

UIS to Fee-for-Service Transition

All-Comer Webinar
September 30, 2026
10 a.m.

Why This is Happening



Approximately
2 million Medi-Cal
members will be
affected.

- » Per new [federal guidance](#), federal Medicaid funding for members with UIS is only allowed for “actually furnished” (i.e., rendered) emergency services.
- » Managed care monthly capitation payments cannot be used because they are not directly for furnished services.
- » To maintain federal funding, California will move members with UIS to FFS, where providers are paid per service.

Keep In Mind

- » **Fee-for-Service ≠ member payment**
- » Under managed care, DHCS pays health plans monthly
- » In Fee-for-Service, DHCS pays providers per visit or service
- » Members **do not** pay fees or co-pays because of this change
- » Coverage remains as long as members stay eligible and renew on time

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.

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).

What This Means for Affected Medi-Cal Members



Members are not losing coverage; the way they get care is changing.

- » Eligible Medi-Cal members will continue receiving full-scope services.
- » Affected members will transition from their Medi-Cal managed care plan (MCP) to Medi-Cal FFS starting January 1, 2027.
- » Members will have access to enrolled Medi-Cal FFS providers (such as doctors, nurses, clinics, and hospitals).
- » Members will lose access to some services, such as Community Supports and Enhanced Care Management (ECM), which are only available in managed care.

Benefits Identification Card (BIC)



- » Members will use their Medi-Cal BIC for care starting January 1, 2027.
- » Their Medi-Cal health plan card will no longer be used in Fee-for-Service.
- » They must bring their BIC to every appointment so providers can confirm Medi-Cal coverage.
- » Members will not get a new BIC for this change. If a BIC is lost or damaged, members can request a replacement from their county Medi-Cal office or BenefitsCal.

What Doesn't Change?



- » Members with full-scope Medi-Cal will keep their medical, mental health, vision and substance use disorder coverage.
- » Due to the enrollment freeze implemented January 1, 2026, they must renew on time to keep their coverage.

- » Members enrolled in the Program of All-Inclusive Care for the Elderly (PACE) will remain in PACE plans.
- » Members in Community-Based Adult Services (CBAS) will continue to receive those services through Fee-for-Service.
- » Pharmacy benefits will continue to be provided through Medi-Cal Rx.



- » Dental benefits remain in place for most members until June 30, 2027
- » Members enrolled in Dental Managed Care (Sacramento and Los Angeles counties) will continue to have dental coverage through managed care.

Behavioral Health

» Non-Specialty Mental Health:

- Therapy, counseling, medication follow-up available through any enrolled Medi-Cal FFS provider
- “No Wrong Door” means providers help members get to the right care even if they start in the wrong system

» Specialty Mental Health and Substance Use Disorder Treatment:

- Delivered through County Behavioral Health Plans
- Members call County Behavioral Health Plan 24/7 Access Line
- Members do not need a referral from a doctor or clinic to call

» Crisis Support:

- Call or text 988

What Members Need to Do



Ask current provider: "Do you take Medi-Cal Fee-for-Service?"

If they don't, choose a new provider using the [Find Doctors and Services](#) tool



Call Medi-Cal at 1-800-541-5555 for help finding providers

Keep contact information [updated](#)



