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

Version 3.0 – Oct. 14, 2026

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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	Data 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	September 1, 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 (subsequently reordered to Appendix F). • 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
Version 3.0	October 14, 2026	The third release of the Policy Guide contains updates based on plan and association feedback to the release v2.0 and aims to clarify QNC, CHIPRA populations and greatly expands on care coordination and high urgent risk member definitions, resources, and requirements: • Added new Appendix D. CBAS Provider Communication Template. • Updated "QNC" and "UIS" Key Terms to provide more clarity. • Added new "CHIPRA 214" Key Term.

		• Updated Medi-Cal certified eligibles breakdown to reflect current published data from April 2026. • Updated to include billing codes for services that remain available following the UIS Transition as detailed in the Provider Billing Guidance section. • Updated CHIPRA 214 subsection under the What is Not Changing with this Transition section. • Significant revisions made to the Members with UIS Receiving Enhanced Care Management (ECM), California Integrated Care Management (CICM), Community Supports, Complex Care Management (CCM), and Transitional Care Services (TCS) and Members with UIS Receiving Targeted Case Management (TCM) sections. • Added columns to Table 3 List of Special Populations. • Added new MCP requirement under the Transition of Care Requirements section. • Added new Expectations for MCPs in Providing Transition Support for High Urgency Members section. • Updated the Member Transition Notification Policy section with the links to DHCS Member notice and NOAI and provided details on use. • Updated Data Sharing Requirements section to reflect current data requirements. • Added Transition Support for Medications section. • Added New Support Services in Medi-Cal FFS section. • Added Care Coordination Support for Transitioning Members section. • Added Medi-Cal FFS Provider Trainings to Appendix A. • Updated title of Appendix B to include "Primary Care Provider (PCP) and Other Provider…" to clarify its use. • Added new Appendix E. Implications for Medi-Medi Plans and new Appendix K. EAE D-SNP Member with UIS Disenrollment Notice Template. • Added new Appendix H. UIST.0001 Transition Plan for CCS Members. • Added new Appendix I. UIST.0002 Attestation of Executed Transition of Care Plans Template.

		• Added new Appendix J. Your Care Checklist Template.

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

Member-Centered: Minimize Member harm and disruption to coverage and care, protect members with complex needs, and ensure access to clear, timely, culturally and linguistically appropriate information to support navigation during the transition to Medi-Cal FFS.

Provider Readiness: Assess active provider capacity and strengthen provider readiness, deliver timely and clear guidance and resources, and reduce administrative burden to support uninterrupted service delivery by simplifying billing, authorization, and referrals. Provide Medi-Cal FFS information as collaboratively and promptly as feasible.

Partnership: Coordinate across MCPs, Providers, counties, advocacy groups and other stakeholders, support timely, accurate information exchange, and use feedback loops to identify challenges, improve operations, and achieve successful transition outcomes.

Operational Stability: Maintain service levels, leverage existing infrastructure, and work within current constraints while building forward so that Members experience the least possible interruption in accessing medically necessary services and are supported during the transition.

Transparency and Accountability: Engage stakeholders early and regularly. Maintain open, clear, and consistent communications with Members, Providers, counties, and DHCS regarding requirements, timelines, and processes; address feedback and issues clearly and promptly; and uphold accountability for adherence to this Policy Guide by establishing and monitoring success measures.

Federal and State Compliance: Comply with applicable federal and state requirements, protect member rights and program integrity, and sustain compliance throughout all transition activities.

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 five-year bar), Cuban/Haitian entrants, and Compact of Free Association (COFA) migrants who remain eligible for federal full scope Medicaid will be considered QNCs. All other QNC members, who are age 21 or older and not pregnant/postpartum, are no longer eligible for federal full scope Medicaid after October 1, 2026. 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.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) 214: CHIPRA 214 is an existing Medi-Cal eligibility provision and is not a new eligibility policy associated with the January 1, 2027, transition. CHIPRA 214 allows states to provide federally funded, full scope Medi-Cal coverage to eligible children and pregnant or postpartum individuals who are lawfully residing in the United States, including those who would otherwise be subject to a five-year waiting period. The provision applies based on an individual's eligibility circumstances, regardless of whether the individual is an existing or newly eligible member. Eligibility under CHIPRA 214 is determined

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

through the Medi-Cal eligibility process. For information on immigration statuses that are considered to be lawfully present please see State Plan Amendment 13-026.

Unsatisfactory Immigration Status (UIS): This is a Centers for Medicare & Medicaid Services (CMS) term to define non-citizens who are not eligible for full scope Medicaid under federal rules because of their immigration status. CMS defines non-citizens who have an immigration status that is eligible for full scope Medicaid under federal rules to have a 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 five-year bar), Cuban/Haitian entrants, and Compact of Free Association (COFA) migrants will be considered Qualified Non-Citizens (QNCs) and will remain eligible for federal full scope Medicaid. All other QNC members, who are age 21 or older and not pregnant or postpartum, will no longer be eligible for federal full scope Medicaid after October 1, 2026, and will be considered to have UIS. Through December 31, 2026, the UIS indicator shared with MCPs on eligibility files will not include the QNC members shifting from SIS to UIS; 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 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 April 2026, 13,207,633 Members were enrolled in an MCP, and 702,547 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 million members are estimated to be enrolled in Medi-Cal FFS, which represents a 2.8-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.

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

Domain	Fee-For-Service	Managed Care
	OB/GYNs. There is no requirement for members to be "assigned" to a PCP.	
Provider Enrollment, Service Authorizations, and Claims Payment	Providers enroll through DHCS' Provider Application and Validation for Enrollment (PAVE) system. Providers submit Treatment Authorization Requests (TARs) to DHCS for approval of medically necessary services when required. Providers submit claims to DHCS for covered services for eligible members enrolled in Medi-Cal FFS.	Providers contracted with MCPs are generally required to enroll through PAVE if there is a pathway. MCPs are responsible for screening, enrollment, credentialing, revalidation, and recredentialing if there is not a statewide enrollment pathway. MCPs are responsible for utilization management – Providers submit authorization requests to MCPs or their delegated entities for the approval of Medically Necessary services. 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 provider bulletins. These materials set forth Medi-Cal FFS policy and implementation guidance.	DHCS establishes managed care coverage policy through the MCP Contract, All Plan Letters, policy guides (e.g., CalAIM: Population Health Management (PHM) Policy Guide; CalAIM Enhanced Care Management

Domain	Fee-For-Service	Managed Care
		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 transportation by private or public vehicle for members who do not have another way to get to their appointment.	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
	» 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. As Members transition from managed care to Medi-Cal FFS, they will no longer have access to Community Supports through their Medi-Cal coverage. [See the Provider Communications to Enable Continuity section of this Policy Guide for more information.]	Community Supports are covered only through Medi-Cal managed care by MCPs.
Non-Specialty Mental Health Services	Members have access to non-specialty mental health services, which include mental health evaluation and treatment (such as individual, group, and family psychotherapy), psychological and neurophysiological testing, outpatient services for monitoring drug therapy, psychiatric consultants, and outpatient laboratory, drugs, supplies, and supplements.	MCPs cover Non-Specialty Mental Health Services in alignment with Medi-Cal FFS policy through their Network Providers.

Domain	Fee-For-Service	Managed Care
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 Hearing requests and may file a complaint with DHCS following the process described here: File a Complaint	Members have the right to file Grievances, Appeals, and State Hearing requests. Members enrolled in Knox-Keene licensed MCPs also have the right to request an Independent Medical Review through the Department

Domain	Fee-For-Service	Managed Care
	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.	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. Additionally, care management billing codes for services that remain available following the UIS Transition are detailed in the Provider Billing Guidance section of this Policy Guide.

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 CHIPRA 214 pregnant or postpartum (i.e., 12 months following the end of pregnancy) Members are not impacted by the transition. CHIPRA 214 applies to certain categories of members with UIS who are lawfully residing in the United States, including those who would otherwise be subject to a five-year waiting period. This does not apply to all pregnant or postpartum members with UIS. Pregnant or postpartum Members who continue to have UIS and do not qualify for federally funded Medi-Cal under CHIPRA 214 will be included in the transition to Medi-Cal FFS. CHIPRA 214 information is not included on MCP 834 eligibility files and MCPs are not responsible for determining whether a Member meets CHIPRA 214 eligibility requirements. Medi-Cal eligibility, including eligibility under CHIPRA 214, is determined through the Medi-Cal eligibility process. MCPs should rely on eligibility and enrollment information provided by DHCS to determine which Members will remain enrolled in managed care and which Members must be transitioned to Medi-Cal FFS.

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

1. 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.
2. 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 a Whole Child Model (WCM) Managed Care Plan 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 enrolled in ECM under the Population of Focus for Children and Youths with Complex Needs may have special needs beyond their CCS condition(s). These Children or Youth have ECM providers, predominantly CCS approved Special Care Center Providers with the capabilities to manage both complex health care and social needs. CCS approved Special Care Centers who accept Medi-Cal FFS may continue to manage the CCS member's complex health care and social needs. For additional support services and billing codes, see the Provider Billing Guidance and Members with UIS Receiving Enhanced Care Management (ECM), California Integrated Care Management (CICM), Community Supports, Complex Care Management (CCM), and Transitional Care Services (TCS) sections 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]

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:

1. Assisted Living Waiver (ALW) Program
2. Medi-Cal Waiver Program (MCWP) (formerly known as the AIDS Waiver)

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

3. Home and Community-Based Services Alternatives (HCBA) Waiver (includes Waiver Personal Care Services)
4. Home and Community Based Services for the Developmentally Disabled (HCBS-DD)
5. Multipurpose Senior Services Program (MSSP)
6. Self Determination Program (SDP)
7. 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. Requirements pertaining to County CCS Programs are outlined in Numbered Letter 03-0926 . Requirements pertaining to MCPs are outlined 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 the 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.

