POLICY GUIDE FOR TRANSITION OF THE UNSATISFACTORY IMMIGRATION STATUS POPULATION FROM MANAGED CARE TO MEDI-CAL FEE-FOR-SERVICE

Version 1.0 – July 21, 2026

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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UPDATES FROM PRIOR VERSIONS

If the requirements contained in this UIS Transition Policy Guide require any updates or revisions to an MCP's contractually required policies and procedures (P&Ps), the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) Contract Manager within 90 days of the release of the Policy Guide or its updates. The MCP's email must include the Chapter title of this Policy Guide, as well as the applicable release date in the subject line. These policies are effective upon release of the Policy Guide and its updates, regardless of the status of the MCP's P&P refinements.

This section will describe version history and relevant updates included in each version.

Table 1 Version History

Version Number	Date of Release	Description
Version 1.0	July 20, 2026	Initial release of Policy Guide: Contains overarching policy goals, **transitions of care policy objectives and data exchange requirements** to support transitions of care, and **provider communications to enable continuity of provider access**.

INTRODUCTION

California is required by federal guidance to transition approximately two million Medi-Cal Members with unsatisfactory immigration status (UIS) from the Medi-Cal managed care delivery system to Medi-Cal Fee-for-Service (FFS) by January 1, 2027. A Medi-Cal Member with UIS is a Medi-Cal Member whose immigration status does not meet the federal criteria for full-scope Medicaid. Medi-Cal Members with UIS who are currently enrolled in managed care may be referred to as either "Members" or "Members with UIS" in this Policy Guide. Herein, the transition of Medi-Cal Members with UIS from managed care to Medi-Cal FFS will be referred to as the "UIS Transition."

The UIS transition will not take away eligibility for Medi-Cal from current Members with UIS; however, it will change how these affected Members navigate their health care beginning January 1, 2027. Instead of having a Medi-Cal managed care plan (MCP) that helps coordinate care, these Members can see any provider, including doctors, clinics, or hospitals, that accept Medi-Cal FFS. The State will pay providers directly for each service.

After January 1, 2027, Members with UIS will lose access to some services, such as Community Supports and Enhanced Care Management (ECM), that are only available through managed care. County Behavioral Health Plans (BHPs) are not impacted by the new federal guidance. Members with UIS will continue to receive behavioral health care services through BHPs. In addition, specific services that have been carved out of Medi-Cal managed care, such as Pharmacy Benefits that Members received through Medi-Cal Rx, will not be affected.

This federally required change necessitates significant, urgent changes to Medi-Cal's systems and processes, including statewide county eligibility systems, provider payment processes, information technology (IT) infrastructure, MCP Contracts, and operational workflows.

The Department of Health Care Services (DHCS) is committed to working closely with Medi-Cal Members, Medi-Cal MCPs, providers, and community partners to support Members throughout this transition.

This *Policy Guide for the Transition of the Unsatisfactory Immigration Status Population From Managed Care to Medi-Cal Fee-for-Service* ("UIS Transition Policy Guide" or "Policy Guide") is intended as guidance for MCPs and will be regularly updated as further guidance is developed and issued.

Purpose and Scope of this Policy Guide

The purpose of this Policy Guide is to communicate expectations for MCPs to support a coordinated, timely, and Member-centered transition of Members with UIS from managed care coverage to Medi-Cal FFS coverage effective January 1, 2027.

This Policy Guide outlines MCP responsibilities related to Member notification and outreach, continuity of provider access and transitions of care, data sharing to support transition activities, such as authorization data, as well as Network Provider communications to enable continuity of provider access.

This Policy Guide is intended to promote continuity of medically necessary services, minimize disruptions of care, and help ensure Members with UIS, Providers, counties, and other stakeholders receive accurate and timely information to the extent feasible. MCPs should work collaboratively with Medi-Cal providers and other partners to facilitate a seamless transition for affected Members. MCPs are required to communicate UIS transition-related information to Network Providers and make required transition resources, guidance, and contact information readily available through their Provider portals, information bulletins, and other Provider-facing communication channels.

DHCS Guiding Principles

Federal and State Compliance: All transition activities must comply with applicable federal and state laws, regulations, and DHCS policy and requirements. MCPs must implement transition activities in a manner that supports program integrity, protects Member rights, and ensures continued compliance throughout the transition process.

Minimize Member Disruptions: Transition activities should be designed to minimize disruptions in coverage and provide access to care, treatment, and services to the extent feasible. Members should receive clear, timely, and culturally and linguistically appropriate information and support to help them understand and navigate the transition to Medi-Cal FFS.

Support for Transition of Care: Members should experience the least possible interruption in accessing medically necessary services during the transition. DHCS, MCPs, and Providers will strive to work collaboratively to support the continuation of covered services under Medi-Cal FFS and the transfer of information necessary to maintain ongoing services and authorizations whenever feasible.

Promote Provider Readiness and Administrative Simplicity: Providers play a critical role in supporting Members through the transition. DHCS expects MCPs to provide

timely communications, clear guidance, and readily accessible resources to Providers to promote preparedness, reduce administrative burden, and facilitate uninterrupted service delivery. DHCS will support this work effort by providing Medi-Cal FFS information as timely and as collaboratively as feasible.

Timely and Accurate Information Sharing: Effective transitions depend on the timely, complete, and accurate exchange of information. MCPs must support the required data sharing, reporting, and transfer activities that are necessary to facilitate Member transitions. They must also support care coordination and participate in required operational readiness activities defined by DHCS.

Transparency and Accountability: MCPs must maintain transparent communications with Members, Providers, counties, and DHCS regarding transition requirements, timelines, and operational processes. MCPs are accountable for meeting the requirements outlined in this Policy Guide and for promptly addressing issues that may adversely affect Members.

Partnership: DHCS values collaboration with delivery system partners including MCPs, Providers, counties, as well as other stakeholders including advocates. Feedback received throughout implementation will be used to identify challenges, inform operational improvements, and support successful transition outcomes.

KEY TERMS[1]

Medi-Cal Fee-for-Service (FFS): Also referred to as Regular Medi-Cal or Straight Medi-Cal. Members enrolled in Medi-Cal FFS access services through providers that are enrolled in the Medi-Cal FFS network. Members enrolled in Medi-Cal FFS are not eligible for services through an MCP.

Medi-Cal Managed Care Plan (MCP): Members enrolled in Medi-Cal managed care select an MCP in their county that is responsible for covering their benefits and services. Members receive health services through their MCP, including medical services, Non-Specialty Mental Health Services, Care Coordination and care management, and other Covered Services such as Enhanced Care Management and Community Supports.

