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

Version 2.0 – Sept. 01, 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 21, 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**.
Version 2.0	Sept. 01, 2026	The second release of the Policy Guide contains updates based on plan and association feedback to the initial release v1.0 and greatly expands on targeted Provider communications including: • Updated definition of Unsatisfactory Immigration Status (UIS) in the Key Terms section to include clarification on QNC members. • Added "Grievance & Appeals" and "Vision" as Domains, updated the "Provider Enrollment, Service Authorizations, and Claims Payment" Domain in Table 2, Key differences between Medi-Cal FFS and managed care affecting Members and Providers during this transition. Updates to the What is Not Changing with this Transition section, clarifying the section pertains to

		current services carved out of managed care; therefore, the delivery system for members does not change. • Added details on roles of counties and DHCS in the Members with UIS Enrolled in a Whole Child Model (WCM) Managed Care Plan section. • Replaced the Care Management section with new Members with UIS Receiving Enhanced Care Management (ECM), California Integrated Care Management (CICM), Community Supports, Complex Care Management (CCM), and Transitional Care Services (TCS), • Added details to numbered list item "4" in the Transition of Care Requirements section. • Added Treatment Authorization Request (TAR) Special Handling Process section. • Updated the Special Populations section to Transition Support For High Risk Members (including Special Populations). • Removed "Enrolled in 1915(c) waiver programs", added "Receiving chemotherapy", "Receiving radiation", and "Living with a seizure or neurological disorder", and edited "Prescribed DME" items listed in Table 3 List of Special Populations. • Added "California Children's Services – Member Notification" section and template to Appendix D. • Updated Notice of Termination of MCP-Provided ECM and Community Supports section to Notice of Termination of MCP-Provided ECM, CICM, Community Supports, CCM, and TCS and updated content to reflect. • Retitled "Medi-Cal FFS Find-A-Provider Search Tool" to "Medi-Cal Find Doctors & Services Application". • Added content to the "General Communications" and "Member Microsite: Fee-for-Service Transition" subsections to "Member Resources" section. • "Member Data Sharing" section updated to "Summary of Requirements".

		• Updated Table 4 Summary of MCP Provided Data Files and the list of excel templates for submission of MCP Data to DHCS. • Added data sharing requirements for CCS Members. • Added intended use of requested data for Transitioning Member Identifying Data, Transitioning Member Utilization Data, and Transitioning Member Authorization Data. • Added brief introduction to the Provider Communications to Enable Continuity section. • Expanded the Targeted Provider Communication section to include outreach requirements for PC, ECM, CICM, CCM, Community Supports, and CHW providers, and Long-Term Care Facilities. • Updated the Provider Communicate template provided in Appendix B. • Added new ECM, CICM, Community Supports, CCM, TCS, and CHW Provider Communication Template in Appendix C.

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 receive 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 access to Medi-Cal FFS providers 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. Members receiving care management services should be actively supported by their care managers for this transition.

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. After October 1, 2026, due to H.R. 1. changes, only lawful permanent residents (if they have met or been exempted from the 5-year bar), Cuban/Haitian entrants, and Compact of Free Association (COFA) migrants will be considered QNCs. 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). Starting October 1, 2026, due to H.R. 1. changes, only lawful permanent residents (if they have met or been exempted from the 5-year bar), Cuban/Haitian entrants, and Compact of Free Association (COFA) migrants will be considered Qualified Non-Citizens (QNC). Members who are no longer considered QNC after October 1, 2026, will be categorized as UIS. Through December 31, 2026, the UIS indicator shared with MCPs on eligibility files will not include the members shifting out of QNC; however, these shifting QNC members will be included as UIS starting January 1, 2027. For more information on immigration statuses and eligibility for Medi-Cal

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

covered services, see DHCS' Immigration Status and Changes to Medi-Cal Eligibility web page.

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.	Members select or are assigned a PCP who is responsible for delivering Primary Care services, making referrals, leading care management, and coordinating

Domain	Fee-for-Service	Managed Care
	Such providers may include general practitioners, internists, family medicine physicians, pediatricians, and OB/GYNs. There is no requirement for members to be "assigned" to a PCP.	with a care management team as needed.
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. MCPs may apply utilization management techniques (including prior authorization criteria) to ensure coverage of medically necessary services in alignment with Medi-Cal coverage policies. 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	DHCS establishes managed care coverage policy through the MCP Contract, All Plan Letters, policy guides (e.g., CalAIM: Population

Domain	Fee-for-Service	Managed Care
	provider bulletins. These materials set forth Medi-Cal FFS policy and implementation guidance.	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, Care Management, and Care Coordination	These services are partly covered in Medi-Cal FFS. Under the Medi-Cal FFS delivery 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 member 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.	MCPs are required to stratify and identify Members by risk, conduct outreach and engagement (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	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
	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, 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. Members who have transitioned from managed care to Medi-Cal FFS 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	MCPs cover Non-Specialty Mental Health Services in alignment with Medi-Cal FFS policy through their Network Providers.

Domain	Fee-for-Service	Managed Care
	outpatient laboratory, drugs, supplies, and supplements.	
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 of DME include infusion equipment, oxygen and respiratory equipment, speech generating devices, therapeutic mattresses and bed products, wheelchairs and wheelchair accessories, and more.	MCPs cover DME services in alignment with Medi-Cal FFS policy through their Network Providers.
Vision	Vision services are covered through Medi-Cal FFS. Covered services include routine eye examinations and eyeglasses (frames and prescription lenses), generally once every 24 months; more frequent exams and replacement eyeglasses are covered when medically necessary or other coverage criteria are met. Certain contact lens services, low-vision services, and artificial eye services may also be covered under certain circumstances. Prescription lenses are generally fabricated through CalPIA optical laboratories.	Vision services are covered by the MCP. MCPs must cover and arrange for eye examinations and prescriptions for corrective lenses and ensure members receive covered eyeglasses. MCPs must generally arrange for prescription lenses to be fabricated through CalPIA; DHCS pays CalPIA for fabrication, while the MCP is responsible for the eye examination and dispensing. If required covered lenses are not available through CalPIA, the MCP must cover their fabrication and dispensing.
Grievances & Appeals	Members have the right to file Grievances, Appeals, and State	Members have the right to file Grievances, Appeals, and State

Domain	Fee-for-Service	Managed Care
	Hearing requests and may file a complaint with DHCS following the process described here: File a Complaint Members are issued a Notice of Action (NOA), which is a formal notice from DHCS that must include the eligibility determination for covered services. NOAs are required whenever there is an "adverse benefit determination", which may be a denial or modification.	Hearing requests. Members enrolled in Knox-Keene licensed MCPs also have the right to request an Independent Medical Review through the Department of Managed Health Care. MCPs communicate this information through Member facing portals and the Member Handbook. Members are issued Notices of Action (NOA) for a variety of reasons including if service requests are denied or modified, but also relating to timeliness of services, Member requests to obtain out-of-Network care, and other actions as described in the MCP Contract, Ex. A, Att. I, Section 1.0 (*Definitions*).

What is Not Changing with this Transition: Services Currently Carved out of Managed Care

Certain Medi-Cal services are currently carved out of the managed care delivery system. These services will remain carved out following the UIS transition. Accordingly for these benefits and services, the delivery system for UIS members will not change as result of their transition from managed care to Medi-Cal FFS; members will continue to access these services through the same delivery system that serves them today.

