CalAIM Skilled Nursing Facility (SNF) Long-Term Care Carve-In

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California Hospital Association

Welcome

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Questions

Online Questions: At any time, submit your questions in the Q/A box at the bottom of your screen. We will take questions throughout the presentation.

Moderator

Pat Blaisdell provides membership support and advocacy for hospital-based post-acute care and case management services, including policy analysis and interpretation, communication with regulatory bodies and third-party payers, and planning and implementation of educational programs. Pat has more than 25 years of experience in hospital and health care management in acute and post-acute settings and has expertise in clinical operations and reimbursement across the post-acute continuum of care.

Speaker

Bambi Cisneros has over nine years of State of California experience with the Department of Health Care Services (DHCS) and currently serves as the Assistant Deputy Director for Managed Care, Health Care Delivery Systems (ADD-MC, HCDS). In this role, Bambi supports the planning, implementation, coordination, and management of the program and policies associated with California's Medi-Cal managed care plans (MCPs) and the managed care delivery system to ensure that Medi-Cal beneficiaries have access to high quality care.

Speaker

Tracy Meeker has 25 years of progressive responsibility in project management, business intelligence, and data integration in the commercial health insurance industry and government health care consulting, including over 15 years of Medi-Cal and other state Medicaid programs. She has supported the Cal MediConnect demonstration project as a subject matter expert, and continues supporting DHCS with several CalAIM initiatives, including the Long-Term Care carve-in.

Agenda

Topics	Time
Welcome and Introductions	2:00 – 2:05 PM
CalAIM LTC Carve-In Background, Continuity of Care, Leave of Absence and Bed Holds, Authorizations and Q&A	2:05 – 2:31 PM
Care Management and Care Coordination, Transportation, Included ad Excluded Services, and Q&A	2:31 – 2:58 PM
Next Steps & Closing	2:58 – 3:00 PM

California Advancing and Innovating Medi-Cal (CalAIM): Long-Term Care (LTC) Carve-In

CalAIM Long-Term Care Skilled Nursing Facility Carve-In Overview

- Effective January 1, 2023, Medi-Cal managed care plans (MCPs) in all counties now cover the LTC benefit for Skilled Nursing Facility (SNF), including a distinct part or unit of a hospital.
- Enrollment in Medi-Cal managed care is mandatory for all Medi-Cal beneficiaries residing in a SNF.

SNF Carve-In Goals

- Standardize SNF services coverage under managed care statewide.
- Advance a more consistent, seamless, and integrated system of managed care that reduces complexity and increases flexibility.
- Increase access to comprehensive care coordination, care management, and a broad array of services for Medi-Cal beneficiaries in SNFs.

What has changed?

- All Medi-Cal only and dual eligible beneficiaries in Medi-Cal FFS residing in a SNF on January 1, 2023, have been enrolled in a Medi-Cal MCP effective January 1, 2023, or February 1, 2023.
- Beneficiaries who enter a SNF and would otherwise have been disenrolled from the Medi-Cal MCP will remain enrolled in managed care ongoing.
- This includes most Medi-Cal beneficiaries:
  - Medi-Cal only beneficiaries
  - Dual eligible beneficiaries – eligible for Medicare and Medi-Cal
  - Medi-Cal beneficiaries with other health coverage, including private coverage
  - Share of Cost (SOC) Medi-Cal beneficiaries in LTC aid codes

SNF Carve-In Policy Overview

Continuity of Care

Leave of Absence (LOA) and Bed Holds

Authorizations

Continuity of Care

Continuity of Care – SNF Services

- Effective January 1, 2023, through June 30, 2023, for members residing in a SNF and transitioning from Medi-Cal FFS to Medi-Cal managed care, MCPs must automatically provide 12 months of continuity of care for the SNF placement. Members do not have to request to remain in their current facility.
- MCPs must provide Continuity of Care (CoC) for all medically necessary LTC services at non-contracting LTC facilities for members residing in a SNF at the time of enrollment.
- To prevent disruptions in care, members must be allowed to stay in their current SNF residence, as long as:
  - The facility is licensed by the California Department of Public Health (CDPH);
  - The facility meets acceptable quality standards, including the MCP's professional standards; and
  - The facility and MCP must agree to work together.