Primary Care Provider (PCP): In managed care, Medi-Cal Members select a PCP who provides their Primary Care services, including regular check-ups, preventive health services, and referrals to specialty care. In Medi-Cal FFS, Members do not have an assigned PCP and can access Primary Care from any provider who is enrolled in Medi-Cal FFS.

Qualified Non-Citizens (QNC): This is an immigration category defined by federal law that includes, but is not limited to, lawful permanent residents (LPRs or green card holders), refugees, asylees, Cuban/Haitian entrants, non-citizens paroled into the U.S. for at least one year, victims of trafficking and their qualifying family Members, and battered spouses, children, or parents. Please note some of the immigration statuses included here will change on October 1, 2026, with H.R. 1. For more information on immigration statuses and eligibility for Medi-Cal covered services, see DHCS' Immigration Status and Changes to Medi-Cal Eligibility web page.

Unsatisfactory Immigration Status (UIS): This is an immigration category defined by federal law that includes individuals who have not yet achieved citizenship status or Satisfactory Immigration Status (SIS). For more information on immigration statuses and eligibility for Medi-Cal covered services, see DHCS' Immigration Status and Changes to Medi-Cal Eligibility web page.

[1] All terms defined here are intended solely to clarify their use within this Guidance.

TRANSITION POLICY

Most Medi-Cal Members are enrolled in managed care through an MCP in their county. As of March 2026, 13,371,840 Members were enrolled in an MCP, and 711,519 members were enrolled in Medi-Cal FFS (Medi-Cal at a Glance June 2026 report, DHCS Data & Statistics Reports | DHCS).

Beginning January 1, 2027, approximately 2.7 million Members are estimated to be enrolled in Medi-Cal FFS, which represents a 3.8-fold increase in the Medi-Cal FFS population at the same time. Given the sizeable increase in the population in Medi-Cal FFS *overnight*, it is critical that DHCS and MCPs plan, collaborate, and effectively execute this transition.

Medi-Cal Fee-for-Service and Managed Care Comparison

Below are some of the key differences between Medi-Cal FFS and managed care that will affect Members and Providers during this transition.

Table 2 Key differences between Medi-Cal FFS and managed care affecting Members and Providers during this transition.

Domain	Fee-for-Service	Managed Care
Provider Choice	Members can go to any provider statewide who is enrolled as a Medi-Cal FFS provider and is accepting Medi-Cal FFS members.	Members access care through Providers in the MCP's Network. Members select or are assigned a PCP and access care through the affiliated Network, which includes hospital/inpatient, specialty, and other ancillary Providers. MCPs are required to maintain an adequate Network to provide Medically Necessary Covered Services.
Primary Care Providers (PCP) Access	Members may receive primary care services from Medi-Cal enrolled providers that offer primary care services and accept Medi-Cal FFS members. Such providers may include general practitioners, internists,	Members select or are assigned a PCP who is responsible for delivering Primary Care services, making referrals, leading care management, and coordinating with a care management team as needed.

Domain	Fee-for-Service	Managed Care
	There is no requirement for Members to be "assigned" to a PCP.	
Provider Enrollment, Service Authorizations, and Claims Payment	Providers enroll through DHCS' Provider Application and Validation for Enrollment (PAVE) system. Providers submit Treatment Authorization Requests (TARs) to DHCS for approval of medically necessary services when required. Providers submit claims to DHCS for covered services for eligible Members enrolled in Medi-Cal FFS.	Providers contracted with MCPs are generally required to enroll through PAVE if there is a pathway. MCPs are responsible for screening, enrollment, credentialing, revalidation, and recredentialing if there is not a statewide enrollment pathway. MCPs are responsible for utilization management – Providers submit authorization requests to MCPs or their delegated entities for the approval of Medically Necessary services. Providers submit claims or encounters for Covered Services to MCPs or their delegated entities for Members enrolled with the MCP on the dates of service.
Medi-Cal Coverage Policy	DHCS communicates Medi-Cal coverage policy for Medi-Cal covered services through the Medi-Cal Provider Manual and provider bulletins. These materials set forth Medi-Cal FFS policy and implementation guidance.	DHCS establishes managed care coverage policy through the MCP Contract, All Plan Letters, policy guides (e.g., CalAIM: Population Health Management (PHM) Policy Guide; CalAIM Enhanced Care Management Policy Guide; Community Supports Policy Guide Volume 1 and Volume 2), as well as the Medi-Cal Provider Manual as applicable.
Population Health Management,	These services are partly covered in Medi-Cal FFS. Under the Medi-Cal FFS delivery	MCPs are required to stratify and identify Members by risk, conduct outreach and engagement

Domain	Fee-for-Service	Managed Care
Care Management, and Care Coordination	system, certain providers may provide other covered care management or care coordination services and bill accordingly. For example, PCPs or community health workers (CHWs) may conduct applicable care coordination for a Members and can bill in accordance with Medi-Cal coverage policy. See the *Provider Communications to Enable Continuity* section of this Policy Guide for more information.	(including assessments as appropriate), and connect Members to the right level of care management or Care Coordination services. See the PHM Policy Guide for more information.
Transportation	Members have access to transportation to and from services covered by Medi-Cal. This includes transportation to medical, dental, mental health, or substance use disorder appointments, and to pick up prescriptions and medical supplies. There are two types of transportation for appointments: » Non-Medical Transportation (NMT) is transportation by private or public vehicle for Members who do not have another way to get to their appointment. » Non-Emergency Medical Transportation (NEMT) is transportation by ambulance, wheelchair van,	MCPs cover NEMT and NMT through their Network Providers in alignment with Medi-Cal FFS policy. However, MCPs must also cover NMT when Members need transportation to services that the MCP does not cover under their MCP Contract, such as Specialty Mental Health Services and Substance Use Disorder services.

Domain	Fee-for-Service	Managed Care
	or litter van when transportation by ordinary public or private means is medically contraindicated and required for obtaining needed medical care.	
Community Supports	Community Supports are not provided in Medi-Cal FFS. As Members transition from managed care to Medi-Cal FFS, they will no longer have access to Community Supports through their Medi-Cal coverage. [See the Provider Communications to Enable Continuity section of this Policy Guide for more information.]	Community Supports are covered only through Medi-Cal managed care by MCPs.
Non-Specialty Mental Health Services	Members have access to non-specialty mental health services, which include mental health evaluation and treatment (such as individual, group, and family psychotherapy), psychological and neurophysiological testing, outpatient services for monitoring drug therapy, psychiatric consultants, and outpatient laboratory, drugs, supplies, and supplements.	MCPs cover Non-Specialty Mental Health Services in alignment with Medi-Cal FFS policy through their Network Providers.
Durable Medical Equipment	Members have access to Durable Medical Equipment (DME) ordered by a doctor or other qualified health care provider and medically necessary to meet their individual medical needs. Types	MCPs cover DME services in alignment with Medi-Cal FFS policy through their Network Providers.

