CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
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DRAFT CLINIC POLICY LETTER 26-002

TO: FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

SUBJECT: CHANGES TO REIMBURSEMENT FOR STATE-ONLY SERVICES

PURPOSE:
This Clinic Policy Letter (CPL) establishes Medi-Cal reimbursement policy for state-only services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to Medi-Cal members effective for dates of services on and after July 1, 2027.

State-only services are services ineligible for federal financial participation (FFP) under the federal Medicaid program but are reimbursed under California's Medi-Cal program. State-only services include most services provided to members with federal Unsatisfactory Immigration Status (UIS), which include Omnibus Budget Reconciliation Act (OBRA) members, as well as certain other Medi-Cal services. State-only services do not include emergency and pregnancy-related services for UIS members, as these services remain eligible for FFP.

This change will not apply to the following exempt Indian Health Care Programs: Indian Health Services Memorandum of Agreement Clinics (IHS-MOA), Tribal FQHCs, and Urban Indian Organizations.

BACKGROUND:
Assembly Bill 116 (Chapter 21, Statutes of 2025) amended Welfare & Institutions Code (WIC) section 14132.100, subdivision (c), effective July 1, 2026, to specify that only services that are eligible for FFP shall be reimbursed using the Prospective Payment System (PPS).

Senate Bill (SB) 164 (Chapter 27, Statutes of 2026) postponed the amendment to WIC section 14132.100, subdivision (c), specifying that only services that are eligible for FFP shall be reimbursed using the PPS, to July 1, 2027.

Currently, Medi-Cal reimburses eligible FQHC and RHC services at an all-inclusive PPS rate for visits with an eligible PPS-billable provider. FQHC and RHC providers who bill for services rendered under the Fee-for-Service (FFS) delivery system must use the appropriate combination of revenue codes and procedure codes, including diagnosis

codes, with modifiers as applicable to receive the PPS rate. FQHCs and RHCs submit FFS claims directly to the Medi-Cal Fiscal Intermediary (FI) and are instructed to include all-inclusive billing code sets and per visit codes on claims for PPS payments for eligible visits.

Medi-Cal Managed Care Plans (MCPs) and Dental MCPs are required to reimburse contracted FQHCs and RHCs in a manner that is no less than the level and amount of payment that the MCP or Dental MCP would make for the same scope of services if the services were furnished by another non-FQHC and RHC provider type, pursuant to WIC section 14087.325(d). 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, Dental 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 is paid once the reconciliation process is complete or a recovery is made if it is determined the FQHC or RHC was overpaid. 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.

DHCS provided public notice of this change to policy on April 24, 2026[1] and issued a clarifying addendum on May 8, 2026[2]. A second addendum was issued on June 3, 2026[3], which included a draft Clinic Policy Letter for state-only services provided to members in the managed care delivery system. State-only services are services not eligible for federal financial participation. A third addendum was issued on July 2, 2026[4] providing notification that this policy has been postponed and will be effective for dates of service on or after July 1, 2027.

Related changes in policy are occurring independently of changes to reimbursement for state-only services:

- Effective January 1, 2027, DHCS will transition all Medi-Cal members with UIS from managed care plans to the Medi-Cal Fee-for-Service delivery system for their medical benefits[5]. For dental benefits, UIS members currently enrolled in Dental MCPs will stay enrolled in the Dental MCP.

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[1] https://www.dhcs.ca.gov/wp-content/uploads/2026/05/FQHC-PPS-for-State-Only-Public-Notice.pdf
[2] https://www.dhcs.ca.gov/wp-content/uploads/2026/05/Addendum-to-FQHC-PPS.pdf
[3] https://www.dhcs.ca.gov/wp-content/uploads/2026/06/PN-Addendum-for-Clinic-Policy-Letter-PPS-State-Only-MC_9c393c.pdf
[4] https://www.dhcs.ca.gov/wp-content/uploads/2026/07/Fqhc-Pn-Addendum-Three_98a107.pdf
[5] https://www.dhcs.ca.gov/wp-content/uploads/2026/08/Version-3.0-DHCS-Policy-Guide.pdf

- Effective July 1, 2027, Medi-Cal will stop covering dental services for most adult members aged 19 and older with UIS[6], except for emergencies. DHCS will transition all UIS members aged 19 and older from Dental MCPs to the Medi-Cal Dental FFS delivery system. UIS members under 19 years of age who are enrolled in a Medi-Cal Dental MCP will stay enrolled in the Dental MCP and keep full-scope Medi-Cal with dental benefits.