Note: CCS Children or Youth enrolled in ECM under the Population of Focus for Children and Youths with Complex Needs may have special needs beyond their CCS condition(s). These Children or Youth have ECM providers, predominantly CCS approved Special Care Center Providers with the capabilities to manage both complex health care and social needs. CCS approved Special Care Centers who accept Medi-Cal FFS may continue to manage the CCS member's complex health care and social needs. For additional support

services and billing codes, see the Provider Billing Guidance and Members with UIS Receiving Enhanced Care Management (ECM), California Integrated Care Management (CICM), Community Supports, Complex Care Management (CCM), and Transitional Care Services (TCS) sections 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. Please see Appendix E for more information regarding implications for Medi-Medi Plans.

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 covered under Medi-Cal FFS. Members will also no longer have access to California Integrated Care Management (CICM), which is covered in place of ECM for applicable dual eligible Members through the MCP's affiliated D-SNP.[3]

See the Provider Billing Guidance section for more information on FFS billable services that may allow some ECM, CICM, CCM or TCS Providers to continue to provide services to members with UIS.

Members with UIS Receiving Targeted Case Management (TCM)

Members with UIS who are currently receiving TCM as Specialty Mental Health Service may continue to receive covered TCM services in Medi-Cal FFS after the transition in certain circumstances. TCM services provided as part of Specialty Mental Health Services to current Members, those who meet access criteria and have a TCM need established by an assessment, will continue to be covered for Members with UIS using State General Funds; for Med-Cal FFS members who are QNC, Permanently Residing in the U.S. Under Color of Law (PRUCOL), and those whose citizenship status are not known, TCM will be covered by the county Behavioral Health Plans (BHPs).

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,

[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).

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 do the following, in accordance with applicable state and federal privacy laws and regulations:

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. Share data on transitioning Members with contracted Providers—specifically PCPs, ECM, Community Supports, CICM, CCM, and TCS Providers—who are providing services to Members with UIS so that these Providers may identify transitioning Members and support care coordination and transition of care efforts.
4. Cooperate with DHCS' efforts to identify high-risk ("Special Population") Members who may require additional transition support.
5. 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.

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

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,

At a minimum, MCPs are required to do the following, in accordance with applicable state and federal privacy laws and regulations:

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 November 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 November 1, 2026).

Transitioning Members in Inpatient Hospital Care

For Members in inpatient hospital care on December 31, 2026, and expected to remain there on January 1, 2027, MCPs must inform DHCS of these Members known to be receiving inpatient care in alignment with the requirements detailed in the Data Sharing Requirements section of this Policy Guide.

In general, MCPs are responsible for paying for all Covered Services prior to January 1, 2027, in accordance with all applicable federal and state statutes and regulations, as well as contractual obligations, and Medi-Cal FFS will assume responsibility on or after January 1, 2027, as applicable. However, MCPs must honor their Network Agreements including payment arrangements that would require payments on an admission, episodic, or other basis that may include the full length of stay associated with the inpatient admission. DHCS will work with MCPs and any hospital in which a transitioning Member is admitted to clarify payment responsibility during the transition period. In no circumstance will the Member be balance billed for covered Medi-Cal services.

Transition Support for Medications

Most transitioning Members currently receive their medications through Medi-Cal Rx and this will continue in Medi-Cal FFS. Network Providers who are able to prescribe medications ("prescribers") may authorize refills and submit prescription drug authorizations in accordance with Medical Necessity and coverage criteria to MCPs prior to the transition to support continuity of access for Members. As part of MCPs member and provider communication, MCPs should support Members with transitioning care to a Medi-Cal FFS enrolled providers as is feasible prior to January 1. As noted in the Provider Communications section, to support continuity of services for members with

UIS, MCPs should encourage Network Providers – including all prescribers to enroll in Medi-Cal FFS.

Members can find more information about how to access prescriptions through these resources:

- Medi-Cal Rx Homepage
- Medi-Cal Rx Member Portal
- DHCS Pharmacy for Medi-Cal Members webpage
- Frequently Asked Questions (FAQs) for Medi-Cal Rx Members.

New Support Services in Medi-Cal FFS

Beginning in January 2027, DHCS will add new coordination and navigation services for Members transitioning to Medi-Cal FFS, including:

- Expanded call center capabilities to help Members find care.
- A Nurse Advice Line with registered nurses who can answer questions and help members find care; and
- Care coordinators engaged with local communities that can support members, their caregivers and their providers in finding services through Medi-Cal FFS.

Care Coordination Support for Transitioning Members

DHCS is contracting with a vendor to provide statewide care coordination and care management support for transitioning Members. Members identified by DHCS as high urgency will be prioritized to minimize care disruption as described in the Transition Support for High Urgency Members (Including Special Populations) section of this Policy Guide. *As workflows and processes for MCP handoffs in December 2026 are finalized, DHCS will share more information with MCPs to facilitate coordination between MCPs and the care coordination vendor.*

TRANSITION SUPPORT FOR HIGH URGENCY 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.

For this transition, DHCS defines **high urgency** as:

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

Below are additional categories DHCS is using to group transitioning Members by transition risk:

1. High urgency;
2. Medium urgency/active problem;
3. Low short term risk/longer term risk;
4. No transition action needed; and
5. Unassessed.

Expectations for MCPs in Providing Transition Support for High Urgency Members

Starting in October 2026, DHCS will provide MCPs with UIS and QNC Member Registries that include all transitioning Members, including **high urgency** Members with high transition risk. DHCS requires that MCPs prioritize transition support for members identified as high urgency, but **this does not limit MCP responsibilities for providing care coordination for any transitioning member who needs assistance**.

DHCS expects MCPs to begin outreach upon receipt of their member registry. MCPs must submit dispositioning for high urgency members and their providers in November 2026, and final dispositioning in early December 2026.

There are two main outreach activities expected of MCPs:

1. Provide direct Member support and outreach by confirming the Member can continue with their current providers or by identifying and coordinating the

Member's transition to new Medi-Cal FFS providers. MCPs may conduct outreach themselves or leverage the plan's contracted provider networks to support Members. For example, Members with Care Managers may be best supported through those existing trusted relationships.

2. Conduct targeted Provider outreach where multiple Members have anticipated service gaps. MCPs should outreach to Providers to streamline and coordinate transitions for multiple Members when possible.

Member registries include the Member's demographic information, identifiers to indicate if the Member is receiving services through the county BHP or CCS, the Member's transition risk status, the qualifying condition or criteria that supports their risk status, and their current providers that are not actively billing Medi-Cal FFS and require outreach.

MCPs are expected to begin outreach and care coordination for high transition risk Members upon receipt of their Member Registry files.

Specifically, MCPs must do the following, in accordance with applicable state and federal privacy laws and regulations:

- Determine if the current Providers identified for that Member are willing to continue providing services for that member in Medi-Cal FFS and capture their status: (1) whether they already bill Medi-Cal FFS and are using a different NPI than what they use to bill the MCP; (2) whether they are planning to be ready to bill for services in Medi-Cal FFS beginning January 1, 2027; (3) whether they are in the process of enrolling in Medi-Cal FFS; or (4) whether they are not planning to continue in Medi-Cal FFS and the Member must transition.
- Collect and submit Provider dispositioning to DHCS in November and December 2026 to support overall provider outreach strategy and engagement. For each high urgency Member on the MCP's registry, DHCS has listed each of the Member's current Providers (up to 10) that are not actively billing Medi-Cal FFS. This means that DHCS cannot confirm the Provider is enrolled in Medi-Cal FFS, or if enrolled, has not submitted any Medi-Cal FFS claims in the last 12 months. To support care coordination for high urgency Members, DHCS requires that MCPs confirm for each Provider whether they will continue to serve that Member after January 1, 2027, or whether the Member needs to transition to a new Provider. If they need to transition, the MCP must report efforts taken to identify a new provider and schedule appointments to support the transition of care. **DHCS recognizes the challenges in relying on verbal confirmations to confirm a**

Provider's willingness to participate in Medi-Cal FFS and will use this information cautiously when confirming gaps in service disruption have been closed and resolved.

- Collect and submit Member dispositioning for high urgency Members identified by DHCS, including whether the Member was transitioned and has new appointments scheduled after January 1, 2027. Submit supplemental data and information to support care coordination for both high urgency Members and all transitioning Members, including care plans, Admission, Discharge, Transfer (ADT) data reports, etc.

See the Data Sharing Requirements section of this Policy Guide for more information.

Identifying New Members at Risk

Under this Policy Guide, DHCS requires MCPs to focus attention and resources on transitioning Members who have been identified by DHCS as high urgency as well as Members the MCP has identified using the additional criteria provided by DHCS. As MCPs have additional data (for example, more real time data from contracted Providers) that can support the identification of Members with high transition risk, DHCS requires that MCPs identify Members that could be high urgency Members.

DHCS expects that MCPs:

1. Utilize the supplemental file shared by DHCS: **DHCS Special Populations Specifications** to identify Members who are not identified by DHCS as high urgency because they may newly meet criteria for Special Populations.
2. Utilize ADT feeds to identify Members who may newly meet criteria for Special Populations.
3. Utilize other MCP data sources or clinical judgment to identify Members with high transition risk who have not been categorized as high urgency.

Updated criteria for Special Populations are listed in the table below, with new populations included for the UIS Transition noted as "New." MCPs should use the column "Actions for MCPs to support identification of high urgency Members" to prioritize identification of Members for specific Special Populations. DHCS has noted where no action is needed from MCPs because DHCS is the source of data and can adequately identify Members. MCPs should prioritize identifying Members with new diagnoses or new treatments that start after April 2026. Plans can also use Column D in the supplemental **DHCS Special Populations Specifications** file to also inform prioritization.