Domain	Fee-for-Service	Managed Care
	of DME include infusion equipment, oxygen and respiratory equipment, speech generating devices, therapeutic mattresses and bed products, wheelchairs and wheelchair accessories, and more.	

What is Not Changing with this Transition

Coverage of Medically Necessary Medi-Cal services will remain unchanged. However, what will change is the delivery system through which Members with UIS access care, along with the discontinuation of services that are available only through managed care, namely ECM and Community Supports.

More specifically, all else being equal, the following will not change:

Pharmacy benefits through Medi-Cal Rx: Medi-Cal Rx refers to the collective pharmacy benefits and services that are administered through the Medi-Cal FFS delivery system for all Medi-Cal Members, including those enrolled in Medi-Cal MCPs. Members will continue to receive pharmacy services from the broader Medi-Cal FFS pharmacy network under the Medi-Cal Rx program.

Behavioral Health Services: Members receiving Specialty Mental Health Services or Substance Use Disorder treatment through a county BHP will continue to receive care through the same provider(s).

California Children's Services (CCS) Program - excluding Whole Child Model (WCM):

- Members enrolled in CCS will remain in the program and may continue to receive care through the same CCS-paneled provider(s). Any care or services received outside of CCS may transition to Medi-Cal FFS providers.
- Members enrolled in CCS through WCM will have medical case management functions for CCS-eligible conditions transitioned to the county CCS Programs. See the Members with UIS Enrolled in Whole Child Model (WCM) section of this Policy Guide for additional information on the specific transition plans for Members currently enrolled in WCM MCPs.
- Note: For CCS Children or Youth who were enrolled in ECM under the Population of Focus for Children and Youths with Complex Needs will need special

consideration. Specifically, there are children and youth enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with additional needs beyond the CCS condition and have been enrolled with ECM providers (predominantly Specialty Care Providers who have capabilities to manage both complex health care and social needs). Additional information will be forthcoming in a future release of this policy guide.

Program of All-Inclusive Care for the Elderly (PACE): Members enrolled in PACE will remain in the program and continue to receive care through their PACE Organization.

In-Home Supportive Services Residual (IHSS-R) Program: Members enrolled in this program will remain in the program and be able to continue to receive care through their IHSS provider. It allows these Members to receive in-home care services to maintain independence and avoid institutionalization.

Health Care Program for Children in Foster Care (HCPCFC): Members will remain in the HCPCFC and continue receiving care coordination and case management from a public health nurse (PHN) to meet their physical, medical, dental, mental, and developmental needs. Members in the HCPCFC are minor and nonminor dependents in foster care. The program maintains an established process through which PHNs consult and collaborate with the child and family team to promote access to comprehensive preventive health care and necessary specialty services.

Medi-Cal Home and Community-Based Services (HCBS) Waiver Programs: Members enrolled in these Medi-Cal HCBS waiver programs will remain in their program and continue to receive care through the same provider(s) enrolled through the waiver, as long as the provider(s) accept Medi-Cal FFS:

- Assisted Living Waiver (ALW) Program
- Medi-Cal Waiver Program (MCWP) (formerly known as the AIDS Waiver)
- Home and Community-Based Services Alternatives (HCBA) Waiver (includes Waiver Personal Care Services)
- Home and Community Based Services for the Developmentally Disabled (HCBS-DD)
- Multipurpose Senior Services Program (MSSP)
- Self Determination Program (SDP)
- California Community Transition (CCT) Program

If a Member is enrolled in an HCBS waiver program, but their primary care or specialty providers do not accept Medi-Cal FFS, the Member will need to find another primary care or specialty care provider who will accept Medi-Cal FFS.

Members with UIS Enrolled in a Whole Child Model (WCM) Managed Care Plan

Members with UIS enrolled in a WCM MCP will remain enrolled in the CCS Program. Case management services and adjudications of service authorization requests will shift to the County CCS Program. Members' care will transition from their WCM MCP to a Medi-Cal FFS provider.

To support the transition, DHCS is partnering with WCM counties and MCPs to shift care management functions of Members with UIS to the County CCS Program. More details are forthcoming in an All Plan Letter to WCM MCPs and a Numbered Letter to CCS County Administrators.

Members with UIS Enrolled in a Medi-Medi Plan

A Medi-Medi Plan is a type of Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) that operates with exclusively aligned enrollment (EAE) with an affiliated Medi-Cal MCP. Dual eligible Members with UIS who are enrolled in a Medi-Medi Plan will be included in the transition from the Medi-Cal managed care delivery system to Medi-Cal FFS. Since EAE D-SNP membership is limited to individuals who are also enrolled in the affiliated Medi-Cal MCO, dual eligible Members with UIS are no longer eligible for enrollment in an EAE D-SNP effective January 1, 2027. Generally, expectations and requirements for Medi-Cal MCPs that are outlined in this Policy Guide apply to Medi-Medi Plan members who are included in the transition.

Transition of Care and Continuity of Provider Access

Unlike prior Medi-Cal transitions that primarily involved Members moving from one MCP to another or members moving from Medi-Cal FFS to managed care, the UIS Transition involves Members moving from managed care to Medi-Cal FFS. As a result, statutory continuity of care requirements applicable to MCPs under California law do not apply here to Members transitioning to Medi-Cal FFS.[2]

To support a smooth transition and minimize disruptions in care, DHCS is highlighting Transition of Care policies and operational requirements designed to preserve access to medically necessary services and to providers, to the extent the provider is enrolled in Medi-Cal FFS, during and after the transition.

Transition of Care Requirements

MCPs must support the transition of Members with UIS to Medi-Cal FFS by providing timely and accurate Member information, care management data, authorization information, and other records necessary to facilitate continued access to services.

At a minimum, MCPs must:

1. Identify Members with UIS receiving ongoing treatment, services, or supports that may require transition planning.
2. Provide DHCS and its designated contractors with the data necessary to support transition activities, including active service authorizations, related Provider authorization information, and other information specified by DHCS.
3. Cooperate with DHCS' efforts to identify high-risk ("Special Population") Members who may require additional transition support.
4. Maintain Member services and Care Coordination functions throughout the transition period (i.e., December 31, 2026) and respond to Member and Provider inquiries regarding changes in coverage and service access.
5. Assist Members and Providers in understanding how services will be accessed under Medi-Cal FFS, leveraging information provided by DHCS.

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2 Health and Safety Code section 1373.96 provides continuity of care protections for Members and requires MCPs to provide for the completion of Covered Services by either a terminated provider or by a nonparticipating provider under certain situations. This statute does not apply to Members transitioning from managed care to Medi-Cal FFS.

