CHCF

Lessons from the Medi-Cal Unwinding

How California Protected Coverage and Policy Options to Improve Renewals

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About the Authors

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About the Foundation

The California Health Care Foundation is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Executive Summary

The COVID-19 pandemic triggered unprecedented growth in Medicaid enrollment, fueled by the continuous coverage requirement of the Families First Coronavirus Response Act (FFCRA). Between February 2020 and March 2023, Medicaid enrollment in the United States grew from 72 million to nearly 95 million, with California's Medicaid program — known as Medi-Cal — increasing from 12.5 million to almost 16 million members. The end of the continuous coverage provision in March 2023 marked the beginning of the "unwinding" process, during which states resumed regular Medicaid redeterminations and disenrollments.

This report examines California's approach to the unwinding process, highlights key successes and challenges, and identifies opportunities to improve continuity of coverage. Drawing on research, expert interviews, and stakeholder discussions, the analysis provides insights into policy decisions, outreach strategies, and operational lessons that can inform future efforts to enhance Medi-Cal renewal processes. The report also provides examples of strategies from other states and associated considerations for California. The following key findings offer a high-level overview of critical themes and insights. More detailed analyses and supporting information are provided in the report, and a complete list of opportunities can be found in Appendix B.

Key Findings

During the unwinding, California processed the largest number of Medicaid redeterminations in the nation, approximately 11 million, and maintained coverage for nearly 9 million members. Roughly 2 million people were disenrolled during the unwinding, and 66% of these disenrollments were due to procedural reasons (e.g., missing renewal paperwork) rather than a determination of ineligibility. Despite disenrollments, Medi-Cal enrollment as of December 2024 remains 2.3 million higher than prepandemic levels, partly due to expanded eligibility policies.

California's unwinding experience offers critical lessons for optimizing ex parte renewal (also known as auto-renewal) processes to reduce administrative burdens for Medi-Cal workers and members and administrative costs for Medi-Cal, decrease procedural disenrollments, and promote continuity of coverage in the future. While the state successfully mitigated coverage losses for millions, there remain opportunities to improve renewal processes, outreach strategies, and stakeholder coordination. With federal unwinding flexibilities set to expire in June 2025, policymakers must weigh the costs and benefits of continuing key policies that have proven effective in reducing coverage disruptions. By applying lessons from the unwinding, California can further refine its Medi-Cal renewal processes and serve as a model for other states striving to maintain Medicaid coverage for eligible people.

Primary Successes

- **Adoption of federal flexibilities.** California adopted over a dozen federal flexibilities to minimize inappropriate disenrollments, improve contact information accuracy, and streamline eligibility verifications.
- **Increased ex parte renewals.** California's ex parte renewal rate more than doubled during the unwinding, rising from 31% to 63%, reducing administrative burdens, and preventing unnecessary coverage losses.
- **Robust outreach and communications.** A statewide multimedia campaign, multilingual materials, and community-based partnerships helped inform members about renewal requirements.
- **Data transparency.** California provided detailed, disaggregated unwinding data through an interactive public dashboard, enabling stakeholders to track trends and target approaches.

- **Stakeholder engagement.** Regular collaboration between the state, counties, managed care plans (MCPs), and community-based organizations (CBOs) improved coordination and messaging.

Notable Challenges

- **Eligibility worker capacity and training.** Counties faced workforce shortages and long call-center wait times, creating barriers for members attempting to renew coverage.
- **Operational inefficiencies.** Manual data entry and system issues, including the simultaneous implementation of a new statewide eligibility system, slowed processing and led to avoidable procedural disenrollments.
- **Member confusion and outreach limitations.** Some beneficiaries reported not receiving renewal notices, while others were overwhelmed by redundant or confusing outreach messages.
- **Variability in county-level coordination.** Collaboration between counties and CBOs was inconsistent, with some organizations struggling to obtain necessary case information to assist members with the renewal process.

Future Opportunities

- **Extend or permanently adopt key federal flexibilities** to maintain high ex parte renewal rates and reduce administrative burdens.
- **Enhance training and capacity for eligibility workers** through improved funding, technology adoption, and interactive learning opportunities.
- **Streamline application and renewal processes** with simpler forms, better data integration, and automation of eligibility verifications.
- **Improve member outreach and accessibility** by refining messaging strategies, ensuring language and disability accommodations, and aligning Medi-Cal communications with those of Covered California.
- **Strengthen partnerships between counties, MCPs, and CBOs** to improve data sharing, enhance trust, and facilitate smoother case resolutions.

