California Children's Services: Overview on Medi-Cal Enrollment and Eligibility Changes

H.R. 1 and State Budget Changes and What County CCS Administrators Need to Know

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Revised October 2026

Purpose

- **Level-set on H.R. 1** - Walk through the federal Working Families Tax Cut (P.L. 119-21) provisions that change Medi-Cal eligibility, enrollment, and immigrant coverage — and the dates they take effect.
- **Connect each change to CCS** - For every provision, show the Medi-Cal program impact on the left and the CCS-specific implication on the right, so county administrators can brief staff and plan operations.
- **Know when CCS-Only applies.** If Medi-Cal ends for a procedural reason (e.g., missed renewal, WCER non-compliance), there is no CCS-Only bridge; the member must restore Medi-Cal first. If Medi-Cal ends for an eligibility reason (e.g., over income), or an undocumented 19–20-year-old qualifies only for restricted-scope Medi-Cal, the county assesses for CCS-Only (see Appendix A).
- **Equip counties for January 1, 2027** - Leave with timelines, source documents, noticing expectations, and a short list of actions County CCS Programs should take before January 1, 2027.

Outline

Overview: At-a-glance table of federal H.R. 1 and California budget changes, and the CCS takeaway for each.

- **Work and Community Engagement (WCER)**: 80-hour monthly requirement for the New Adult Group beginning January 1, 2027.
- **Six-Month Renewals**: ACA expansion adults move from annual to semi-annual eligibility checks.
- **Qualified Non-Citizen Definition**: Federal full-scope funding narrows on October 1, 2026. QNC CCS youth under 21 retain Satisfactory Immigration Status (SIS).
- **UIS Transition to Fee-For-Service**: All UIS members, including CCS, move from managed care to FFS on January 1, 2027.
- **Undocumented Adult Enrollment Freeze**: In effect since January 1, 2026 — implications for Undocumented CCS members ages 19–20.
- **UIS Monthly Premiums**: Proposed $30–$50 premium beginning July 1, 2027; final amount pending.
- **Appendix A/B, Q&A**: Checklist, when CCS-Only applies, Classic vs WCM frame, Questions and Answers.

Federal and State Changes at a Glance

Change	Source	Effective	Who is primarily affected
Work/community engagement (WCER)	H.R. 1 §71119	Jan 1, 2027	ACA New Adult Group, ages 19-64
Six-month renewals	H.R. 1 §71107	Jan 1, 2027	ACA New Adult Group, ages 19-64
Qualified non-citizen (QNC) definition	H.R. 1 §71109	Oct 1, 2026	Specified lawfully present immigrants age 21 and older. No effect on CCS eligibility
UIS managed care to FFS transition	SMDL #25-003	Jan 1, 2027	All UIS members in managed care will transition to Medi-Cal FFS
Undocumented adult enrollment freeze	State Budget	Jan 1, 2026 (already in effect)	Undocumented persons ages 19+ (for CCS 19-20)
UIS monthly premiums	State Budget	Jul 1, 2027	Specified UIS members; amount pending
Retroactive Coverage limits	H.R. 1	Jan 1, 2027	1 month for New Adult Group; 2 months for all other members

What Does This Mean for CCS

- **WCER:** Ages 19–20 in the New Adult Group must comply or meet an exclusion. Caregivers of a child 13 or under are excluded. DHCS is pursuing use of CCS eligibility to establish medical frailty (CMS guidance is pending); if not approved for 2027, members may self-attest. Losing Medi-Cal for WCER non-compliance is procedural and there is no CCS-Only bridge.

- **Six - Month Renewal:** Expansion adults face a six-month redetermination cycle. Children and CCS members 0–18 are not subject. A 19–20-year-old who misses a renewal can be reinstated retroactively by completing it within the 90-day reconsideration period. After that, there is no CCS-Only bridge; Medi-Cal must be restored first.

- **Qualified Non-Citizen:** Under the federal Children's Health Insurance Program Reauthorization Act (CHIPRA) 214 coverage, QNC youth is considered SIS who are 20 years of age and younger. Thus, QNC CCS members ages 20 and under keep full-scope Medi-Cal and Medi-Cal CCS, remain in their managed care plan, and do not transition to FFS.

What Does This Mean for CCS (Cont.)

- **UIS managed care to FFS transition:** CCS members with UIS stay in Medi-Cal and Medi-Cal CCS. However, the delivery system changes from managed care to FFS. In Whole Child Model (WCM) Counties, case management moves from the WCM MCP to the County CCS Program on January 1, 2027. Classic counties continue case management as today.