Continuity of Care – Providers

- Under CoC, members may continue seeing their out-of-network Medi-Cal providers for up to 12 months.
  - The member, authorized representative, or provider contacts the new MCP to make the request.
  - The member can validate that they have seen the provider for at least one non-emergency visit in the prior 12 months.
  - The provider meets the MCP's professional standards and has no disqualifying quality of care issues.
  - The provider is willing to work with the MCP (i.e., agree on payment and/or rates).
- Members entering managed care residing in a SNF after June 30, 2023, **will not** receive automatic CoC and must request CoC.

Continuity of Care – Other Services

- **Prescription Drugs:** Maintenance of current drug therapy, including non-formulary drugs, until the member is evaluated or re-evaluated by a Network Provider.
  - Claim type determines the financial responsibility for prescription drugs.
    - If drugs are dispensed by a pharmacy and billing on a pharmacy claim, they are carved out and covered by Medi-Cal Rx.
    - If drugs are furnished by the SNF or provider and billed on a medical or institutional claim, the MCP is responsible.
  - MCPs may choose to cover drugs not covered by Medi-Cal Rx, inclusive of over-the-counter drugs and other therapies otherwise not covered.

Continuity of Care – Other Services (Cont'd)

- **Other Services:** CoC provides continued access to the following services, although could require a switch to in-network providers.
  - Durable Medical Equipment Rentals and Medical Supplies
  - Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT)
  - Facility Services
  - Professional Services
  - Select Ancillary Services
  - Appropriate level of care coordination

Leave of Absence and Bed Holds

Leave of Absence and Bed Holds

- A Leave of Absence (LOA) and Bed Holds are periods of time when a member may leave their facility while retaining the ability to return, and the facility will continue to receive some payment.
- Nursing facility residents, in accordance with their care plan, may take a short LOA from the facility either for an inpatient hospital stay or for therapeutic leave (e.g., family visits).
  - When a recipient residing in a nursing facility is admitted to an acute care hospital, providers must bill Bed Hold days.

Leave of Absence

- Allowable LOA length of time per calendar year:
  - 73 days per calendar year for developmentally disabled patients
  - 30 days for patients in certified special treatment program for mentally disordered persons, or patients in a mental health therapeutic program approved and certified by a local mental health director
  - 18 days for all other patients, with up to 12 days of additional days of leave per year approved in increments of up to two consecutive days. Additional days must follow individual care plan and appropriate to physician and mental well-being of the patient. At least five days of inpatient care must be provided between each approved leave of absence.
- LOA payment is not made if a member is discharged during the LOA or discharged within 24 hours after returning to the SNF.
- LOAs and Bed Hold Medi-Cal requirements are in Title 22, CCR, Sections 51535 and 51535.1
- Medi-Cal Provider Manual: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/leave.pdf)

Bed Hold

- When a member residing in a nursing facility is admitted to an acute care hospital (for example, an NF-A, NF-B, ICF/DD, ICF/DD-H, ICF/DD-N, or a swing bed), providers must bill bed hold days.
- For residents in a nursing facility (NF-A or NF-B) that are admitted to an acute care hospital, MCPs will provide a **Bed Hold authorization** for period of **seven days** when a member is admitted to acute care.
- Claims for Bed Holds will be denied if a member's stay in a hospital will be longer than seven days.
- LOAs and Bed Hold Medi-Cal requirements are in Title 22, CCR, Sections 51535 and 51535.1
- Medi-Cal Provider Manual: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/leave.pdf)

Leave of Absence and Bed Holds: Member Protections

- MCPs must allow members to return to the same SNF where a member previously resided under the LOA and Bed Hold policies.
- MCPs must ensure the SNF notifies members or authorized representative in writing about their right to a Bed Hold provision.
- Members must receive transition assistance and care coordination if there is an exception or a SNF fails to comply with regulations.
- MCPs should address any SNF denials of Bed Holds with the SNFs to ensure appropriate member access.
- MCPs must ensure that SNFs notify members of their right to Bed Holds in writing upon admission to SNF, and upon transfer to hospital.

Leave of Absence and Bed Holds: How to Support Medi-Cal Managed Care Members

- MCPs have Utilization Management (UM) policies and procedures in place to support the receipt, review, and approval or denial of authorizations for LOAs and Bed Holds.
- SNFs will work closely with the UM and/or LTSS liaisons at the MCP to ensure the appropriate documentation is provided to obtain approvals for LOAs and Bed Hold authorizations, as needed. MCPs may require prior authorization for LOAs and Bed Holds.
- Timely and accurate authorization submissions are critical to ensure member care access.

