California Policy Needs During and After COVID: Eligibility, Enrollment, and Retention

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I. Introduction

The COVID-19 public health emergency (PHE) has fundamentally altered how California's Medi-Cal program is administered. At the start of the pandemic, the state worked swiftly to seek waivers and other flexibilities of federal Medicaid requirements and to implement these COVID-19 flexibilities, including significant changes intended to streamline Medi-Cal eligibility and enrollment. In order to preserve Medi-Cal coverage for low-income Californians once the pandemic ends, California's Medicaid agency, the Department of Health Care Services (DHCS), needs to plan now for its end. This issue brief highlights various policies the state put in place during the pandemic that should be continued after the pandemic, as well as other policies it needs to put in place now to mitigate harm to the Medi-Cal population once the pandemic is over.

A. Overview of Federal Guidance and the Moratorium on Negative Actions

The Families First Coronavirus Response Act (FFCRA) increased the federal government's share of Medicaid costs (also known as the federal medical assistance percentage, or FMAP) by 6.2 percent to help states manage increased enrollment and state budget shortfalls due to the COVID-19 PHE.[1] The increase lasts through the end of the calendar year quarter in which the PHE ends. As of the date of this publication, the Secretary of Health & Humans Services has extended the existing PHE through January 20, 2021 and therefore, the FMAP increase

[1] Families First Coronavirus Response Act [hereinafter FFCRA], Pub. L. No. 116-127, 134 Stat. 178 § 6008(a) (2020), https://www.congress.gov/116/bills/hr6201/BILLS-116hr6201enr.pdf; Ctrs. for Medicare and Medicaid Servs., *Families First Coronavirus Response Act - Increased FMAP FAQs* (April 13, 2020), https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf.

remains in effect through at least March 31, 2021.[2] In order to receive the increased FMAP, California must meet strong maintenance of effort (MOE) requirements.[3] The state must retain eligibility standards that are no more restrictive than those in place as of January 1, 2020, and cannot charge higher premiums than were in place as of January 1, 2020. The state must also cover COVID-19 testing and treatment without cost-sharing. Additionally, under the continuous coverage provision, the state Medicaid agency cannot disenroll most beneficiaries who were enrolled as of March 18, 2020 through the end of the PHE.

The continuous coverage requirement has played a critical role in preserving coverage for low-income Medicaid beneficiaries during the COVID-19 pandemic. CMS guidance interpreted the continuous coverage requirement as prohibiting most Medicaid negative actions during the PHE, including barring states from cutting benefits or increasing cost-sharing for Medicaid beneficiaries.[4] To align with federal guidance, and Governor Newsom's executive order N-29-20, DHCS placed a moratorium on discontinuances and negative actions in the Medi-Cal program through the end of the PHE.[5] DHCS also instructed counties to delay processing Medi-Cal annual redeterminations.[6]

Recently, CMS issued a new interim final rule (IFR) and proposed regulations that attempt to cut away at the continuous coverage requirement, by permitting states to eliminate optional benefits and increase co-payments and cost-sharing levels, among other harmful changes. As of the date of this publication, the impact of the IFR and the CMS proposed regulations on

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[2] HHS Office of the Assistant Sec'y for Preparedness and Response, U.S. Dept. Health & Human Servs., *Renewal of Determination That A Public Health Emergency Exists* (Oct. 2, 2020), https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-2Oct2020.aspx.

[3] *See* FFCRA, *supra* note 1; *See also* Hannah Eichner, Nat'l Health Law Prgm., *Top Ten List: Maintenance of Effort Requirement Compliance* (June 2020), https://healthlaw.org/resource/top-ten-list-maintenance-of-effort-requirement-compliance-1-top-ten-list-maintenance-of-effort-requirement-compliance/.

[4] Ctrs. for Medicare and Medicaid Servs., *COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies* 29 (June 30, 2020), https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf.