Background

In 2020, Congress passed the Families First Coronavirus Response Act (FFCRA), which provided resources to support response to the COVID-19 pandemic public health emergency (PHE), including funding for states to maintain continuous Medicaid coverage for nearly all members through the end of the PHE.[1] Typically, states redetermine eligibility for Medicaid members on an annual basis and disenroll people who are no longer eligible. The FFCRA provided additional Medicaid funding to states via a 6.2% increase to states' Federal Medical Assistance Percentage (FMAP), contingent on states pausing Medicaid disenrollments during the PHE unless members moved to a different state, died, or requested to be disenrolled.[2] The continuous coverage requirement reduced "churn" among Medicaid members, preventing coverage gaps that occur when members are disenrolled from Medicaid and reinstated within a short period of time.[3] The continuous coverage requirement also contributed to a nationwide increase in Medicaid enrollment from roughly 72 million to almost 95 million members between February 2020 and March 2023.[4]

On March 31, 2023, Congress ended the continuous coverage requirement and began phasing out the enhanced FMAP, requiring states to return to normal operations by resuming Medicaid redeterminations and disenrollments of ineligible people. This process was commonly referred to as the "unwinding" of the continuous coverage requirement. The

federal Centers for Medicare & Medicaid Services (CMS) established requirements for states, provided a range of flexibilities that states could adopt, and developed extensive guidance and technical assistance to support states during the unwinding period.[5] States were required to develop unwinding operational plans outlining how they intended to complete all renewals, applications, and redeterminations within 14 months; how they would avoid inappropriate disenrollments; and what unwinding flexibilities they would adopt.[6] Additionally, CMS imposed multiple member contact requirements, including requiring states to attempt to update members' contact information before beginning a renewal, contact members via multiple modalities before disenrolling them due to returned mail, and publicly report data on redeterminations, renewals, and disenrollments every month.[7]

Federal unwinding flexibilities were intended to help states maintain continuity of coverage for members, streamline processes, and ease eligibility worker caseloads. Certain flexibilities, including Section 1902(e)(14)(A) waivers and State Plan Amendments (SPAs), required federal approval, whereas others could be implemented through state unwinding or eligibility verification plans, with appropriate CMS notification.[8] Flexibilities included options to update member contact information more seamlessly, help members complete renewal forms, and increase rates of ex parte renewals, which use available data to verify eligibility rather than requiring members to complete a form.

States varied widely in their approaches to unwinding, including when they began processing renewals, their timeline for completing renewals, and the number and type of federal flexibilities adopted.[9] For example, 17 states adopted 5 or fewer Section 1902(e)(14)(A) waiver flexibilities, while 18 states, including California, adopted 10 or more flexibilities.[10] However, a majority of states conducted outreach campaigns and engaged with managed care plans (MCPs) and community-based organizations (CBOs) during the renewal process.[11]

Nationwide, 25 million members were disenrolled from Medicaid, and 56 million members had their coverage renewed during the unwinding.[12] As of December 2024, nationwide Medicaid enrollment had decreased by 17% from its peak of 94 million in March 2023, but was still 10% higher than prepandemic levels, likely due to a combination of increased awareness of the program, improved renewal processes that reduced inappropriate coverage loss, and Medicaid expansions in several states.

California's Approach to the Unwinding and Associated Enrollment Outcomes

During the public health emergency, enrollment in Medi-Cal, California's Medicaid program, increased from 12.5 million to nearly 16 million.[13] The state began redeterminations in April 2023; adopted over a dozen Section 1902(e)(14)(A) waiver flexibilities, as well as other nonwaiver flexibilities; and invested in a robust statewide communications and outreach campaign to maximize continuity of coverage. California processed the largest caseload of redeterminations in the country during the unwinding and was successful in maintaining Medi-Cal coverage for a majority of members. Notable outcomes from California's unwinding period (April 2023–May 2024) include:

- A lower disenrollment rate and a higher ex parte renewal rate compared to national averages.[14]
- Approximately 11 million redeterminations completed, maintaining coverage for nearly nine million people and disenrolling roughly two million.[15]
- A procedural disenrollment rate of 66% of all disenrollments. Procedural disenrollments were due to procedural issues, such as members not receiving or completing renewal forms or eligibility workers not processing documents before a case closed, as opposed to people being deemed ineligible.[16]

- Reinstatement of Medi-Cal coverage for 15% of the two million members who were initially disenrolled.[17]
- More than doubling the state's ex parte renewal rate from 31% during the first three months of unwinding to 63% during the last three months.[18]

Despite disenrollments, by December 2024, Medi-Cal enrollment had increased by 2.3 million since the start of the pandemic, in part due to coverage expansions (e.g., expansion of coverage for adults ages 26 through 49 regardless of immigration status).[19]

In 2024, CMS issued the Eligibility and Enrollment Final Rule (Final Rule), which streamlines the Medicaid application and enrollment process, strengthens coverage for children, and promotes enrollment and continuity of coverage for eligible people.[20] The Final Rule made certain unwinding flexibilities permanent. However, many flexibilities are set to expire in June 2025, some of which have no mechanism for continuation, while others can be continued with federal approval through SPAs; through Section 1115 demonstration waivers; or through state eligibility verification plans, policies, and procedures. Most states reported improvements to their renewal processes during the unwinding and expressed interest in continuing at least some Section 1902(e)(14)(A) waiver flexibilities.[21]

It is unclear whether the current federal administration will approve continued use of currently approved unwinding flexibilities and how cost may factor into state decisionmaking amid potential budget constraints and discussion of cuts to Medicaid funding at the federal level.[22]

In California, the 2025–2026 budget continues unwinding flexibilities through June 2025 but projects a 3% decrease in Medi-Cal enrollment, or approximately 450,000 people, in 2025–2026 as flexibilities expire.[23]

Methodology

The California Health Care Foundation (CHCF) partnered with Aurrera Health Group to identify lessons learned from California's experience with unwinding Medi-Cal continuous coverage and, drawing from those lessons, identify opportunities for improving renewal processes and continuity of coverage. This project aimed to better understand and document the impact of unwinding flexibilities adopted by California, successes and challenges from the unwinding process, remaining opportunities to improve retention, and considerations in the context of evolving federal policy.

CHCF and Aurrera Health Group leveraged multiple modalities to collect information, including desk research; expert interviews with California stakeholders, national organizations, and other states; and an in-person roundtable that brought together state and local experts to reflect on lessons learned from California's unwinding experience and share perspectives on remaining opportunities. Roundtable attendees included representatives from the California Department of Health Care Services (DHCS), counties, consumer advocacy organizations, Medi-Cal enrollment assisters, MCPs, and clinics. The following sections of this report summarize insights from expert interviews and roundtable discussion.

California Unwinding: Key Lessons and Future Opportunities

During the unwinding, California implemented an array of strategies to process coverage redeterminations and support continuity of coverage for Medi-Cal members. Analysis of California's approach offers valuable insights into both successful practices and areas for improvement. The following sections review key successes, notable challenges, and remaining opportunities to improve renewal processes and continuity of coverage in three overarching areas:

- **Policies and systems:** state-level eligibility and enrollment policies, systems, and operational structures
- **Stakeholder engagement and community partnerships:** formal and informal partnerships between stakeholders
- **Member outreach and education:** engagement with members to ensure awareness of renewal processes and access to resources and support

Policies and Systems

California took significant steps to adapt policies, systems, and operations to manage the unprecedented volume of redeterminations and preserve coverage for eligible members during the unwinding.

Key Successes

Comprehensive and flexible approach. California developed a comprehensive Medi-Cal unwinding strategy centered on maintaining continuity of coverage, as outlined in its Unwinding Operational Plan.[24] The state's approach included robust guidance to ensure that all stakeholders understood Medi-Cal policies and procedures and numerous stakeholder forums to enable information exchange with key partners. The state recognized the dynamic nature of the unwinding process and the importance of adapting as new information became available. Stakeholders commented on the value of the state's adaptive approach, which enabled quick identification and resolution of policy and operational challenges as they emerged.