DHCS is working with MCPs and stakeholders on Transition of Care planning to minimize disruption in service for high-risk Members. More details are forthcoming.

Continuity of Provider Access

Although continuity of care protections under California law do not apply to transitions from managed care to Medi-Cal FFS, DHCS seeks to minimize disruptions by supporting Members' continued access to existing providers whenever possible.

Members transitioning to Medi-Cal FFS may continue receiving services from providers who are enrolled in Medi-Cal and eligible to bill through the Medi-Cal FFS delivery system. MCPs will be required to provide Members with information on how to determine whether their current Providers participate in Medi-Cal FFS and, when necessary, assist Members in identifying alternative providers. *More details are forthcoming.*

For Providers who are not enrolled in Medi-Cal FFS, DHCS intends to partner and coordinate with MCPs and provider associations on provider enrollment support activities or other mechanisms, as appropriate, to minimize disruption of medically necessary services. At minimum, MCPs are required to:

1. Provide DHCS and its designated contractors with the data necessary to identify active authorizations from Network Providers so that DHCS may determine continuity of services or treatment with the Providers enrolled in Medi-Cal FFS.
2. Communicate to Network Providers who serve Members with UIS on how they can continue to serve their patients using DHCS-provided information and templates. [See the Provider Communications to Enable Continuity section of this Policy Guide for more information.]

Care Management

DHCS is evaluating care management services. More details are forthcoming.

SPECIAL POPULATIONS

All transitioning Members with UIS will need support for a smooth transition and to minimize disruptions in their care, but some transitioning Members—referred to as Special Populations—will need additional support from their current Providers, their MCP, and DHCS to ensure care is coordinated leading up to and throughout the UIS Transition.

Under this Policy Guide, DHCS requires MCPs to focus attention and resources on transitioning Members who meet Special Populations criteria to minimize the risk of harm from disruptions in their care, as detailed below. DHCS is currently utilizing the Special Populations that were defined for the 2024 Managed Care Transition but is in the process of evaluating modifications to the Special Populations for this UIS transition to identify Members who are likely to experience service disruptions. More details are forthcoming.

Transitioning Members in Special Populations are generally individuals living with complex or chronic conditions (see Table 3, List of Special Populations). Members will be identified using DHCS or MCP data, including program enrollment, specific pharmacy claims, DME claims, screening and diagnostic codes, procedure codes, or aid codes. See the Data Sharing Requirements section of this Policy Guide for more information.]

Table 3 List of Special Populations

Members Who Are:
» Adults and children with authorizations to receive ECM services[3,4]
» Adults and children with authorizations to receive Community Supports[5]
» Adults and children receiving Complex Care Management[6]
» Enrolled in 1915(c) waiver programs[7]
» Receiving In-Home Supportive Services (IHSS)
» Children and youth enrolled in CCS/CCS WCM
» Children and youth in foster care, and former foster youth through age 25[8]
» In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C
» Taking immunosuppressive medications, immunomodulators, and biologics
» Receiving treatment for end-stage renal disease
» Living with an intellectual or developmental disability diagnosis
» Living with a dementia diagnosis

[3] Members do not have to be actively receiving ECM on December 31, 2026.

[4] This population includes dual eligible Members who are enrolled in the MCP's affiliated D-SNP and receive California Integrated Care Management (CICM) from the D-SNP. As noted in the CalAIM D-SNP Policy Guide, CICM requirements apply to Members who may be eligible to receive ECM from their MCP, with the inclusion of an additional population of focus (Members with Documented Dementia Needs).

[5] Members do not have to be actively receiving Community Supports on December 31, 2026.

[6] Complex Care Management is the same as Complex Case Management as defined by National Committee for Quality Assurance (NCQA).

[7] Multipurpose senior services program (MSSP); Assisted living waiver; Home and community-based alternatives (HCBA); HIV/AIDS Waiver; Home and community-based services (HCBS) waiver for developmental disabilities; Self-determination program for intellectual and developmental disabilities

[8] This population includes children and youth receiving foster care and former foster youth through age 25.

Members Who Are:
» In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months
» Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
» Receiving Behavioral Health Services (adults, youth, and children)
» Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality
» Receiving hospice care
» Receiving home health
» Residing in Skilled Nursing Facilities (SNF)
» Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
» Receiving hospital inpatient care
» Post-discharge from an inpatient hospital, SNF, or sub-acute facility on or after December 1, 2026
» Newly prescribed DME (within 30 days of January 1, 2027)
» Members receiving Community-Based Adult Services

MEMBER-FACING MATERIALS AND COMMUNICATIONS

Member Transition Notification Policy

DHCS will be mailing one notice to impacted Members to inform them of the UIS Transition. The notice will have a link to a Notice of Additional Information (NOAI) that will be posted on the DHCS website and accessible through a Quick Reference (QR) code included on the notices. Members are expected to receive the notice by December 1, 2026. To ensure Members receive the notice, MCPs must work with their Members now to inform them that their mailing address needs to be current and accurate with the county Medi-Cal office. To find their local Medi-Cal office, Members can go to: www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx.

DHCS will translate the Member notice into Medi-Cal's 19 threshold languages and provide them in alternative formats such as large print and Braille if requested. DHCS will provide the NOAI as a print copy by mail or in an alternative format for any Member who requests it.

DHCS will share a template copy of the Member notice when available.

MCPs are not required to send this Member notice.

Beneficiary Identification Card (BIC) Requests

DHCS will not issue new Medi-Cal Beneficiary Identification Cards (BICs) as part of the transition from managed care to Medi-Cal FFS. Members should continue using their existing BIC to access covered services under Medi-Cal FFS.

If a BIC is lost, stolen, or damaged, Members may request a replacement card through their local county office which can be located on DHCS' Find Your County Medi-Cal Office web page.

Members are also encouraged to submit replacement requests through the BenefitsCal web page.

MCPs must reinforce these requirements in Member communications and direct Members to county resources for replacement card requests.

Notice of Termination of MCP-Provided ECM and Community Supports

MCPs must identify Members who are receiving ECM and Community Supports and notify them that these MCP-provided services are terminating, including the specific termination date. MCPs are encouraged to include information on alternative resources and supports, leveraging the MCPs' understanding of the communities they serve and DHCS resources. *DHCS is evaluating options to support transition planning for Members receiving ECM or Community Supports. More details are forthcoming.*

Furthermore, MCPs must provide resources and referrals to Members directly or through contracted ECM and Community Supports Providers that are serving transitioning Members. [See the Provider Communications to Enable Continuity section of this Policy Guide for more information.] These resources and referrals may include, but are not limited to, Medi-Cal FFS providers, CHWs, housing supports, or programs in other delivery systems that provide alternative services. MCPs should also offer connections to local resources but make it clear that local resources may not be covered by Medi-Cal (e.g., county resources, local community-based organizations, etc.). MCPs are encouraged to always leverage existing, trusted care Providers whenever possible.

