MEDI-CAL FEE-FOR-SERVICE PROVIDER TOOLKIT

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

TABLE OF CONTENTS

Medi-Cal Fee-for-Service Provider Toolkit 1

- Overview of Transition 3
- Seeing Patients & Accepting New Ones 4
- Enroll as a Provider in Medi-Cal FFS 5
- Verifying Eligibility for Medi-Cal Members 6
- TAR Continuity Under FFS 7
- Transportation Services in Medi-Cal Fee-for-Service 8
- Services Available in Both Managed Care and FFS 9

OVERVIEW OF TRANSITION

Starting January 1, 2027, federal rules require that Medi-Cal members with Unsatisfactory Immigration Status (UIS) get their care through Medi-Cal Fee-for-Service (FFS) instead of a Medi-Cal managed care plan (MCP).

This transition affects how care is delivered, not whether members remain eligible for Medi-Cal. Members will keep full-scope coverage if they renew on time.

Impacted members can see any doctor, clinic, or hospital that accepts Medi-Cal FFS. Members pick their own providers, and Medi-Cal pays providers directly for each visit or service.

What this means for Providers:

- Members you see through an MCP will no longer be enrolled in that plan.
- You'll bill DHCS directly instead of the MCP.
- Authorizations go through DHCS via Treatment Authorization Requests (TARs) rather than the MCP.

Actions providers can take now:

- Update your enrollment through PAVE or verify your enrollment to be sure you are enrolled in Medi-Cal FFS
- Update your Provider Directory Information
- Review FFS billing requirements including TARs
- Update capacity information within your Provider Portal to reflect whether you are accepting new FFS members.

Where to learn more:

- DHCS FFS Transition Website
- Policy Guide for Transition of UIS Population

SEEING PATIENTS & ACCEPTING NEW ONES

Thank you for the role you play as a provider in caring for members with unsatisfactory immigration status (UIS) through their transition from managed care to Medi-Cal FFS.

You can keep seeing your patients, but only if you are enrolled in Medi-Cal FFS. Under Medi-Cal, members are not assigned to a specific provider, so they can receive services from any provider who accepts Medi-Cal FFS.

In Medi-Cal FFS, a provider that is "accepting new patients" means something different. If you choose to begin or continue to accept Medi-Cal FFS, you will not be "assigned" to your new patients as you would be in managed care.

If you have capacity to provide care for some of California's most vulnerable members, please update your availability by logging into your DHCS Provider Portal and indicating whether you are accepting new FFS patients.

Please note: This action is now required quarterly for all Provider Portal Administrators.

Accepting new patients is a choice. Enrolling in FFS doesn't obligate you to take every member who asks for services. It does mean you can accept new patients if you choose to, and that you need a clear, current answer ready when a patient or another provider's office asks whether you're taking new patients.

If you currently see members with UIS in managed care and choose not to enroll in Medi-Cal FFS, you can still help by referring these patients to a provider who is enrolled in Medi-Cal FFS. Your MCP is responsible for helping coordinate this transition and supporting continuity for members with ongoing treatment needs.

- When possible, refer to other providers who are enrolled in Medi-Cal FFS.

ENROLL AS A PROVIDER IN MEDI-CAL FFS

Thank you for continuing to care for Medi-Cal members through FFS. Your willingness to see these patients through this transition helps ensure they don't experience a gap in care.

If you want to keep seeing these members, you must be enrolled as a provider in Medi-Cal FFS. In FFS, there is no primary care physician assignment, and your status as a member's provider under an MCP does not automatically transfer. Serving as a member's doctor under an MCP does not carry forward, **only enrollment in Medi-Cal FFS does**.

If you are already enrolled in Medi-Cal FFS as a billing provider, you don't need to do anything new for this transition. You can continue treating and billing for patients who move from MCP to FFS. (Callout box/sidebar – Check FFS Enrollment Now)

If you are not currently enrolled**, you must submit your application by January 1, 2027** to bill for these members.

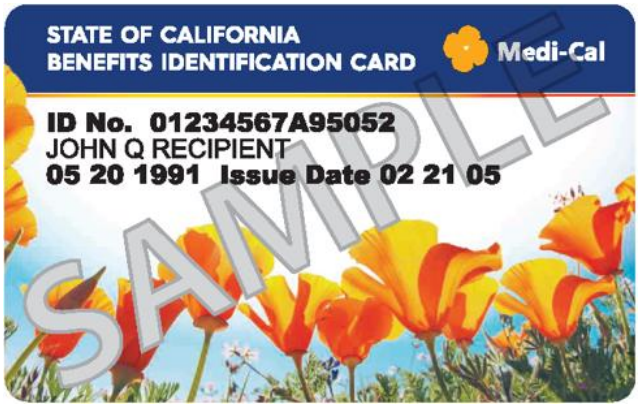
Enrollment can take time to process, so don't wait! MCPs are required to notify contracted providers about the transition, but the enrollment application itself is something each provider must initiate and complete.