Adoption of numerous flexibilities. California adopted roughly 16 federal flexibilities during the unwinding, including those focused on increasing ex parte renewal rates, improving contact information updates, promoting continuity of coverage for key populations, and facilitating reinstatement of eligible people for procedural reasons. California's strategic adoption of flexibilities supported coverage continuity and helped streamline administrative processes. Flexibilities focused on increasing ex parte renewals (discussed in more detail below) were particularly effective in maintaining coverage for eligible members and reducing administrative burden for both members and those processing their renewals.

California's implementation of a 20% reasonable compatibility threshold for the modified adjusted gross income (MAGI) population also helped reduce burden on members and eligibility staff.[25] The reasonable compatibility threshold is the allowable difference between a member's self-attested income and data from electronic sources. If self-attested information is reasonably compatible with electronic data sources within the established threshold, states may not request additional information to verify the information. By implementing a 20% reasonable compatibility threshold, California was able to reduce additional verification requests, alleviate staff burden, and limit paperwork for members, which is often a significant barrier to renewals.

Early implementation of the flexibility allowing a member's case record to be updated with contact information received from the National Change of

Address (NCOA) database helped ensure that communications reached beneficiaries at their current residences. The state also adopted a flexibility that allowed counties to complete an eligibility redetermination for hard-to-reach populations based on a change in circumstances. If counties received sufficient information about a change in circumstance, they could renew coverage for eligible members based on the change (e.g., a change in income or household size), and the next renewal period would not occur for another 12 months. Stakeholders noted that this strategy was helpful in retaining coverage for at-risk populations, especially those experiencing homelessness or housing insecurity who may have difficulty receiving or responding to renewal notices.

Strategies to increase ex parte renewals. Stakeholders highlighted the distinct value of strategies that helped increase ex parte renewals, reducing the risk of eligible members losing coverage due to incomplete or missed renewal submissions.

Effective strategies to increase ex parte renewals in California:

- **Zero-dollar income strategy:** allowed ex parte renewals for Medi-Cal members with no reported income and no income data returned from electronic sources
- **100% income strategy:** allowed ex parte renewals for Medi-Cal members with incomes at or below 100% of the federal poverty level (FPL), and for whom no income data was returned from electronic sources
- **Stable income and asset strategy:** allowed ex parte renewals without requiring verification from external data sources for members with fixed income sources, such as Title II benefits or pensions, or stable assets such as burial funds

Processing renewals on an ex parte basis without requiring members to complete renewal forms limits burdens on both members and eligibility staff. By eliminating unnecessary paperwork and verification requests, eligibility staff and enrollment assisters who support members in applying for and renewing coverage gain capacity to work on more difficult cases. Ex parte renewals are particularly beneficial for at-risk populations who may face increased challenges navigating renewal systems and processes, including older adults, people with disabilities, those experiencing homelessness, those with limited-English proficiency (LEP), immigrant populations, and people who are or have been incarcerated.

Publicly available data. To provide transparent, up-to-date information on progress during the unwinding, DHCS developed an interactive dashboard with information updated monthly across a range of eligibility measures, including total enrollment, applications in progress, redeterminations, and disenrollments.[26] Stakeholders believed that the state's commitment to transparency through publicly accessible data enhanced accountability and allowed them to identify trends and emerging issues during the unwinding. Further, stakeholders' ability to disaggregate and analyze data by demographic factors including race, ethnicity, and language made it easier to implement focused strategies to support specific populations.

Notable Challenges

Capacity and training. With the significant number of redeterminations processed during the unwinding, California counties faced challenges with staff capacity, especially for county call centers. Long call-center wait times created barriers for members and led to difficult scenarios for county staff who answered calls. One "secret shopper" study, conducted by The Children's Partnership, found that the average call-center wait time was approximately one hour, and that staff trainings and call triage can

help reduce wait times. The study also found that counties with lower enrollment had shorter hold times; however, 3 of the 10 counties with the highest enrollment had hold times of 15 minutes or less.[27] While this study provided useful information, the absence of publicly available state-level call-center performance data limited the ability to fully understand varied county experiences and share best practices in real time during the unwinding.

Stakeholders also highlighted the need for additional training and technical support for eligibility staff. Most eligibility workers had either not processed a Medi-Cal renewal since before the unwinding or had never processed renewals because they were hired during or after the PHE and were adapting to new policies and processes with the implementation of federal waivers.