[5] Cal. Dep't Health Care Servs., MEDIL I 20-07: *Access to Care During Public Health Crisis or Disaster for Medi-Cal* (Mar. 16, 2020), https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I20-07.pdf. [hereinafter "MEDIL 20-07"]; *See also,* Cal. Dep't Health Care Servs., MEDIL I 20-14: *Extension of Delaying Annual Redeterminations, Discontinuances, and Negative Actions Due to COVID-19 Public Health Emergency* (May 29, 2020), https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I20-14.pdf. [hereinafter "MEDIL 20-14"]; *See also*, MEDIL I 20-26: *Additional FAQs Due to the COVID-19 Public Health Emergency* (Aug. 14, 2020), https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I20-26.pdf.; *See also,* MEDIL I 20-18: *FAQs Due to the COVID-19 Public Health Emergency* (June 2, 2020), https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I20-18.pdf. [hereinafter "MEDIL 20-18"]

[6] *Id.*

California's Medi-Cal program is not yet known.[7] The proposed regulations are undergoing a public comment period, which has not yet closed.

II. Flexibilities California Put in Place During the COVID-19 Pandemic

Here in California, DHCS implemented a variety of policies based on state and federal requirements and flexibilities, mandating the suspensions of negative actions for the duration of the PHE, halting discontinuances, and delaying processing of most annual renewals.[8] The requirement to maintain continuous coverage applies to individuals who might otherwise lose coverage or have benefits negatively affected, such as individuals who age out of a Medi-Cal eligibility group, individuals who lose benefits (like SSI) that would affect their Medi-Cal eligibility, individuals who would move from Medi-Cal without a premium to one requiring a premium, and individuals who would move from a no share-of-cost (SOC) to Medi-Cal with a SOC.[9] Additionally, DHCS instructed county eligibility staff to focus their limited resources on processing new applications and processing cases that would help beneficiaries gain access to care like inter-county transfers, a reported decrease in income, and adding a family member to the Medi-Cal case. These policy changes recognized that county workers had to quickly pivot operations because they started working from home and their work hours may have been impacted by caregiving duties or COVID-19. More importantly, these policy changes prioritize access to care for Medi-Cal applicants and beneficiaries living in the middle of the COVID-19 pandemic.

Once the PHE ends, the Department will have to develop a system to methodically process backlogged Medi-Cal renewals so that beneficiaries do not inappropriately lose coverage, and to resume normal business operations. The following recommendations would help the state with planning for the unwinding of the current PHE-related flexibilities.

A. Self-Attestation for Eligibility Requirements During the Public Health Emergency

In line with longstanding DHCS guidance specific to public health emergencies and natural disasters, Medi-Cal applicants and beneficiaries can self-attest to eligibility information

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[7] *Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency*, Interim Final Rule, 85 Fed. Reg. 71142 (Nov. 6, 2020), https://www.federalregister.gov/documents/2020/11/06/2020-24332/additional-policy-and-regulatory-revisions-in-response-to-the-covid-19-public-health-emergency.

[8] Cal. Dep't Health Care Servs., MEDIL I 20-15: *Prioritizing Case Processing Activities Through the Duration of the COVID-19 Public Health Emergency* (May 13, 2020), https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I20-15.pdf. [hereinafter "MEDIL 20-15"]

[9] Cal. Dep't Health Care Servs., MEDIL I 20-08: *Follow-Up Guidance To MEDIL I 20-07* (April 10, 2020), https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I20-08.pdf. [hereinafter "MEDIL 20-08"]; *See also* MEDIL 20-18, *supra* note 5.

including income, California residency, and property, *if* the individual is unable to provide necessary verifications due to the public health crisis.[10] In order to exercise this option, the county has the option of accepting a signed affidavit, under penalty of perjury, to verify the eligibility requirements in place of the requested verification documents.[11] The only exception to this is citizenship or immigration status verification.[12] This temporary policy allows individuals to complete an application without tracking down verifying documents such as pay stubs, tax documents, or bank statements. Additional guidance clarified that counties shall accept written affidavits telephonically signed. For individuals displaced due to the disaster or those who cannot access their verification documents, self-attestations offer a more convenient application process and ensure expedient access to coverage. This flexibility is particularly important for applicants and beneficiaries without internet access or a computer, or for populations who often encounter barriers in accessing benefits, such as persons with disabilities, older adults, and those who are unhoused.