POLICY:
Effective dates of services on and after July 1, 2027, only services that are eligible for FFP shall be reimbursed at the PPS rate[7]. Accordingly, the Medi-Cal FI will deny claims for PPS reimbursement and will implement non-PPS reimbursement methodologies for FQHC and RHC claims for reimbursement of state-only services, including most services provided to the UIS population, for dates of services on and after July 1, 2027.

Fee-for-Service (FFS) Medical Payments
Pursuant to WIC 14132.100 and beginning July 1, 2027, DHCS will reimburse medical services provided in FQHCs and RHCs based on the applicable Medi-Cal Fee Schedule reimbursement rate for services not eligible for FFP. Medi-Cal policy and the Health Insurance Portability and Accountability Act (HIPAA) requires complete and appropriate service-level coding on all claims including procedure codes, diagnosis codes, and emergency indicator in accordance with the Medi-Cal Provider Manual. The scope of allowable services, rates, and requirements for FQHCs and RHCs billing FFS will be the same scope of allowable services currently in place for community clinic providers. Medi-Cal reimbursement rates will be the same as current system rules for all Medi-Cal providers and will be subject to the same applicable business rules, claiming edits, frequency limitations, and Treatment Authorization Requests (TARs).

In the FFS delivery system, the Medi-Cal FI will deny claims for PPS payments submitted for FQHC and RHC state-only service visits effective for dates of services on and after July 1, 2027. The Medi-Cal FI will note each applicable denial via Remittance Advice Detail (RAD) code(s). State-only service claims billed through FFS will not be eligible for Alternative Payment Methodologies (APM). Following denial of a state-only service claim, the FQHC or RHC may submit a claim per the FFS methodology using procedure codes and diagnosis codes in accordance with the Medi-Cal Provider Manual[8].

[6] Exceptions are included on the Medi-Cal Dental Benefit Changes webpage https://www.dhcs.ca.gov/services/medi-cal-dental-benefit-changes/
[7] Currently, the only services for Medi-Cal UIS members that are eligible for federal financial participation and shall be reimbursed at the PPS rate are emergency and pregnancy-related services.
[8] DHCS advises that FQHCs and RHCs verify patient eligibility through the eligibility portal before submitting a claim for PPS reimbursement.

See below for policy on emergency and pregnancy-related services.

FFS Dental Payments

In the Dental FFS delivery system, FQHCs and RHCs will directly bill the Medi-Cal Dental FI for state-only non-emergency dental service visits for UIS members under 19 years of age and foster youth or former foster youth under age 26 who were in foster care on their 18th birthday, effective for dates of services on and after July 1, 2027. UIS members 19 and older are no longer eligible for non-emergency dental benefits effective July 1, 2027.

Beginning July 1, 2027, the Medi-Cal Dental FI will reimburse services not eligible for FFP provided in FQHCs and RHCs based on the applicable FFS rates set forth in the Medi-Cal Dental Schedule of Maximum Allowances in Section 5 of the California Medi-Cal Dental Program Provider Handbook otherwise applicable to dental providers. Medi-Cal dental policy and HIPAA require complete and appropriate service-level coding using Current Dental Terminology (CDT) codes on all dental claims in accordance with the Provider Handbook.

The scope of allowable services, rates, and requirements for FQHCs and RHCs billing Dental FFS will be the same scope of allowable services currently in place for dental providers as outlined in the Manual of Criteria in Section 5 of the Provider Handbook. Medi-Cal Dental FFS reimbursement rates will be the same as the current system rules for dental providers and will be subject to the same applicable business rules, claiming edits, frequency limitations, and TARs. See below for policy on emergency and pregnancy-related dental services.

Managed Care Medical Payments

Effective for dates of services on or after January 1, 2027[9], DHCS will transition medical benefits for all Medi-Cal members with UIS from managed care plans to the Medi-Cal Fee-for-Service delivery system. DHCS will no longer provide differential "wrap" payments for state-only medical services effective January 1, 2027. For dates of services between January 1, 2027, through June 30, 2027, FQHCs and RHCs will be eligible to bill PPS for state-only medical services through the Medi-Cal Fee-for-Service delivery system. For dates of services on or after July 1, 2027, FQHCs and RHCs will be required to submit claims for state-only medical services to the Medi-Cal FI, in accordance with the policy above. See below for policy on dental managed care.