These requirements are also applicable for Members who receive California Integrated Care Management (CICM) through the Medi-Cal MCP's affiliated D-SNP. As described in the CalAIM D-SNP Policy Guide, CICM requirements apply to Members who may be eligible to receive ECM from their MCP, with the inclusion of an additional population of focus (Members with Documented Dementia Needs).

Member Resources

MCPs must provide information to Members on how to determine whether their Providers participate in Medi-Cal FFS. As of the release of this Policy Guide, MCPs must direct Members to DHCS resources specified below and in the Appendix. *Additional guidance regarding MCP outreach to Members is forthcoming.*

Medi-Cal FFS Find-A-Provider Search Tool

There is no Medi-Cal FFS resource equivalent to the Provider Directory provided by MCPs. To support Members in finding a Medi-Cal FFS provider, DHCS publishes a centralized web page that includes a Medi-Cal Fee-for-Service Provider Finder App. Members can use the Medi-Cal Fee-for-Service Provider Finder App to search for Medi-Cal FFS providers.

DHCS is preparing enhancements to this tool to better support Member transition planning and will update this Policy Guide when more details are available.

In addition, Members may contact the Medi-Cal FFS Member Telephone Service Center at 1-800-541-5555. The Telephone Service Center currently operates Monday through Friday, 8 a.m. to 5 p.m. PST. DHCS' Medi-Cal Contacts web page lists the phone numbers Members can call for assistance with Medi-Cal questions.

DHCS will include links and references to additional Member resources as they are developed.

myMedi-Cal Resources

There is no Medi-Cal FFS resource equivalent to the MCP Member Handbook or Evidence of Coverage. DHCS publishes the following resources to help Members understand Medi-Cal:

Medi-Cal: Serves as a comprehensive resource for understanding, applying for, using, and maintaining Medi-Cal health coverage.

How To Get the Care You Need: A centralized web page that provides links to key resources, including How to Apply, Program Resources, Rights and Responsibilities, and Contact Information. It also includes a link to *myMedi-Cal: How to Get the Health Care You Need*, a guide designed to help Californians understand the Medi-Cal program, including sections explaining Medi-Cal FFS and how medical or dental expenses are paid under Medi-Cal FFS coverage.

General Communications

The DHCS Office of Communications (OC) will provide consistent, accurate, and timely public-facing information about the UIS Transition across DHCS external channels, including web updates, FAQs, fact sheets, Coverage Ambassadors, and social media. OC will also maintain clear, plain-language messaging that helps Members, Providers, counties, advocates, and community partners understand the shift from managed care to Medi-Cal FFS and how to navigate their coverage beginning January 1, 2027. OC has responded to early inquiries from media and stakeholders, issued holding statements, and published initial web updates to reflect the federal policy change and upcoming transition.

MCP's Communications offices should review and regularly check DHCS' web site for available resources to support consistent messaging. Consistency in messaging will be important to minimize Member and provider confusion to the extent feasible.

DATA SHARING REQUIREMENTS

Successful data sharing between DHCS and MCPs will be critical in supporting impacted Members for this transition. MCPs must transmit Member information, utilization data, authorization data, accompanying data for Special Populations, and any additional data elements identified by DHCS.

DHCS is assessing data needs for this transition and will update the requirements in this section as those details are clarified.

Member Data Sharing

MCPs must complete all data sharing requirements outlined below. This Section outlines a standardized set of "minimum necessary" data elements for data shared from the MCP to DHCS, as well as standard file formats, transmission methods, and transmission frequencies.

MCPs will transmit the data files in Table 4, Summary of MCP Provided Data Files, to DHCS. DHCS will perform verification checks to confirm successful data sharing according to timeliness and quality expectations. If the MCP does not meet data requirements, the MCP may be subject to enforcement actions.

Table 4 Summary of MCP Provided Data Files

File	Description	Refresh Frequency
A. Transitioning Member Identifying Data	Identifying information (e.g., name, date of birth) and contact information for transitioning Members	Initial transfer November 9, 2026 Weekly refreshes beginning December 7, 2026
B. Transitioning Member Utilization Data	Claims and encounter information for transitioning Members	Initial transfer November 9, 2026 Weekly refreshes beginning December 7, 2026
C. Transitioning Member Authorization Data	Prior authorization information for transitioning Members	Initial TEST file for current Members with UIS – due September 15, 2026 Weekly files starting October 19, 2026, through December 14, 2026 Daily files starting December 15, 2026, through January 11, 2027

File	Description	Refresh Frequency
D. Transitioning Member NEMT/NMT Schedule and Physician Certification Statement Data	Scheduled transportation information for transitioning Members	Initial transfer November 9, 2026 Weekly refreshes beginning December 7, 2026
E. Transitioning Member Special Populations Information Data	Transitioning Members who meet Special Populations criteria* and relevant accompanying data elements	Details forthcoming
F. Special Populations Member Supportive Information Data	Transitioning Member screening and assessment findings, and Member Care Management Plans	Details forthcoming

**DHCS is in the process of identifying Special Populations for this transition and will update details in a future release of this Policy Guide.*

Excel Template for Submission of MCP Data to DHCS

DHCS will compile the outlined data elements above into four accompanying Excel workbooks for MCPs to prepare data files to transmit to DHCS. The accompanying Excel workbooks include additional guidance for MCPs around expected values and file requirements. *DHCS is in the process of identifying Special Populations for this transition and will update this section in a future release of this Policy Guide.*

1. Transition of Care Data Template - 1) Data Elements for All Members

   - MCPs must use this template to prepare Member level data files for transitioning Members in accordance with requirements outlined in the section below.

2. Transition of Care Data Template - 2a) Special Populations Specifications

   - MCPs must use these specifications to identify relevant Members and prepare Transitioning Member Special Populations Data files using the Transition of Care Data Template – 2b) Special Population Member File and Transition of Care Data

Template – 2c) Special Populations Accompanying Data workbooks for transmittal to DHCS.

3. Transition of Care Data Template – 2b) Special Population Member File

   - MCPs must use this template to prepare a file identifying Members that meet the criteria outlined in Transition of Care Data Template - 2a) Special Populations Specifications for transmittal to DHCS.

4. Transition of Care Data Template – 2c) Special Populations Accompanying Data

   - MCPs must use this template to prepare Special Populations accompanying data for certain Special Population groups for transmittal to DHCS.