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).

Children's Health Insurance Program Reauthorization Act 214 (CHIPRA): The Children's Health Insurance Program Reauthorization Act (CHIPRA) 214 pregnant or postpartum members are not impacted by the transition.

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 Program. 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: 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 CCS with additional needs beyond their CCS condition(s) 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.

Dental Services

Transitioning from an MCP to Medi-Cal FFS does not change the member's dental delivery system or dental benefit as dental services is already carved out of the medical MCP. Dental services are covered through Medi-Cal Dental FFS or a Dental Managed Care (DMC) plan. Covered services include preventive and diagnostic services (e.g., exams, X-rays, and cleanings), fillings, extractions, root canals, crowns, periodontal services, dentures, emergency dental services, and qualifying orthodontic services for children. Dental services are provided separately through Medi-Cal Dental FFS or, where applicable, a DMC plan. DMC plans cover the same dental benefits available through Medi-Cal Dental FFS. DMC operates in Sacramento County (generally mandatory) and Los Angeles County (voluntary).[2]

[2] The separate immigration-status-related reduction in adult dental coverage has now been delayed until July 1, 2027.

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, if 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 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. 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 WCM MCPs to shift care management functions of Members with UIS to the County CCS Program. More details are forthcoming in a Numbered Letter to CCS County Administrators. Requirements pertaining to MCPs are outlined in this document under the Member-Facing Materials and Communications, Data Sharing Requirements, and Provider Communication to Enable Continuity sections of this Policy Guide. In addition, APL-26-016 provides an overview of the overarching policies pertaining to CCS Program and outlines which Counties are in Classic or Whole Child Model; or Independent or Dependent Counties, as requirement for MCPs vary by the CCS Program model type. Again, *Requirements* are outlined in this document.

Note: 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 CCS WCM with additional needs beyond their CCS condition(s) 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.

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.

Members with UIS Receiving Enhanced Care Management (ECM), California Integrated Care Management (CICM), Community Supports, Complex Care Management (CCM), and Transitional Care Services (TCS)

Members with UIS who are currently receiving ECM, Community Supports, CCM, and TCS through Medi-Cal managed care will no longer have access to these services once they transition to the Medi-Cal FFS delivery system, as these services are not available under Medi-Cal FFS. Members will also no longer have access to California Integrated Care Management (CICM), which is provided in place of ECM to applicable dual eligible Members through the MCP's affiliated D-SNP.[3]

Exception: Some members with UIS may be able to enroll in Medi-Cal managed care if they are pregnant or post-partum under Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA 214). These members will still have access to Medi-Cal managed care services, including ECM, Community Supports, CCM, and TCS, while they are in managed care during the perinatal and postpartum periods.

Members may continue to access and receive Community Health Worker (CHW) services through Medi-Cal FFS. CHW services are preventive health services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and mental health and well-being. CHW services may assist with a variety of concerns impacting MCP members, including but not limited to, the control and prevention of chronic conditions or infectious diseases, behavioral health conditions, and need for preventive services. CHWs may include individuals known by a variety of job titles, including promoters, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals. CHWs often work in collaboration with primary care providers and care management teams and can help address care management needs to the extent they are within their scope.

DHCS recognizes the significance of these care management and supportive services and continues to actively evaluate which Medi-Cal FFS care management functions, such as Principal Care Management, Chronic Care Management, and CHW services, may

[3] 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).

serve as potential replacements to continue supporting transitioning Members. *More details are forthcoming*.

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.[4]

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

Through December 31, 2026, 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, Care Coordination, and care management functions throughout the transition period (i.e., December 31, 2026) and respond to Member and Provider inquiries regarding changes in coverage and service

[4] 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.

access. This includes supporting Members in identifying their current Providers and understanding whether the Provider will continue to provide care for the Member in Medi-Cal FFS. If not, MCPs must provide Care Coordination and care management to ensure that the Member's care is transitioned to another provider.

5. Assist Members and Providers in understanding how services will be accessed under Medi-Cal FFS, leveraging information provided by DHCS.

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

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 accepting patients 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. 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 a 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 these members by ensuring their enrollment as Medi-Cal FFS providers using DHCS-provided information and templates. See the Provider Communications to Enable Continuity section of this Policy Guide for more information.

Treatment Authorization Request (TAR) Special Handling Process

To prevent delays in service, DHCS will implement a new Treatment Authorization Request (TAR) special handling option to support Members transitioning from MCPs to Medi-Cal FFS. This option will be available when DHCS has a MCP authorization on record for a service and a Medi-Cal FFS provider is requesting a new authorization for

the same service. Medi-Cal FFS Providers will still need to complete an eTAR with its minimum requirements; however, free-form attachments will not be necessary.

Additionally, DHCS will accept TARs for services for Members with UIS for dates of service on or after January 1, 2027, starting October 1, 2026.

DHCS will alert providers of this option through the Medi-Cal Provider Portal and publish a Frequently Asked Questions document to support Providers through the process. Plans must continue to authorize services through December 31, 2026. For authorizations received by the MCP prior to January 1, 2027, for services on or after January 1, 2027, MCPs have the option to continue processing provider authorizations, or referring the provider to submit a TAR through the DHCS' Medi-Cal FFS TAR process (after October 1, 2026).

TRANSITION SUPPORT FOR HIGH RISK MEMBERS (INCLUDING 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 with higher risk of service disruption 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.

DHCS has identified Members with UIS that are higher risk based on:

- Meeting qualifying criteria for Special Populations; and
- Having anticipated service gaps based on the Member's current providers not actively billing Medi-Cal FFS.

Under this Policy Guide, DHCS requires MCPs to focus attention and resources on transitioning Members who have been identified by DHCS as high risk as well as Members the MCP has identified using additional criteria.

DHCS is currently refining its analysis for Member risk and will provide details on timing for sharing member lists as well as data requirements for MCPs related to high risk populations in the next release of this Policy Guide.

Updated criteria for Special Populations are listed in the table below, with new populations included for the UIS Transition noted as "New."

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 or CICM services[5]
» Adults and children with authorizations to receive Community Supports[6]
» Adults and children receiving Complex Care Management[7]
» Receiving In-Home Supportive Services (IHSS)
» Children and youth enrolled in CCS/CCS WCM

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

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

[7] "Complex Care Management" is the same as "complex case management" as defined by the National Committee for Quality Assurance (NCQA).

Members Who Are:
» 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 or receiving ongoing dialysis. » Living with an intellectual or developmental disability diagnosis » Living with a dementia diagnosis » 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 » Prescribed DME » Receiving Community-Based Adult Services » NEW: Receiving chemotherapy » NEW: Receiving radiation » NEW: Living with a seizure or neurological disorder

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

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 their 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.

California Children's Services – Member Notification

MCPs must notify families who are enrolled in California Children's Services to ensure that they are aware that their CCS benefits will continue. In addition, the messaging will

vary depending on whether the MCP's member is in a Whole Child Model CCS County or a Classic CCS County. Please see Appendix D for the approved template that MCPs may use to conduct the early outreach to families. Please note the MCPs have the flexibility to include additional detailed information pertaining to how Members can navigate services within the county.