[9] https://www.dhcs.ca.gov/wp-content/uploads/2026/08/Version-3.0-DHCS-Policy-Guide.pdf

Managed Care Dental Payments

Effective for dates of services on or after July 1, 2027, DHCS will transition dental benefits for all UIS members aged 19 and older from Dental MCPs to the Medi-Cal Dental FFS delivery system. DHCS will no longer provide differential "wrap" payments for state-only dental services provided to UIS members under 19 who remain in Dental MCPs effective July 1, 2027. Dental MCPs will continue to reimburse FQHCs and RHCs at contracted rates for services provided to UIS members under 19. See below for policy on emergency and pregnancy dental services.

Emergency and Pregnancy Services

Emergency and pregnancy-related FQHC and RHC services are federally covered services under Section 1903(v) of the Social Security Act and remain eligible for PPS reimbursement.

- FFS Medical: DHCS will continue to pay the PPS reimbursement rate for federally eligible pregnancy and emergency-related visits, identified through complete and appropriate service-level coding including procedure codes, diagnosis codes, modifiers, and emergency indicators on the claim consistent with the Medi-Cal Provider Manual.
- FFS Dental: For FFS emergency dental services provided to UIS members as well as non-emergency dental services provided to UIS members who are either pregnant or postpartum, FQHCs and RHCs should continue to bill the Medi-Cal FI for PPS reimbursement rates. DHCS has identified the Current Dental Terminology (CDT) codes for emergency dental procedures[10]. For emergency dental services, FQHCs and RHCs must report both the appropriate CDT code and emergency indicator on the claim.
- Managed Care Medical: Beginning on January 1, 2027, there will be no UIS members enrolled with a Medi-Cal MCP for medical services. See "FFS Medical" bullet for reimbursement policy for emergency and pregnancy medical services delivered to UIS members.
- Managed Care Dental: Emergency and pregnancy dental services for UIS members who remain enrolled with a Dental MCP after July 1, 2027, will be reimbursed at contracted rates for services and eligible for differential "wrap" payments.

Differential "Wrap" Payment Reconciliation

Effective for dates of service on or after January 1, 2027, Medi-Cal members with UIS will transition from the Medi-Cal MCP to the Medi-Cal FFS delivery system except as noted above for specified dental services. Following the transition, there will be no MCP

[10] https://www.dhcs.ca.gov/services/medi-cal-dental-benefit-changes/

differential rate (wrap) visits or payments for medical services to report on the annual Reconciliation Request. In addition, because UIS members are not eligible for Medicare, there will be no Medicare crossover visits or payments to report. DHCS will continue to provide differential "wrap" payments until July 1, 2027 for state-only dental services provided to UIS members under 19 who remain in Dental MCPs.

FFS Medical and Dental Implementation

To ensure continuity of care and assist FQHC and RHC clinics with the transition from PPS to non-PPS methodologies, DHCS will provide a timeliness override, effective six (6) months from the July 1, 2027, effective date. For dates of service from July 1, 2027, through December 1, 2027, FQHCs and RHCs will have the ability to submit medical FFS claims with the required individual service-level codes, including procedure codes, diagnosis codes, and emergency indicator on the claim consistent with the Medi-Cal Provider Manual, within 12 months without applying timeliness cutbacks. For these dates of service, FQHCs and RHCs will also have the ability to submit dental FFS claims with the required individual service-level codes using CDT codes on dental claims consistent with the Medi-Cal Dental Program Provider Handbook within 12 months without applying timeliness cutbacks. All applicable business rules, claim edits, and frequency limitations will still apply for all medical and dental FFS claims.

CLINIC POLICY LETTER ADOPTION:

Subdivision (r) of WIC section 14132.100 authorizes DHCS to implement, interpret, or make specific FQHC and RHC PPS reimbursement policies by means of policy letters without taking regulatory action, notwithstanding Chapter 3.5 of Part 1 of Division 3 of Title 2 of the Government Code (commencing with Section 11340). Therefore, this policy letter has the full force and effect of California law.

This CPL supersedes all prior guidance, bulletins, instructions, and regulations issued by DHCS on the matters described herein. DHCS reserves the right to modify, waive, or rescind any provision of this Policy Letter. This Policy Letter is not intended to, and does not, create any rights or benefits, substantive or procedural, enforceable at law or in equity, against the State of California, its agencies, departments, entities, officers, employees, or any other person.

A copy of this CPL is posted on the Medi-Cal FQHCs and RHCs website under Clinic PL 26-002.

If you have any questions regarding this Policy Letter, please contact the Medi-Cal FQHC and RHC inbox at: FQHCBenefitsandRates@dhcs.ca.gov.