Renew Medi-Cal on time

Use the BIC; request replacements via county or BenefitsCal

What This Means for Plans and Providers

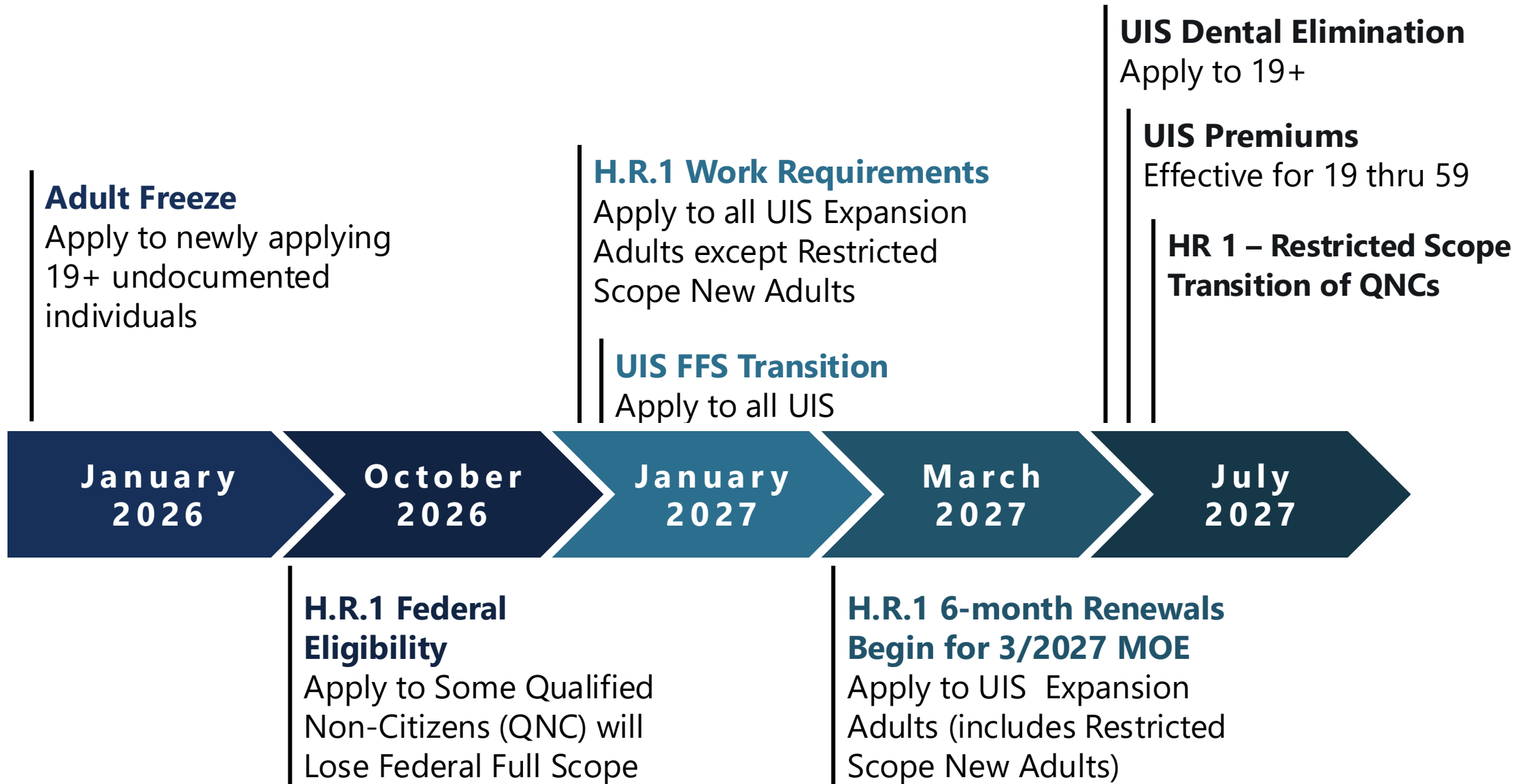
Medi-Cal MCPs

- » MCPs must maintain member services, care coordination, and care management functions throughout the transition period (through December 31, 2026) and respond to member and provider inquiries regarding changes in coverage and service access.
- » MCPs must support members in identifying their current providers and understanding whether the provider will continue to provide care for the member in Medi-Cal FFS.
- » MCPs must assist with provider communication and outreach through provider portal postings and other provider-facing communication channels, leveraging DHCS draft communication templates.
- » MCPs must work with DHCS to share data to support transitions of care and help minimize care disruption (especially for special/high risk populations) to the extent possible.

Medi-Cal Providers

- » Providers who do not regularly provide care to members in Medi-Cal FFS must reacquaint themselves with Medi-Cal coverage requirements, including utilization management controls, as outlined in the Medi-Cal Provider Manual.
- » Providers who do not regularly use the Medi-Cal FFS billing systems must reacquaint themselves with Medi-Cal FFS billing requirements, such as how to submit authorization requests and claims, both on paper and electronically.
- » In areas with fewer Medi-Cal FFS providers, existing Medi-Cal FFS providers may see an increase in appointment requests as members transition.

Eligibility Changes Impacting UIS



How DHCS is Preparing for the Transition

Guiding Principles for the Transition

- » **Member-Centered:** Minimize disruption and harm, protect members with complex needs, and provide clear and accessible navigation support.
- » **Provider Readiness:** Assess active provider capacity, deliver timely guidance and resources, and simplify billing, authorization, and referrals.
- » **Partnership:** Coordinate across MCPs, providers, and counties, support timely, accurate information exchange, and use feedback loops to improve implementation.
- » **Operational Stability:** Maintain service levels, leverage existing infrastructure, and work within current constraints while building forward.
- » **Transparency and Accountability:** Engage stakeholders early and regularly, respond clearly to feedback and access issues, and establish and monitor success measures.
- » **Federal and State Compliance:** Comply with applicable requirements, protect member rights and program integrity, and sustain compliance throughout the transition.