Table 3 List of Special Populations Used to Identify Transition Risk for Members with UIS

No.	Members Who Are:	Potential High Urgent Risk	Actions for MCPs to Support Identification of High Urgency Members
1.	Receiving treatment for end-stage renal disease (ESRD) or receiving ongoing dialysis	YES	Identify transitioning members with new dialysis
2.	Living with a dementia diagnosis	YES	Identify transitioning members with new dementia diagnosis
3.	In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months	YES	Identify transitioning members newly on waitlist or undergoing or received new transplants
4.	Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality	YES	No action needed; DHCS can identify through Medi-Cal Rx claims
5.	Receiving Home Health services	YES	Identify transitioning members with new home health services
6.	Post-discharge from an inpatient hospital, SNF, or sub-acute facility on or after December 01, 2026	YES	Identify transitioning members with new hospital, SNF, sub-acute facility admissions
7.	Newly prescribed or ongoing life-sustaining Durable Medical Equipment (DME)	YES	Identify transitioning members with new DME
8.	NEW: Receiving chemotherapy	YES	Identify transitioning members with new chemotherapy treatment
9.	NEW: Receiving radiation	YES	Identify transitioning members with new radiation treatment

No.	Members Who Are:	Potential High Urgent Risk	Actions for MCPs to Support Identification of High Urgency Members
10.	Adults and children with authorizations to receive ECM or CICM services[5]	NO	Identify transitioning members with new ECM or CICM enrollment
11.	Adults and children with authorizations to receive Community Supports[6]	NO	Identify transitioning members with new Community Supports enrollment
12.	Adults and children receiving CCM[7]	NO	Identify transitioning members receiving CCM
13.	Receiving In-Home Supportive Services (IHSS)	NO	No action needed; DHCS can identify through state data sources
14.	Children and Youth enrolled in CCS/CCS WCM	NO	No action needed; DHCS can identify through state data sources
15.	Children and Youth in foster care, and former foster youth through age 25	NO	No action needed; DHCS can identify through state data sources
16.	In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C	NO	Identify transitioning members newly in active treatment
17.	Taking immunosuppressive medications, immunomodulators, and biologics	NO	Identify transitioning members receiving new immunosuppressive medications
18.	Living with an intellectual or developmental disability (I/DD) diagnosis	NO	Identify transitioning members with new I/DD diagnosis

[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).

No.	Members Who Are:	Potential High Urgent Risk	Actions for MCPs to Support Identification of High Urgency Members
19.	Pregnant or postpartum (within 12 months of the end of a pregnancy)	YES – if expected to deliver Jan – Mar 2027	Identify transitioning members with a new pregnancy diagnosis
20.	Receiving Behavioral Health Services (Specialty Mental Health Services, or Substance Use Disorder treatment, or Non-Specialty Mental Health Services)	NO	Identify transitioning members newly receiving Non-Specialty Mental Health Services
21.	Receiving hospice care	NO	Identify transitioning members newly receiving hospice services
22.	Residing in Skilled Nursing Facilities (SNF)	NO	Identify transitioning members residing at a SNF
23.	Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)	NO	Identify transitioning members residing in ICF/DDs
24.	Receiving Hospital Inpatient Care (expected to be inpatient on 1/1/2027)	NO	Identify transitioning members receiving hospital inpatient care on 1/1/2027
25.	Receiving Community-Based Adult Services (CBAS)	NO	Identify transitioning members newly receiving CBAS
26.	NEW: Living with a seizure or neurological disorder	YES	Identify transitioning members with a new seizure or neurological disorder diagnosis
27.	Experiencing homelessness or receiving street medicine services	NO	Identify transitioning members newly homeless or with new street medicine services
28.	Living with an eating disorder diagnosis	NO	Identify transitioning members with a new eating disorder diagnosis

No.	Members Who Are:	Potential High Urgent Risk	Actions for MCPs to Support Identification of High Urgency Members
29.	Receiving Electroconvulsive Therapy (ECT)	NO	Identify transitioning members with new ECT
30.	Enrolled in Genetically Handicapped Persons Program (GHPP)	NO	No action needed; DHCS can identify through state data sources
31.	NEW: Living with a hereditary blood disorder	YES	Identify transitioning members with a new blood disorder diagnosis

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 is posted on the DHCS website and accessible through a Quick Reference (QR) code included on the notice. 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.

The Member notice and NOAI are posted on the DHCS UIS Transition to FFS web page:

- Member Notice
- Notice of Additional Information

MCPs can utilize the information DHCS has provided in this Policy Guide and available resources on the DHCS UIS Transition to FFS web page to create member communications including, but not limited to, notices and call center scripts. DHCS will accept these materials as file and use and the materials do not have to go through a DHCS review process to be approved, if the Plan utilizes the information DHCS has provided. MCPs must ensure materials comply with readability requirements.

Members who remain enrolled in managed care because they are federally eligible under CHIPRA 214 will not receive a notice informing them that they are transitioning to FFS.

Benefits Identification Card (BIC) Requests

DHCS will not issue new Medi-Cal Benefits 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. CCS Member noticing must be sent no later than December 1, 2026. Please see Appendix G. UIS Transition Member Notice WCM 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. MCPs must submit to DHCS via the Operational Readiness Submission Portal a signed Attestation confirming the CCS Member Notices were sent to the CCS Member no later than December 1, 2026. An Attestation template will be provided by DHCS at a later date.

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

MCPs must identify Members with UIS who are receiving ECM, CICM, any 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[8], CICM[9], Community Supports[10], CCM[11], and TCS[12], 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. Please reference the Provider Billing

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

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

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

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

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

Guidance section of this Policy Guide to find more information on identified billing code options.

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 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. Resources to help Members identify FFS providers and get assistance are described below.

In addition, MCPs should leverage DHCS' Member Communication resources to communicate to and educate transitioning Members about how this transition will affect how they access care and providers. MCPs should consider using a variety of communication modalities such as texting, emails, and member facing portals while considering Member's preferred language and alternative formats.

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

Medi-Cal Find Doctors & Services Tool

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.

DHCS is actively working to improve the Find Doctors & Services tool and requests that users submit their feedback, issues and suggestions using the form here: Feedback Form for Find Doctors and Services tool

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.

Medi-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.

DHCS Webpage for 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/.

Stakeholder-Facing Page

DHCS has published a stakeholder resource page tailored for providers, partners, and other organizations. This page includes foundational information such as a transition overview; key explanations of the transition; links to relevant notices, webinars, policy guides, and other resources; as well as tools to help members locate FFS providers and understand their benefits.

General Communications

The DHCS Office of Communications (OC) will continue delivering 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. Messaging will remain clear and plain-language, supporting members, providers, counties, advocates, and community partners in navigating the transition to Medi-Cal FFS.

OC responds to inquiries from media and stakeholders, issues statements as needed, and publishes web updates that reflect federal policy changes and the timeline for the transition.

Member Texting Campaign

To support broad member awareness and reduce confusion, OC will incorporate texting as a core part of its outreach strategy. Text messages will deliver simple, direct reminders to potentially impacted members regarding upcoming changes to their Medi-Cal coverage, key dates, and how members can confirm or navigate their future Medi-Cal FFS coverage. Messages will be sent in October, November, and December 2026 and will direct members to the Fee-for-Service Transition member webpage for clear guidance on what the change means and what actions to take. Texts will be delivered in members' preferred languages.

Paid Advertising Strategy

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 is critical in supporting impacted Members for this transition. As allowed by applicable state and federal privacy laws governing Member data, MCPs must transmit Member information, authorization data, Member and Provider dispositioning for high transition risk members identified by DHCS, and any additional data elements identified by DHCS.

DHCS expect MCPs to use and exchange information for the purposes of care management and care coordination for this population. In this context, the UIS indicator is protected health information (PHI) 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 other applicable laws and regulations, with the same level of sensitivity as required by these laws.

For the requirements described in the following sections, DHCS requires that MCPs submit data for (1) the entire transitioning membership; or (2) members identified as high urgency by DHCS or the MCP.

MCPs should identify their transitioning Members by taking the following steps:

1. Members with a UIS indicator from Medi-Cal eligibility sent to the MCP in the most recent eligibility month.
2. Add the Members from the most recent QNC list sent by DHCS to the MCP (Note that this list will exclude Members aged 21 and under that are not transitioning). DHCS uploaded the QNC CIN List to each MCP's SFTP folder and notified plans via email on September 4, 2026. A refreshed QNC list may be uploaded in late October or early November. DHCS will keep MCPs updated if a refreshed list is provided.
3. Remove Members from the most recent CHIPRA list sent by DHCS to the MCP.

Plans should not include any members that are on hold during the most recent eligibility month, unless they were identified by DHCS as a high urgency member for the plan. See the Transition Support for High Urgency Members for MCP requirements related to transition support for high urgency Members.

Summary of Requirements

In accordance with applicable state and federal privacy laws and regulations, 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.

A summary of required data sharing is detailed in Appendix F. Schedule of MCP Data Submissions.

Table 4 Summary of MCP Provided Data Files

File	Description	Refresh Frequency
A. Member Contact Info & Authorized Representative	Additional contact info available for **all transitioning Members** not provided to MCPs by DHCS on 834 eligibility files (phone numbers, email address, etc.) and information about the member's Authorized Representative, if available.	One file due November 6, 2026, no refreshes.
B. Transitioning Member Authorization Data	Prior authorization information for **all 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-

File	Description	Refresh Frequency
		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."
C. Transitioning Member NEMT/NMT Schedule and Physician Certification Statement Data	Transportation scheduled after January 1, 2027, for **all transitioning Members**	One file due December 7, 2026, no refreshes.
D. High Urgency Member Disposition Data	Status of transition for the MCP's **high urgency Members** and dispositions for each of the providers for that Member sent to the MCP in October and November.	Mid-point disposition status due November 6, 2026. Final disposition status due December 7, 2026.
E. New Members at Risk	Members identified by the MCP as having transition risk that were not identified by DHCS as high urgency. Includes Members who meet Special Populations criteria or who the MCP has determined have transition risk.	Files due: 11/6/2026 12/7/2026 1/4/2027 1/29/2027 Each file must contain newly identified Members since the prior file submission. MCPs may opt to submit only net new Members or a cumulative list with each submission.
F. ADT Reports	Standard ADT reports for **all transitioning Members**	Files due: 11/6/2026 12/7/2026 1/4/2027

File	Description	Refresh Frequency
G. High Urgency Member Care Plans	The most recent Care Plan data within the last 12 months for **high urgency Members** identified by DHCS if available. MCPs may use the template provided by DHCS or may submit care plan data as an export from their system or send document attachments (PDFs).	Files due: 11/6/2026 12/7/2026
H. All Member Care Plan Data	The most recent Care Plan data within the last 12 months for **all transitioning Members** identified by DHCS if available. MCPs may use the template provided by DHCS or may submit care plan data as an export from their system or send document attachments (PDFs).	Files due: 12/7/2026 1/4/2027 1/29/2027 Each file should contain newly obtained Care Plan data received by the MCP since the last submission.