We have heard from advocates that counties are not universally accepting telephonic written affidavits without an additional wet signature. We urge DHCS to reiterate the importance of this flexibility to secure Medi-Cal during the pandemic and ensure all counties are following it.

B. Premiums Waivers

During the PHE, DHCS has allowed beneficiaries impacted by the COVID-19 pandemic to waive their Medi-Cal premiums.[13] Unfortunately, beneficiaries must opt in to obtain the premium waiver.[14] While DHCS has mailed flyers about the waiver option to impacted beneficiaries, many beneficiaries remain unaware of the flexibility and there are abysmally low opt in rates.[15] In order to ensure individuals and families benefit from this flexibility during the PHE and resulting recession, premium waivers should be automatic. As discussed in NHeLP's issue brief, *California Policy Needs During COVID and Beyond: Reproductive and Sexual Health*, DHCS should also place a short-term extension on premium waivers after the PHE expires to give beneficiaries enough notice to financially prepare to pay their premiums.

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[10] Cal. Dep't Health Care Servs., MEDIL I 20-06: *Public Health Crisis or Disaster Reminders For Medi-Cal* (Mar. 12, 2020), https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I20-06.pdf. [hereinafter "MEDIL 20-06"]; *See also* MEDIL 20-08, *supra* note 9.

[11] *Id. See also* Dep't Health Care Servs., ACWDL 19-01: *Exceptions Due to Public Health Crisis or Disaster* (Jan. 9, 2019), https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/c19-01.pdf.; *See also* MEDIL I 17-16: *Processing Applications from Individuals Affected by Disasters* (Oct. 2, 2017), https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I17-16.pdf.

[12] 42 U.S.C. § 1320b-7(d).

[13] *See* MEDIL 20-18, *supra* note 5.

[14] *Id*.

[15] Cal. Dep't Health Care Servs., *Premium Waiver due to COVID-19* (April 20, 2020), https://www.dhcs.ca.gov/services/medi-cal/eligibility/MCAP/Documents/Premium-Waiver-due-to-COVID.pdf.

Beneficiaries who have paid premiums during the PHE may also be entitled to credit for premiums paid. To date, the Department has committed to providing a credit (not a reimbursement) to beneficiaries for premiums they paid during the PHE before receiving a retroactive waiver. The one exception is that the Department has agreed to provide reimbursements (rather than a credit) to individuals who are no longer eligible for a Medi-Cal program with a premium once the PHE ends. This helps beneficiaries like those transitioning from the 250 Percent Working Disabled Program into the Aged, Blind, Disabled Expansion, who will no longer be required to pay a premium after the pandemic and will not be able to use their credit. To put money back into the pockets of those who need it most, the Department should provide reimbursements instead of account credits to *all* beneficiaries eligible for premium waivers.

C. COVID-19 Uninsured Group Program

In an effort to combat the spread of COVID-19, and ensure access to care for those who are uninsured or underinsured, the state implemented the COVID-19 Uninsured Group Program to cover COVID-19 testing, testing-related services, and treatment services, including hospitalization, for Californians who are uninsured or underinsured.[16] To be eligible, a person must be a California resident but there are no income, asset, or immigration criteria to be eligible for the program. Coverage starts on the date of application and ends after twelfth month, or when the PHE ends, whichever comes first. In accordance with federal guidance, coverage is also available retroactive to April 8, 2020. We commend the Department for swiftly implementing this program at the start of the pandemic because it provides critical health coverage to those fighting the COVDI-19 virus, which ultimately helps stop the spread of the virus. As of the date of this publication, over 60,600 individuals have enrolled in and benefitted from the program.

Although the federal authority for the COVID-19 Uninsured Group Program ends at the end of the PHE, DHCS should consider continuing coverage for those individuals already enrolled in the program who have medically necessary COVID-19 treatment that extends beyond the PHE.[17] This is particularly important given what we know about COVID-19 "long-haulers" with medical complications well after recovery.