Authorizations

Authorizations

- **Treatment Authorization Requests (TARs)**
  - MCPs must maintain continuity of care for members in a SNF by recognizing any treatment authorization requests for SNF services made by DHCS for the member enrolled into the MCP.
  - MCPs are responsible for all other approved TARs for services in a SNF exclusive of the SNF per diem rate for a period of 90 days after enrollment in the MCP, or until the MCP is able to reassess the member and authorize and connect the member to medically necessary services
- **Service Authorizations**
  - Prior authorization requests for members who are transitioning from an acute care hospital must be considered ***expedited,*** requiring a response time no greater than 72 hours, ***including weekends***.

Authorizations (Cont'd)

- **Expedited authorizations:**
  - The 72-hour time period is inclusive of any time outside normal business hours, including weekends and after hours.
  - For example, if a request is received at 4:30 pm on a Thursday, a notice would have to be received by 4:30 pm on Saturday.
  - If an expedited authorization does not receive a response within this 72-hour time period, you may file a complaint through the MCP's Grievance Process.

For more information on this process, see APL 21-011 Grievance and Appeals Requirements, Notice and "Your Rights" Templates

Authorizations (Cont'd)

- MCPs have utilization management (UM) policies and procedures in place to support the receipt, review, and approval or denial of authorizations. As case managers continue working and/or establish new connections and partnerships with MCPs, a few steps to support the managed care operations around authorizations:

- ❑ Member eligibility validation steps
- ❑ Provision of acceptable clinical documentation and evidence, as needed
- ❑ Understanding of placement criteria for an appropriate level of care evaluation
- ❑ Detailed and clear documentation to ensure comprehensive initial submission to MCP
- ❑ Obtaining clarity on the length of time of different types of authorization approvals
- ❑ Understanding reauthorizations process when an authorization termination date is approaching

Questions?

Continuity of Care, LOAs and Bed Holds, and Authorizations

Care Management and Care Coordination

Care Management and Care Coordination

- MCPs are required to provide care coordination to support members.
- Care coordination is scaled to member needs, but for those in LTC it would likely include:
  - Comprehensive assessment of the member's condition
  - Determination of available benefits and resources
  - Development and implementation of a Care Management Plan (CMP) with performance goals, monitoring and follow-up
- MCPs also must assess for and provide additional care coordination services if medically necessary:
  - Enhanced Care Management (ECM) and Community Supports
  - Complex Care Management
  - The SNF LTC Carve-In will not change the administration of Medi-Cal benefits that are carved out of managed care and will continue to be carved out after January 1, 2023

Care Management and Care Coordination: How to Support Medi-Cal Managed Care Members

- MCPs must implement a Population Health Management (PHM) Program that ensures all Medi-Cal managed care members, including those using SNF services, have access to a comprehensive set of services based on their needs and preferences across the continuum of care, including Basic Population Health Management (BPHM), care management programs, and Community Supports.
  - The PHM Service began in January 2023 and MCPs will be rolling out in a phased approach.

- ❑ Identification of an MCP representative (e.g., LTSS Liaison) to coordinate care and provide care management together on behalf of the member
- ❑ Obtain an understanding of MCP policies and procedures around Enhanced Care Management, Community Supports, and other care management services to connect them with the Medi-Cal managed benefits and services available

Hospital Case Managers and the Long-Term Care SNF Carve-In

- Hospital case managers play an important role for members in the SNF carve-in, and MCP care management standards are closely aligned with the role of case managers.
- Hospital case managers are encouraged to work closely with Medi-Cal MCP LTSS liaisons to assist in coordinating member care, including access to Enhanced Care Management, Community Supports, and other care management services.
- Hospital case managers are also called upon to advocate for their patients, and for effective resolution of delays and problems affecting access to care.

Transportation

Medi-Cal: Transportation Benefits

- Providers should work closely with Medi-Cal MCPs to understand the transportation request process. Prior authorizations may be required for NEMT. Medi-Cal MCPs contract with different transportation vendors and have policies and procedures in place to ensure timely access and to offer transportation options that can meet a member's needs.
- Additional information may be found on the DHCS Transportation Services FAQ.