- **Undocumented Adult Enrollment Freeze:** Already in effect. UIS members ages 19–20 with full-scope Medi-Cal keep it if they renew on time or within the 3-month grace period. If they reapply after that, they qualify only for restricted-scope Medi-Cal and the county assesses for CCS-Only. If they do not reapply, there is no CCS-Only bridge.

- **UIS Premiums:** If adopted, $30–$50/month beginning July 1, 2027, for specified UIS members ages 19–59.

Work and Community Engagement Requirements (WCER)

Who is Subject to WCER?

MEDI-CAL PROGRAM IMPACT

- Applies to the MAGI New Adult Group when all of the following are true:
  - Ages 19–64
  - Not pregnant or within 12 months postpartum
  - Not enrolled in / entitled to Medicare A or B
  - Not otherwise eligible in a mandatory Medi-Cal group
  - Income under 138% FPL ($22,025 individual / $45,540 family of four)
- Must show 80 hours/month of work, community service, a work program, half-time education — or meet an exclusion or exception.

HOW THIS APPLIES TO CCS

- WCER does not apply to children, ages 0-18; WCER does not apply to CCS children, ages 0-18.
- CCS members, ages 19–20 who remain in Medi-Cal through the New Adult Group, must comply or qualify for an exclusion/exception.
- Parents/caregivers of a CCS child, age 13 or under are excluded from WCER; this is the largest family-level protection.
- DHCS is reviewing CCS eligibility as a categorical exemption on the basis of medical frailty.
- Not meeting WCER is a procedural reason for losing Medi-Cal, like an unreturned renewal packet. For individuals losing Medi-Cal due to not fulfilling WCER requirements, there is no CCS-Only bridge; the member must restore Medi-Cal before Medi-Cal CCS can resume.

Screen for Exclusion First - then Qualifying Activities

CMS requires states to check specified exclusions before applying WCER. Only people who do not meet an exclusion are subject to the 80-hour rule.

- **Medically Frail** -Serious/complex conditions that significantly impair ability to work. DHCS will map eligibility, claims/encounter, and where available, EHR data. DHCS is reviewing CCS eligibility as a categorical exemption on the basis of medical frailty
- **Caregiver** - Parent, guardian, or primary caregiver of a child age 13 or under. Guidance on caregivers of CCS members over age 13 is pending.
- **Other specified** - AI/AN, pregnant / 12 months postpartum, TANF-compliant, veterans with total disability rating, incarcerated in last 3 months.

- **Work** - Paid, in-kind, or unpaid work counts. Seasonal income may be averaged over 12 months.
- **Education -** Half-time or more, including high school / equivalency. Enrollment continues through normal breaks.
- **Community Service/Work Program** - Structured, supervised unpaid work for a public agency or nonprofit. Job search may count for part of the 80 hours.

Short-term hardship exceptions (California will offer all of them)
Declared emergency and high-unemployment exceptions will be automated by residence. Inpatient care and medical-travel exceptions must be requested by the individual. The interim final rule imposes a lookback (one month in California at application), which can create coverage gaps if the prior month is not documented**.**

Medical Frailty — CCS-Critical Exclusion

MEDI-CAL PROGRAM IMPACT-- Updated

On October 29, 2026, A federal court vacated CMS's requirement in the Interim Final Rule that a qualifying condition must also "significantly impair" a person's ability to work.

- States must apply the statutory medical-frailty definition. Individuals may qualify based on a condition within one of the statutory categories, **without** a separate work-impairment test.
- DHCS is revising its identification and verification approach to align with the court ruling and forthcoming federal guidance.
- For 2027, medical frailty may be established through available program or health data, documentation, or self-attestation, as permitted under federal rules.

HOW THIS APPLIES TO CCS

- DHCS will map available data, such as eligibility, claims/encounter, and where available, EHR data to identify medically frail members automatically, so families are not lost to paperwork. Diagnostic codes (ICD-10), procedure codes (CPT/HCPCS codes), and drug codes on encounters and claims will be used for mapping. Many CCS conditions are included.
- **In light of recent court vacating CMS IFR rule on Medical Frailty, DHCS anticipates that CCS Members will qualify under Medical Frailty.**
- Counties should request paper documentation if ex parte (automated verification) fails.

If the categorical exemption is not approved for 2027, members may self-attest that their condition limits their ability to work.

CCS Impact: What Counties Should Do

» Protect the Caregiver Exclusion

- When a CCS child is 13 or under, the parent/guardian/primary caregiver is excluded from WCER. Make sure case notes and contacts identify the caregiver relationship clearly.