The Department has submitted a waiver request to CMS to permit COVID-19 vaccine coverage under the COVID-19 Uninsured Group Program, an effort we strongly support given

[16] The COVID-19 Uninsured Group Program is in part authorized by Section 6004 of the Families First Coronavirus Response Act (FFCRA). *See also,* Cal. Dep't Health Care Servs., *Frequently Asked Questions (FAQs) Coronavirus (COVID-19) Uninsured Group*, https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/COVID-19UninsuredGroupProgram/COVID-19UninsuredGroupFAQ.pdf (last visited December 23, 2020).

[17] *See* FFCRA, *supra* note 1.

the health equity implications and the importance of vaccinating *all* Californians in order to combat COVID-19. The outcome of the waiver request is pending as of the date of this publication.

D. Expansion of the Hospital Presumptive Eligibility Population and PE Periods

Hospital presumptive eligibility (HPE) provides immediate access to temporary, no cost Medi-Cal while applying for permanent Medi-Cal coverage.[18] The Affordable Care Act established HPE for all states and requires hospitals, at a minimum, to make HPE determinations for MAGI populations.[19] States can also permit hospitals to make HPE determinations for additional populations through a State Plan Amendment (SPA) or an 1115 waiver.[20] In response to the PHE, California expanded the HPE program to individuals who are 65 years of age or older, blind, and disabled under 138 percent of the federal poverty level (FPL).[21] Washington and New York implemented a similar HPE expansion for certain non-MAGI groups. California also increased the number of PE periods an individual can have within a 12-month period.

Once the pandemic ends, the Department should continue offering HPE to the aged, blind and disabled populations using the flexibilities afforded to states.[22] This policy change is critical to provide swift access to Medi-Cal enrollment, particularly for those who are more likely to experience serious health outcomes from COVID-19.

III. New Policies to Streamline Medi-Cal Eligibility, Enrollment and Retention After the Pandemic

Given the continuous coverage requirement and the moratorium on negative actions during the PHE, it is anticipated that California's Medi-Cal population will experience significant churn (disruption in coverage) post-pandemic. County eligibility workers will need to resume processing a high volume of backlogged renewals in addition to processing an anticipated higher volume of new Medi-Cal applications, as the recession is anticipated to continue well

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[18] Dept. Health & Human Servs., *Medicaid and CHIP FAQs: Implementing Hospital Presumptive Eligibility Programs* (Jan. 2014), https://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/Downloads/FAQs-by-Topic-Hospital-PE-01-23-14.pdf.
[19] 42 C.F.R. § 435.1110(a).
[20] 42 C.F.R. § 435.1110(c)(2).
[21] Cal. Dept. Health Care Servs., *Request for Additional State Plan Amendments Related to Novel Coronavirus Disease (COVID-19) National Emergency/Public Health Emergency* (April 3, 2020), https://www.dhcs.ca.gov/Documents/COVID-19/20200403-COVID-19-SPA-20-0024-Pending.pdf.; *See also* Dept. Health & Human Servs., SPA 20-0024 Approval Packet (May 13, 2020), https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-20-0024-COVID-Approval.pdf.
[22] Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program.

after the end of the PHE. DHCS should implement the additional policies outlined below now to simplify the Medi-Cal application process and streamline access to Medi-Cal.

A. Establish Uniform Protocols to Access County Offices

Accessibility to county welfare offices is particularly important during the PHE. Governor Newsom's executive orders state that court and county employees *may* be designated as "essential workers" during the PHE.[23] As such, county offices across the state have either shut down or significantly reduced their hours to prevent the spread of COVID-19. Although the efforts to reduce in-person gatherings to prevent the spread of COVID-19 is vital to the state's public health response, county offices are still obligated to remain accessible to the public.[24] While it is helpful that there are options to apply for Medi-Cal by telephone and online, these options are not necessarily responsive to the needs of all beneficiaries. For example, individuals who are unhoused may not have a telephone or access to the internet. Furthermore, preserving an in-person application option is vital when phone lines are busy, and people cannot otherwise reach their worker online or by phone. Currently, some county offices still have inconsistent hours or remain closed, which makes applying for Medi-Cal or accessing information about a Medi-Cal case a difficult or impossible task.