Non-Emergency Medical Transportation (NEMT) is transportation by ambulance, wheelchair van, or litter van for beneficiaries who cannot use public or private transportation.

- Available when medical or physical condition does not allow travel.
- Services must be prescribed by a health care provider.

Non-Medical Transportation (NMT) is private or public transportation to and from covered Medi-Cal services for eligible beneficiaries.

- Available to all beneficiaries with full-scope Medi-Cal and to pregnant women.
- Beneficiaries will need to attest to the provider they have an unmet transportation need and all available resources have been exhausted.

SNF Per Diem: Inclusive and Exclusive Services

Per Diem Rate: Included SNF Services

- Rates for LTC facilities include all supplies, drugs, equipment and services necessary to provide a designated level of care. Other inclusive items include:
  - Room and board
  - Nursing and related care services
  - Commonly used items of equipment, supplies, and services (e.g., personal hygiene items)
  - Routine therapy services
  - Leave of absence days and bed holds
- Medi-Cal MCPs are obligated to pay for all SNF levels of care, including custodial care, skilled nursing facility care (NF-B), and intermediate care (NF-A).
- Additional Information: Medi-Cal Provider Manual: LTC Inclusive and Exclusive Services

Per Diem Rate: Inclusive Therapy Services

- Per the Medi-Cal Provider Manual, many routine services needed to attain and/or maintain the highest practicable level of functioning can and should be performed as part of the per diem rate—and thus are ***included*** under the directed payment. Examples include:
  - Keeping recipients active and out of bed for reasonable periods of time, except when contraindicated by a physician's order
  - Supportive and restorative nursing and personal care needed to maintain maximum functioning of the recipient
  - Changing position of bedfast and chairfast recipients
  - Encouraging and assisting in self-care and activities of daily living
  - Maintaining proper body alignment and joint movement to prevent contractures and deformities
- Additional Information: Medi-Cal Provider Manual: LTC Inclusive and Exclusive Services

Per Diem Rate: Exclusive SNF Services

- **Services outside the per-diem rate** are not subject to the Directed Payment policy and would follow the Medi-Cal MCP and providers normal negotiation process.
- These exclusive items are separately reimbursable and subject to the utilization review controls and limitations of the Medi-Cal program.
- Exclusive items (not included in the per diem rate) include supplies, drugs, equipment or services such as:
  - Durable Medical Equipment as specified in CCR, Title 22, Section 51321(g) and (h)
  - Laboratory services and X-rays
  - Dental services
- Medi-Cal Provider Manual: LTC Inclusive and Exclusive Services and excluded items are outlined in 22 CCR, Sections 51123(b) and (c) and 51511(c) and (d).

Per Diem Rate: Exclusive Therapy Services

- Medi-Cal MCPs and SNFs can negotiate payment for other therapy services outside of the directed payment rate.
- A physician must determine if a patient requires intensive therapy (beyond the normal course typically provided to SNF residents) to attain or maintain the highest practicable occupational, mental, and psychosocial functioning in accordance with their individualized plan of care.
- Includes many occupational, physical, and speech therapies such as:
  - Ongoing occupational therapist involvement to conduct periodic assessments of the patient and evaluation of the patient-specific treatment plan.
  - A physical therapist trains staff on a recipient plan of care that states the beneficiary (who has suffered a stroke) needs hemislings to prevent shoulder subluxation and a hand splint to prevent muscle contracture and deformity in the hand.
  - Speech therapy for a poststroke patient who is dysphasic.
- Further details regarding exclusive services not covered under the per diem rate are available at TAR Criteria for NF Authorization (Valdivia v. Coye).

Questions?

Care Management and Care Coordination, Transportation Coordination, and Included and Excluded Services

Next Steps

SNF Carve-In Webinars

Topic	Audience	Date and Time
Medi-Cal Managed Care SNF Policy Update	SNFs and MCPs	February 24, 2023, 2pm – 3pm
Medi-Cal Managed Care and Skilled Nursing Facility Residents	SNFs	January 30, 2023, 2pm – 3pm
LTC Billing and Payment Rules	SNFs and MCPs	December 2, 2022, 1pm – 2pm
Promising Practices for Contracting	SNFs and MCPs	November 4, 2022, 1pm – 2pm
CalAIM LTC Statewide Carve-In 101 for SNFs	SNFs	October 7, 2022, 1pm – 2pm
CalAIM LTC SNF Carve-In 101 for MCPs	MCPs	September 21, 2022, 10am –11am