Transition of Care – Recent Data Insights



1.93M

Total UIS members (April)

~**251K** Children (under 21)

1.21M

Members with UIS who utilized services in managed care over the last 12 months



151K

Managed care providers serving UIS members*

~**86K**

Providers enrolled and meaningfully FFS-active*

~**45K**

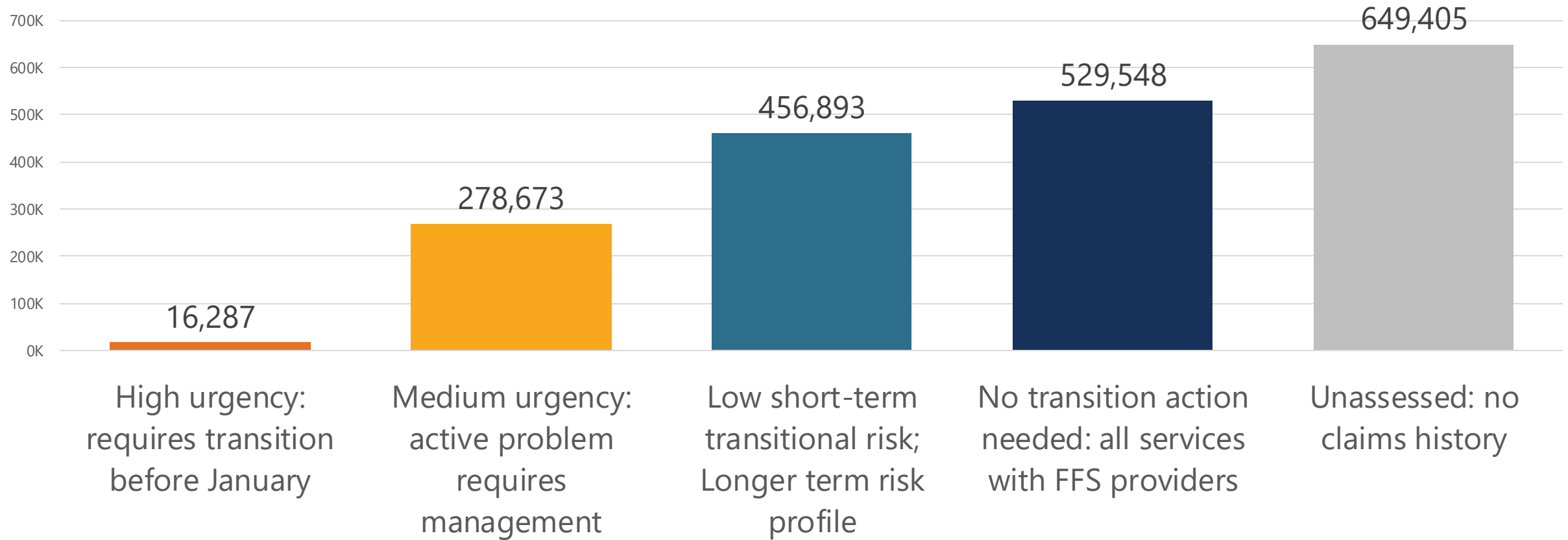
Providers enrolled but not meaningfully FFS-active*

~**20K**

Providers not enrolled in FFS*

*Note: all numbers on this slide are preliminary.

Risk Stratification Distribution for Members Transitioning (1/2)



*Note: all numbers on this slide are preliminary.

Risk Stratification Distribution for Members Transitioning (2/2)

High/medium urgency. 16,287 members carry the most urgent risk with critical continuity of care risk; another 278,673 have an active problem, like dialysis, at a not-ready facility or withdrawal-risk medications with an exposed prescriber — which require active management.

Low short-term risk. 456,893 carry a longer-term risk profile (special populations whose current services are with providers who already bill FFS or members who are not part of a special population and have less risk).