Although DHCS has developed protocols in the event of natural disasters, the PHE has highlighted why it is important to have a uniform plan amongst counties during a public health crisis. The state must implement consistent policies for counties to follow during the pandemic and in the future to ensure that all beneficiaries can access county offices and apply for Medi-Cal in some capacity. It is challenging enough to apply for Medi-Cal in non-COVID times, absent the shuttering of county welfare offices.

B. Accept Universal Self-Attestation of Income at Application

Under federal law, states can elect to allow Medicaid applicants to self-attest to all eligibility criteria, except for citizenship and immigration status when applying for Medicaid.[25] As discussed in the prior sections, California does not yet permit self-attestation of income, outside of a public health emergency, despite the fact that income verification is the eligibility criteria that most often requires verification. Such flexibility is particularly important during a recession, when income changes are expected. Given county workforce strains from the pandemic, as well as the reduced capacity for applicants to collect and send in documentation,

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[23] Executive Dep't State of Cal., Executive Order N-55-20 (April 22, 2020), https://www.gov.ca.gov/wp-content/uploads/2020/04/EO-N-55-20.pdf.; Executive Dep't State of Cal., Executive Order N-63-20 (May 7, 2020), https://www.gov.ca.gov/wp-content/uploads/2020/05/5.7.20-EO-N-63-20-text.pdf.; Executive Dep't State of Cal., Executive Order N-33-20, Essential Workforce (March 19, 2020), https://files.covid19.ca.gov/pdf/EssentialCriticalInfrastructureWorkers.pdf.

[24] 42 C.F.R. § 435.907; Welf. & Inst. Code § 15926.

[25] 42 C.F.R. § 435.945(a).

DHCS should adopt a policy that permits applicants and beneficiaries to self-attest to their income in non-emergency situations. These changes would need to be programmed in California's Single Streamlined Application (SSApp) computer system, California Health Electronic Eligibility & Retention System (CalHEERS), as well as other application pathways. This policy change would free up the time of the SSApp Service Center and county eligibility workers, allowing them to focus on more complicated eligibility, enrollment and retention issues.

C. Adopt Post-Enrollment Verification

In the alternative, if DHCS does not accept self-attestation of income at the point of application, the Department should adopt post-enrollment verification, including expanding Accelerated Enrollment (AE) now available through the SSApp to children to adults on MAGI Medi-Cal. Post-enrollment verification policies allow individuals to be determined immediately eligible based on their attestation of income or other needed information while eligibility information would be verified after enrollment. This would allow individuals to use Medi-Cal benefits while the state determines eligibility and matches information to electronic data sources *after* the person is enrolled. This policy would enable applicants to access to care immediately and also helps county eligibility workers who will have to shift a larger portion of their work after the PHE ends to processing renewals and redeterminations (*See also* NHeLP's September blog on this topic).[26] DHCS has indicated they will be implementing an AE policy for adults who apply through the CalHEERS SSApp in 2021.

D. Expand Utilization of Additional Electronic Data Sources

The state's Medi-Cal application portals already use electronic data matching sources to verify eligibility and conduct ex parte verification.[27] DHCS should build on this system by incorporating additional electronic data sources to cross-reference with applications. DHCS could leverage contact information changes reported to other public benefits programs, such as the United States Postal Service's National Change of Address System and California's Employment Development Department (EDD). An eligibility worker should not require additional verification unless an applicant's information returns materially inconsistent data. Casting a wider net to link to additional online databases for verification would allow DHCS to

[26] Alicia Emanuel & Kim Lewis, Nat'l Health Law Prgm., *California Should Do More to Get Eligible Individuals on Medi-Cal During this Unprecedented Pandemic and Wildfire Crisis* (Sept. 23, 2020), https://healthlaw.org/california-should-do-more-to-get-eligible-individuals-on-medi-cal-during-this-unprecedented-pandemic-and-wildfire-crisis/.