What can providers do now?

1. Check the enrollment requirements for your provider type and gather the required documents.
2. Determine the correct enrollment pathway by provider type.
3. For most provider types, create a User Profile and submit an enrollment application through the Provider Application and Validation for Enrollment (PAVE) Provider Portal. Each individual provider must have a unique user profile. Refer to alternative pathways for non-PAVE enrollments.
    - View PAVE tutorials.
    - PAVE Help Desk – (866) 252-1949
      Monday – Friday, 8 a.m. to 6 p.m. Pacific Time
4. Sign up for DHCS' Medi-Cal Subscription Service (MCSS), which keeps providers up-to-date on the latest Medi-Cal news.
5. If a provider chooses not to enroll as a Medi-Cal FFS provider, **help the member transfer their care** to a colleague who is or will be enrolled.

VERIFYING ELIGIBILITY FOR MEDI-CAL MEMBERS

Following the transition of Medi-Cal members with Unsatisfactory Immigration Status (UIS) from managed care to FFS on January 1, 2027, members will no longer present their prior plan card to access services. They will present their Benefits Identification Card (BIC) and are eligible to receive care from any FFS provider.



Members will not automatically receive a new or replacement BIC as part of this transition. They should continue using their existing BIC to access care starting January 1, 2027.

Method	How
Via Phone (AEVS) **(800) 456-AEVS (2387)**	Using the Automated Eligibility Verification System (AEVS), providers can check a member's eligibility status. You can use either an SSN or BIC number. AEVS will return a 10-digit Eligibility Verification Number (EVC) which is **only valid** for the provider who submitted the inquiry.
Via Point of Sale (POS)	If your location already has a POS device that reads BICs, swipe the BIC at every member visit, and log the confirmation number received in the member's record.

No BIC or SSN?

Contact the county Medi-Cal Office where the member lives using the Medi-Cal County Contacts for Providers list. For security purposes, providers must identify themselves as a Medi-Cal provider and identify the member.

To request a replacement BIC, members can use these contacts or visit BenefitsCal.

Additional Resources

- Provider Helpline – (800) 541-5555 for additional support.
- Medi-Cal Dental – (800) 423-0507 for additional provider support.
- AEVS General Instructions

TAR CONTINUITY UNDER FFS

In Medi-Cal FFS, providers submit Treatment Authorization Requests (TARs) to DHCS for approval of medically necessary services when required.

TAR Special Handling Process for Transition of Members with UIS

To prevent delays in service, DHCS will implement a new TAR special handling option to support members transitioning from MCPs to Medi-Cal FFS. This option will be available when DHCS has an 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 electronic TAR (eTAR) meeting minimum requirements; however, attachments to support medical justification will not be necessary if an approved authorization exists with the member's MCP.

Starting October 1, 2026, DHCS will accept TARs for impacted members for dates of service on or after January 1, 2027.

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 refer the provider to submit a TAR through the DHCS' Medi-Cal FFS TAR process.

TAR/eTAR Resources and Support

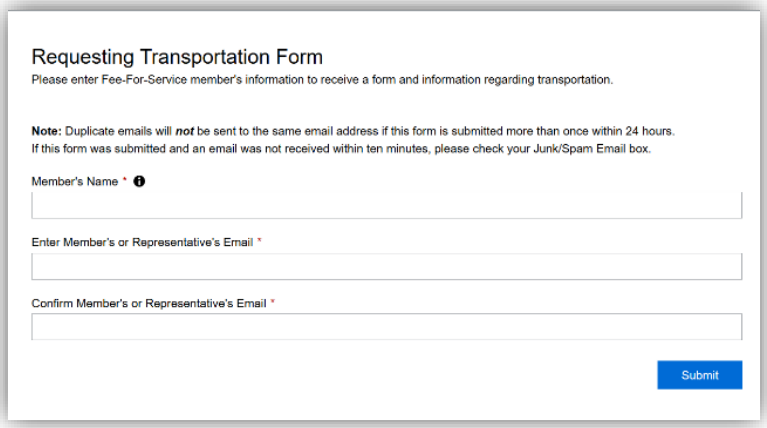
- TAR Website
- Medi-Cal Learning Portal

TRANSPORTATION SERVICES IN MEDI-CAL FEE-FOR-SERVICE

Transportation to appointments and services is a key component of access to care for Medi-Cal members.