Materials from previous webinars and information on upcoming public webinars and registration details can be found at: https://www.dhcs.ca.gov/provgovpart/Pages/Long-Term-Care-Carve-In-Transition.aspx

Resources and Contact Information

Questions? Please contact info@calduals.org

- APL 22-018 Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care
- CalAIM SNF LTC Carve-In Resources for MCPs
- Frequently Asked Questions (FAQs)
- CHA/Pat Blaisdell – pblaisdell@calhospital.org

- DHCS Resources
  - Long-Term Care Carve-In Transition: https://www.dhcs.ca.gov/provgovpart/Pages/Long-Term-Care-Carve-In-Transition.aspx
  - CalAIM: https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx
  - Integrated Care for Dual Eligible Beneficiaries: https://www.dhcs.ca.gov/services/Pages/Integrated-Care-for-Dual-Eligible-Beneficiaries.aspx

Thank You

Thank you for participating in today's webinar.

For education questions, contact: education@calhospital.org.

Appendix

Appendix A: Additional Resources – Inclusive and Exclusive Services

Occupational Therapy: Inclusive and Exclusive Services Chart

- This table illustrates the relationship between therapy services. This is not intended to be an all-inclusive list for when additional therapy services (beyond what is covered in the per diem) but provides some examples for specific therapy service types. Additional details on the inclusive and exclusive services chart can be found at TAR Criteria for NF Authorization (Valdivia v. Coye).

Occupational Therapy Services Table	
Inclusive Service	**Exclusive Service**
The nursing staff supports and encourages the Medi-Cal beneficiary at group activities program. The nursing staff encourages the Medi-Cal beneficiary at homemaking tasks and dressing skills.	Ongoing occupational therapist involvement would be necessary to conduct periodic assessments of the patient and evaluation of the patient specific treatment plan. A patient's plan of care calls for an occupational therapist to evaluate the patient's compensatory techniques and safety with regard to lower extremity dressing, hygiene, toileting and bathing.

Physical Therapy: Inclusive and Exclusive Services Chart

- This table illustrates the relationship between therapy services. This is not intended to be an all-inclusive list for when additional therapy services (beyond what is covered in the per diem) but provides some examples for specific therapy service types. Additional details on the inclusive and exclusive services chart can be found at TAR Criteria for NF Authorization (Valdivia v. Coye).

Physical Therapy Services Table	
Inclusive Service	**Exclusive Service**
The Medi-Cal recipient's plan of care calls for the application of foot, hand and arm splints to prevent contractures and allows range of motion exercises. The nursing staff applies the splints consistently and appropriately. The nursing staff encourages the Medi-Cal recipient's self-feeding at meals and his/her participation in NF activity programs.	A physical therapist trains NF staff on a Medi-Cal recipient plan of care that states the recipient (who has suffered a stroke) needs hemislings to prevent shoulder subluxation and a hand splint to prevent muscle contracture and deformity in the hand.

Speech Therapy: Inclusive and Exclusive Services Chart

- This table illustrates the relationship between therapy services. This is not intended to be an all-inclusive list for when additional therapy services (beyond what is covered in the per diem), but provides some examples for specific therapy service types. Additional details on the inclusive and exclusive services chart can be found at TAR Criteria for NF Authorization (Valdivia v. Coye).

Speech Therapy Services Table	
Inclusive Service	**Exclusive Service**
Repetitive exercises, commonly a part of status post cerebral vascular accident plan of care, are rendered to improve gait or maintain strength and endurance.	The speech therapist's plan of care calls for speech therapy for a poststroke patient who is dysphasic.

Appendix B: Grievances and Appeals

Grievances

- APL 21-011 Grievance and Appeal Requirements, Notice, and "Your Rights" Template defines a **grievance** as:
- "(…) any expression of dissatisfaction about any matter other than an adverse benefit determination (defined below). Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the member's right to dispute an extension of time proposed by the Medi-Cal MCP to make an authorization decision."

Note: While state regulations do not specifically distinguish "grievances" from "appeals," federal regulations define "grievance and appeal system" to mean the processes the MCP implements to handle grievances and appeals, with the terms "grievance" and "appeal" each separately defined. Due to distinct processes delineated for the handling of each, health plans must adopt the federal definition but also incorporate applicable sections of the existing state definition do not pose conflicts.