A. Transitioning Member Identifying Data

Required Data Elements

MCPs must share *Transitioning Member Identifying Data* files with DHCS in accordance with the required data elements and format outlined in Table 5, Transitioning Member Identifying Data, and Table 6, Transitioning Member Primary Care Provider Information.

Table 5 Transitioning Member Identifying Data

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Member First Name	Alpha-Numeric, Text
Member Last Name	Alpha-Numeric, Text
Member Date of Birth	MM/DD/YYYY, Date
Member Gender Code[9]	Numeric 3-digit, Text
Member Homelessness Indicator[10]	Numeric, 1-digit, Text
Member Residential Address[11]	Alpha-numeric, Text

[9] This will be limited to the Medi-Cal 834 file acceptable values.

[10] Identifier for if the member is experiencing "homelessness," as defined in the ECM Policy Guide (pgs. 11-13), available CalAIM Enhanced Care Management Policy Guide. If "homeless," enter "2", if not, enter "1", if unknown, enter "0".

[11] MCPs may complete data element as "99999" if the member is identified as homeless by the "Member Homelessness Indicator" and Residential City is not available.

Data Element	Format
Member Residential City[12]	Alpha-numeric, Text
Member Residential Zip Code[13]	Alpha-numeric, Text
Member Mailing Address[14]	Alpha-numeric, Text
Member Mailing City[15]	Alpha-numeric, Text
Member Mailing Zip Code[16]	Numeric, 5-digit
Member Phone Number[17]	Numeric, 10-digit
Member Email Address	Alpha-Numeric, Text
Member's Preferred Form of Contact[18]	Alpha-Numeric, Text
Description of Member's Selected Alternative Format[19]	Alpha-Numeric, Text
Member's Preferred Language (Spoken)[20]	Alpha-Numeric, Text

[12] MCPs may complete data element as "99999" if the member is identified as homeless by the "Member Homelessness Indicator" and another zip code is not available.

[13] MCPs may complete data element as "99999" if the member is identified as homeless by the "Member Homelessness Indicator" and another zip code is not available.

[14] MCPs may complete field as "HOMELESS" if the member is identified as homeless by the "Member Homelessness Indicator" and another address is not available.

[15] MCPs may complete field as "HOMELESS" if the member is identified as homeless by the "Member Homelessness Indicator" and another address is not available.

[16] MCPs may complete data element as "99999" if the member is identified as homeless by the "Member Homelessness Indicator" and another zip code is not available.

[17] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[18] Member's Preferred Form of Contact, as known by MCP (e.g., "CALL", "TEXT", "EMAIL", "MAIL"). If not known, MCP may report "UNKNOWN".

[19] If applicable, member's selected alternative format, as known by MCP (e.g., "LARGE PRINT", "AUDIO CD", "DATA CD", "BRAILLE"). If not known, MCP may report "UNKNOWN".

[20] If available, Member's Preferred Spoken Language (e.g., "ENGLISH", "SPANISH"). If not known, MCP may report "UNKNOWN".

Data Element	Format
Member's Preferred Language (Written)[21]	Alpha-Numeric, Text

Table 6 Transitioning Member Primary Care Provider Information

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Primary Care Provider Name (Assigned PCP)	Alpha-numeric, Text
Primary Care Provider National Provider Identifier (NPI)	Numeric, 10-digit, Text
Primary Care Provider Phone Number[22]	Numeric, 10-digit
Primary Care Facility Name	Alpha-numeric, Text
Primary Care Facility NPI	Numeric, 10-digit, Text
Primary Care Facility Phone Number	Numeric, 10-digit
Primary Care Facility Address	Alpha-numeric, Text
Medical Group	Alpha-numeric, Text
Medical Group TIN	Numeric, 9-digit
Last Visit Date[23]	MM/DD/YYYY, Date

B. Transitioning Member Utilization Data

Required Data Elements

MCPs must share Transitioning Member Utilization Data files with DHCS in accordance with the required data elements and format outlined in Table 7, Transitioning Member Claims / Encounter Information.

[21] If available, Member's Preferred Written Language (e.g., "ENGLISH", "SPANISH"). If not known, MCP may report "UNKNOWN".

[22] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[23] As known by the MCP; if no visits on record, MCP will enter "00/00/0000".

Table 7 Transitioning Member Claims / Encounter Information

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Detail Service Date	MM/DD/YYYY, Date
Procedure Code[24]	Alpha-Numeric, Text
HCPCS Modifier[25]	Alpha-Numeric, Text
Revenue Code[26]	Numeric, 4-digit, Text
Place of Service[27]	Numeric, 2-digit, Text
Bill Type	Alpha-Numeric, Text
Billed Units	Numeric, 6-digit, Text
Tax Identification Number	Numeric, 9-digit, Text
Billing Provider NPI	Numeric, 10-digit, Text
Billing Provider First Name	Alpha-Numeric, Text
Billing Provider Last Name	Alpha-Numeric, Text
Billing Provider Phone Number[28]	Numeric, 10-digit
Billing Provider Tax Identification Number (TIN)	Numeric, 9-digit, Text
Rendering Provider Specialty Type[29]	Alpha-Numeric 9-digit, Text
Rendering Provider NPI	Alpha-Numeric, Text

[24] Primary procedure code for this line of service. Do not code decimal point.

[25] Procedure modifiers are required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. If not submitted by the provider or captured by the carrier leave blank.

[26] Codes that identify specific accommodations, ancillary service or unique billing calculations or arrangements. NUBC Code using leading zeroes, left justified, and four digits. Required for institutional claims only. Please leave blank for professional claims.

[27] Required for professional claims only, please leave blank for institutional claims.

[28] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[29] Standard taxonomy codes issued by the NUCC, available here. If number not available to the MCP, MCP may report "0000000000".

Data Element	Format
Rendering Provider First Name	Alpha-Numeric, Text
Rendering Provider Last Name	Numeric, 10-digit
Rendering Provider Phone Number	Alpha-Numeric, Text
Admittance Low Service Date	MM/DD/YYYY, Date
Discharge High Service Date	MM/DD/YYYY, Date
Diagnosis Code 1[30]	Alpha-Numeric, Text
Diagnosis Code 2[31]	Alpha-Numeric, Text
Diagnosis Code 3	Alpha-Numeric, Text
Diagnosis Code 4	Alpha-Numeric, Text

C. Transitioning Member Authorization Data

Required Data Elements

MCPs must share *Transitioning Member Authorization Data* files with DHCS in accordance with the required data elements and format outlined in Table 8, Transitioning Member Authorization Information.

Table 8 Transitioning Member Authorization Information

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Requesting Provider Name	Alpha-numeric, Text
Requesting Provider NPI	Numeric, 10-digit, Text
Requesting Provider Phone Number[32]	Numeric, 10-digit
Requesting Facility Name	Alpha-numeric, Text
Requesting Facility NPI	Numeric, 10-digit, Text

[30] ICD-9-CM or ICD-10-CM. Do not code decimal point.