» If Medi-Cal Ends, Check the Reason

- A WCER termination is procedural. There is no CCS-Only bridge; refer the member to Medi-Cal to restore coverage within the 90-day reconsideration period or by reapplying. Medi-Cal CCS resumes once Medi-Cal is restored. *Note, in light of recent court vacating CMS IFR rule on Medical Frailty, DHCS anticipates that CCS Members will qualify under Medical Frailty.*

» Watch the 19–20 Cohort

- This is the CCS age band inside the ACA New Adult Group. Confirm Medi-Cal aid code, immigration status, and whether the youth is medically frail or otherwise excluded.

» Use Existing Eligibility Tools

- CMS 39 (Active Cases with Recently Terminated Medi-Cal) and MEDS in CMS Net remain the county tools to confirm whether Medi-Cal is active after January 2027.

Six-Month Renewals

Annual Renewals to Twice-Yearly Check

MEDI-CAL PROGRAM IMPACT

- Required for the MAGI New Adult Group (non-disabled adults, 19–64).
- Tribal members, pregnant members, and members 12 months postpartum are not subject — even if enrolled through the New Adult Group.
- The process for renewals will mirror the 12-month renewal: ex-parte, renewal timeline, reminder notices.
- Only the individuals who are subject to the six-month cycle must complete and return the renewal.
- DHCS is streamlining the MAGI renewal form to reduce burden.
- ACWDL 26-14, released August 27, 2026.

HOW THIS APPLIES TO CCS

- CCS members ages 0–18 are not on a six-month cycle.
- The operational risk is the CCS young adult (19–20) in the New Adult Group who misses a mid-year packet.
- DHCS is using encounters/claims known to DHCS to electronically verify ("ex parte") an individual's medical frailty status. If this ex parte process fails, families will be sent a medical frailty screener with their Medi-Cal renewal package.
- Counties may use CMS 39 or MEDS in CMS Net to confirm Medi-Cal status.

A missed renewal is procedural reason for Medi-Cal discontinuance. If the member completes it within the 90-day cure period, Medi-Cal is reinstated retroactively with no gap. After that, there is no CCS-Only bridge; the member must reapply for Medi-Cal before Medi-Cal CCS can resume.

What Happens if a 19–20-year-old Loses Medi-Cal?

A missed six-month renewal ends Medi-Cal and Medi-Cal CCS. There is no CCS-Only bridge. Complete the renewal within the 90-day reconsideration period to restore coverage with no gap; otherwise, reapply.

» **What to do:**

- **Check the reason** in MEDS, the CMS 39 report, or the Medi-Cal notice of action.
- **Procedural loss (missed renewal, WCER):** No CCS-Only bridge. Refer to Medi-Cal to use the 90-day reconsideration period or reapply. Medi-Cal CCS resumes once Medi-Cal is restored.
- **Eligibility loss (e.g., over income):** Assess for CCS-Only (residential, financial, PSA, fees/hardship).
- **Undocumented member who reapplies after the 3-month grace period** and qualifies only for restricted-scope Medi-Cal: assess for CCS-Only.

» **What not to do:**

- Do not move a member who lost Medi-Cal for procedural reasons to CCS-Only.
- Do not skip the Medi-Cal referral.

* NL 03-0926 is being revised to reflect this policy.

Qualified Non-Citizen (QNC) Definition

Who Still Qualifies for Federal Full-Scope Funding

This is a change to the federal definition of Qualified Non-Citizen (QNC).

- **REMAINS FEDERALLY FUNDED FULL-SCOPE**
  - Lawful Permanent Residents (LPRs / green card)
  - Cuban or Haitian Entrants
  - COFA migrants (Micronesia, Marshall Islands, Palau)
- **Also unchanged:**
  - Lawfully present children under 21, including QNC CCS members and lawfully present pregnant or postpartum individuals, continue to receive federally funded full-scope Medi-Cal if otherwise eligible.

- **LOSES FEDERAL FULL-SCOPE FUNDING OCT 1**
  - Refugees and asylees
  - Withholding of removal / deportation withheld
  - Conditional entrants
  - Paroled into the U.S. for one year or more
  - Amerasian immigrants
  - Victims of trafficking
  - Battered non-citizens and certain family members

QNC Changes Do Not Affect CCS

» **MEDI-CAL PROGRAM IMPACT**

- Federal full-scope Medicaid/CHIP funding ends October 1, 2026, **for adults 21 and older** in the statuses listed on the prior slide.
- Beginning January 1, 2027, this group will be considered UIS and move from managed care to FFS.
- California will continue full-scope state-funded Medi-Cal for this population through June 30, 2027.
- After that date, absent a further policy change, federal claiming rules and state-only coverage rules diverge.