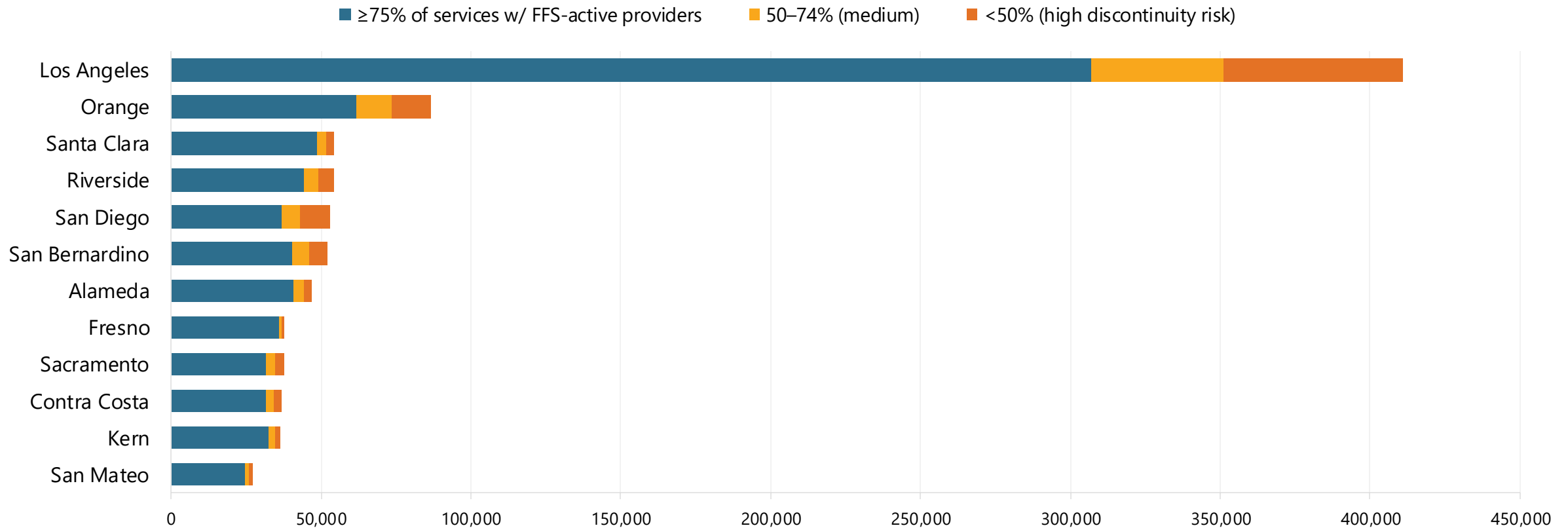
No transition action/unassessed. 529,548 members do not need to take action, because every service they use is already with an active FFS provider. 649,405 are unassessed with no claims history, so we cannot tell if they are healthy or disconnected from care.

DHCS will continue to run analytics on a weekly basis and will do a comparison with Managed Care utilization data to further stratify member risk.

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Managed Care Utilization and FFS Discontinuity Risk by County

For every UIS member with managed care utilization, below shows the share of their current services delivered by FFS providers already active in FFS. Members below 50% depend mostly on providers who are not billing FFS. Six counties account for 80.4% of high-risk members.



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DHCS Transition Support

MCPs

- » [MCP Transition Guide](#) (iterative)
- » Whole-Child Model (WCM) Policy Guidance

Members

- » Member Outreach and Support
- » [Find Doctors and Services](#) Tool
- » Clinic and Community-Based Organization Navigation
- » Care Coordination and Care Management

Providers

- » Provider-Focused Communications
- » Targeted Provider Outreach Strategy
- » Additional Provider Trainings

California Children's Services (CCS) Program

- » Members enrolled in county 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.
- » DHCS is partnering with Whole Child Model (WCM) counties and WCM MCPs to shift care management functions of members with UIS to the county CCS program.
 - Case management services will shift to the county CCS programs, and adjudications of service authorization requests will shift to DHCS in dependent counties and the county CCS program in independent counties.
 - Member care will transition from their WCM MCP to a Medi-Cal FFS provider.
- » More details have been provided in Numbered Letter 03-0926 (released 9/1/2026) to CCS County Administrators. Requirements for MCPs vary by the CCS program model type. An [All-Plan Letter](#) released September 1, 2026 provides guidance specific to MCP noticing and supporting members receiving CCS.
- » Children and youth enrolled in CCS with complex needs beyond their CCS condition(s) who have been enrolled with ECM providers (predominantly specialty care providers who have capabilities to manage both complex health care and social needs) will be handled on a case-by-case basis, according to member needs.

Member-Focused Outreach and Support

Member-focused outreach and support will roll out in a phased approach.