[31] ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank.

[32] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

Data Element	Format
Requesting Facility Phone Number[33]	Numeric, 10-digit
Rendering Provider Name	Alpha-numeric, Text
Rendering Provider NPI	Numeric, 10-digit, Text
Rendering Provider Phone Number[34]	Numeric, 10-digit
Rendering Facility Name	Alpha-numeric, Text
Rendering Facility NPI	Numeric, 10-digit, Text
Rendering Facility Phone Number[35]	Numeric, 10-digit
Authorization Begin Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date
Units	Numeric 7-digit, Text
Service Code	Alpha-Numeric, 5-digit, Text
Service Code Description	Alpha-Numeric, Text
Diagnosis Code[36]	Alpha-Numeric, Text
Diagnosis Description	Alpha-Numeric, Text
Authorization Status[37]	Alpha-Numeric, Text
Authorization Type	Alpha, 2-digit, Text
Previous MCP Authorization Number	Alpha-Numeric, Text
Discharge Status	Alpha-Numeric, Text

[33] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[34] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[35] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[36] ICD-9-CM or ICD-10-CM. Do not code decimal point.

[37] Indication of authorization status (e.g., "APPROVED", "DENIED", "PARTIAL").

D. Transitioning Member NEMT/NMT Schedule and Physician Certification Statement Data

Required Data Elements

MCPs must share *Transitioning Member NEMT/NMT Schedule Data and Physician Certification Statement Data* files with DHCS in accordance with the required data elements and format outlined in Table 9, Transitioning Member NEMT/NMT Schedule Data, and Table 10, Transitioning Member Physician Certification Statement Information.

Table 9 Transitioning Member NEMT/NMT Schedule Data

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Level Of Transportation Service[38]	Numeric, 1-digit, Text
Date of Scheduled Transportation Service	MM/DD/YYYY, Date
Time of Scheduled Transportation Service	hh:mm:ss, Time
Recurring Transportation Service Indicator[39]	Numeric, 1-digit, Text
Member Phone Number[40]	Numeric, 10-digit
Pickup Location[41]	Alpha-Numeric, Text
Pickup Address	Alpha-Numeric, Text
LTC/SNF Phone Number [42]	Numeric, 10-digit
Mode of Transport[43]	Alpha-Numeric, Text

[38] Identifier for NEMT and NMT services. If NEMT, enter "0", if NMT, enter "1".

[39] Identifier for if one-time or recurring NEMT/NMT services. If one-time, enter "0", if recurring, enter "1".

[40] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[41] Indicates NEMT/NMT pickup locations (e.g., "MEMBER HOME", "SNF", "LTC").

[42] If applicable. Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[43] Member's Mode of Transportation, as known by MCP (e.g., "AMBULANCE", "ADVANCED LIFE SUPPORT AMBULANCE", "BASIC SUPPORT AMBULANCE", "GURNEY VAN/LITTER VAN", "WHEELCHAIR VAN", "AIR TRANSPORT").

Data Element	Format
Transportation Provider Name	Alpha-Numeric, Text
Transportation Provider Phone Number[44]	Numeric, 10-digit
Dropoff Provider Name	Alpha-Numeric, Text
Dropoff Provider Address	Alpha-Numeric, Text
Dropoff Provider Phone Number[45]	Numeric, 10-digit
Current NMT/NEMT Vendor	Alpha-Numeric, Text
Transportation Notes[46]	Alpha-Numeric, Text

[44] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[45] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[46] May include appointment reason (e.g., PCP visit, cardiologist visit) or member needs (e.g., oxygen, stair chair, attendants).

Table 10 Transitioning Member Physician Certification Statement Information

Data Element	Format
Medi-Cal Member Client Index Number (CIN)	Alpha-Numeric 9-digit, Text
Level Of Service	Alpha-Numeric, Text
Authorization Begin Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date
Start Date of Standing Order[47]	MM/DD/YYYY, Date
Mode of Transportation[48]	Alpha-Numeric, Text
Requesting Provider Name	Alpha-Numeric, Text
Requesting Provider NPI	Numeric, 10-digit, Text
Requesting Provider Phone Number[49]	Numeric, 10-digit
Rendering Provider Name	Alpha-numeric, Text
Rendering Provider NPI	Numeric, 10-digit, Text
Rendering Provider Phone Number	Numeric, 10-digit
Physician Certification Statement Notes[50]	Alpha-numeric, Text

E. Transitioning Member Special Populations Information Data

DHCS is in the process of finalizing the Special Populations for this transition (See Special Population section above). *A future release of this Policy Guide will outline the data needs for Special Populations in this section.*

[47] If applicable, start date of standing orders. Please leave blank if not applicable.

[48] Member's Mode of Transportation, as known by MCP (e.g., "AMBULANCE", "ADVANCED LIFE SUPPORT AMBULANCE", "BASIC SUPPORT AMBULANCE", "GURNEY VAN/LITTER VAN", "WHEELCHAIR VAN", "AIR TRANSPORT").

[49] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[50] May include functional limitations justification among other items.

PROVIDER COMMUNICATIONS TO ENABLE CONTINUITY

Provider Communications Requirements

Initial Communications to Providers Serving Impacted Members

Within 30 days of the initial publication of this Policy Guide, MCPs must communicate with all contracted Network Providers serving Members with UIS regarding the transition of their patients from managed care to Medi-Cal FFS. MCPs may elect to extend communications broadly to their entire contracted Network to ensure that any Provider who may serve an impacted Member prior to January 1, 2027, is aware of the changes. MCP communications must explain:

- The transition timeline and effective date.
- Identify the populations affected.
- Outline steps Providers may take to support continued access to care and continuity of Provider-patient relationships.
- Provide detailed instructions regarding Medi-Cal enrollment requirements for Providers that wish to continue serving transitioning Members under Medi-Cal FFS.

Communications shall direct Providers to complete or update all necessary Medi-Cal enrollment, screening, and revalidation requirements through the applicable DHCS enrollment processes and shall include information on enrollment resources, timelines, and technical assistance.

MCPs must disseminate these communications through Provider bulletins and other established Provider communication channels, post transition materials and messaging on Provider portals, and ensure Providers receive timely updates as DHCS finalizes transition policies and operational requirements.

Separately, DHCS will provide standardized messaging for MCPs to inform their ECM and Community Supports Providers via information bulletins and posting on their Provider portals or other established Provider communication channels. The standardized messaging will help ensure that ECM Providers and Community Supports Providers are equipped with the necessary guidance to support Members during and after the transition.