» **HOW THIS APPLIES TO CCS**

- Does not affect CCS eligibility.
- QNC ages 20 and younger, (under CHIPRA Section 214) retain SIS.
- They keep full-scope Medi-Cal and Medi-Cal CCS.
- Because they are not UIS, they remain enrolled in their managed care plan, and do not transition to FFS.
- Do not change aid codes or convert cases to CCS-Only because of the QNC change.

UIS Managed Care to Fee-For-Service Transition

Who are the Impacted Medi-Cal Members?

Affected Populations:

- Medi-Cal members with UIS.
- All undocumented immigrants, including children and pregnant people.
- Lawful Permanent Residents (green card holders) who have been in the U.S. for less than five years.
- Permanently Residing Under Color of Law (PRUCOL) non-citizens living in the U.S. with the knowledge and permission of immigrations authorities (such as those with pending asylum or stay of deportation) while they wait for a final status.
- Qualified Non-Citizens (QNC) who lose federal full-scope eligibility due to H.R. 1. Applies to those who are ages 21 or over

Not Affected Populations:

- U.S. citizens.
- Other immigrants:
  - Lawful Permanent Residents (green card holders) who have been in the U.S. for five years or longer.
  - Cuban and Haitian entrants
  - COFA Migrants (Micronesia, Marshall Islands, and Palau)
  - When they are lawfully present (Children's Health Insurance Program Reauthorization Act):
    - People under age 21
    - Pregnant people (including 12 months postpartum)
  - Members enrolled in Program of All-Inclusive Care for the Elderly (PACE).

Affected Population

Classic CCS	WCM	Total
5,676	1,463	7,139

What is Changing — What is Not

MEDI-CAL PROGRAM IMPACT

- On January 1, 2027, members with UIS move from Medi-Cal managed care to Medi-Cal Fee-For-Service.
- This is a delivery-system change. Members remain enrolled in Medi-Cal unless they lose coverage under a different policy (enrollment freeze, premiums, WCER, or renewal).
- Governing documents (all released September 1, 2026):
  - CCS NL 03-0926 (supersedes 06-1225)
  - Policy Guide for Transition of the UIS from Managed Care to Medi-Cal FFS
- For Managed Care Plans
  - APL 26-016
  - UIS–FFS Policy Guide v2 (v3 released October 14, 2026; posting soon)

HOW THIS APPLIES TO CCS

- CCS members with UIS stay in Medi-Cal and Medi-Cal CCS.
- All CCS members with UIS will be disenrolled from their managed care plan effective January 1, 2027.
- WCM CCS members with UIS no longer receive CCS case management from the MCP. The County CCS Program takes case management beginning January 1, 2027.
- CCS benefits for the eligible condition continue to be covered under FFS.
- QNC CCS members under 21 retain SIS due to CHIPRA 214 and are not part of this transition.

County CCS Program Timeline

OCT 9, 2026

- **CCS member list**
  - DHCS shared the list of CCS UIS transitioning members with County CCS Programs and WCM plans. Classic county plan lists to follow. DHCS will refresh lists closer to January 1, 2027.

NOV 9, 2026

- **Transition of Care Plans**
  - WCM plans submit a Transition Plan for each member. Counties upload into CMS Net.

By DEC 31, 2026

- **Provider Identification**
  - If care will not continue with the current provider, the MCP must identify the new provider before year-end.

JAN 1, 2027

- **Go-live**
  - County CCS Programs begin case management. Counties (or DHCS for dependent counties) begin authorizing services.

For County Awareness: Deliverable Calendar for WCM MCPs

Deliverable	Deliverable Code	Due	Goes to
CCS UIS member list (DHCS produces)	—	**Oct 9**	All Counties, WCM MCPs. Classic MCPs before October 23, 2026.
General CCS Transition Plan	UIST.0001	**Oct 15**	DHCS Operational Readiness Portal
Transition of Care Plan for each member	—	**Nov 9**	County CCS Program (then CMS Net)
Member Authorization Data (Excel only)	UIST.0005	**Nov 16**	DHCS (SFTP)
Member Notice (Policy Guide App. D)	—	**Dec 1**	Members / families
Attestation that Transition of Care Plans submitted	UIST.0002	**Dec 1**	DHCS Operational Readiness Portal

Policy Guide v3 released October 14 includes the attestation template and confirms the November 16 date.