Notice of Termination of MCP-Provided ECM, CICM, Community Supports, CCM, and TCS

MCPs must identify Members with UIS who are receiving ECM, CICM, Community Supports, CCM, and TCS and notify them that, as of January 1, 2027, these managed care services will be terminated. MCPs (or in the case of CICM, their affiliated D-SNPs) must continue to authorize, deliver, and pay for ECM[9], CICM[10], Community Supports[11], CCM[12], and TCS[13], through December 31, 2026, to eligible Members with UIS. Referrals for these services received through December 31, 2026, must be reviewed and, if Members meet the criteria, be authorized for services through December 31, 2026. DHCS recognizes the significance of these care management and supportive services and continues to evaluate which Medi-Cal FFS care management functions, such as principal care management, chronic care management, and CHW services, may be used to continue supporting transitioning Members. *More details are forthcoming*.

Furthermore, MCPs must direct ECM, CICM, Community Supports, CCM, and TCS Providers to actively support transitioning Members in seeking alternative services. MCPs are also encouraged to provide resources and referrals to Members directly to supplement, but not replace, required communications through care management Providers. See the Provider Communications to Enable Continuity section of this Policy Guide for more information. Support provided to transitioning Members may include, but is not limited to, identifying, facilitating referrals to, and ensuring connection 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

[9] MCP Contract, Ex. A, Att. III, Section 4.4 (*Enhanced Care Management*).

[10] State Medicaid Agency Contract (SMAC), Ex. A, Att. 1, Section 1.G.8.

[11] MCP Contract, Ex. A, Att. III, Section 4.5 (*Community Supports*).

[12] MCP Contract, Ex. A, Att. III, Subsection 4.3.7 (*Care Management Programs*).

[13] MCP Contract, Ex. A, Att. III, Subsection 4.3.10 (*Transitional Care Services*).

resources, local community-based organizations, etc.). MCPs are encouraged to always leverage existing, trusted care Providers whenever possible.

Member Resources

MCPs must provide information to Members on how to determine whether their Providers participate in Medi-Cal FFS. *Additional guidance regarding MCP outreach to Members is forthcoming.*

Medi-Cal Find Doctors & Services Application

To support Members in finding a Medi-Cal FFS provider, DHCS has developed the new Find Doctors & Services tool. Members can use this tool to search for Medi-Cal FFS providers by location, provider type, or provider specialty. DHCS will continue to enhance the new app, with additional data improvements. For providers and call center staff, the pre-existing Medi-Cal Fee-For-Service Provider Finder remains available as an additional resource.

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.

Member Microsite: Fee-for-Service Transition

DHCS has launched the following public facing website to support this transition: https://www.dhcs.ca.gov/medi-cal/updates/fee-for-service-transition/.

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, frequently asked questions, 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 responds to inquiries from media and stakeholders, issues holding statements, and publishes web updates to reflect the change in the federal policy and upcoming transition.

To support broad member awareness and minimize confusion, OC will incorporate texting as part of its outreach strategy. Text messages will provide simple, direct reminders to potentially impacted members about upcoming changes, key dates, and how members can confirm or navigate their coverage. Messaging will ensure clarity, accessibility, and alignment with DHCS' plain-language standards.

OC will also develop a paid advertising strategy to reinforce transition messaging across multiple channels. Paid efforts may include digital advertising, social media promotion, radio, print, and other formats. Ethnic media partnerships will be prioritized to ensure information reaches communities with limited English proficiency or limited access to traditional media, using culturally relevant and multilingual messaging.

MCPs' 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.

While the UIS indicator is protected health information under the Health Insurance Portability and Accountability Act (HIPAA) since it relates to the provision or payment of health care of an individual, and must be handled in compliance with HIPAA, the California Confidentiality of Medical Information Act, and all applicable laws and regulations, with the same level of sensitivity as required by these laws, we expect MCPs to use and exchange information for the purposes of care management and care coordination for this population.

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

Summary of Requirements

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. MCPs must transmit all data to DHCS in a manner consistent with the safeguards outlined and required within the MCP Contract. DHCS will perform verification checks to confirm successful data sharing according to timeliness and quality expectations as outlined in Exhibit A, Attachment III, Subsection 1.1.37 (*Data Sharing*) of the MCP Boilerplate Contract. 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), contact information and PCP for transitioning Members	One file due December 7, 2026, no refreshes

File	Description	Refresh Frequency
B. Transitioning Member Utilization Data	Claims and encounter information for transitioning Members	One file due December 7, 2026, no refreshes
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 MCPs must share data files with DHCS via SFTP, location DHCS-MCOD-Operations/PlanName/UIST.004_Member_Auth Data Further guidance on submission requirements can be found in the Transition of Care Template - Member Authorization Data Workbook, "Additional Guidance and Notes."
D. Transitioning Member NEMT/NMT Schedule and Physician Certification Statement Data	Scheduled transportation information for transitioning Members	*Details forthcoming*
E. High Risk Member Disposition Data	Status of transition to new providers for high-risk members identified by DHCS, addition of high-risk members identified by the MCP, and supplemental information to support care	*Details forthcoming*

File	Description	Refresh Frequency
	coordination handoffs to Medi-Cal FFS.	

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

Data Sharing Requirements for CCS Members

Please see APL-26-016 for an overview of the overarching policies pertaining to CCS Program and outlines which Counties are in Classic or Whole Child Model; or Independent or Dependent Counties, as requirements for MCPs vary by the CCS Program model type.

Prior to January 1, 2027, while all MCPs must take steps to prepare for the transition from managed care to County CCS Program for their CCS members with UIS, WCM MCPs have additional requirements to share data as outlined below.

By October 1, 2026, DHCS will provide all MCPs with a list of CCS members with UIS who will need to be transitioned from their MCP to the CCS County Program.

Transition Plan For all Transitioning California Children's Services Members

By October 15, 2026, MCPs must submit to DHCS via SFTP folder, *Transition Plan For all Transitioning California Children's Services Members (Deliverable UIST.0001*). This document provides details on the planning efforts MCPs are undertaking including:

- Transition of authorized services (leverage UIST.0005 Deliverable).
- Provider Communication to enable continuity of provider access to CCS paneled providers and specialty care centers actively treating CCS Members (leverage the Provider Communication guidance outlined in the Provider Communications to Enable Continuity section of this Policy Guide for more information.
- Member Outreach (leverage the Member Communication Templates outlined in the Section above.

Member Authorization Data

By November 15, 2026, MCPs must submit to DHCS via SFTP folder *Member Authorization Data UIST.0005.xlsx*. This file will be used by DHCS, and to share with CCS Independent Counties the information necessary to ensure continued SARs for eligible members to the extent feasible.

Transitions of Care Plans to Enable Continuity of Case Management for WCM MCPs

No later than November 1, 2026, WCM MCPs must provide the County CCS Program with a CCS Transition of Care Plan for each CCS member with UIS who will be transitioned out of the WCM MCP. The CCS Transition of Care Plan will assist the County CCS Program in providing continuation of CCS Program-covered services to CCS members with UIS.

All CCS Transition of Care Plans must be in Portable Document Format (PDF) format. The County CCS Program and WCM MCP are required to work together to establish a mutually agreed format for sending the CCS Transition of Care Plans. The County CCS Program must work with the WCM MCP's CCS liaison to resolve any questions or concerns about the CCS Transition of Care Plan.

The CCS Transition of Care Plan must include:

- Most recent care management plan(s), including Transition to Adulthood care plans;
- Plan for each member's care. The plan for each Member's care must identify if care will continue with each of their existing providers or require new providers. If a new provider is required, the plan must include the information of each new provider(s). If this is not yet available on November 1, 2026, this information must be made available prior to December 31, 2026;
- Current authorized CCS services and treatment including clinical documentation supporting the services; and
- A list of DME and Provider contact information.