Targeted Communications for Specific Provider Types

MCP requirements for targeted Provider messaging to Primary Care Providers, ECM and Community Support Providers, Skilled Nursing Facilities, and other provider types are in development and will be included in a future release of this Policy Guide. In addition, guidance pertaining to communicating with providers who are currently assigned Members subject to this transition or have members enrolled in care management programs (such as CCM, ECM) to support ongoing patient-provider relationships will be included in a future Policy Guide release.

APPENDICES

A. DHCS Resources for Providers

General Medi-Cal FFS Provider Resources

- General information about enrolling as a Provider in Medi-Cal FFS can be found on the For Medi-Cal Providers page.
- Providers that are enrolled in Medi-Cal FFS may access various resources via the Provider Portal. For Providers not yet enrolled in Medi-Cal FFS, there are publicly available resources available on the Provider Portal References Page.

Medi-Cal FFS Enrollment

MCPs, Providers and Members can check to see if a Provider is enrolled to bill Medi-Cal FFS: Profile of Enrolled Medi-Cal Fee-for-Service (FFS) Providers

Medi-Cal FFS Provider types are available here: Provider Enrollment Options

Requirements for enrollment by specific provider type: Application Information by Provider Type

New Providers enroll in Medi-Cal FFS by submitting a PAVE application. Tutorials on how to complete the application process are available here: Provider Application and Validation for Enrollment

Questions about Provider Enrollment can be submitted using the Provider Inquiry form.

Medi-Cal FFS Provider Trainings

DHCS will update this section as trainings are developed and scheduled to help support the UIS Transition.

B. Provider Communication Template

Below is a template communication that MCPs should use to communicate with Providers about this transition. At minimum, MCPs must communicate the transition to Providers serving Members with UIS but may elect to communicate more broadly across their Networks. As noted above, MCPs must at minimum include this information on their Provider portals, and Provider bulletins or blasts.

Dear Provider:

Effective **January 1, 2027**, Medi-Cal managed care plan (MCP) Members with unsatisfactory immigration status (UIS) will transition to the Medi-Cal Fee-for-Service (FFS) delivery system.

To support a smooth transition for you and your patients, the Department of Health Care Services (DHCS) is providing the following important information regarding provider enrollment, billing, and ongoing care responsibilities.

1. Medi-Cal FFS Enrollment Requirements

To continue to serve Medi-Cal Members transitioning to Medi-Cal FFS, providers must be enrolled in Medi-Cal FFS. To enroll, providers must complete a provider enrollment application with the DHCS Provider Enrollment Division (PED). Although Members will no longer be assigned a Primary Care Provider under Medi-Cal FFS, you may continue to see your patients if you are enrolled in Medi-Cal FFS.

If you are already enrolled in Medi-Cal through PED via Provider Application and Validation for Enrollment (PAVE), you may continue to provide services to your members that have transitioned to Medi-Cal FFS and be eligible for reimbursement under Medi-Cal FFS.

If you are **not currently enrolled** through PAVE, you must submit an application and be approved to enroll by **January 1, 2027**, in order to receive reimbursement at FFS rates. For more information on PAVE enrollment, please visit https://www.dhcs.ca.gov/providers-partners/provider-application-and-validation-for-enrollment/.

Please ensure that a hand off with appropriate records is shared with your colleague who will continue to care for these patients. A list of providers who are enrolled in Medi-Cal FFS can be found https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers.

1. Preparing for FFS Billing

DHCS strongly encourages all providers to familiarize themselves with Medi-Cal FFS billing processes to prepare for billing Medi-Cal FFS after January 1, 2027.

This includes:

- Understanding FFS billing requirements (https://www.dhcs.ca.gov/providers-partners/tar-billing/)
- Reviewing FFS rates (https://mcweb.apps.prd.cammis.medi-cal.ca.gov/rates?page=1&tab=rates)
- Accessing the Medi-Cal Provider Manual and Provider Bulletins (https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications)

Medi-Cal providers have access to billing and claims assistance through DHCS' California Medicaid Management Information System (CA-MMIS) and its contracted Fiscal Intermediary (FI). CA-MMIS and FI staff can assist providers with questions about paper claim submissions, electronic claim submission, and Treatment Authorization Requests (TARs and electronic-TARs, or eTARs).

Medi-Cal providers can also contact the Telephone Service Center (TSC) by phone at (800) 541-5555 (outside of California, (916) 636-1980), Monday through Friday, except holidays, from 8:00 a.m. to 5:00 p.m. For faster access to TSC resources, Medi-Cal providers can refer to the TSC Main Menu Prompt Options Guide (https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/82E2E926-5998-44E3-A478-965E0B59FFE8/provrelfrm1ref.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO)

3. Support for Transition of Care

While Enhanced Care Management and Community Supports are not covered under Medi-Cal FFS, certain care management, care coordination, or case management services; as well as community health worker services are available for coverage and reimbursement when billed in accordance with Medi-Cal Coverage Policy by eligible providers. Specifically, providers enrolled in Medi-Cal FFS may bill for eligible care management, case management, or care coordination activities using existing Medi-Cal FFS billing codes to receive reimbursement for case management and care management functions.

DHCS plans to provide links and/or a resource document that includes the available codes for billing purposes under FFS. The resource will include lists of potential codes, such as the

ones listed below with links to the appropriate provider manual that includes details on billing guidance.

- CHWs: CPT codes 98960, 98961, and 98962. HCPCS codes G0019 and G0022.
- Doula: CPT codes 59409, 59612, 59620, and 59840. HCPCS codes Z1032, Z1034, T1033, T1032, and Z1038.
- Principle Care management /Chronic Care Management: CPT codes 99424, 99425, 99426,99427, 99490, 99491, 99437, 99439; HCPCS code G0506
- Case Management: CPT codes 99366, 99368, G9012 (HCBS/JI only)
- General Behavioral Health Integration Care Management: CPT code 99484 (JI only)
- Transitional Care Management Services: CPT codes 99439 (JI only)
- Targeted CM: HCPCS code T1017
- Psychiatric Collaborative CM services: CPT code 99492, 99493, 99494
- CPSP: HCPCS codes Z1032, Z6500, Z6200, Z6202, Z6204, Z6206, Z6208, S0197, Z6300, Z6302, Z6304, Z6306, Z6308, Z6400, Z6402, Z6404, Z6406, Z6408, Z6410, Z6412, and Z6414.

Providers are encouraged to remind members to refill prescriptions before **January 1, 2027**, to avoid disruptions.

4. Questions & Support

[MCP Name] will provide additional information as DHCS finalizes transition updates, including:

- Care management applicable billing codes in Medi-Cal FFS
- Member support pathways
- Contact information for DHCS or MCP support channels

Sincerely,

[MCP Contact Information]