[27] Ctrs. for Medicare and Medicaid Servs., *California MAGI-Based Eligibility Verification Plan* (May 18, 2016), https://www.medicaid.gov/sites/default/files/2019-12/california-verification-plan-template-final.pdf.; *See also*, Cal. Health Care Found., *Pathway to Enrollment: A Virtual Tour of Covered California's Online Application* (Sept. 11, 2014), https://www.chcf.org/wp-content/uploads/2017/12/PDF-PathwayToEnrollmentStatic.pdf.

streamline application and renewal processing, especially when a large volume of cases is expected post-PHE. DHCS should also accept reasonable explanations for certain discrepancies in data-matching sources for income or eligibility, for example because an applicant has recently lost their job.

IV. New Policies to Streamline and Simplify Medi-Cal Renewals and Redeterminations After the Pandemic

While negative actions are suspended, uncertainty exists about how case handling will occur at the expiration of the PHE. Once the moratorium on negative actions is lifted, counties will have to process a high volume of renewals, which is expected to be a lengthy and burdensome process. Balancing efforts to mitigate loss of coverage with new application backlogs should be prioritized for the expected high volume of cases.

Although renewal packets are going out right now, county eligibility workers are currently instructed to disregard, and not process, returned renewal packets during the PHE. Under federal Medicaid rules, Medicaid agencies must conduct renewals of beneficiaries' eligibility annually from the date of a beneficiary's enrollment into Medi-Cal.[28] Eligibility can also be redetermined if counties receive new eligibility information about the beneficiary, such as an income or household size changes.[29] The Department will need to set policies well in advance of the PHE ending in order to mitigate needless Medi-Cal coverage losses from processing backlogged redeterminations. DHCS should adopt the recommendations below to allow a more seamless transition of renewals and redeterminations post-PHE.

A. Seek CMS Approval for 12-Month Enrollment Extensions During the Pandemic

In an effort to reduce the renewal backlog at the end of the PHE, and to shore up county resources, the Department should seek a 12-month extension on renewals. Although recent DHCS guidance states that CMS timeliness flexibilities do not include pushing out Medi-Cal renewals for twelve months, some states have obtained federal approval for renewal flexibilities.[30] For example, New York has requested through their 1135 waiver to implement enrollment extensions on a 12-month rolling basis during the PHE.[31] Implementing a rolling 12-

[28] 42 C.F.R. § 435.916(a); 45 C.F.R. § 155.335; 10 C.C.R. §§ 6472, 6474; *See also* Cal. Dep't Health Care Servs., Policies and Procedures for Annual Renewal and Change in Circumstance Redeterminations and Discontinuance from Medi-Cal (April 8, 2014), https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/c14-18.pdf.
[29] *Id*.
[30] MEDIL 20-18, *supra* note 5.
[31] United Hospital Fund, *Lessons Learned from the Great Recession: New York Medicaid Enrollment During the COVID-19 Crisis* (June 2020), https://uhfnyc.org/media/filer_public/a4/3e/a43e07a9-dff6-43cb-b188-f4d03eb5cca5/medicaid-enrollment-20200608-b.pdf. *See also* N.Y. Dep't of Health, *New*

month extension in this state would preserve coverage and prevent unnecessary lapses in coverage, while maintaining monthly caseloads at current levels.

Alternatively, DHCS should invest in additional data sources to increase *ex parte* renewals now. Federal regulations require Medicaid agencies to attempt to automatically renew an enrollee's eligibility using available data sources before requesting any information from the beneficiary. If DHCS performs *ex parte* renewals, pulling data from other electronic sources, coverage could be extended for 12 months so that cases remain current, and not backlogged, at the end of the PHE. This policy change would help alleviate the volume of backlogged renewals post-pandemic.