Note: For one-time DME authorizations, the WCM MCP must ensure CCS members with UIS receive their approved DME by December 1, 2026. Subsequent or reoccurring DME must be authorized by December 31, 2026. The WCM MCP is responsible for payment and delivery of DME when authorized on or before December 31, 2026, even in cases where the DME is delivered after January 1, 2027.

County CCS Programs may request the following additional documentation from WCM MCPs for continuation of CCS Program covered services for the following categories:

- Authorizations issued for CCS eligible conditions;
- Clinical documentations submitted in support of authorizations issued for CCS eligible conditions;
- Care plans; and

- Member contact information.

By December 1, 2026, WCM MCPs must submit to DHCS via SFTP folder, a signed Attestation confirming that the CCS Transition of Care Plans and clinical documentation supporting the service authorization pertaining to the CCS eligible condition was submitted to the County CCS Program directly. *This new template will be provided by DHCS at the forthcoming update of this Policy Guide.*

Submission of MCP Data to DHCS: Templates

DHCS will compile the outlined data elements above into three 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.

1. Transition of Care Data Template - 1) Member Authorization Data 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.

- This is deliverable UIST.0004 outlined in version 1.0 of the DHCS Work Plan for Unsatisfactory Immigration Status Transition (UIS-T) Deliverables released Monday, July 27, 2026. DHCS released an updated template for use via email from the DHCS MCOD Readiness mailbox on Tuesday, August 25, 2026.

2. Transition of Care Data Template – 3) Transitioning Member Data

- MCPs must use this template to prepare Member level data files for transitioning Members in accordance with requirements outlined in the section below. This template will be used to report the data described in Tables 5, 6, 7, 9 and 10 below.

- Release to plans forthcoming.

3. Transition of Care Data Template - 3) High Risk Member Disposition Data

- MCPs must use this template to send additional high-risk Members identified by the MCP and status/dispositioning for all high risk Members on the file.
- Release to plans forthcoming.

A. Transitioning Member Data

Required Data Elements

MCPs must share *Transitioning Member 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. This information will be used to support care coordination for transitioning Members with the most recent contact information and Primary Care Provider information available.

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[14]	Numeric 3-digit, Text
Member Homelessness Indicator[15]	Numeric, 1-digit, Text
Member Residential Address[16]	Alpha-numeric, Text
Member Residential City[17]	Alpha-numeric, Text
Member Residential Zip Code[18]	Alpha-numeric, Text
Member Mailing Address[19]	Alpha-numeric, Text
Member Mailing City[20]	Alpha-numeric, Text
Member Mailing Zip Code[21]	Numeric, 5-digit

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

[15] 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".

[16] 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.

[17] 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.

[18] 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.

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

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

[21] 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.

Data Element	Format
Member Phone Number[22]	Numeric, 10-digit
Member Email Address	Alpha-Numeric, Text
Member's Preferred Form of Contact[23]	Alpha-Numeric, Text
Description of Member's Selected Alternative Format[24]	Alpha-Numeric, Text
Member's Preferred Language (Spoken)[25]	Alpha-Numeric, Text
Member's Preferred Language (Written)[26]	Alpha-Numeric, Text

Table 5 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[27]	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

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

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

[24] 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".

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

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

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

Data Element	Format
Last Visit Date[28]	MM/DD/YYYY, Date

B. Transitioning Member Utilization Data

Required Data Elements

MCPs must share *Transitioning Member Data* files with DHCS in accordance with the required data elements and format outlined in Table 7, Transitioning Member Claims / Encounter Information. This information will be used to support care coordination for transitioning Members with the most recent service utilization data available to assess Member risk.

Table 6 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[29]	Alpha-Numeric, Text
HCPCS Modifier[30]	Alpha-Numeric, Text
Revenue Code[31]	Numeric, 4-digit, Text
Place of Service[32]	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

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

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

[30] 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.

[31] 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.

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

Data Element	Format
Billing Provider Phone Number[33]	Numeric, 10-digit
Billing Provider Tax Identification Number (TIN)	Numeric, 9-digit, Text
Rendering Provider Specialty Type[34]	Alpha-Numeric 9-digit, Text
Rendering Provider NPI	Alpha-Numeric, Text
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[35]	Alpha-Numeric, Text
Diagnosis Code 2[36]	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. Please provide the data file in csv format.

Table 7 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

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

[34] Standard taxonomy codes issued by the NUCC, available at https://taxonomy.nucc.org/. If number not available to the MCP, MCP may report "0000000000".

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

[36] 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.

Data Element	Format
Requesting Provider Phone Number[37]	Numeric, 10-digit
Requesting Facility Name	Alpha-numeric, Text
Requesting Facility NPI	Numeric, 10-digit, Text
Requesting Facility Phone Number[38]	Numeric, 10-digit
Rendering Provider Name	Alpha-numeric, Text
Rendering Provider NPI	Numeric, 10-digit, Text
Rendering Provider Phone Number[39]	Numeric, 10-digit
Rendering Facility Name	Alpha-numeric, Text
Rendering Facility NPI	Numeric, 10-digit, Text
Rendering Facility Phone Number[40]	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[41]	Alpha-Numeric, Text
Diagnosis Description	Alpha-Numeric, Text
Authorization Status[42]	Alpha-Numeric, Text
Authorization Type	Leave Blank
Previous MCP Authorization Number	Alpha-Numeric, Text
Discharge Status	Alpha-Numeric, Text

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

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

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

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

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

[42] 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 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 8 Transitioning Member NEMT/NMT Schedule Data

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Level Of Transportation Service[43]	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[44]	Numeric, 1-digit, Text
Member Phone Number[45]	Numeric, 10-digit
Pickup Location[46]	Alpha-Numeric, Text
Pickup Address	Alpha-Numeric, Text
LTC/SNF Phone Number [47]	Numeric, 10-digit
Mode of Transport[48]	Alpha-Numeric, Text
Transportation Provider Name	Alpha-Numeric, Text
Transportation Provider Phone Number[49]	Numeric, 10-digit

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

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

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

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

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

[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".

Data Element	Format
Dropoff Provider Name	Alpha-Numeric, Text
Dropoff Provider Address	Alpha-Numeric, Text
Dropoff Provider Phone Number[50]	Numeric, 10-digit
Current NMT/NEMT Vendor	Alpha-Numeric, Text
Transportation Notes[51]	Alpha-Numeric, Text

Table 9 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[52]	MM/DD/YYYY, Date
Mode of Transportation[53]	Alpha-Numeric, Text
Requesting Provider Name	Alpha-Numeric, Text
Requesting Provider NPI	Numeric, 10-digit, Text
Requesting Provider Phone Number[54]	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[55]	Alpha-numeric, Text

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

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

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

[53] 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").

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

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

E. High Risk Member Disposition Data

DHCS is finalizing the policy for identifying high-risk Members for this transition. See *Transition Support for High Risk Members* section above. A future release of this Policy Guide will outline the data needs for high-risk Members in this section.

PRE/POST TRANSITION ISSUE AND QUESTION ESCALATION

Details are forthcoming.