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 County CCS Programs 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.

On October 9, 2026, DHCS provided WCM MCPs with a list of CCS Members with UIS who will need to be transitioned from their MCP to the CCS County Program. By October 23, 2026, DHCS will provide MCPs in Classic CCS Counties with a list of CCS Members with UIS who are transitioning from their MCP and into FFS.

Transition Plan For all Transitioning California Children's Services Members

By October 15, 2026, all MCPs must submit to DHCS, a Transition Plan For all Transitioning California Children's Services Members (Deliverable UIST.0001) via the Operational Readiness Submission Portal. 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 Special 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).

See Appendix H for the General Transition Plan UIST.0001 template.

CCS Member Authorization Data

By November 16, 2026, MCPs must submit to DHCS via SFTP folder Member Authorization Data (UIST.0005). This file will be used by DHCS, and to share with CCS Independent Counties the information necessary to ensure continued Service Authorization Requests (SARs) for CCS members to the extent feasible.

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

No later than November 2, 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.

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, MCPs must submit to DHCS, via the Operational Readiness Submission Portal, a signed Attestation (UIST.0002) confirming one of the following:

- It is a non-WCM MCP and the deliverable does not apply;

- It is a WCM MCP and has submitted directly to the County CCS Program a CCS Transition of Care Plan for each CCS Member, which follows all care plan requirements and DME obligations, along with the clinical documentation supporting the service authorization pertaining to the Member's CCS eligible condition; or
- It is both a non-WCM MCP and WCM MCP and has submitted directly to the County CCS Program a CCS Transition of Care Plan for each CCS Member, which complies with all care plan requirements and DME obligations, along with the clinical documentation supporting the service authorization pertaining to the Member's CCS eligible condition.

See Appendix I for the Attestation template.

Submission of MCP Data to DHCS

DHCS has compiled the outlined data elements above into accompanying Excel workbooks for MCPs to prepare data files to transmit to DHCS. Data must be submitted in .csv format and adhere to file naming conventions details in the workbooks. MCPs must also use the templates provided in the workbook unless otherwise directed that other options are also acceptable (e.g. Care Plan data).

A summary of MCP data files and requirements is in Appendix F Schedule of MCP Data Submissions.

A. Transitioning Member Authorization Data

File Description & Schedule

In accordance with applicable state and federal privacy laws and regulations, MCPs must submit authorization data for all transitioning Members to DHCS in accordance with the required data elements and format outlined in the **Transition of Care Template - Member Authorization Data Workbook.**

Files are due to DHCS on the following schedule:

- 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

Files must be in .csv format and be submitted to DHCS via SFTP, location DHCS-MCOD-Operations/PlanName/UIST.004_Member_Auth Data.

B. Transitioning Member Contact Information & Authorized Representative

File Description & Schedule

The Transitioning Member Contact Information and Authorized Representative information must include any additional and available contact information for all transitioning Members. This information will be used to support care coordination and Member outreach activities by DHCS and its vendors.

This data submission is due on 11/6/2026.

Please note, it is possible for a single Member to have multiple records if the Member has more than one authorized representative.

The template for this data submission can be located in the **Transitions of Care_Required MCP Data Sharing** workbook titled **UIST.0006_Template_Contact**.

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

File Description & Schedule

In accordance with applicable state and federal privacy laws and regulations, this file must include data on transportation services scheduled on or after January 1, 2027, for all transitioning members.

This data submission is due on 12/7/2026.

Please note the data should contain multiple rows for a single Member to illustrate a Member with multiple scheduled transportation services.

The template for this data submission can be located in the **Transitions of Care_Required MCP Data Sharing** workbook titled **UIST.0007_Template_Transport**.

D. High Urgency Member Disposition Data

File Description & Schedule

In accordance with applicable state and federal privacy laws and regulations, MCPs must submit dispositioning for high urgency Members to report the status of transition support.

Data submissions are due on 11/6/2026 and 12/7/2026. The 11/6/2026 file should include data for all Members identified as high urgency on MCP Member Registries sent

to MCPs in October 2026. The 12/7/2026 file should include data for all Members identified as high urgency on MCP Member Registries sent to MCPs in November 2026.

The template for this data submission can be located in the **Transitions of Care_Required MCP Data Sharing** workbook titled **UIST.0008_Template_Disposition**.

E. New Members at Risk Data

File Description & Schedule

In accordance with applicable state and federal privacy laws and regulations, MCPs must identify transitioning Members not previously identified by DHCS as high urgency, but who MCPs can confirm may have high transition risk. MCPs can utilize the Special Populations Specifications and more recent Member data to identify Members and report to DHCS.

Data submissions are due on 11/6/2026, 12/7/2026, 1/4/2027 and 1/29/2027. For each submission, MCPs must report any new Members identified by the plan. The MCP may include Members identified on previous files, but this is not required. The template for this data submission can be located in the **Transitions of Care_Required MCP Data Sharing** workbook titled **UIST.0008_Template_Disposition**.

The template for this data submission can be located in the **Transitions of Care_Required MCP Data Sharing** workbook titled **UIST.0009_Template_New Member.**

F. All Member ADT Reports

File Description & Schedule

In accordance with applicable state and federal privacy laws and regulations, DHCS requires MCPs submit available Admissions, Discharge and Transfer (ADT) reports for transitioning Members to support care coordination activities at DHCS. MCPs should use standard formats and submit reports for events during the month prior to the submission date.

Data submissions are due on 11/6/2026, 12/7/2026, and 1/4/2027.

G. High Urgency Member Care Plans

File Description & Schedule

In accordance with applicable state and federal privacy laws and regulations, DHCS requires that MCPs submit available Care Plan data for high urgency Members to support care coordination activities at DHCS. MCPs may use the data template provided

in the Excel workbook, a custom MCP-defined template, or may submit Care Plan attachments (e.g. PDFs). DHCS aims to provide flexibility for how MCPs submit this data as Care Plans are collected and stored in a variety of formats. MCPs do not need to include Care Plan data already submitted and can include only new Care Plan data received or obtained since the last submission.

Data submissions for high urgency Care Plans are due on 11/6/2026 and 12/7/2026.

The template for this data submission can be located in the **Transitions of Care_Required MCP Data Sharing** workbook titled **UIST.0011&0012_Templ_Care Plan.**

Please note the data should contain multiple rows for a single Member to illustrate a Member with multiple care plans and/or multiple goals within a single care plan.

H. All Transitioning Member Care Plans

File Description & Schedule

In accordance with applicable state and federal privacy laws and regulations, DHCS requires that MCPs submit available Care Plan data for all transitioning Members to support care coordination activities at DHCS. MCPs may use the data template provided in the Excel workbook, a custom MCP-defined template, or may submit Care Plan attachments (e.g. PDFs). DHCS aims to provide flexibility for how MCPs submit this data as Care Plans are collected and stored in a variety of formats. MCPs do not need to include Care Plan data already submitted and can include only new Care Plan data received or obtained since the last submission.

Data submissions are due on 12/7/2026, 1/4/2027, and 1/29/2027.

The template for this data submission can be located in the **Transitions of Care_Required MCP Data Sharing** workbook titled **UIST.0011&0012_Templ_Care Plan.**

Please note the data should contain multiple rows for a single Member to illustrate a Member with multiple care plans and/or multiple goals within a single care plan.

PRE/POST TRANSITION ISSUES AND ESCALATIONS

Prior to January 1, 2027, MCPs must work collaboratively with Providers and other partners to facilitate a seamless transition for affected Members. DHCS has provided web resources and this Policy Guide to help ensure MCPs, Members with UIS, Providers, counties, and other stakeholders receive accurate and timely information related to the transition.

Beginning January 1, 2027, Members with UIS and Providers should contact the Medi-Cal Helpline as the primary intake pathway for all Medi-Cal service-related concerns, including benefit navigation, provider access, claims, and general inquiries.

DHCS will provide more details on secondary pathways for MCPs, vendors, and community stakeholders to escalate transition issues starting January 1, 2027, as they become available.

Table 9 Pre/Post Transition Issues and Escalations Resources

Medi-Cal Support	Telephone Service Center	Web Resources
Members	**Medi-Cal Helpline** (800) 541-5555 Monday through Friday, except holidays, from 8:00 a.m. to 5:00 p.m.	Fee-for-Service Transition | Medi-Cal
Provider		For Medi-Cal Providers | DHCS
Community Stakeholders		Transition to Medi-Cal Fee-for-Service | DHCS
County Behavioral Health Plans and Providers, County Social Services Departments (including County Welfare Departments), Local Health Jurisdictions and other Local Governmental Agencies	Continue to use existing escalation pathways. DHCS will share details of secondary pathways as they become available.	
Managed Care Plans & Vendors	Continue to use existing escalation pathways. DHCS will share details of secondary pathways as they become available.	

PROVIDER BILLING GUIDANCE

This section describes FFS billing guidance that MCPs can share with contracted Providers.