Medi-Cal FFS 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 treatment appointments, and to pick up prescriptions and medical supplies. There are two types of transportation for appointments:

- Non-Medical Transportation (NMT) is transportation by private or public vehicle for members who do not have another way to get to their appointment.
- Non-Emergency Medical Transportation (NEMT) is transportation by ambulance, wheelchair van, or litter van when transportation by ordinary public or private means is medically contraindicated and required for obtaining needed medical care.



Providers and their teams may continue to use the Requesting Transportation Form to assist impacted members with arranging transportation.

Become a Medi-Cal FFS NMT and NEMT Transportation Provider

Just like medical providers, transportation providers must be enrolled in Medi-Cal FFS to continue serving impacted members after January 1, 2027. Joining Medi-Cal FFS as a transportation provider is an impactful way to ensure members in your community can get to and from the care they need.

- » DHCS Non-Medical Transportation – To enroll as a NMT provider and register NMT vehicles.
- » DHCS Treatment Authorization Request (TAR) – Training, TAR forms, instructions for preparing and submitting, and information on the Appeals process.
- » Transportation Provider FAQs

» Provider Helpline at (800) 541-5555 – Eligibility and billing support.

SERVICES AVAILABLE IN BOTH MANAGED CARE AND FFS

DHCS recognizes the significance of care management and supportive services. DHCS encourages providers to continue caring for impacted members currently receiving care management services, with minimal disruption.

Care management billing codes for services that remain available following this transition are detailed below.

DHCS is actively working to identify additional care management billing codes available in Medi-Cal FFS to allow Enhanced Care Management (ECM), Community Supports, Complex Care Management (CCM), and Transitional Care Services (TCS) providers to continue providing care management services to FFS members.

Please note: The following information does not guarantee that any provider types will be able to receive Medi-Cal FFS payment for the following billing codes. Providers should reference all relevant guidance materials to confirm compliance with existing billing requirements, including DHCS billing manuals, the CPT codebook, and relevant CMS guidance.

Service	Who can bill?	Billing Tips	Billing Guidance
Community Health Worker (CHW) Services	Enrolled Medi-Cal supervising provider, CHWs	» Document the date, duration, service provided, and member outcome for every CHW encounter.	Community Health Worker (CHW) Preventive Services
Psychiatric Collaborative Care Management	Treating physician or qualified health professional	» Document consent, psychiatric consultant review, and care management time.	Evaluation & Management (E&M) (pages 36 – 37)
Comprehensive Perinatal Service Program (CPSP)	CPSP-certified providers (physicians, CNMs, NPs, PAs, clinics)	» Complete initial CPSP assessments before billing follow-up services. » Verify allowable units and frequency limits before billing.	Pregnancy: Comprehensive Perinatal Services (CPSP) List of Billing Codes

Doula Services	Certified Doulas	» Track visit limits and additional postpartum visit requirements. » Each service claim must include a required ICD-10-CM diagnosis code.	Doula Services
Dyadic Services	Licensed or associate-level medical and behavioral health providers.	» Apply required dyadic billing modifiers. » Bill under the correct Medi-Cal member (child or caregiver, as applicable).	Dyadic Services
Asthma Preventive Services (APS)	Physicians, NPs, PAs, and certified APS providers	» Unlicensed APS providers must be supervised by a physician, PA, NP, clinic, hospital, LHJ, or CBO. » Include ICD-10-CM diagnosis code on all APS claims.	Asthma Preventive Services (APS)

Members Receiving Targeted Case Management (TCM)

- **Specialty Mental Health TCM may continue** when members meet access criteria and have an assessed TCM need.
- County Behavioral Health Plans (BHPs) will continue to cover Specialty Mental Health TCM for members who are QNC, PRUCOL, or whose citizenship status is not known.
- Non-Specialty TCM is generally not available in Medi-Cal FFS for impacted members, **except for pregnant members when federally reimbursable.**

Services Not Available in Medi-Cal FFS

- Members who are currently receiving ECM, California Integrated Care Management (CICM), Community Supports, CCM and TCS will no longer have access to these services in Medi-Cal FFS.
- To support members who receive these services, providers and their teams can:
    - Coordinate referrals to community-based and other support services.
    - Assist members with transitioning to other available resources to prevent gaps in care.