PROVIDER COMMUNICATIONS TO ENABLE CONTINUITY

Provider Communications Requirements

Provider communication requirements are meant to help Members with UIS keep seeing their current Providers whenever possible and ensure Members are smoothly connected to new providers when needed. Additionally, MCPs must direct ECM, CICM, CCM, TCS, and Community Supports Providers that the MCPs have agreements with, including Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements, to help Members find appropriate ongoing services from current or alternative providers. MCPs must also provide specific information to CCS paneled providers and specialty care centers that the MCPs have agreements with, including Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and letters of agreement (LOA)/ or single case agreements, to support the transition of active treatment for CCS Members.

Initial Communications to Providers Serving Impacted Members

Within 30 days of the publication of version 1.0 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 Providers 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

Provider Communications Requirements – Primary Care Providers (PCP), including Federally Qualified Health Centers and Rural Health Centers which serve as PCPs

MCPs should include DHCS-provided template messaging to all PCPs who have transitioning Members assigned to them.

At a minimum, MCP communications to PCPs must:

1. Explain how PCPs may maintain ongoing treatment relationships with the Member and minimize disruptions in access to medically necessary care by ensuring that they are enrolled as Medi-Cal FFS providers and are able to submit Medi-Cal FFS claims to DHCS.
2. Provide detailed instructions regarding Medi-Cal provider enrollment requirements, including enrollment pathways, application processes, revalidation requirements, timelines, and technical assistance resources available through DHCS.
3. Inform PCPs of Medi-Cal FFS billing and claims submission requirements, including applicable billing manuals, provider identifiers, rendering and billing provider requirements, and points of contact for billing support.
4. Explain expectations regarding referrals to specialists, behavioral health providers, DME providers, home health agencies, and other providers that may be involved in a Member's ongoing course of treatment. **MCPs will continue to accept referrals and authorize covered services through December 31, 2026. For services that are expected to (1) start after October 1, 2026, and continue after January 1, 2027, or (2) start January 1, 2027, DHCS requests that the referrals made by PCPs from October 1, 2026, to December 31, 2026, be**

made to MCP Providers who are also enrolled in Medi-Cal FFS, when possible, to minimize disruptions to Member care and promote continuity of provider access.

5. Identify resources available to assist PCPs in helping Members select or establish relationships with Medi-Cal FFS providers when continuity with the existing PCP is not feasible (e.g., if the PCP does not wish to actively participate in Medi-Cal FFS.)
6. Encourage PCPs to educate transitioning Members regarding the importance of maintaining established appointments, obtaining medication refills before the transition date when appropriate, and understanding how to access services after the transition to Medi-Cal FFS.

MCPs must utilize multiple communication channels, including Provider bulletins, webinars, Provider portal postings, direct Provider outreach, and frequently asked questions documents, to ensure PCPs receive timely and actionable information throughout the transition period.

DHCS will develop separate template messaging for MCPs to share with all Medi-Cal enrolled PCPs. This communication will clarify that, as Medi-Cal enrolled Providers, PCPs may also be able to furnish specific care management services to Members. MCPs must include in the communication the relevant list of billing codes to ensure Providers and their employed staff, such as CHWs, understand both their role in care management and the pathways to reimbursement.

Provider Communications Requirements – Enhanced Care Management (ECM), California Integrated Care Management (CICM), Complex Care Management (CCM), and Transitional Care Services (TCS) Providers

Members receiving ECM, CICM, CCM, and TCS have higher needs and are at greater risk of poor outcomes; therefore, MCPs must identify and conduct outreach to all ECM, CICM, CCM and TCS Providers that the MCPs (or affiliated D-SNPs, as applicable) have agreements with, including Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, serving Members with UIS. Communications must clearly state that ECM, CICM, CCM, and TCS will not be available under Medi-Cal FFS after the transition and must outline required transition planning and care coordination expectations before January 1, 2027. When the MCP itself (or its affiliated D-SNP, in the case of CICM) delivers these services, it must perform all required activities internally.

At a minimum, MCP communications to ECM, CICM, CCM, and TCS Providers that the MCP (or affiliated D-SNP, as applicable) has agreements with must:

1. Inform Providers that the MCP (or in the case of CICM, its affiliated D-SNP) will cover ECM, CICM, CCM, and TCS services for all eligible Members through December 31, 2026.
2. Provide information and resources on what steps interested ECM, CICM, CCM, and TCS Providers can take to continue to provide other care management services for impacted Members, including:
    a. Steps for enrolling as a Medi-Cal FFS provider through systems such as PAVE, including available information on enrollment pathways, application processes, revalidation requirements, timelines, and DHCS technical assistance;
    b. Instructions for delivering Medi-Cal FFS care management services and using Medi-Cal FFS care management billing codes, once this guidance is available from DHCS; and
    c. Information that CHW services[56] remain available in Medi-Cal FFS and that eligible supervising providers[57] may enroll as Medi-Cal FFS providers to supervise and bill for CHW services, which include health education, navigation, screening and assessment, and member support.
3. Direct and require ECM, CICM, CCM, and TCS Providers to engage in transition planning and care coordination with Members with UIS prior to January 1, 2027, including, but not limited to:
    a. Coordinate with Members' PCPs and other clinical, behavioral health, county, social service, and community-based partners to minimize service disruptions before the transition.
    b. Verify whether current Providers can and are willing to continue services under Medi-Cal FFS and identifying alternative Medi-Cal FFS providers when necessary by using tools that include, but not limited to, the DHCS Medi-Cal Fee-for-Service Provider Finder App.

[56] Learn more about CHWs at Community Health Workers | DHCS.

[57] A supervising provider can only be a licensed provider; a hospital; an outpatient clinic as defined in 42 CFR section 440.90, which includes an IHS MOA 638 Clinic and Tribal FQHC; a pharmacy; a CBO; or an LHJ. Although non-tribal FQHC and RHC providers may use CHWs to provide covered CHW preventive services, CHWs are not considered to be FQHC and RHC billable.

c. Assess whether Members may qualify for other services, including CHW services, behavioral health care, home and community-based services, county programs, or other available supports within and outside of Medi-Cal delivery systems.

d. Conduct warm hand offs of assessments and/or care plans to receiving Medi-Cal FFS providers and future care management providers whenever feasible.

Provider Communications Requirements – Community Supports Providers

MCPs shall identify and conduct outreach to all Community Supports Providers that the MCPs have agreements with, including Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, serving Members with UIS. Communications must clearly explain that Community Supports services will not be available under Medi-Cal FFS following the transition and outline expectations for transition planning and care coordination activities prior to January 1, 2027.

At a minimum, MCP communications to Community Supports Providers that the MCP has agreements with must:

1. Inform Community Supports Providers that the MCP will continue to cover Community Supports services that the MCP elected to offer for all eligible Members through December 31, 2026. MCPs must be specific in its outreach to Community Supports Providers – for example, communications to Asthma Remediation providers should specify "Asthma Remediation" services versus generically referring to all Community Supports.
2. Provide information and resources on what steps interested Community Supports Providers can take to provide Medi-Cal covered services for impacted Medi-Cal FFS-members. While Community Support Providers may no longer deliver Community Supports services under Medi-Cal FFS, they may take steps to enroll and bill for certain covered Medi-Cal services for eligible Members:
    a. Steps for enrolling as a Medi-Cal FFS provider through systems such as PAVE, including available information on enrollment pathways, application processes, revalidation requirements, timelines, and DHCS technical assistance.
    b. Instructions for delivering Medi-Cal FFS care management services and using Medi-Cal FFS care management billing codes, once this guidance is available from DHCS.

c. Information that CHW services remain available in Medi-Cal FFS and that eligible supervising providers may enroll as Medi-Cal FFS providers to supervise and bill for CHW services, which include health education, navigation, screening and assessment, and member support.[58]

3. Direct Community Supports Providers to engage in transition planning and care coordination with Members with UIS prior to January 1, 2027, in ways that include identification of, referral to, and ensuring transition to post-transition service providers within the Medi-Cal FFS delivery system. Medi-Cal FFS providers can be found using tools that include, but are not limited to, the DHCS Medi-Cal Fee-For-Service Provider Finder App.