Care Management and Supportive Service Billing Guidance

DHCS recognizes the significance of care management and supportive services. Where possible, DHCS hopes that transitioning Members currently receiving care management services can continue receiving services with minimal disruption, preferably from the same Providers. In this version of the Policy Guide, DHCS provides preliminary guidance on potential billing code options for Medi-Cal FFS providers to use when offering care management services. DHCS will issue additional implementation guidance in a future release regarding which Medi-Cal FFS provider types may submit charges for these codes. **The information and billing codes identified in this section do not guarantee Medi-Cal FFS payment for any provider types.**

Care Management Billing Codes in the FFS Delivery System

In addition to the codes in the following section, DHCS is actively working to identify additional care management billing codes available in Medi-Cal FFS to allow ECM, Community Supports, CCM, and TCS Providers to continue providing care management services to FFS members. Additional details and billing guidance will be issued in a future update to the UIS Transition Policy Guide or a Population Health Management Information Notice. In this effort, DHCS aims to identify options that allow current care management Providers to continue services using similar care teams while also capturing sustainable revenue.

Care Management and Supportive Services Available in Both Managed Care and FFS Delivery Systems

The following benefits and services are available to members in both the Medi-Cal managed care and FFS delivery systems, meaning that current service Providers may continue, if enrolled and eligible, to provide services while shifting claim submissions to the Medi-Cal FFS delivery system. These benefits and services may partially or fully meet care management needs for members. Providers should reference all relevant guidance materials to ensure compliance with existing billing requirements, including DHCS billing manuals, the CPT codebook, and relevant CMS guidance.

- **Community Health Worker (CHW) Services**: CHW services may address issues that include, but are not limited to, the control and prevention of chronic

conditions or infectious diseases; mental health conditions and Substance Use Disorders; the need for preventive services; maternal health conditions; sexual and reproductive health; environmental and climate-sensitive health issues; child health and development; oral health; aging; injury; domestic or interpersonal violence by CHWs with the appropriate training; and community violence prevention. CHW services may also be used to support members in meeting redetermination needs to receive public benefits. Refer to Community Health Worker (CHW) Preventive Services for additional program and billing guidance.

- **Psychiatric Collaborative Care Management**: Psychiatric collaborative care management services are reimbursable when billed by the treating physician or other qualified health professional for treatment of a member's mental health or Substance Use Disorder. Refer to Evaluation & Management (E&M) for billing guidance.
- **Comprehensive Perinatal Service Program**: Comprehensive psychosocial services and health education services are reimbursable under program guidance. Refer to Pregnancy: Comprehensive Perinatal Services (CPSP) List of Billing Codes for billing guidance.
- **Doula Services**: Doulas provide members with person-centered, culturally competent care that supports the racial, ethnic, linguistic and cultural diversity of the members while adhering to evidence-based best practices. Refer to Doula Services for billing guidance.
- **Dyadic Services**: Dyadic Services are a unique model of care that are comprised of dyadic behavioral health visits, access to Community Supports services, psychoeducational services, and family training and counseling for child development. Refer to Dyadic Services for billing guidance.
- **Asthma Preventive Services**: Medi-Cal Asthma Preventive Services (APS) includes clinic-based and home-based asthma self-management education, as well as in-home environmental trigger assessments for eligible members of any age, as Medically Necessary. Refer to Asthma Preventive Services (APS) for billing guidance.

Providers interested in continuing to serve transitioning Members are responsible for ensuring they are enrolled in Medi-Cal FFS and eligible to provide the services listed above, including reviewing all relevant guidance materials to ensure their compliance with existing Medi-Cal FFS billing requirements.

Care Management Services Not Available in Medi-Cal FFS and With No Identified Alternatives

For Members currently receiving care management services that are not covered in Medi-Cal FFS, such as many Community Supports, MCPs must contact these Members' current care management providers and direct them to provide transition support no later than November 15, 2026. This support includes coordinating with and making referrals to community-based organizations and other external resources to address Member needs and help mitigate the impacts of this transition.

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 Special 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.

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. This communication must occur as soon as feasible, **no later than November 15, 2026.**

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 has developed 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. This communication must occur as soon as feasible, **no later than November 15, 2026.**

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[13] remain available in Medi-Cal FFS and that eligible supervising providers[14] 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.

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

[14] 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.

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.

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. 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.[15]

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.

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.[16]

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[15] 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.

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

Provider Communications Requirements – California Children's Services Providers

MCPs must identify and conduct outreach to CCS paneled providers and Special Care Centers that 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.

MCPs may use the Provider Communication Template in Appendix B and include the following:

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 CCS 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 Special Care Centers are already Medi-Cal enrolled, provide information regarding enrollment resources and 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/
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.

Provider Communications Requirements – Community-Based Adult Services (CBAS) Providers

MCPs must identify and conduct outreach to Community-Based Adult Services (CBAS) Providers/Centers in their Networks serving Members with UIS. Communications must clearly explain that CBAS remains available in Medi-Cal FFS for eligible Members with UIS following the January 1, 2027, transition. The change in delivery system does not terminate the CBAS benefit. MCPs should send the CBAS Provider Communication Template in Appendix D to all CBAS centers as soon as feasible, aiming to complete distribution no later than November 15, 2026.

Note, because CBAS centers are enrolled to participate in Medi-Cal through the California Department of Aging enrollment process, there is not a requirement for them to currently enroll through PAVE[17].

At a minimum, MCP communications to CBAS Providers must:

- Explain that MCPs will continue to authorize and pay for covered CBAS services for eligible Members through December 31, 2026. For transitioning Members, CBAS Providers must submit TARs and/or claims for covered services furnished on or after January 1, 2027, to DHCS through Medi-Cal FFS, subject to applicable eligibility, authorization, and billing requirements.
- Explain how to prepare and submit CBAS claims using the applicable Medi-Cal claims process. Direct Providers to the CBAS Provider Manual for required provider identifiers, service dates, authorization information, billing codes, modifiers, documentation, and reimbursement rates applicable to the date of service.

[17] https://aging.ca.gov/Programs_and_Services/Community-Based_Adult_Services/

- Direct Providers to review CBAS Individual Plan of Care (IPC) and Treatment Authorization Request (TAR) requirements and the TAR Special Handling Process section of this Policy Guide. Explain that DHCS accepts TARs beginning November 1, 2026, for transitioning Members' services on or after January 1, 2027, and provide updated DHCS transition TAR guidance as it becomes available.
- Request that the CBAS Center confirm their ability and willingness to continue serving transitioning Members, coordinate with the MCP, and identify potential authorization, billing, or service gaps before January 1, 2027.
- Provide MCP transition contacts and DHCS billing support information, including:
  - 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)
- Include the following CBAS resources:
  - Medi-Cal CBAS Provider Bulletin, Issue 613
  - CBAS Billing Codes and Reimbursement Rates
  - CBAS Provider Manual, including Billing Examples and IPC and TAR Form Completion
- If a CBAS center cannot continue services, the MCP must assist the Member with identifying an alternative Medi-Cal FFS CBAS Provider and coordinate transfer of relevant records consistent with applicable privacy requirements.

For CBAS Providers that also serve as ECM Providers, MCP communications must clarify that CBAS remains available in Medi-Cal FFS for eligible transitioning Members, but ECM is not available in Medi-Cal FFS. These Providers may continue delivering and billing for covered CBAS services under applicable FFS requirements; they may no longer bill for ECM services furnished to transitioned Members on or after January 1, 2027. MCPs must direct these Providers to follow the ECM transition planning and care coordination requirements in this Policy Guide and Appendix C, including coordinating with Members' PCPs and other Providers, identifying available ongoing services, and transmitting relevant assessments and care management plans and completing warm handoffs, where feasible, by December 31, 2026, consistent with applicable privacy requirements.

MCPs must also post CBAS transition materials and links on their Provider portals and

disseminate updates through Provider bulletins and other established Provider communication channels.

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.
- A Frequently Asked Questions (FAQ) document on completing transition TARs will be published here Medi-Cal Managed Care to Fee-for-Service Transition in the upcoming weeks.
- A Provider Toolkit is available on the Medi-Cal Managed Care to Fee-for-Service Transition webpage and will be updated as new chapters are released.

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

Providers can sign up for trainings on Medi-Cal FFS by visiting the Medi-Cal Learning Portal. DHCS will be adding trainings as they are developed so encourages Providers to check regularly for updates. The following trainings are currently planned to support the transition:

Table 10 Planned Medi-Cal FFS Provider Trainings

Date	Course Title	Start Time	Duration
Tuesday, December 1, 2026	Introduction to Medi-Cal 101	1 p.m.	1 hr. 30 mins
Thursday, December 3, 2026	Medi-Cal Provider Resources 102	10 a.m.	1 hr. 30 mins
Tuesday, December 8, 2026	eTAR Basics	1 p.m.	1 hr. 30 mins
Thursday, December 10, 2026	Medi-Cal Claims Overview and Electronic Methods Live Webinar	10 a.m.	1 hr. 30 mins

B. Primary Care Provider (PCP) and Other Provider Communication Template

Below is a template communication that MCPs should use to communicate with PCPs and other 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. This communication must occur as soon as feasible, **no later than November 15, 2026.**

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 for enrollment by **January 1, 2027**, to receive reimbursement at Medi-Cal FFS rates in order to begin providing services on January 1, 2027. 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. Alternative providers available to Members post-transition within the Medi-Cal FFS delivery system can be identified using tools including, but not limited to, the DHCS Medi-Cal Fee-for-Service Provider Finder App.

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.

Please reference the Provider Billing Guidance section to find more information on DHCS-identified Medi-Cal FFS alternative services to support transition of care.

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. This communication must occur as soon as feasible, **no later than November 15, 2026.**

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, any 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 covered for transitioned members in Medi-Cal FFS, CHW services will continue to remain available to transitioned members after January 1, 2027. There are also several care management services covered under Medi-Cal FFS. 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

DHCS is actively working to identify additional care management billing codes available in Medi-Cal FFS to allow ECM, CICM, Community Supports, CCM, and TCS Providers to continue providing care management services to FFS members. Further details and billing guidance will be issued in a future update to the UIS Transition Policy Guide or a Population Health Management Information Notice. In this effort, DHCS aims to identify options that allow current care management providers to continue services using similar care teams while also capturing sustainable revenue.