Simultaneous implementation of new statewide eligibility system. As counties navigated the high volume of redeterminations during the unwinding, capacity and training challenges were amplified by the simultaneous implementation of the state's new Medi-Cal eligibility system. Implementation of the California Statewide Automated Welfare System (CalSAWS) intensified county workloads, necessitated additional staff training, and resulted in case management disruptions for some members.

Insights from Other States

To address capacity challenges during the unwinding, the Washington State Health Care Authority (HCA), the state's Medicaid agency, established memoranda of understanding with other state agencies, which allowed HCA to temporarily redeploy a portion of its eligibility workforce and maintain staffing levels during the public health emergency. Additionally, as unwinding began, HCA received funding from the state legislature for 50 full-time employees who were hired for 18- to 24-month periods to support redeterminations and to help reduce caseloads.

System and operational inefficiencies. System and operational dynamics led to inefficiencies that delayed processing of certain renewals or, in some cases, may have resulted in termination of coverage for eligible members. Some stakeholders noted situations in which members uploaded their renewal packets online, but the information was not recognized by the system as a renewal, requiring eligibility worker intervention to code the information correctly and avoid auto-discontinuance. These situations may have occurred due to systems errors, because members faced challenges navigating the system and did not use the CalSAWS renewal option when uploading information into the system, or as a result of county clerical staff errors entering renewals in the systems.

Other inefficiencies emerged related to processes for updating member contact information. In some counties, staff capacity was strained and processing was delayed when county staff were required to manually enter member information from data lists provided by MCPs into the eligibility system. Further, when MCPs or CBOs provided counties with updated member contact information, county staff took steps to verify the data before using it, including confirming whether updated contact details applied to the entire household. These additional verification steps were not aligned with policy objectives aimed at using trusted sources for member contact updates. They required extra time and resources, while also placing additional burden on members who had to re-report their contact information. Furthermore, delays in updating contact information increased the risk of members missing important notices from DHCS due to outdated contact details in the system.

Insights from Other States

To support continuity and familiarity with system dynamics, Washington continued processing renewals throughout the public health emergency and manually extended coverage for three months at a time for members who would have otherwise been disenrolled. This approach meant that members were accustomed to receiving notices from the state prior to unwinding, and eligibility staff remained familiar with the renewal process. Additionally, by accepting address updates from managed care plans as well as sister state agencies, Washington was able to obtain accurate contact information.

Opportunities

- **Recognizing and revisiting the distinct value of federal flexibilities and state options** to increase ex parte renewals and support continuity of coverage. Since the end of the unwinding period, ongoing use of federal flexibilities has continued to increase ex parte renewal rates.[28] While federal unwinding flexibilities are set to expire on June 30, 2025, states retain discretion in leveraging available policy options, including reasonable compatibility thresholds. Although state budget dynamics may limit the feasibility of making these strategies permanent in the near term, they remain important opportunities to consider in longer-term policy discussions.
- **Increasing funding, training, and technical assistance for eligibility workers** to ensure sufficient capacity and understanding of policies and systems. Increasing funding would allow counties to offer more competitive salaries for eligibility workers, helping improve recruitment and retention. While the PHE and associated unwinding were unique events, additional training may be necessary to help eligibility workers (many of whom may only be familiar with processing renewals during the unwinding) understand and adapt to evolving policies and operations as federal flexibilities end. Interactive training and technical assistance forums can also address some of the more nuanced system dynamics that lead to inefficiencies in processing renewals, such as issues with accessing or loading renewals. Specific strategies identified by stakeholders include:
  - **Developing a "sandbox" training environment within CalSAWS** to provide hands-on learning opportunities for eligibility workers without affecting live data
  - **Establishing a CalSAWS certification program in partnership with community colleges** to equip eligibility workers with essential system knowledge, allowing counties to focus training on local needs
- **Adopting call-center innovations** such as callback functionality to reduce wait times and improve access for members, advocates, and stakeholders, and leveraging AI to take detailed notes and summarize calls, allowing eligibility workers to focus on addressing members' concerns and identifying necessary case actions.[29]
- **Providing additional guidance on processes to update member contact information,** including clarifying that a change in contact information should default to the entire household and that MCPs are considered a trusted source of updated contact information.
- **Streamlining and simplifying application and renewal forms** to reduce member and eligibility worker burden and improve access and continuity of coverage. Simplifying forms by using plain language, reducing redundant questions, and incorporating digital features such as autofill and guided assistance can make it easier for all applicants to complete processes accurately and efficiently. Updates to renewal forms fall within the state's discretion, presenting a near-term opportunity to enhance the member experience. However, because application updates involve multiple levels of oversight and approval, they may constitute a longer-term project.