Provider Communications Requirements – Community Health Worker (CHW) Service Providers

MCPs must identify and conduct outreach to all CHW Providers that they have agreements with, including Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, that serve Members with UIS. Communications must clearly explain that CHW services will continue to be available under Medi-Cal FFS following the transition and outline expectations for transition planning and care coordination activities prior to January 1, 2027.

At a minimum, MCP communications to CHW Providers that they have agreements with must:

1. Inform CHW Providers that:
    a. The MCP will continue to cover CHW services for all eligible Members through December 31, 2026.
    b. As applicable under the MCP's agreements with its CHW Providers, CHW Providers must deliver CHW services to transitioning Members through December 31, 2026, and bill the MCP for those services.
    c. CHW supervising providers should remain enrolled as Medi-Cal FFS providers and submit bills and claims to DHCS if they want to continue providing services to transitioning members starting on January 1, 2027.

[58] A supervising provider can only be a licensed provider; a hospital; an outpatient clinic as defined in 42 CFR section 440.90, which includes an IHS MOA 638 Clinic and Tribal FQHC; a pharmacy; a CBO; or an LHJ. Although non-tribal FQHC and RHC providers may use CHWs to provide covered CHW preventive services, CHWs are not considered to be FQHC and RHC billable.

Medi-Cal FFS. To understand billing rules for CHW services under Medi-Cal FFS, see this landing page: https://www.dhcs.ca.gov/providers-partners/community-health-workers/. Specifically see the CHW Preventive Services Provider Manual which includes the specific billing codes CHW may use to seek reimbursement for services in Medi-Cal FFS, provided that that they are enrolled and submit claims in accordance with the policy outlined in the Provider Manual.

2. State that as transitioning Members will no longer have access to services such as ECM and Community Supports, there may be increased needs for CHW services.
3. Provide information and resources on what steps interested CHW Providers can take to continue serving transitioning Members:
    a. Ensuring that CHW supervising providers are enrolled as Medi-Cal FFS providers, through systems such as PAVE, if they are not already enrolled as Medi-Cal FFS providers. Information must include resources on enrollment pathways, application processes, revalidation requirements, timelines, and technical assistance resources available through DHCS.[59]
4. Direct CHW Providers to engage in transition planning and care coordination with Members with UIS prior to January 1, 2027, in the following ways that include, but are not limited to:
    a. Coordinate with Members' PCPs and other clinical, behavioral health, county, social service, and community-based partners to minimize service disruptions before transition.
    b. Verify whether current Providers can and are willing to continue services under Medi-Cal FFS and identifying alternative Medi-Cal FFS providers when necessary, using tools that include, but are not limited, to the DHCS Medi-Cal Fee-for-Service Provider Finder App.
    c. Assess whether Members may qualify for other services, including behavioral health care, home and community-based services, county programs, or other available supports within and outside of Medi-Cal delivery systems.

[59] A supervising provider can only be a licensed provider; a hospital; an outpatient clinic as defined in 42 CFR section 440.90, which includes an IHS MOA 638 Clinic and Tribal FQHC; a pharmacy; a CBO; or an LHJ. Although non-tribal FQHC and RHC providers may use CHWs to provide covered CHW preventive services, CHWs are not considered to be FQHC and RHC billable.

Provider Communications Requirements – Long-Term Care Facilities

Transitioning Members who reside in Long-Term Care facilities will need support to ensure they have continued access to needed care. MCPs must monitor transitioning Members at Long-Term Care facilities, including Skilled Nursing Facilities and subacute facilities, and communicate with the facilities about their legal obligations.

Federal law prohibits facilities from transferring or discharging Medi-Cal members due to a change in the member's insurance coverage, such as from managed care to Medi-Cal FFS.[60]

Provider Communications Requirements – California Children's Services Providers

MCPs must identify and conduct outreach to CCS paneled providers and specialty care centers that the MCPs have agreements with, including Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, or active LOAs or single case agreements ("CCS Providers"), serving CCS Members with UIS. Communications must clearly explain that CCS services will continue to be available under Medi-Cal FFS following the transition and outline expectations for transition planning and care coordination activities prior to January 1, 2027.

At a minimum, MCPs must:

1. Inform CCS Providers that:
    a. [For MCPs in Whole Child Model Program] The MCP will continue to cover all CCS services for all eligible Members through December 31, 2026.
    b. As applicable under the MCP's agreements with CCS Providers, CCS Providers must continue to deliver authorized services through December 31, 2026.
2. Provide information and resources on what steps interested CCS Providers can take to continue serving transitioning Members.
    a. While CCS paneled providers and specialty care centers are already Medi-Cal enrolled provide information regarding enrollment resources, provide information required to enroll in CCS. For example, https://cmsprovider.cahwnet.gov/PANEL/index.jsp and https://www.dhcs.ca.gov/services/california-childrens-services/becoming-a-california-childrens-services-provider/

[60] See 42 CFR § 483.15(b)(1) and (c).

3. Request that CCS Providers engage in transition planning and care coordination with Members with UIS prior to January 1, 2027, in the following ways to the extent it is related to the CCS eligible condition and to the extent it is within the scope of the MCP's agreement with the CCS Provider:
    a. Verify with the MCP whether current CCS Providers can and are willing to continue providing services under Medi-Cal FFS. When necessary, CCS Providers can identify alternative Medi-Cal FFS providers using tools that include, but are not limited, to the DHCS Medi-Cal Fee-for-Service Provider Finder App.
    b. Coordinate with CCS County Administrators, Members' PCPs and other clinical, behavioral health, county, social service, and community-based partners to minimize service disruptions before the transition.
4. If the CCS Provider was contracted to serve as an ECM Provider for the Population of Focus targeting children and youth enrolled in CCS who have additional needs beyond their CCS-eligible condition, the MCP should also include specific information pertaining to care management and CHW services included in the sections above.

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**, to receive reimbursement at Medi-Cal FFS rates. For more information on PAVE enrollment, please visit https://www.dhcs.ca.gov/providers-partners/provider-application-and-validation-for-enrollment/.

2. Not Continuing to Serve a Member Who Transitions to Medi-Cal FFS

If you are not planning to continue to care for a Member who transitions to Medi-Cal FFS, 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 at https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers.

3. Preparing for Medi-Cal 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 Medi-Cal FFS billing requirements (https://www.dhcs.ca.gov/providers-partners/tar-billing/)
- Reviewing Medi-Cal 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 (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)

4. Support for Transition of Care

While certain care management services, such as Enhanced Care Management (ECM) 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 (CHW) 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. Claims for CHW services must be submitted by an enrolled Medi-Cal supervising provider.

DHCS plans to provide links and/or a resource document that includes the available codes for billing purposes under Medi-Cal 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.