Noticing, Continuity, and Case Management

Member Noticing

- DHCS mails one notice to all impacted members, in 19 threshold languages and alternative formats. Members should have it by December 1. Plans must also send the Member notice using the approved template (Policy Guide Appendix D) no later than December 1 — earlier is encouraged.
- DHCS texting UIS members in October, November, and early December.

Case Management Handoff

- Before January 1, the MCP must give the county a plan of care, say whether current providers continue, and identify new paneled providers if needed (by December 31). On January 1, the county provides case management and authorizes SARs.

Continuity of Care

- MCP statutory 90-day continuity rules apply to plan-to-plan or FFS-to-plan moves. They do not apply when members move from managed care into FFS. CCS benefits for the eligible condition continue; service authorizations (SARs) on January 1 are a county (or DHCS dependent-county) function.

Voluntarily Not Renewing / Disenrolling

- If a family declines to renew Medi-Cal because of immigration fears or other reasons, Medi-Cal ends for a procedural reason. There is no CCS-Only bridge. Encourage the family to renew and refer questions to the local Medi-Cal office.

Additional information is located on the Providers and Partners webpage.

For UIS Transition to FFS: Two Different Operational Pictures on January 1, 2027

CLASSIC CCS COUNTIES

- Classic counties continue to provide CCS case management.
- Independent Classic counties continue to adjudicate SARs.
- In Dependent Classic counties, DHCS will continue to adjudicate SARs.
- Families should hear that CCS services will continue without interruption.

WCM CCS COUNTIES

- CCS case management moves from the WCM MCP to the County CCS Program.
- Independent WCM counties take SAR adjudications.
- Dependent WCM counties: DHCS adjudicates.
- DHCS has adjusted the FY 2026–27 CCS administrative budget by $1.9 million to support this WCM County workload.
- Families should hear that CCS services will continue through DHCS and FFS CCS paneled providers – no longer an MCP.

Specialty Care Centers and ECM Providers

- **Not Covered in FFS**
  - Enhanced Care Management, Community Supports, Complex Care Management, Transitional Care Services, and California Integrated Care Management are MCP benefits. They are not available in Medi-Cal FFS after January 1, 2027.
- **Care-Management Codes**
  - CCS-paneled providers and SCCs enrolled in Medi-Cal FFS may bill existing FFS care-management, care-coordination, and case-management codes. DHCS will publish a code resource tied to the Provider Manual.

- **What Continues in FFS**
  - Community Health Worker (CHW) services remain a Medi-Cal FFS benefit. Enrolled supervising providers may bill CHW services for transitioning members. Need for CHW is expected to rise when ECM ends. Many Specialty Care Centers employ CHWs today and may consider leveraging this Medi-Cal covered benefit to continue providing certain care coordination services within scope.
- **What DHCS will be Doing**
  - Working to engage with CCS Specialty Care Centers and ECM providers that serve the Children and Youth with Complex Needs population of focus, so they can convert ECM-style work onto CHW and FFS care-management billing.

Provider Actions Counties Should Encourage

- **Enroll in FFS/PAVE:**
  - A provider who is not enrolled through PAVE cannot bill Medi-Cal FFS on January 1.
- **Become a CHW Supervising Provider:**
  - Eligible types: licensed provider, hospital, outpatient clinic (incl. IHS/Tribal FQHC), pharmacy, Community-Based Organizations, or local health jurisdiction. Non-tribal FQHCs and RHCs cannot supervise CHW in FFS.
- **Use FFS Care-Management Codes:**
  - Principal care management, chronic care management, and other existing FFS case-management codes can replace some of the work ECM was doing. Codes are published in the Medi-Cal Provider Manual.
- **Stay CCS-Paneled:**
  - CCS benefits still require a CCS-paneled provider or approved SCC. If the provider will not continue, the Transition of Care Plan must name the replacement by December 31.
- **Bill CHW under a Supervising Provider:**
  - CHW claims in FFS must be submitted by an enrolled supervising provider. See Coverage of Community Health Worker Services in the CCS Program Information Notice 25-05.