Member Outreach and Education

The state, counties, MCPs, CBOs, and advocates all played key roles in conducting member outreach and education during the unwinding, which was critical to ensuring continuity of coverage.

Key Successes

Investment in robust outreach campaign. The state's development of a comprehensive and sophisticated outreach strategy was highlighted as a critical component of its approach to the unwinding. DHCS received $25 million from the state legislature to hire a vendor for a statewide outreach and communication campaign that included printed materials, social media content, and advertising via television, radio, and other modalities.[30] Stakeholders also noted the value of the state's translation of outreach materials into 19 threshold languages, which reduced their workload and allowed them to easily adapt materials to meet local needs.[31] During the roundtable, some MCP representatives noted that outreach and increased visibility of Medi-Cal resulted in an increase of up to 30% in enrollment during unwinding.

Coordinated outreach strategy across the state and counties. The state and counties took a coordinated approach to developing outreach materials. For example, counties were able to provide input on state-developed collateral before it was publicly released, helping ensure standardized messaging and buy-in and allowing sufficient time to familiarize county staff with messaging so they could anticipate and better respond to member questions. Coordination across state programs also helped support effective messaging and outreach to members. Coordination between Medi-Cal and Covered California allowed the state to elevate key messages during renewal and open enrollment periods, efficiently leverage resources across programs, and facilitate transitions from Medi-Cal to marketplace coverage when appropriate.[32] Coordination across programs at the local level also helped build member trust with key partners to support Medi-Cal eligibility and enrollment.

Use of multiple communication modalities, including text messages. The use of multiple modalities to reach members enabled effective member communications and helped increase awareness of unwinding requirements and timelines. A Federal Communications Commission ruling allowing Medicaid agencies and their partners, including MCPs, to text members provided a new communication vehicle and mitigated issues related to sending mailings to outdated member addresses.[33] During the unwinding, members received texts from DHCS, counties, MCPs, and CBOs reminding them to update their contact information, complete renewal forms, and check on the status of their renewal. Although some members reported feeling overwhelmed by the amount of outreach they received, stakeholders generally agreed that contacting members through different modalities increased the likelihood that members received timely information about redeterminations and took appropriate action.

Notable Challenges

Member awareness and comprehension of renewal processes and forms. Some members reported not receiving renewal forms, and others lacked key information, such as how to reenroll and consequences of not completing their renewal.[34] As noted earlier, obtaining correct contact information was an ongoing challenge that may have impeded receipt of renewal forms for some members and was often compounded by issues related to entering data into eligibility systems. Those who did complete or attempted to complete renewal forms often encountered difficulties finding accurate information, navigating websites, and getting connected to call-center staff in a timely manner. Some people with disabilities or whose primary language was not English also experienced barriers to accessing consistent and timely accessibility and

interpretation services, making the renewal process more difficult. In particular, poor translation of technical documents, long wait times for interpretation services, and a lack of fluent translators (especially for dialects) made the renewal process challenging for some non-English speaking members.[35]

Volume of communications and use of preferred modalities. Some members found the volume of communications overwhelming as they received multiple mailed notices, phone calls, and texts from diverse entities, including the state, counties, MCPs, and CBOs. The use of new modalities also created confusion about which information to trust; for example, text messages with links to BenefitsCal, a statewide online platform for Californians to manage food, cash, and health assistance benefits, were misinterpreted as a scam by some members. Stakeholders also flagged that lack of data on the impact of distinct outreach modalities limited understanding of which ones were preferred or most effective for different populations.

Opportunities

- **Coordinating and co-branding with Covered California** to align messaging, efficiently use communication resources, and help members retain coverage. Building on successful efforts during the unwinding, the state can continue to leverage Covered California to amplify key Medi-Cal renewal and open enrollment messages. This strategy may include co-branding communications and can help reach people who are transitioning from one program to the other.
- **Identifying members' preferred method of communication and collecting data on the efficacy of different outreach strategies** to ensure that members take action when needed during the renewal process. Stakeholders can also use data on outreach strategies to better target messaging, especially for populations that are hard to reach, including Hispanic and Spanish-only speaking households and those who are chronically unhoused.
- **Improving member experience and accessibility** by ensuring that key information about eligibility and renewals is easily available on county websites, providing timely and consistent access to language and accessibility services, and expanding translation of materials to include additional modalities (e.g., robocalls and texts) and dialects. If the state invests in future efforts to streamline and simplify application and renewal forms, as noted in the "Policy and Systems" section, member input will be indispensable in making the forms more user friendly, faster to complete, and accessible for those with disabilities or whose primary language is not English.