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

5. 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]

C. ECM, CICM, Community Supports, CCM, TCS, and CHW Provider Communication Template

Below is a template communication that MCPs should use to communicate with ECM, CICM, Community Supports, CCM, TCS, and CHW Providers about this transition. As noted above, MCPs must identify and conduct outreach to all ECM, CICM, Community Supports, and CCM, TCS, and CHW Providers that the MCPs (or affiliated D-SNPs, as applicable) have agreements with, including Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, serving

Members with UIS, and at a minimum, include this information on their Provider portals, Provider bulletins, and Provider 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.

As further outlined in [this document], Enhanced Care Management (ECM), California Integrated Care Management (CICM), Community Supports, Complex Care Management (CCM), Transitional Care Services (TCS), and Community Health Worker (CHW) services Providers that have agreements with the MCP (or its affiliated Dual Eligible Special Needs Plan [D-SNP], as applicable), including Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, are required to actively support transitioning Members to facilitate a smooth transition for Providers and their patients. The Department of Health Care Services (DHCS) is providing the following important information regarding provider enrollment, billing, and requirements for ongoing care responsibilities.

ECM, CICM, Community Supports, CCM, TCS, and CHW Services:

MCPs (or in the case of CICM, their affiliated D-SNPs) are required to continue authorizing, providing, and paying for ECM, CICM, Community Supports, CCM, TCS and CHW services for all eligible Members with UIS through December 31, 2026. While ECM, CICM, Community Supports, CCM, and TCS services will no longer be available to transitioned members in Medi-Cal FFS, CHW services will continue to remain available to transitioned members after January 1, 2027. Since transitioned members in Medi-Cal FFS will no longer have access to ECM, CICM, Community Supports, CCM, and TCS services, there may be increased needs for CHW services.

Steps Providers of ECM, CICM, Community Supports, CCM, TCS, and CHW Services Can Take to Start or Continue Serving Transitioning Members:

This transition creates a significant opportunity for Providers to begin serving Medi-Cal FFS members or to expand their existing participation.

Enrolling in Medi-Cal FFS

Interested Providers must be enrolled in Medi-Cal FFS by January 1, 2027, to begin or continue serving Medi-Cal members transitioned to Medi-Cal FFS. In order to receive reimbursement at Medi-Cal FFS rates for services provided, unenrolled Providers must complete an enrollment application with the DHCS Provider Enrollment Division (PED)

through the Provider Application and Validation for Enrollment (PAVE) portal. For more information on PAVE enrollment, please visit https://www.dhcs.ca.gov/providers-partners/provider-application-and-validation-for-enrollment/.

Providing Medi-Cal FFS Care Management Services

Certain care management, care coordination, or case management services, as well as CHW services are available for coverage and reimbursement when billed in accordance with Medi-Cal coverage policy by eligible providers. Claims for CHW services must be submitted by an enrolled Medi-Cal supervising provider.

DHCS plans to provide links and/or a resource document that includes the available codes for billing purposes under Medi-Cal FFS. The resource will include lists of potential codes with links to the appropriate Provider Manual that includes details on billing guidance.

Becoming CHW Service Providers (for Providers of ECM, CICM, Community Supports, CCM, and TCS Services)

CHW services remain available in Medi-Cal FFS and providers who meet all Medi-Cal provider requirements for an allowable supervising provider type, as outlined in Medi-Cal policy, may enroll to supervise and bill on behalf of CHWs for Medi-Cal FFS CHW services.

A supervising provider can only be a licensed provider; a hospital; an outpatient clinic as defined in 42 Code of Federal Regulations (CFR) section 440.90, which includes an Indian Health Services (IHS) Memorandum of Agreement (MOA) 638 Clinic and Tribal federally qualified health center (FQHC); a pharmacy; a community-based organization (CBO); or a local health jurisdiction (LHJ). However, non-tribal FQHC and Rural Health Clinic (RHC) cannot serve as supervising providers in Medi-Cal FFS.

Please refer to the DHCS CHW website at https://www.dhcs.ca.gov/providers-partners/community-health-workers/ for more information on becoming a CHW provider. Questions may be sent to CHWBenefit@dhcs.ca.gov.

Requirements for ECM, CICM, CCM, TCS, and CHW Provider Care Coordination with Transitioning Members prior to January 1, 2027:

ECM, CICM, CCM, TCS, and CHW Providers that have agreements with the MCP (or its affiliated D-SNP, as applicable), including Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, must conduct transition planning and care coordination for Members with UIS prior to January 1, 2027. Required activities include, but are not limited to:

- ECM, CICM, CCM, TCS, and CHW Providers must coordinate with Members' PCPs, other care management service providers, behavioral health providers, county agencies, social service agencies, and community-based organizations to minimize disruptions in services prior to the transition.
- ECM, CICM, CCM, TCS, and CHW Providers must verify whether Members' current Providers can and are willing to continue to provide services in the Medi-Cal FFS delivery system. In instances that provider transition is needed, care management Providers must identify alternative providers available to Members post-transition within the Medi-Cal FFS delivery system using tools including, but not limited to, the DHCS Medi-Cal Fee-for-Service Provider Finder App.
- ECM, CICM, CCM, TCS, and CHW Providers must also assess whether Members may qualify for other available Medi-Cal FFS services, including Chronic Care Management, behavioral health services, home and community-based services, county-based programs, or other supports available under Medi-Cal FFS or local delivery systems.

Once new providers who will be receiving transitioning Members are identified, current ECM, CICM, CCM, TCS, and CHW Providers must transmit Member assessments and care management plans, ensuring compliance with all required data privacy and confidentiality safeguards, to the appropriate Medi-Cal FFS delivery system providers. If the receiving Medi-Cal FFS provider is able to accept a warm handoff, current and future care management Providers must complete that handoff as soon as possible, but no later than December 31, 2026. The receiving provider will not be able to receive reimbursement for the warm handoff. Receiving providers may start providing services and submit bills and claims to Medi-Cal FFS starting January 1, 2027, when those Members have been transitioned to the Medi-Cal FFS delivery system.

Questions & Support:

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

- Updated billing codes for Medi-Cal FFS care management services;
- Member support pathways; and
- Contact information for DHCS or MCP support channels.

Sincerely,

[MCP Contact Information]

D. UIS Transition Member Notice WCM

The template for the UIS Transition Member Notice for WCM begins on the next page.

Medi-Cal

[Placeholder for Plan Header/Logos]

<Date>
<Member>
<Address Line>
<City, State, Zip Code>

Important changes to your child's Medi-Cal coverage

A new federal rule requires California to change how some immigrants get Medi-Cal. **Your child will still have Medi-Cal.** This means your child will keep their Medi-Cal benefits and have access to almost all the same health services as before. All medically necessary services will still be covered by their Medi-Cal. But the way they get benefits will change and they may have to change where they get services. Some benefits may also change.

What is changing?

Starting January 1, 2027, your child will no longer get their care through a Medi-Cal health plan. Your child will still have Medi-Cal coverage, but they will get their care through Medi-Cal Fee-for-Service instead. Fee-for-Service is a way Medi-Cal pays doctors and other care providers. With Medi-Cal Fee-for-Service, your child can go to any doctor, clinic, and other providers that accept Medi-Cal Fee-for-Service.