B. Adopt a Staggered Approach to Processing Renewals

For those renewals that are outstanding after the PHE, DHCS should instruct counties to process renewals in a phased approach to mitigate loss of coverage, while not overwhelming counties offices. If the county welfare offices tried to process all renewals in a few months after the PHE, this would certainly overwhelm Medi-Cal beneficiaries, health care advocates, Medi-Cal managed care plans, and county staff who are trying to process the cases of beneficiaries. DHCS should develop a prioritization list based on multiple factors, including ease and availability of verification information, potential ineligibility, length of time until the renewal date, and health equity considerations for marginalized groups and populations.[32]

C. Leverage Medi-Cal Managed Care Plans and Electronic Data Sources to Update Beneficiary Contact Information

Before the PHE ends, the Department should work to obtain up-to-date contact information for Medi-Cal beneficiaries. The economic repercussions of the pandemic have led to a large number of people being displaced. Some individuals are now unhoused, and many have moved to a new county within California or possibly out of state. Many low-income Californians may not update their address with the county welfare office when they move because they are focused on putting food on the table and finding new shelter. Once the pandemic ends, these Medi-Cal beneficiaries risk being cut off Medi-Cal if they don't receive important notices, or fail to return required information.

Since the vast majority of Medi-Cal beneficiaries are enrolled in a Medi-Cal managed care plan, DHCS and the counties should rely on the Medi-Cal managed care plans to do outreach, including mailers and phone calls, to enrollees to obtain their most up-to-date mailing address and contact information. The Department should also instruct county welfare offices to

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York State: Medicaid 1135 Waiver Request (Mar. 23, 2020), https://coronavirus.health.ny.gov/system/files/documents/2020/03/1135_waiver_request.pdf.

[32] *See* MEDIL 20-15, *supra* note 8.

proactively obtain Medi-Cal beneficiary contact information. Additionally, as recommended above, access to additional electronic data sources, such as the EDD's consumer contact information, would allow workers to verify beneficiary information more easily. This would help to ensure that beneficiaries receive notices and their renewal paperwork post-pandemic, increasing the likelihood that more people will retain Medi-Cal coverage.

V. Conclusion

The COVID-19 pandemic has forced the Department of Health Care Services (DHCS) to alter Medi-Cal eligibility, enrollment and retention policies in order to address the complexities of the PHE. Many of the flexibilities the state has adopted have been critical to helping applicants get, and beneficiaries retain, Medi-Cal. Many of the COVID-19 Medi-Cal eligibility, enrollment and retention flexibilities should stay in place well after the PHE ends, and DHCS should consider adopting additional flexibilities that will ease Medi-Cal enrollment, prioritize continuity of care, and lessen the administrative burden put on the state and county welfare offices.

Complete List of Recommendations

- DHCS should automatically waive Medi-Cal premiums during the COVID-19 PHE, and moving forward, develop a consistent mechanism to suspend premiums automatically in the event of another public health emergency or natural disaster. DHCS should place a short-term extension on premium waivers after the PHE expires.
- DHCS should extend coverage under the COVID-19 Uninsured Group Program for Californians who still need medically necessary COVID-19 related treatment post-PHE. To advance DHCS' commitment to health equity, the Department should keep pursuing the waiver to cover COVID-19 vaccinations through the COVID-19 Uninsured Group Program.
- DHCS should continue eligibility under HPE for aged, blind and disabled Medi-Cal beneficiaries once the PHE ends.
- DHCS should establish uniform, statewide protocols so all beneficiaries can access county offices who cannot reach the offices by telephone or online.
- DHCS should permit self-attestation of income in non-emergency situations.
- DHCS should adopt post-enrollment verifications, including the Department's current efforts to expand Accelerated Enrollment, to streamline access to Medi-Cal benefits and avoid overburdening eligibility workers.
- DHCS should expand e-verification capabilities through additional electronic data sources, such as the EDD, to efficiently process Medi-Cal applications and cases.
- DHCS should seek CMS approval to extend enrollment for an additional 12 months to enable optimal retention of Medi-Cal benefits, while mitigating overburdening eligibility workers. In the alternative, DHCS should invest in additional data sources to increase *ex parte* renewals now, during the PHE.

- DHCS should process redeterminations/renewals in a phased approach and develop a case prioritization strategy to prevent gaps in coverage and avoid overwhelm of eligibility workers.
- DHCS should leverage managed care plans and electronic data sources to update beneficiary contact information for renewal and redetermination readiness after the negative action moratorium is lifted.