Stakeholder Engagement and Community Partnerships

Close collaboration among stakeholders was crucial to identifying issues, implementing solutions, sharing best practices, and communicating about quickly changing state and federal policies during the unwinding.

Key Successes

Meaningful state-led engagement. Stakeholders noted that meaningful engagement at the state level helped build trust between parties and helped identify issues and implement solutions quickly. Counties and other stakeholders highlighted that consistent communication from the state, including regular meetings where they could raise issues, clarify guidance, and share best practices, was essential to the success of California's unwinding process. Additionally, the state's willingness to acknowledge and address stakeholder feedback ensured that distinct perspectives were heard. Further, the state's ability to be nimble and responsive in addressing policy and operational issues allowed timely identification and resolution of challenges. Advocates

appreciated that the state was open to receiving input and collaborating on solutions.

Multilevel partnerships. Collaborative partnerships at all levels also contributed to the overall success of the unwinding. In addition to meetings between the state and counties, partnerships developed among MCPs, CBOs, and advocates to help coordinate and align messaging. Many counties established formal and informal partnerships with CBOs and MCPs to strengthen outreach, including by developing data-sharing agreements, hosting co-branded webinars and community events to raise awareness about the renewal process, collaborating on outreach strategies and sequencing, and leveraging CBO and MCP capabilities to fill gaps in county capacity. Advocates and CBOs developed their own forums for engagement where they could share successes and barriers members were facing, which could then be elevated to the state or county level. In some counties, liaison lists helped CBOs get in touch with county eligibility workers more seamlessly to address urgent or difficult cases and bypass call-center wait times.

Coverage Ambassadors and navigators. Stakeholders highlighted the success of the DHCS Coverage Ambassadors and Medi-Cal Health Enrollment Navigators programs in using trusted messengers to help members retain coverage.[36] A standardized toolkit helped partners align messaging and engage members in culturally and linguistically appropriate ways.[37]

Insights from Other States

Similar to California, stakeholder engagement and community partnerships were central to unwinding efforts in other states. North Carolina took a community-centered approach to the unwinding, working closely with community-based organizations (CBOs) and other local organizations.[38] The state developed a customizable community engagement toolkit and trained volunteer Medicaid Ambassadors to help people complete online applications and answer basic questions about the application process, alleviating burden on county staff. Similarly, Washington conducted trainings for volunteers, CBOs, and navigators and leveraged community-based eligibility specialists located on-site at clinics, universities, and other facilities throughout the state to support members with renewals.

Notable Challenges

Clarity and variable coordination. Even with regular meetings and frequent communication from the state, the adoption of new flexibilities and a high volume of guidance sometimes resulted in confusion for stakeholders regarding current state policy. The level of collaboration with stakeholders also varied across counties, and some CBOs struggled to develop strong relationships with counties, encountering issues when attempting to connect members to county workers and update information.

Fully leveraging CBOs as trusted partners. CBOs noted limitations in their ability to fully assist members with renewals due to the transition to CalSAWS and issues establishing an authorization for Release of Information (ROI). Under the new system, CBOs were unable to look up member case information, adding extra coordination steps with the county. This dynamic also required counties to dedicate more staff time to tasks that a navigator with full system access could have handled.

