are receiving outpatient mental health coverage. Please note per MEDIL 21-09, telephonic applications may be accepted for Minor Consent beyond the end of the PHE.

If the minor is receiving outpatient mental health coverage, the minor may continue to remain eligible through the duration of time listed on a letter from a mental health provider without contacting the county in person or via telephone.

Consumer Protection

Counties shall continue to follow published guidance regarding individuals whose eligibility is protected. This includes the following groups:

- Transitional Medi-Cal (TMC), Four-Month Continuing Eligibility, California Work Opportunity and Responsibility to Kids denials and discontinuances, and Continued Eligibility for Children policy (ACWDL 21-27)
- Pregnant and postpartum beneficiaries (MEDILS I 21-13 and I 21-13E)
- Infants (ACWDL 11-33)

The months an individual retained no-cost Medi-Cal due to the continuous coverage requirement when they should have been on TMC, or were on TMC and had their eligibility protected due to the PHE, count towards their TMC period.

COVID-19 Uninsured Group

On March 18, 2020, Public Law 116-127, (the Families First Coronavirus Response Act), authorized state Medicaid programs to provide access to coverage for medically necessary COVID-19 diagnostic testing, testing-related services, and treatment at no cost to the individual. The COVID-19 Uninsured Group (UIG) eligibility will end on the last day of the calendar month in which the federal COVID-19 PHE ends. The following information is relevant to the end of the COVID-19 PHE:

- On a date to be determined, DHCS will send out a notice to individuals enrolled in the COVID-19 UIG program (aid code V2) advising them of when their coverage will end and how to apply for no-cost or low-cost health coverage through Medi-Cal or Covered California. Counties may find this notice on the DHCS website once it is posted.

- The COVID-19 UIG program will end the last day of the calendar month in which the federal COVID-19 PHE ends.

- Individuals enrolled in the COVID-19 UIG program may contact counties to apply for Medi-Cal and/or Covered California. Counties should prioritize these applications to preserve the continuity of coverage for these individuals who have COVID-19 or are still recovering from it. If individuals apply for Medi-Cal and have a bill for COVID-19 related services before or after the program ends, counties should assist applicants with requesting three-month retroactive eligibility.

If you have any questions, or if we can provide further information, please contact Derek Soiu by phone at (916) 345-8193 or by email at Derek.Soiu@dhcs.ca.gov.

Original Signed By

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