Providers who wish to continue providing care management and supportive services to Medi-Cal FFS members on or after January 1, 2027, must be enrolled in Medi-Cal FFS and meet all applicable requirements to submit claims for such services to Medi-Cal FFS. The following benefits and services are available to members in both the Medi-Cal managed care and FFS delivery systems, meaning that current service providers may continue, if enrolled and eligible, to provide services while shifting claim submissions from managed care to the Medi-Cal FFS delivery system. These benefits and services may partially or fully meet care management needs for members. Providers should reference all relevant guidance materials to ensure compliance with existing billing requirements, including DHCS billing manuals, the CPT codebook, and relevant CMS guidance.

Care Management and Supportive Services That Will Remain Available:

- **Community Health Worker (CHW) Services**: CHW services may address issues that include, but are not limited to, the control and prevention of chronic conditions or infectious diseases; mental health conditions and Substance Use Disorders; the need for preventive services; maternal health conditions; sexual and reproductive health; environmental and climate-sensitive health issues; child health and development; oral health; aging; injury; domestic or interpersonal violence by CHWs with the appropriate training; and community violence prevention. CHW services may also be used to support members in meeting redetermination needs to receive public benefits. Refer to Community Health Worker (CHW) Preventive Services for additional program and billing guidance.
- **Psychiatric Collaborative Care Management**: Psychiatric collaborative care management services are reimbursable when billed by the treating physician or other qualified health professional for treatment of a member's mental health or Substance Use Disorder. Refer to Evaluation & Management (E&M) for billing guidance.
- **Comprehensive Perinatal Service Program**: Comprehensive psychosocial services and health education services are reimbursable under program guidance. Refer to Pregnancy: Comprehensive Perinatal Services (CPSP) List of Billing Codes for billing guidance.
- **Doula Services**: Doulas provide members with person-centered, culturally competent care that supports the racial, ethnic, linguistic and cultural diversity of the members while adhering to evidence-based best practices. Refer to Doula Services for billing guidance.
- **Dyadic Services**: Dyadic Services are a unique model of care that are comprised of dyadic behavioral health visits, access to Community Supports services, psychoeducational services, and family training and counseling for child development. Refer to Dyadic Services for billing guidance.
- **Asthma Preventive Services**: Medi-Cal Asthma Preventive Services (APS) includes clinic-based and home-based asthma self-management education, as well as in-home environmental trigger assessments for eligible members of any age, as Medically Necessary. Refer to Asthma Preventive Services (APS) for billing guidance.

Some care management and supportive services available in Medi-Cal managed care have no clear alternatives in the Medi-Cal FFS delivery system. Providers assisting Members transitioning from managed care to the Medi-Cal FFS delivery system should coordinate and make referrals to community-based organizations and other external resources to address Member needs and help mitigate the impacts of this transition.

Becoming a CHW Service Provider

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. ECM, CICM, CCM, TCS, and CHW Providers are required to offer the following transitional support, at minimum:

- 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.
- 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.
- Assess whether Members may qualify for other available Medi-Cal FFS services, including Chronic Care Management, Principal 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. Community-Based Adult Services (CBAS) Provider Communication Template

Below is a template communication that MCPs should use to communicate with CBAS Providers in their Network. MCPs should send this letter as soon as feasible, aiming to complete distribution no later than November 15, 2026. MCPs should customize contact information and post the communication on their Provider portals and in Provider bulletins or blasts.

Subject: Continuing CBAS for Members Transitioning to Medi-Cal Fee-for-Service

Dear **CBAS 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. This transition changes how covered services are authorized and paid; it does not, by itself, end Members' Medi-Cal eligibility. CBAS remains available in Medi-Cal FFS for eligible Members, and your center may continue serving these Members if it meets applicable Medi-Cal enrollment, CBAS program, authorization, and billing requirements.

Please take the following steps now to help maintain access to CBAS for your transitioning Members.

1.

2. Prepare for FFS authorizations and claims

[MCP Name] will continue to authorize and pay for covered CBAS services for eligible Members through December 31, 2026. Continue submitting claims to [MCP Name] for services furnished during that period. For Members transitioning to FFS, submit TARs and claims for covered CBAS services furnished on or after January 1, 2027, to DHCS through Medi-Cal FFS.

Use the applicable Medi-Cal electronic institutional claims process, following the CBAS Provider Manual. Ensure TARS and claims include the required provider identifiers, service dates, authorization information, and billing codes. Use the codes, modifiers, and reimbursement rates that apply to the services furnished and the date of service. Review the following resources with your billing and service authorization staff:

Medi-Cal CBAS Provider Bulletin, Issue 613

CBAS Billing Codes and Reimbursement Rates

CBAS Provider Manual, including Billing Examples, UB-04 Completion, and IPC and TAR Form Completion

Review the CBAS IPC and TAR requirements and submit the applicable FFS authorization request for ongoing services. As described in the UIS Transition Policy Guide, DHCS accepts TARs beginning November 1, 2026, for transitioning Members' services on or after January 1, 2027. The guide also describes a TAR special handling option when DHCS has an MCP authorization on record and an FFS Provider requests authorization for the same service. Follow DHCS transition TAR instructions and updates when preparing your request.

3. Coordinate continued services for your Members

Please confirm with [MCP Contact] whether your center can continue serving transitioning Members under Medi-Cal FFS. Work with [MCP Name], Members and their

authorized representatives, PCPs, and other Providers to identify and address potential gaps in services before January 1, 2027

4. If your center is also contracted to provide Enhanced Care Management

Your center may continue to provide covered CBAS services to eligible transitioning Members and submit CBAS claims to Medi-Cal FFS. However, Enhanced Care Management (ECM) is not covered in Medi-Cal FFS. You may no longer bill for ECM services furnished to transitioned Members on or after January 1, 2027. Continue providing authorized ECM services through December 31, 2026, in accordance with your agreement with [MCP Name].

Before the transition, follow the ECM transition planning and care coordination requirements in the UIS Transition Policy Guide and Appendix C. Coordinate with Members' PCPs and other Providers, identify available ongoing services, and transmit relevant assessments and care management plans to the appropriate receiving Providers, consistent with applicable privacy requirements. Complete warm handoffs, when receiving Providers can accept them, as soon as possible and no later than December 31, 2026. **You may not submit claims under FFS for those services or bill separately for services already included in the CBAS payment.**

5. Questions and support

For questions about transitioning Members, current MCP authorizations, or care coordination, contact [MCP Contact Name, Phone Number, and Email]. For Medi-Cal FFS billing, claims, or TAR assistance, contact information for DHCS or MCP support channels.

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)

General billing and TAR resources are available at:

DHCS TAR and Billing Resources

[MCP Name] will share additional DHCS guidance as it becomes available. Thank you for helping eligible Members continue to receive CBAS throughout this transition.

Sincerely,

[MCP Name and Contact Information]

E. Implications for Medi-Medi Plans

As previously noted in this Policy Guide, 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, which means these Members must also be disenrolled from the companion EAE D-SNP. This appendix provides information to EAE D-SNPs on the expected disenrollment process and other considerations for impacted Members.

EAE D-SNP Disenrollment Process for Members with UIS

According to 42 CFR section 422.74(b)(2)(iv), a Medicare Advantage (MA) plan that exclusively serves and enrolls special needs individuals must disenroll individuals who no longer meet the special needs status of that plan (or deemed continued eligibility, if applicable). Since EAE D-SNP enrollment is limited to individuals who are also enrolled in the affiliated Medi-Cal MCP, dual eligible Members with UIS are no longer eligible for enrollment in an EAE D-SNP effective January 1, 2027. Deeming continued eligibility per 42 CFR section 422.52(d) does not apply in this situation since Members with UIS are not expected to regain eligibility for EAE D-SNPs within the following six months.

EAE D-SNPs must follow Medicare rules regarding submitting disenrollment transactions due to loss of eligibility for the EAE D-SNP. Per CMS, the disenrollment reason code should be "93 – Lost Specific Plan Eligibility (SNP Only)" and the effective date should be January 1, 2027.

In accordance with 42 CFR section 422.74(d)(8), EAE D-SNPs must send a notice to Members with UIS at least 30 days in advance of the disenrollment. In Appendix K of this Policy Guide, DHCS has provided a template notice (based on a CMS model) that plans can modify as appropriate and issue to impacted Members by December 1, 2026.

Changes to Medicare Eligibility

Due to the statutory changes to Medicare eligibility made by H.R. 1, individuals who are not U.S. citizens or U.S. nationals and who have an immigration status other than lawful permanent residents, Cuban/Haitian entrants, and COFA migrants, and who were entitled to, or enrolled for, Medicare as of July 4, 2025, will no longer be eligible for Medicare on the date that is 18 months after July 4, 2025. Under the calendar year (CY)

2027 Medicare Physician Fee Schedule Proposed Rule (CMS-1848-P) (Proposed Rule), CMS has proposed that individuals who no longer qualify for Medicare due to these changes will be terminated effective February 1, 2027. Please note that termination timing may be different for some individuals, such as those who gained Medicare after July 4, 2025, and those whose status changed prior to the implementation of the Proposed Rule, if finalized as proposed.

This means that certain Members with UIS who are disenrolled from an EAE D-SNP effective January 1, 2027, may be subsequently terminated from the Medicare program effective February 1, 2027. Impacted Members are expected to receive a notice from the Social Security Administration regarding changes to their Medicare eligibility.

Proactive Outreach to EAE D-SNP Members with UIS

DHCS encourages EAE D-SNPs to reach out to Members with UIS to explain the upcoming disenrollment due to the transition from Medi-Cal managed care to Medi-Cal FFS. Pursuant to 42 CFR section 422.2264(b), MA organizations may call current enrollees to discuss other Medicare products or plan benefits. As such, EAE D-SNPs may provide information to Members with UIS about other Medicare products available from the plan's parent organization. Although DHCS anticipates that Members with UIS who are involuntarily disenrolled from the D-SNP due to loss of SNP eligibility will qualify for a Special Enrollment Period to select a new MA plan if desired, DHCS suggests discussing the upcoming change and plan options with impacted Members as soon as possible during the annual Medicare Open Enrollment Period that runs from October 15 through December 7, 2026. EAE D-SNPs may also refer Members to the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222 and the Medicare and Medi-Cal Ombudsperson Program (MMOP) at 1-855-501-3077 for further assistance.