Undocumented Adult Enrollment Freeze

Who Can Keep Coverage - Who Cannot Newly Enroll

MEDI-CAL PROGRAM IMPACT

- Since January 1, 2026, some adults can no longer newly enroll in full-scope Medi-Cal because of immigration status. See the DHCS Immigration Status Categories chart.
- Individuals who already have full-scope Medi-Cal keep it if they meet renewal timelines and remaining eligibility rules.
- A three-month grace period exists if a deadline is missed. After that, members who reapply qualify only for restricted-scope Medi-Cal.
- Exception: Undocumented foster youth and nonminor dependents will remain eligible for full-scope Medi-Cal.

HOW THIS APPLIES TO CCS

- Impact concentrates on CCS undocumented members ages 19–20.
- If the member misses their renewal and does not restore Medi-Cal in the three-month grace period, Medi-Cal and Medi-Cal CCS end. If they reapply and qualify only for restricted-scope Medi-Cal, the county assesses for CCS-Only. If they do not reapply, there is no CCS-Only bridge.
- Newly presenting undocumented members must apply to Medi-Cal first. If they qualify for restricted-scope Medi-Cal, the county assesses for CCS-Only.

Ex: 19-20-year-old Undocumented Member with Restricted-Scope Medi-Cal

Under the undocumented adult enrollment freeze, newly enrolled members will only have restricted-scope Medi-Cal and may be assessed for CCS-Only enrollment.

» Case Example

- A 20-year-old undocumented member with hemophilia is not eligible for full-scope Medi-Cal but qualifies for restricted-scope Medi-Cal and CCS-Only.

» Restricted-scope Medi-Cal Covers:

- Emergency medical services
- Pregnancy-related services
- Certain nursing facility / long-term care services

Illustrative example only – no a confirmed DHCS billing policy

» Who Covers What

- Restricted-Scope Medi-Cal
  - Emergency hospitalization for a severe bleeding episode
  - Emergency surgery

    if services meet emergency coverage criteria
- CCS-Only
  - Routine hematology visits
  - Ongoing clotting-factor therapy
  - Routine laboratory monitoring

    If authorized and otherwise eligible
- CCS-Only
  - CCS case management and other eligible services

    Subject to program requirements

UIS Monthly Premiums for Members ages 19-20

Premiums Start July 1, 2027 — Design is Not Final

MEDI-CAL PROGRAM IMPACT

- Beginning July 1, 2027, some Medi-Cal members will pay a monthly premium to keep full-scope coverage.
- Who pays is defined by the DHCS Immigration Status Categories chart — the same population framework as the freeze.
- Proposed amount: $30–$50 per month. Final amount pending May Budget Revision.
- Members may not miss more than three months of payments and keep full-scope Medi-Cal.
- After that, coverage falls to restricted-scope Medi-Cal.

HOW THIS APPLIES TO CCS

- UIS CCS members ages 19–20 are the CCS cohort that could face the premium.
- Refer members who lose Medi-Cal for non-payment to the local Medi-Cal office.
- CCS-Only bridge is not available for Members who disenroll due to nonpayment of premiums (which is considered a procedural reason for disenrollment)

Recap and Resources

CCS Members Ages 19–20: If Medi-Cal Ends

If Medi-Cal ends …	Driver	County action now
New procedural non-compliance reasons: » WCER non-compliance » Missed 6-month renewal » Family voluntarily disenrolls	H.R. 1 H.R. 1 Family Choice	No CCS-Only bridge. Medi-Cal CCS ends with Medi-Cal. Refer the family to Medi-Cal to restore within the 90-day cure period (no gap) or reapply. Resume Medi-Cal CCS once Medi-Cal is restored.
UIS premium unpaid (beginning 7/1/2027)	State budget	No CCS-Only bridge. Premium amounts are pending.
May Apply for CCS-Only: » Restricted-Scope Medi-Cal » Medi-Cal ineligible (i.e., higher income)	State budget Not a new policy	Assess for CCS-Only: Medical, residential, and financial eligibility.

County CCS Checklist Between Now and January 1

- **Now:**
  - Procedural loss: no CCS-Only bridge; refer to Medi-Cal. Eligibility loss or restricted-scope only: assess for CCS-Only (see 'If Medi-Cal Ends' table in prior slide).
  - Validate the DHCS CCS UIS member list (sent October 9). Send errors, with member identifiers, to CCSProgram@dhcs.ca.gov. DHCS will refresh lists closer to January 1.
- **By Nov 9:**
  - WCM counties: Set up a tracker for Transition of Care Plans. Agree on file format with each WCM MCP.
- **By Dec 1:**
  - Know how families will hear from DHCS and from the plan. Prepare County phone scripts: CCS benefits continue, and members must complete Medi-Cal renewals on time to keep Medi-Cal CCS.
- **By Dec 31:**
  - Reconcile provider lists. Identify members whose MCP has not named a CCS-paneled provider.
- **Jan 1, 2027:**
  - WCM counties assume case management for UIS CCS members. Independent counties adjudicate SARs; DHCS will adjudicate SARs for dependent counties.