[If MCP is in a Classic CCS County, use this:] **Will my child keep the same benefits they have in the California Children's Services (CCS) Program?**

Yes. Your child will have the same CCS benefits they had in the CCS Program. Your child will keep getting CCS services that are medically necessary and prescribed by your child's CCS-paneled provider. *Your child will continue to receive these services from the Department of Health Care Services and the [insert County CCS Administrator].*

[If MCP is in a WCM CCS County, use this:] **Will my child keep the same benefits they have in the Whole Child Model California Children's Services (WCM CCS) Program?**

Yes. Your child will have the same WCM CCS benefits they had in the WCM CCS Program. Your child will keep getting CCS services that are medically necessary and prescribed by your child's CCS-paneled provider. If your child's current CCS-paneled

provider is not a Fee-For-Service provider, you may need to find a new CCS-paneled provider. Your child will receive CCS services from the Department of Health Care Services, CCS-paneled Fee-For-Service providers and the [insert County CCS Administrator] rather than [insert MCP].

Where can I learn more or get help?

If you have questions about your child's CCS services and the move from your Managed Care Plan, call [MCP]'s Member Services [MCP hours] at [MCP phone number/TTY]. This call is free.

Members will be moved from the Medi-Cal health plan they are in today into Medi-Cal Fee-for-Service starting on **January 1, 2027**:

Starting **January 1, 2027**:

- Your Medi-Cal health plan will no longer provide or coordinate your Medi-Cal covered services.
- You will not use your Medi-Cal plan network to find providers.
- You will be enrolled in Medi-Cal Fee-for-Service.
- You will still have Medi-Cal coverage, but you will get our care through Medi-Cal Fee-for-Service.
- You can only see a provider such as a doctor or clinic who accepts Medi-Cal Fee-for-Service.
- You can keep your current doctor if they accept Medi-Cal Fee-for-Service.
- You can keep using your Medi-Cal Benefits Identification Card (BIC).

Certain services from your current Medi-Cal health plan will no longer be available in Medi-Cal Fee-for-Service. Medi-Cal Fee-for-Service does not offer Enhanced Care Management (ECM) or Community Supports. If you have a Lead Care Manager through ECM that provides you with extra support, or if you get medically tailored meals, housing-related supports, or similar services, these services will no longer be available. Other services may still be available to help you. Contact your current Medi-Cal health plan or your ECM or Community Supports provider to prepare for this change.

You will need to go to providers who take Medi-Cal Fee-for-Service, starting January 1, 2027

What you should do now:

- Before January 1, 2027, ask your current providers such as your doctor or clinic if they take Medi-Cal Fee-for-Service.
- If your provider does not accept Medi-Cal Fee-for-Service, you will need to find a new provider before January 1, 2027 by:
    - Calling the Medi-Cal Helpline at 1-800-541-5555.
    - Using the Medi-Cal FFS Provider Lookup tool at: https://bit.ly/Medi-CalProviderLookup
    - Using the online list of Medi-Cal FFS providers at: https://bit.ly/Medi-CalProviderList
- You can also contact your local California Children's Services County Office at **[insert CCS County Program Phone Number]**

Keep using your Benefits Identification Card (BIC)

Always take your Medi-Cal BIC to medical, dental, and pharmacy visits. Your BIC is a plastic card. It has a "poppy flower" or blue and white design. "State of California" is on the card. If you need a new BIC, call your county Medi-Cal office. You can find a list of County Medi-Cal offices at:

www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx.

If you have both Medicare and Medi-Cal and are enrolled in a Medi-Medi Plan

- You will be moved from your Medi-Medi Plan starting January 1, 2027. This is because you will no longer qualify to be in a Medi-Cal health plan.
- For questions about changes to your Medicare coverage, call 1-800-MEDICARE (1-800-633-4227).
- You can also call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222. Or call the Medicare and Medi-Cal Ombudsperson Program (MMOP) at 1-855-501-3077.

Where to learn more

You can read more about this change in the Notice of Additional Information About Your Rights and Benefits (NOAI). Find it at www.dhcs.ca.gov/file/noai-ffs-transition/. The NOAI has more information about Medi-Cal Fee-for-Service. It has resources on who to call with questions. The resources are also listed at the end of this letter. Or use your

smartphone to scan the Quick Response (QR) code at the end of this letter to read the NOAI.

If you want a printed NOAI mailed to you, call Medi-Cal Health Care Options (HCO) Monday – Friday, 8 a.m. to 6 p.m., at 1-800-430-4263 (TTY: 1-800-430-7077).

If you want this notice in another language or format like large print, audio, or braille, call Medi-Cal HCO Monday – Friday, 8 a.m. to 6 p.m., at 1-800-430-4263 (TTY: 1-800-430-7077).

Questions?

- If you have general Medi-Cal questions, call the Medi-Cal Helpline Monday – Friday, 8 a.m. to 5 p.m., at 1-800-541-5555. The call is free. They will help you learn more about what services you can get through Medi-Cal.
- If you have questions about dental care, call the Medi-Cal Dental Telephone Service Center Monday – Friday, 8 a.m. to 5 p.m., at 1-800-322-6384. The call is free. Or visit www.smilecalifornia.org.
- If you need help using your Medi-Cal benefits or understanding your rights, call the Medi-Cal Ombudsman Office Monday – Friday, 8 a.m. to 5 p.m., at 1-888-452-8609 (TTY: 711 for California State Relay). The call is free. Or email MMCDOmbudsmanOffice@dhcs.ca.gov.
- If you have both Medicare and Medi-Cal, call the Medicare and Medi-Cal Ombudsperson Program (MMOP) at 1-855-501-3077. The call is free. The MMOP can help dual eligible members with questions about coverage, enrollment, and getting care.
- To learn more about Medi-Cal Medi-Medi Plans, go to: www.dhcs.ca.gov/services/Documents/MMP-Provider-Factsheet.pdf.

  Or go to: www.dhcs.ca.gov/services/Pages/Medi-Medi-Outreach.aspx.
- If you want a printed copy of the NOAI mailed to you, or you want a copy of this notice in another format like large print, audio, or braille, call Medi-Cal HCO Monday – Friday, 8 a.m. to 6 p.m., at 1-800-430-4263 (TTY: 1-800-430-7077). The call is free. Or go to Medi-Cal HCO at www.healthcareoptions.dhcs.ca.gov. HCO is a service that helps members

learn about Medi-Cal health and dental plans.

- To learn more about Medi-Cal program changes, go to:

www.dhcs.ca.gov/Medi-Cal/Pages/changes.aspx.

- For questions about changes to the scope of Medi-Cal coverage based on immigration status call the Medi-Cal Helpline Monday – Friday, 8 a.m. to 5 p.m., at 1-800-541-5555. The call is free.
- To find your local county Medi-Cal office, go to:

www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx.

- For questions about your Medi-Cal health plan, contact your Medi-Cal health plan. To find your Medi-Cal health plan, go to: www.dhcs.ca.gov/individuals/medi-cal-managed-care-health-plan-directory/.
- For questions about your local California Children's Services County Office you can also contact the County Office using the online list at: https://www.dhcs.ca.gov/services/california-childrens-services/county-offices-for-california-childrens-services/.

Thank you,

Medi-Cal
Department of Health Care Services

Medi-Cal

SCAN ME

California Department of Health Care Services
Health Care Options
P.O Box 989009
West Sacramento, CA 95798-9850
1-800-430-4263 (TTY 1-800-430-7077) | www.healthcareoptions.dhcs.ca.gov

State of California
Gavin Newsom, Governor

California Health and Human Services Agency