Please note, as discussed above, certain Members with UIS are expected to lose Medicare due to eligibility changes under H.R. 1. Many of these Members may be terminated from the Medicare program effective February 1, 2027, if the CY 2027 Medicare Physician Fee Schedule Proposed Rule is finalized as proposed. DHCS strongly encourages EAE D-SNPs to acknowledge the possible impacts to Medicare entitlement when discussing Medicare coverage options with Members with UIS.

New EAE D-SNP Enrollment of Members with UIS

DHCS will not institute an EAE D-SNP enrollment moratorium for Members with UIS. As such, Members with UIS can newly enroll in EAE D-SNPs through December 1, 2026, due

to the Integrated Care Special Enrollment Period that allows for monthly enrollment into an EAE D-SNP. However, DHCS strongly encourages EAE D-SNPs to appropriately counsel Members with UIS who seek to newly enroll in the EAE D-SNP. This would include informing the Member about the upcoming transition from Medi-Cal managed care to Medi-Cal FFS that will make the Member ineligible for the EAE D-SNP as of January 1, 2027, and therefore the Member may wish to avoid EAE D-SNP enrollment. EAE D-SNPs can provide information to the Member regarding other available Medicare products, but as noted above, plans are encouraged to acknowledge the possibility of upcoming impacts to Medicare entitlement.

F. Schedule of MCP Data Submissions

Data Element	MCP Data Submission								
	Member Authorization Data	**CCS Member Authorization Data**	**Member Contact Info**	**NEMT/NMT Data**	**High Urgency Member Disposition Data**	**New Members at Risk**	**All Member ADT Reports**	**High Urgency Member Care Plans**	**All Member Care Plans**
Member cohort	**All transitioning members**	All CCS transitioning members	**All transitioning members**	**All transitioning members**	High Urgency members identified by DHCS	Transitioning members that are not included on high-urgency registries and have been identified by the MCP only	**All transitioning members**	High Urgency members identified by DHCS and MCPs only	**All transitioning members**
MCP Deliverable ID	UIST.0004	UIST.0005	UIST.0006	UIST.0007	UIST.0008	UIST.0009	UIST.0010	UIST.0011	UIST.0012
Frequency	Initial submission: 9/15/2026; weekly in Oct; daily beginning mid-Dec	Single submission due on 11/16/2026	Single submission due on 11/6/2026	Single submission due on 12/7/2026	Two (2) submissions due: 11/6/2026 and 12/7/2026	Four (4) submissions due: 11/6/2026 12/7/2026 1/4/2027 1/29/2027	Three (3) submissions due: 11/6/2026 12/7/2026 1/4/2027	Two (2) submissions due: 11/6/2026 12/7/2026	Three (3) submissions due: 12/7/2026 1/4/2027 1/29/2027

Data Element	MCP Data Submission								
	Member Authorization Data	**CCS Member Authorization Data**	**Member Contact Info**	**NEMT/NMT Data**	**High Urgency Member Disposition Data**	**New Members at Risk**	**All Member ADT Reports**	**High Urgency Member Care Plans**	**All Member Care Plans**
Data sharing	Post to Operational Readiness (OR) SFTP	Post to OR SFTP	SCAN to post to OR SFTP All other MCPs to post to Medi-Cal Connect SFTP	SCAN to post to OR SFTP All other MCPs to post to Medi-Cal Connect SFTP	SCAN to post to OR SFTP All other MCPs to post to Medi-Cal Connect SFTP	SCAN to post to OR SFTP All other MCPs to post to Medi-Cal Connect SFTP	SCAN to post to OR SFTP All other MCPs to post to Medi-Cal Connect SFTP	SCAN to post to OR SFTP All other MCPs to post to Medi-Cal Connect SFTP	SCAN to post to OR SFTP All other MCPs to post to Medi-Cal Connect SFTP

G. 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

H. UIST.0001 Transition Plan for CCS Members

General Transition Plan Guide for UIST.0001 was released to MCPs via email on September 14, 2026. For convenience, it is also provided in this document beginning on the next page.

TRANSITION PLAN FOR ALL TRANSITIONING CALIFORNIA CHILDREN'S SERVICES MEMBERS

DELIVERABLE: UIST.0001

This document provides guidance to Managed Care Plans (MCPs) for the Transition Plan for transitioning CCS Members for managed care to Fee-for-Service (FFS).

For all MCPs, to Ensure Transitions of Care and Continuity of Provider Access to CCS Paneled Providers and Specialty Care Centers:

- **Transition of Authorized Services:** Narrative (not exceeding 1 page) detailing the process of a warm handoff to County CCS Program to support transition of authorized services to DHCS or the County CCS Program, including transportation and recurring durable medical equipment (DME).
    - *Note MCP should leverage UIST.0005 which will include the authorizations pertaining to CCS eligible conditions that the Independent County CCS Programs must adjudicate for this population beginning January 1, 2027.*
- **Provider Communication to Enable Continuity of Provider Access:** Narrative (not exceeding 1 page) on how the plan will conduct outreach to CCS paneled providers and specialty care centers actively treating CCS Members to encourage them to continue to serve transitioning CCS Members through the FFS delivery system.
    - *Note MCP should leverage the Provider Communication guidance outline in the UIS Transition Policy Guide V.2.*
- **Member Outreach and Communication:** Narrative (not exceeding 1 page) on how the MCP will identify and refer CCS Members with UIS to CCS paneled providers and specialty care centers. MCPs should include detail on how they plan to conduct outreach to CCS Members and their families.
    - *Note MCP should leverage the Member Communication templates included in the UIS Transition Policy Guide V.2.*

For Whole Child Model MCPs, Ensuring continuity of case management with CCS County Program Administrators:

WCM MCPs operate in the 33 WCM Counties today and are currently responsible for conducting care management for CCS Members – Including case management pertaining to the child's CCS condition. Following the UIS transition, the County CCS Programs will be responsible for conducting case management pertaining to the child's CCS condition. While County CCS Programs are not responsible for conducting care management more broadly for the CCS Member, some may opt to conduct additional care coordination or management for the child and their families.

- Narrative (not exceeding 1 page) detailing the process of a warm handoff to County CCS Program to support continuity of authorized services, including transportation and recurring DME.
    - Note MCP should leverage UIST.0005 which will include the authorizations pertaining to CCS eligible conditions that the Independent CCS Counties must adjudicate for this population beginning January 1, 2027.

Collaboration with County CCS Programs

Provide a narrative (not exceeding 1 page) summarizing the collaboration with the County CCS Program to ensure engagement to address UIS transition concerns and identify solutions and resources that will assist families with the transition.

DHCS encourages both the County CCS Program and MCPs to attempt to resolve all disputes collegially, effectively, and at the local level before submitting the dispute to the State for resolution. Either party may submit the dispute to DHCS vis email to CCSProgram@dhcs.ca.gov for review and a final determination.

I. UIST.0002 Attestation of Executed Transition of Care Plans Template

UIST.0002 Attestation of Executed Transition of Care Plans template was released to MCPs via email on September 29, 2026. For convenience, it is also provided in this Policy Guide beginning on the next page. MCPs must submit a completed UIST.0002 attestation on MCP letterhead no later than the close of business on December 1, 2026.

UIST.0002 Managed Care Plan Attestation: Transition of Care Plans for California Children's Services Members with Unsatisfactory Immigration Status

Deliverable/Submission Number: UIST.0002

Deliverable Description: *Whole Child Model (WCM)Managed Care Plans (MCPs) must provide a signed attestation confirming that the California Children's Services (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 no later than November 2, 2026, as directed in Policy Guide Version 2.0. Non-WCM MCPs must provide a signed attestation that the deliverable does not apply to them. MCPs which are both WCM in some counties and Non-WCM in other counties, must provide a signed attestation confirming the completion of WCM county requirements.*

Submission Deadline: December 1, 2026

Submission Method: Operational Readiness Submission Portal

This attestation is submitted to the Department of Health Care Services (DHCS) by the undersigned MCP representative to confirm compliance with the requirements regarding the transition of California Children's Services (CCS) members with Unsatisfactory Immigration Status (UIS) from managed care to Medi-Cal Fee-for Service (FFS).

Attestation Statement

I, _____, in my capacity as _____

for _____ (MCP Name), hereby attest and certify that:

☐ **As a Non-WCM MCP, this deliverable does not apply; or**

☐ **As a WCM MCP,**

☐ **As both Non-WCM and WCM MCP, we have completed the following:**

1. **Submission of CCS Transition of Care Plans**

No later than November 2, 2026, the WCM MCP provided the County CCS Program with a CCS Transition of Care Plan for each CCS member with UIS who will transition out of the WCM MCP.

- The WCM MCP collaborated with each County CCS Program to establish a mutually agreed upon format for submitting the CCS Transition of Care Plans.
- The WCM MCP responded to and coordinated with the County CCS Program's CCS liaison to address any questions or concerns regarding the submitted Transition of Care Plans.

2. Content Requirements

- Each CCS Transition of Care Plan submitted includes:
  - The most recent care management plan(s), including Transition to Adulthood plans when applicable;
  - A plan for each member's care, specifying whether care will continue with existing providers or require new providers;
  - Provider information for any new providers. If new provider information was unavailable as of November 2, 2026, the WCM MCP will submit the required details no later than December 31, 2026;
  - A complete list of current authorized CCS services, treatments, and supporting clinical documentation related to the CCS eligible condition(s);
  - A list of relevant Durable Medical Equipment (DME) and provider contact information.

3. DME Obligations

- For one-time DME authorizations, the WCM MCP ensured CCS members with UIS received their approved DME on or before December 1, 2026.
- For subsequent or recurring DME, authorizations were completed by December 31, 2026.
- The WCM MCP remains responsible for payment and delivery of authorized DME when authorized on or before December 31, 2026, even if delivered after January 1, 2027.