Resources

- **CCS NL 03-0926:** CCS Members with UIS — Numbered Letter (Sept 1, 2026; supersedes 06-1225). Being revised to reflect the October 2026 CCS-Only clarification.
- **APL 26-016:** All Plan Letter for the UIS CCS transition (Sept 1, 2026)
- **Policy Guide for UIS–FFS v3:** Operational guide
- **ACWDL 26-14:** Six-month renewals for the New Adult Group (preliminary)
- **H.R. 1 Fact Sheet/Implementation plan:** DHCS May 2026 materials on federal eligibility changes
- **CCS Admin Case Management Manual:** County workflow for State-Only, PSA, fees, MEDS, CMS Net, and annual review
- **CCS IN 25-05 (CHW services):** Coverage of Community Health Worker Services in the CCS Program; supports care coordination after ECM ends for UIS members.

Appendix A:
When CCS-Only Applies

CCS-Only Eligibility Criteria

» **Medical Eligibility**

- A CCS-eligible condition that is physically disabling or requires medical, surgical, or rehabilitative services. Already established for open CCS cases. Confirm with current medical reports (within 12 months) at annual medical review.

» **Residential Eligibility**

- The child lives in the county. Verify with a utility bill, DMV document, or other proof. Use the custodial parent's address for minors. Transfer the case if the family has moved.

» **Financial Eligibility**

- Family AGI under $40,000, or AGI above $40,000 if the cost of care for the CCS condition is expected to exceed 20% of income. MTP-only, diagnostic-only, and some adoption cases do not use the income test.

If any CCS member loses Medi-Cal for procedural non-compliance, there is no CCS-Only bridge. Medi-Cal must be restored, within the 90-day cure period or by reapplying, before Medi-Cal CCS can resume. CCS-Only applies to two groups: (1) members ineligible for Medi-Cal due to higher income, and (2) UIS members who qualify only for restricted-scope Medi-Cal. Foster youth and NMDs with UIS keep full-scope Medi-Cal to age 26.

When Medi-Cal Ends - Detect, Outreach, Refer

» Detect

- Check MEDS and the CMS 39 report (Active Cases with Recently Terminated Medi-Cal) frequently to confirm the Medi-Cal end date and reason. Do not wait for the family to call.

» Outreach First

- Contact the family immediately. Help them submit the missing renewal information; if the reconsideration period has passed, send a Medi-Cal application or the link.

» Refer Promptly

- Refer the member/family to the local Medi-Cal office promptly. After the 90-day reconsideration period, they must reapply.

Completing CCS-Only for Eligible Members

» **Access CCS-Only**

- For members ineligible for Medi-Cal (i.e., higher income) or with restricted-scope Medi-Cal only, assess residential and financial eligibility.
- Medical eligibility has already been established for open cases.

» **Complete the CCS-Only Process**

- Obtain a signed Program Services Agreement. Calculate enrollment and $20 assessment fees; apply hardship waiver or exemption if the family qualifies.

» **Keep Services Moving**

- Update CMS Net (aid code such as 9K CCS-Only), keep SARs active, and continue case management.
- Start annual review 60 days before the eligibility end date.

Tools, Fees and What Not to Do

CMS 39 Report / MEDS

- Confirm the Medi-Cal end date and reason. If procedural, the member may still be in the 90-day reconsideration period; refer to Medi-Cal. Assign a CCS-Only aid code only to members ineligible for Medi-Cal (higher income) or with restricted-scope Medi-Cal only.

CMS Net

- Update financial and residential determinations, aid code, case notes, and the Transition of Care Plan if the member is UIS/WCM.

C-38 Series and PSA

- Redetermination letters go out 60 days before the end date. CCS-Only requires a signed Program Services Agreement; Medi-Cal full-scope no SOC does not.

Fee and Hardship Path

- Enrollment fee and $20 assessment fee may apply. Exempt if income is under 200% FPL, MTP-only, diagnostic-only, or other listed exceptions. Counties may waive or reduce for hardship.

DO NOT

- Move a member to CCS-Only after a procedural loss of Medi-Cal.
- Skip the Medi-Cal referral.
- Assign a CCS-Only aid code without completing residential and financial determinations.
- Stop adjudicating SARs while a CCS-Only review is pending for a member in an eligible group.

