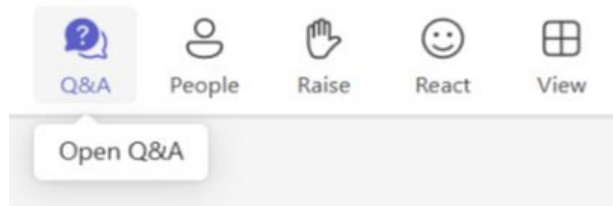


**Federally Qualified Health Centers
and Rural Health Clinics
Reimbursement Changes for State-
Only Services in the Managed Care
Delivery System**

June 17, 2026

Housekeeping

- » The chat function has been disabled for this meeting. If you are joining from a desktop computer, please submit your questions via the Teams Q&A feature, located in the top ribbon of this meeting.



- » Please note that participants joining by phone will not have access to this feature.
- » Please only submit general questions to the Q&A. If you do not receive an answer during the webinar, we will respond in a follow-up email. All provider-specific questions should be submitted to our email at FQHCBenefitsandRates@dhcs.ca.gov.

Introductions

- » Alek Klimek, Assistant Deputy Director, Health Care Financing
- » Aditya Voleti, Division Chief, Provider Rates Division
- » Michelle Tamai, Branch Chief, Provider Rates Division
- » Carlyne Bamfield, Section Chief, Provider Rates Division
- » Jessica Chan, Unit Chief, Provider Rates Division

Webinar Objectives

- » Discuss the draft Managed Care Clinic Policy Letter (CPL) 26-001, pursuant to Welfare & Institutions Code (WIC) section 14132.100, subdivision (r).
- » Inform providers of reimbursement policy changes for State-Only Services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to Medi-Cal members enrolled in Managed Care Plans.

Clinic Policy Letter Background



Clinic Policy Letter Adoption

- » Clinic Policy Letters (CPLs) convey information, and/or interprets changes in policy or procedures at the federal or state levels and provides guidance to FQHCs and RHCs on how to implement changes on an operational basis.
- » In accordance with section (r) of Welfare & Institutions Code (WIC) 14132.100, DHCS may, without taking regulatory action, pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 or Title 2 of the Government Code, implement, interpret, or make specific this section by means of a provider bulletin or similar instruction.

Clinic Policy Letter Adoption

- » DHCS is required to notify and consult with interested parties and appropriate stakeholders, including all of the following:
 1. Notifying provider representatives in writing of the proposed action or change. The notice shall occur, and the applicable draft provider bulletin or similar instruction, shall be made at least 10 days prior to the meeting as described above.
 2. Scheduling at least one meeting with interested parties and appropriate stakeholders to discuss the proposed action or change.

Clinic Policy Letter Adoption

3. Allowing for written input regarding the proposed action or change, to which the department shall provide summary written responses in conjunction with the issuance of the applicable final written provider bulletin or similar instruction.
 4. Providing at least 60 days advance notice of the effective date of the proposed action or change. The advance notice for this policy was posted on April 24, 2026.
- » This CPL supersedes all prior guidance, bulletins, instructions, and regulations issued by DHCS on the matters described herein.

Changes to Reimbursement for State-Only Services in the Managed Care Delivery System



Background

- » Medi-Cal reimburses eligible FQHC and RHC services at an all-inclusive PPS rate for encounters with a PPS-billable provider.
- » Pursuant to Welfare and Institutions Code (WIC) section 14087.325(d), Medi-Cal Managed Care Plans (MCPs) are required to reimburse contracted FQHCs and RHCs in a manner no less than the level and amount of payment that the MCP would make for the same scope of services if the services were furnished by another non-FQHC and RHC provider type.

Background

- » DHCS provides a differential “wrap” payment that is equal to the difference between visits reimbursed at the FQHC’s or RHC’s PPS rate and the amount received by third-party payers including MCPs and Medicare.
- » DHCS pays the “wrap” payment in two stages: an interim payment is paid on a per visit basis each time the FQHC/RHC files a claim, and, if necessary, a final payment once the reconciliation process is complete.

Background

- » FQHCs and RHCs must complete and submit a reconciliation request annually to:
 - Reconcile the amount of Medi-Cal interim payments and third-party payments received by the FQHC or RHC against the PPS rate and actual number of visits the FQHC or RHC reimbursed by the Medi-Cal Program.

Policy

- » Assembly Bill 116 (Chapter 21, Statutes of 2025) amended Welfare & Institutions Code (WIC) section 14132.100, subdivision (c), to specify that only services that are eligible for federal financial participation shall be reimbursed using the PPS, effective July 1, 2026.
- » Effective for dates of service on and after July 1, 2026, the Medi-Cal Fiscal Intermediary will deny reimbursement of managed care differential “wrap” payments submitted by FQHCs and RHCS for state-only services.
- » The Medi-Cal Fiscal Intermediary will note each applicable denial via Remittance Advice Detail (RAD) code(s).

State-Only Services

- » State-only services are services ineligible for federal financial participation under the federal Medicaid program, but are covered under California's Medi-Cal program.
 - Includes members with federal Unsatisfactory Immigration Status (UIS) other than pregnancy and emergency-related services as well as certain other Medi-Cal Services.
- » State-only services will continue to be reimbursed at the negotiated rate between the MCP and the FQHC or RHC, without additional managed care differential "wrap" payments from DHCS that apply to PPS-eligible services.

Exemptions for Emergency and Pregnancy Services

- » DHCS will continue to reimburse differential “wrap” payments for federally-eligible pregnancy and emergency-related services.
- » Services will be identified through complete and appropriate service-level coding including procedure codes, diagnosis codes, and emergency indicators on the claim.
- » The codes and indicators must be consistent with the *Medi-Cal Provider Manual*.

Annual Reconciliation

- » Effective for fiscal years including dates of service on or after July 1, 2026, FQHCs and RHCs will be required to exclude state-only services on the submitted annual Reconciliation Request.
- » Visits for federally-eligible emergency and pregnancy-related services, will continue to be included in the annual reconciliation.
- » Since state-only visits are not eligible for PPS reimbursement, the visits are not subject to the MCP and Medicare crossover visit reconciliation.

Stakeholder Feedback and Next Steps

- » DHCS requests feedback and input regarding the draft MCP CPL 26-001 by **Friday June 19, 2026.**
 - Please submit feedback and input to FQHCBenefitsandRates@dhcs.ca.gov using the stakeholder feedback matrix.

- » Next Steps:
 - DHCS will provide a summary of written responses in conjunction with the issuance of this policy letter.

Fee-For-Service Delivery System

- » Further policy guidance regarding the Fee-For-Service (FFS) Delivery System will be forthcoming.
- » To receive updates on forthcoming clinic policy letters, please subscribe to the FQHC and RHC List Serv on the [Clinic Policy Letter webpage](#).

Thank you!