4. Clinical Documentation for CCS Case Management

The WCM MCP confirms that clinical documentation supporting service authorization related to CCS eligible conditions were submitted directly to the County CCS Program, including any additional documentation requested by the County CCS Programs such as:

- Authorizations issued for CCS eligible conditions;
- Clinical documentation submitted to support those authorizations;
- Care plans;
- Member contact information

Certification

By signing below, I certify that the information contained in this Attestation is true, accurate, and complete to the best of my knowledge and is submitted in accordance with DHCS requirements.

Authorized Representative Name: _____

Title: _____

MCP Name: _____

Email: _____

Phone: _____

Signature: _____

Date: _____

J. Your Care Checklist Template

This checklist is designed to help Members with UIS and their caregivers identify and address any potential service gaps as Members transition to Medi-Cal Fee-for-Service. It provides step-by-step guidance for confirming providers, medications, equipment, supplies, and transportation, and includes a section to track any changes needed before January 1, 2027. For convenience, the full template is provided in this Policy Guide beginning on the next page.

YOUR CARE CHECKLIST

Members moving to Medi-Cal Fee-for-Service (FFS) may need help making sure their care will continue. Use these steps with the Member or caregiver before January 1, 2027. **Call or confirm each provider, prescriber, or service will continue serving the Member through Medi-Cal FFS. Do not assume—confirm directly.**

1. **Complete the Care Checklist.** Help the Member list their current providers, medications, medical equipment, supplies, and transportation. A caregiver or other support person may help. The checklist is optional.
2. **Call each provider.** Ask the provider's office if the provider accepts Medi-Cal FFS and is taking new Medi-Cal FFS patients. Check all physical health, mental health, and substance use care providers. For mental health care, note whether it is specialty or non-specialty. If you cannot confirm, add the provider to "What Is Changing?"
3. **If the provider(s) does not accept Medi-Cal FFS, find a replacement.** The Find Doctors & Services online tool can help search for a Medi-Cal FFS provider with the same specialty, ideally near the Member's location.
    a. The Find Doctors & Services online tool will be updated early to mid-December with more user-friendly features to make it easier for members to find providers. **Not all providers listed in the Find Doctors & Services online tool will be accepting Medi-Cal FFS, so always ask/call the new provider(s) to confirm.**
    b. Call the Medi-Cal Help Line (1-800-541-5555) for help finding providers.
4. **Check medications.** List each medication, who prescribes it, the next refill date, and how many refills are left. Ask if the prescribing provider accepts Medi-Cal FFS. If the prescriber must change, make sure the new provider knows what medications the Member takes and when refills are needed.
5. **Check medical equipment and supplies.** List each item and note whether it is rented, owned, or provided as needed. Ask the DME supplier if it accepts Medi-Cal FFS. Find out if a new approval or supplier is needed.
6. **Check transportation.** Ask if the Member has scheduled rides. Explain that Managed Care transportation providers do not automatically transfer to FFS. List the service, phone number, type of ride, and next scheduled ride.
7. **List what is changing.** Add anything that will not continue or has not been confirmed to "What Is Changing?" Write down the next step, who will do it, and the target date. If a provider changes, help schedule the new appointment and transfer the Member's records before January 1, 2027.

YOUR CARE CHECKLIST

Purpose: Use this checklist to write down the people, medicines, equipment, supplies, and services that help with your care. For each item, check if it will stay the same or if something needs to change before January 1, 2027. Write down any steps you need to take.

Who should fill out this checklist: You can fill out this checklist on your own or you can ask someone you trust to help, like a family member, friend, caregiver, or another person who helps you with your health care. This checklist is optional, but it is a good way to make sure nothing is missed and your care continues without gaps.

Full Name		**Last Updated**	
Primary Contact		**Phone Number**	

Providers

List the doctors, specialists, therapists, or other providers you see now. Include their specialty, phone number, and whether they take Medi-Cal Fee-for-Service and new Medi-Cal Fee-for-Service patients. Include physical health, mental health, and substance use care providers. If you see someone for mental health care, note if it is specialty or non-specialty care. Specialty mental health care means help for serious mental health or substance use problems, like seeing a psychiatrist, psychologist, or getting treatment for addiction. This care is usually provided by your county's Behavioral Health Plan. Non-specialty mental health care means help for common mental health needs, like therapy, counseling, or getting medicine for anxiety or depression.

YOUR CARE CHECKLIST

Current Provider	Specialty	Accepts Medi-Cal FFS and new patients?	Phone Number	Notes

Medications

List the medicines you take now. Write down who prescribes each one, your next refill date, how many refills you have left, and whether that provider accepts Medi-Cal Fee-for-Service.

Medication	Prescribing provider	Next refill date	Refills left	Does the provider accept Medi-Cal Fee-for-Service?

Medical Equipment and Supplies

List any medical equipment or supplies you use. Say whether each item is rented, owned, or given to you as needed. Write the supplier's name and phone number. Check if the supplier accepts Medi-Cal Fee-for-Service.

Equipment or supply	Rented, owned, or as needed?	Supplier and phone number	Does the supplier accept Medi-Cal Fee-for-Service?

Transportation

List the transportation service you use for rides to your health care appointments. Include the phone number, type of transportation, whether it will be available through Medi-Cal Fee-for-Service, and the date of your next scheduled ride.

YOUR CARE CHECKLIST

- Non-Medical Transportation (NMT): A regular car ride for people who can walk on their own but need help getting to appointments.
- Non-Emergency Medical Transportation (NEMT): A medical ride, like a wheelchair van, for people who cannot safely ride in a regular car.

For help, call the Medi-Cal Help Line at 1-800-541-5555 or learn more online.

Transportation service	Phone number	Type of transportation (NMT/NEMT)	Available through Medi-Cal Fee-for-Service?	Next scheduled ride date

What Is Changing?

Use this section to write down anything in your care that will change. Write down what needs to happen, who will do it, and the date it should be done.

Type	What is changing?	What needs to happen or be replaced?	Who will do it?	Target date / Done

K. EAE D-SNP Member with UIS Disenrollment Notice Template

DHCS is providing this notice template for EAE D-SNPs to use to inform Members with UIS that they are being involuntarily disenrolled from the EAE D-SNP due to the Medi-Cal FFS transition. This notice template is based on Exhibit 33 from the CMS Medicare Advantage Enrollment and Disenrollment Guidance. The notice template is provided in this Policy Guide beginning on the next page.

Modified Exhibit 33: Model Notice for Loss of D-SNP Status - Notification of Involuntary Disenrollment

Dear <Name of Member>:

We are writing to let you know that your enrollment in <plan name> will end on January 1, 2027. <Plan name> is a Medi-Medi Plan that combines your Medicare and Medi-Cal benefits. Because of a new federal rule regarding immigration status, you can no longer enroll in a Medi-Cal health plan. That also means you can no longer enroll in a Medi-Medi Plan.

You will still keep your Medi-Cal benefits. Starting January 1, 2027, you will get your Medi-Cal through Fee-for-Service instead of a health plan. Fee-for-Service means you can see any provider who accepts Medi-Cal. Fee-for-Service does not mean you pay; Medi-Cal still pays for your covered care. You can learn more about this change and what it means for your Medi-Cal benefits in a separate <date> letter from the California Department of Health Care Services.

You will get your Medicare benefits through Original Medicare, or you can choose another Medicare plan. However, you may see changes to your Medicare eligibility in 2027. Keep reading this notice for more information about your Medicare benefits.

Why am I receiving this notice?

According to records provided to us, you will be ineligible for <plan name> as of January 1, 2027, due to a new federal rule about your immigration status. Therefore, we asked Medicare to disenroll you from <plan name> beginning January 1, 2027. After that time, you will no longer receive care through <plan name>.

What if I don't agree with this decision?

You have the right to ask us to reconsider your disenrollment through the grievance process described in your [*insert* "Member Handbook" or "Evidence of Coverage", *as appropriate*]. Please note, <plan name> does not make immigration status decisions. If you think your immigration status may be incorrectly noted, contact your local county Medi-Cal office.

Will I keep my Medicare benefits?

Due to a change in federal rules, Medicare eligibility is limited to U.S. citizens, U.S. nationals, lawful permanent residents, Cuban and Haitian entrants, and people who live in the U.S. under the Compacts of Free Association. Depending on your immigration status, you may see

changes to your Medicare eligibility in 2027. The Social Security Administration will mail you a notice if there are changes to your Medicare eligibility.

For questions about your Medicare status or appeal rights, please call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. Help from Medicare is available 24 hours a day, seven days a week, except for some federal holidays.

How will I get Medicare as of January 1, 2027?

Due to your disenrollment from <plan name>, you will be covered by Original Medicare beginning January 1, 2027, unless you choose a different option.

You have a special one-time opportunity to enroll in a different Medicare Advantage Plan or Medicare Prescription Drug Plan. This opportunity will end when you enroll in a different plan or on March 31, 2027, whichever is earlier.

Once you use the special one-time opportunity to change plans, there are limits to when and how often you can change the way you get Medicare:

- **From October 15 through December 7**, anyone with Medicare can switch plans or return to Original Medicare. This includes adding or dropping Medicare prescription drug coverage for the following year.

- **From January 1 through March 31,** anyone enrolled in a Medicare Advantage Plan (except a Medicare Medical Savings Account Plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan).

Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

Remember, you may see changes to your Medicare eligibility in 2027. Keep that in mind when you decide how you want to get your Medicare as of January 1, 2027.

Where can I get help?

If you have any questions, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>. For information about your Medicare coverage, call 1-800-MEDICARE (1-800-633-4227).

Additionally, you may call the Health Insurance Counseling and Advocacy Program at 1-800-434-0222 for help understanding your Medicare coverage options. Finally, you can call the Medicare and Medi-Cal Ombudsperson Program at 1-855-501-3077 for answers to your questions about Medicare and Medi-Cal coverage, enrollment, and getting care.

We provide materials in other languages and accessible formats at no cost (for example, large print or Braille). Call <phone number> to request an alternate format, free interpreter assistance, or translated information.

Thank you.