Appendix B:
Coverage Pathways for CCS ages 19-20

CCS Coverage Pathways 19–20-Year-Olds Losing or Ineligible for Medi-Cal

Intent: Preserve CCS for eligible youth while aligning with Medi-Cal eligibility. Pathways remain open through Medi-Cal CCS or CCS-Only. Youth who lose full-scope Medi-Cal for noncompliance with renewal or other applicable requirements do not move to CCS-Only; they must restore Medi-Cal first.

» UNDOCUMENTED ADULT ENROLLMENT FREEZE

- **Newly presenting (19–20, Undocumented)** Eligible for restricted-scope Medi-Cal and then must be assessed for CCS-Only.
- **Existing full-scope who lose Medi-Cal for procedural non-compliance (Undocumented)** Existing full-scope individual who lose Medi-Cal at renewal for procedural reasons and then restore Medi-Cal eligibility during the three-month grace period will have their Medi-Cal CCS restored. If the undocumented group misses the three-month grace period and reapply for Medi-Cal, they will qualify only for restricted-scope Medi-Cal, and the County CCS Program may assess for CCS-Only. If they do not reapply, there is no CCS-Only bridge.

» H.R. 1 • WCER AND 6-MONTH RENEWALS

- **Non-Compliance* ends the CCS-Only Door** Members who lose Medi-Cal for failure to comply with procedural requirements cannot apply for CCS-Only. They must reapply or restore Medi-Cal eligibility and coverage to restore Medi-Cal CCS.
- **Under H.R. 1 WCER, not meeting work or volunteer requirements counts as a procedural reason** for losing coverage, like an unreturned renewal packet. It is not an eligibility reason, like being over the income limit.

DHCS is reviewing CCS eligibility as a categorical exemption on the basis of medical frailty.

CCS Coverage: 19–20-Year-Old UIS Losing or Ineligible for Medi-Cal

Medi-Cal Status	Compliant with Medi-Cal Procedural Requirements?	Reason for Medi-Cal Status	CCS Eligibility Status	Funding	Next Step
Full-Scope (1)	Yes	Full-Scope Eligible	Medi-Cal + Medi-Cal CCS	State (2)	Coverage Continues
Ineligible	Yes	Over Income	Potentially CCS-Only Eligible	50% State | 50% County	County Assesses for CCS-Only Eligibility

(1) Those who are grandfathered (i.e., currently enrolled) retain full-scope Medi-Cal unless they don't comply with Medi-Cal procedural requirements or become ineligible for other reasons.
(2) State will draw FFP only for FMAP-eligible services (e.g., emergency medical services)

CCS Coverage: 19–20-Year-Old Undocumented Member Losing or Ineligible for Medi-Cal

Medi-Cal Status	Compliant with Medi-Cal Procedural Requirements?	Reason for Medi-Cal Status	CCS Eligibility Status	Funding	Next Step
Restricted-Scope Medi-Cal	Yes	NEW Undocumented or Discontinued (3)	Restricted-Scope Medi-Cal + Potentially CCS-Only Eligible (4)	After FMAP, 50% State | 50% County (5)	County Assesses for CCS-Only Eligibility

(3) Previously enrolled members who were discontinued, then reapplied after the 3-month grace period and qualified only for restricted-scope Medi-Cal.
(4) Policy Clarification: 19–20-year-old undocumented members who comply with Medi-Cal procedural requirements and qualify for restricted-scope Medi-Cal (newly applying or reapplied after the 3-month grace period) may be assessed for CCS-Only.
(5) Restricted scope covers certain FMAP-eligible services (e.g., emergency medical services). State will draw FFP only for FMAP-eligible services.

CCS Coverage: 19–20-Year-Old Undocumented Member Losing or Ineligible for Medi-Cal

Medi-Cal Status	Compliant with Medi-Cal Procedural Requirements?	Reason for Medi-Cal Status	CCS Eligibility Status	Funding	Next Step
Full-Scope, QNC	Yes	QNC, 20 years old or younger will remain as SIS due to CHIPRA 214 authority.	Medi-Cal + Medi-Cal CCS	State | Federal	Coverage Continues
All Statuses (6)	No	N/A	No Medi-Cal CCS No CCS-Only	N/A	Reapply for Medi-Cal

(6) Policy Clarification: Current NL 03-0926 will need to be updated to reflect that individuals who do not comply with Medi-Cal's procedural requirements are not eligible for CCS-Only and must reapply for Medi-Cal.