Health Plan Grievance

- **Standard Grievance Process**
- *Through the health plan*
- Plan must resolve within 30 calendar days

- **Expedited Grievance Process**
- *Through the health plan*
- Plan must resolve within 72 hours

Note: Member can request a State Fair Hearing at any time during the appeals process.

Appeals

- APL 21-011 Grievance and Appeal Requirements, Notice, and "Your Rights" Template defines an **appeal** as:
- "(…) federally defined as a review by the Medi-Cal MCP of an adverse benefit determination. While state regulations do not explicitly define the term "appeal," they do delineate specific requirements for certain types of grievances that would fall under the federal definition of appeal because they involve the delay, modification, or denial of services based on medical necessity or a determination that the requested service is not a covered benefit. The Medi-Cal MCP must treat these grievances as appeals under federal regulations. Medi-Cal MCPs must use the federal definition of "appeal" and comply with all existing state regulations as they pertain to the handling of appeals."

Note: While state regulations do not specifically distinguish "grievances" from "appeals," federal regulations define "grievance and appeal system" to mean the processes the MCP implements to handle grievances and appeals, with the terms "grievance" and "appeal" each separately defined. Due to distinct processes delineated for the handling of each, health plans must adopt the federal definition but also incorporate applicable sections of the existing state definition do not pose conflicts.

Level 1: Health Plan Appeal

Standard Appeal Process

- *Through the health plan*
- Plan must resolve within 30 calendar days
- Benefits continue (Aid Paid Pending) if filed within 10 days of the NOA.

Expedited Appeal Process

- *Through the health plan*
- Plan must resolve within 72 hours
- Benefits continue (Aid Paid Pending) if filed within 10 days of the NOA

Note: Member can request a State Fair Hearing after completing the health plan's internal appeal process or in cases of Deemed Exhaustion at any time during the appeals process.

Level 2: Independent Medical Review

- *Through DMHC* (After filing Plan Grievance/Appeal)
- The member may ask for an Independent Medical Review (IMR) if the NOA indicates that the member's treatment is 'not medically necessary" or "experimental" or "investigational."
- The member may ask for an IMR after 30 days from the date the grievance/appeal is filed or as soon as it's denied, whichever comes sooner.

Note: Member can request a State Fair Hearing after completing the health plan's internal appeal process or in cases of Deemed Exhaustion.

Level 3: State Fair Hearing Process

- *Through Department of Social Services*
- Must be filed within 120 days of receiving the Notice of Appeal Resolution
- Standard hearings must be resolved within 90 calendar days.
- Expedited hearings must be resolved within three working days.

Note: Member can request a State Fair Hearing after completing the health plan's internal appeal process or in cases of Deemed Exhaustion.

Grievances and Appeals Resources

- APL 21-011 Grievance and Appeal Requirements, Notice, and "Your Rights" Template
- DHCS Discrimination Grievance Policies and Procedures Website

Appendix C: Continuous Coverage Unwinding

Continuous Coverage Unwinding

- **The continuous coverage requirement will end on March 31, 2023, and Medi-Cal beneficiaries may lose their coverage.**
- **Medi-Cal redeterminations will begin on April 1, 2023, for individuals with a June 2023 renewal month.**
- **Top Goal of DHCS:** Minimize beneficiary burden and promote continuity of coverage for our beneficiaries.
- **How you can help:**
  - Become a **DHCS Coverage Ambassador**
  - Download the Outreach Toolkit on the DHCS Coverage Ambassador webpage
  - Join the DHCS Coverage Ambassador mailing list to receive updated toolkits as they become available
  - Check out the Medi-Cal COVID-19 PHE and Continuous Coverage Unwinding Plan (Updated January 13, 2023)!

Continuous Coverage Unwinding Communications Strategy

- **Phase One: Encourage Beneficiaries to Update Contact Information**
  - **Already launched**
  - Multi-channel communication campaign to encourage beneficiaries to update contact information with county offices.
    - » Flyers in provider/clinic offices, social media, call scripts, website banners.
- **Phase Two: Watch for Renewal Packets in the mail. Remember to update your contact information!**
  - **Launch approximately 60 days prior to termination of the Continuous Coverage requirement.**
  - Remind beneficiaries to watch for renewal packets in the mail and update contact information with county office if they have not done so yet.