Opportunities

- **Using stakeholder engagement forums and communication strategies used during unwinding,** including regular meetings between the state and counties and robust outreach campaigns for the rollout of major state policy initiatives, to coordinate the state response to future emergencies, or to implement significant federal policy changes.
- **Encouraging more formal partnerships and data sharing between counties and CBOs,** including through ROIs and liaison lists, to enable navigators to better support members with renewals and eligibility issues and reduce county workloads. These strategies can be enhanced by matching members with someone who speaks their preferred language and triaging outreach so that those who have medical appointments or are at risk of losing services are contacted first.
- **Providing funding for Coverage Ambassadors and navigators** to ensure that they have the resources and communication tools necessary to educate members, connect people to services, and more fully support the renewal process. With state funding for the Health Enrollment Navigators program set to expire in June 2025, additional support (e.g., county-level funding) will likely be necessary to maintain access to this resource.[39]
- **Aligning communication efforts between counties, MCPs, and CBOs** to support unified messaging, improve trust, and avoid overwhelming members with outreach. Counties and MCPs can coordinate on outreach plans and co-brand materials to ensure standardized messaging.
- **Further developing partnerships across organizations and sectors** to help build trust in the community, broaden the reach of messaging, and provide more avenues for members to learn about and access services for which they may be eligible, such as Medi-Cal and CalFresh. DHCS and counties can also engage cross-sector partners to address reluctance to engage with government services in a coordinated manner.

Conclusion

The unwinding of Medicaid's continuous coverage requirement marked a significant shift in enrollment and eligibility processes, with states implementing varied strategies to balance an increased workload, streamline redeterminations, and maintain continuity of coverage. Federal flexibilities, such as Section 1902(e)(14)(A) waivers, played a crucial role in mitigating procedural disenrollments and ensuring continuity of coverage. California's approach, characterized by its increase in ex parte renewals, proactive outreach campaigns, and coordinated stakeholder engagement, proved effective in preserving coverage for millions of Californians despite challenges related to system inefficiencies and staff capacity. Looking ahead, the expiration of many federal unwinding flexibilities in June 2025 raises concerns about potential disruptions in coverage, particularly for at-risk populations. While pathways exist for states to continue certain strategies, uncertainties regarding state budgets and federal approvals could affect feasibility. Insights from the unwinding process offer an array of opportunities California may consider in the near- and longer-term to improve renewal processes and ensure that eligible Californians retain their Medi-Cal coverage.

Appendix A. Interview and Roundtable Participants

Mayra E. Alvarez, The Children's Partnership

Kevin Bassett, CalOptima Health

Eilona Betkolia-Gevargiz, Social Services Agency, County of Santa Clara

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Appendix B. Opportunities to Improve Medi-Cal Renewals and Continuity of Coverage

- **Recognize and revisit the distinct value of federal flexibilities and state options** to increase ex parte renewals and support continuity of coverage, including zero-dollar income strategy, 100% income strategy, stable income and asset strategy, and increased reasonable compatibility threshold.
- **Increase funding, training, and technical assistance for eligibility workers** to ensure sufficient capacity and understanding of policies and systems, such as developing a "sandbox" training environment within CalSAWS or establishing a CalSAWS certification program in partnership with community colleges.
- **Adopt call-center innovations,** such as call-back functionality or AI notetaking, to reduce wait times, improve accessibility, and allow eligibility workers to focus on member concerns and case actions.
- **Provide guidance to counties on processes for updating member contact information,** including clarifying trusted sources of information and specifying that a change in contact information should default to the entire household.
- **Streamline and simplify application and renewal forms** by using plain language, reducing redundant questions, and incorporating digital features such as autofill and guided assistance.
- **Coordinate and co-brand with Covered California** to align and amplify messaging, efficiently use communication resources, and help members retain coverage, particularly those who may be transitioning from one program to the other.
- **Identify members' preferred methods of communication and collect data on the efficacy of different outreach strategies** to enable targeted messaging and ensure that members take action when needed during the renewal process.
- **Leverage stakeholder engagement forums and communication strategies used during the unwinding,** such as regular meetings between the state and counties and robust outreach campaigns, for future emergencies or the rollout of major initiatives.
- **Encourage formal partnerships and data sharing between counties and CBOs** using ROIs and liaison lists, to enable better support for members and reduce county workloads.
- **Provide funding for Coverage Ambassadors and navigators** to ensure that they have the resources and communication tools necessary to educate members, connect people to services, and more fully support the renewal process.
- **Align communication efforts between counties, MCPs, and CBOs** to support unified messaging, including co-branded materials; improve trust; and avoid overwhelming members with outreach.
- **Develop partnerships across organizations and sectors** to build trust in the community, broaden the reach of messaging, and provide more avenues for members to learn about and access services for which they may be eligible, such as Medi-Cal and CalFresh.

Endnotes

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