- » **Summer – Fall 2026 (Awareness):** [Foundational materials](#) — talking points, FAQs, fact sheet, toolkit resources shared with MCPs, counties, providers, and CBOs. [Member-focused webpage](#) provides clear, plain-language information for affected members, while [stakeholder page](#) provides more detail. [Find Doctors and Services tool](#) updated, with more enhancements by December 2026.
- » **Fall 2026–January 2027 (Readiness):** [Member notices](#) sent by December 1, 2026; multilingual text-message campaign; updated materials for Coverage Ambassadors, counties, CHWs, promotoras, Tribal reps, and CBOs; targeted ethnic/community/digital media; and an expanded Help Line. Members may use MCP call centers through December 31, 2026.
- » **January 2027 onward (Member Action):** Plain-language guidance on finding providers and accessing care; [complaint](#) and [appeal](#) support. On January 1, DHCS will launch the new Medi-Cal Fee-for-Service Nurse Advice Line.

UIS Transition Clinic and CBO Navigation

- » \$8 million State General Fund investment for contracts with clinics and CBOs to deliver culturally and linguistically appropriate navigation services.
- » DHCS is partnering with California Primary Care Association (CPCA) to implement this effort and administer sub-awards to subcontractors.
- » CPCA and its subcontractors will provide support to UIS members as they move from managed care to FFS.
 - Navigators will help affected members understand these changes and connect them with services.
 - The emphasis will be on assisting individuals on navigating this transition, retaining their coverage, and managing care coordination.
- » Target contract implementation date: January 1, 2027.
- » Investments in media, navigators, and care coordination services will be braided and coordinated with similar investments and resources in helping members, including UIS members, with navigating HR 1 work requirements.

Care Coordination and Care Management

- » DHCS is contracting with a vendor to provide a statewide care coordination and care management function and to coordinate with local health care delivery partners.
- » Priority will be transitional care management, and focused on individuals with highest clinical risk to minimize care disruption.
- » DHCS will proactively identify and engage members identified as high risk through analytics, as well as through referral pathways (from our call centers/Nurse Advice Line, CBOs, and MCPs).
- » The vendor will leverage partner engagement locally to connect to care management services, and clinical care.
 - Vendor will actively engage Federal Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and other providers to encourage them to accept more members.

Provider Engagement

Provider-Focused Communications

- » [Providers and Partners Page](#).
- » [Provider FAQ](#).
- » [Provider Bulletin](#) (published September 11, 2026).
- » MCP requirements for general provider communications through established channels.
- » MCP requirements for communications to specific provider types (e.g., Primary Care Physicians, ECM Providers, Community Supports Providers).

Targeted Provider Outreach Strategy

- » Multi-phased, data-driven, targeted outreach strategy.
- » Tailored messaging based on provider status (e.g., not enrolled in FFS Medi-Cal, enrolled in FFS Medi-Cal but not actively billing, and actively enrolled in Medi-Cal with capacity to accept more patients).
- » Target known priority areas and services (e.g., transportation providers, Los Angeles County).
- » Interventions range from high-level relationship management to on-the-ground vendor-supported provider engagement.

Medi-Cal Member Resources

These Medi-Cal member resources provide easy access to key information, tools, and guidance to help members understand the FFS transition and access support.

- » [FFS Transition All-Comer Webinar](#)
- » [What Medi-Cal Members Need to Know](#)
- » [Member-Focused Webpage](#)
- » [Stakeholder Page](#)
- » [Find Doctors and Services Tool](#)
- » [Medi-Cal Changes Toolkit](#)
 - » [General Fact Sheet](#)
 - » [Member FAQ](#)
 - » [Provider FAQ](#)
- » [How to File a Complaint](#)
- » [How to File an Appeal](#)



Join the network: Scan the code or visit www.dhcs.ca.gov/coverage-ambassadors to sign up.

Become a Coverage Ambassador

Help your community stay covered.

Many Californians are navigating changes to Medi-Cal. Coverage Ambassadors are trusted messengers who help members stay informed and understand what to do to keep vital health benefits.

Ambassadors:

- » Stay up-to-date on Medi-Cal information through regular webinars and newsletters.
- » Educate members about key deadlines and upcoming changes.
- » Help members understand steps to keep their coverage.
- » Share multilingual flyers, FAQs, and social media content.
- » Provide feedback on outreach materials.
- » Stay connected to CalHHS outreach on coming federal changes to CalFresh, Covered California, data sharing, and public charge.

Thank you!

