

Medi-Cal Enrollees with Unsatisfactory Immigration Status: What to Know About the Transition to Fee-for-Service

How California Can Protect Access and Continuity of Care as 1.9 Million Enrollees Leave Managed Care in January 2027

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Issue Brief

Introduction and Background

Beginning January 1, 2027, nearly two million immigrants with unsatisfactory immigration status (UIS) currently enrolled in Medi-Cal will no longer receive their care through a health plan.¹ Instead, they will move to a fee-for-service (FFS) system, where they will have to rely on the Department of Health Care Services (DHCS) to fill the role of a health plan and will have to find providers who accept Medi-Cal directly. This change dials back more than a decade of work to improve access to and quality of care for this population through managed care. Other recent budget provisions, like the UIS enrollment freeze and upcoming premiums for many UIS Medi-Cal enrollees, will also limit access. Researchers project that California’s uninsured rate for the UIS population will rise from 25% in 2024 to over 50% by 2030.²

The transition is largely driven by federal policy. Guidance from the US Centers for Medicare & Medicaid Services directs states that use state-only dollars to cover people with UIS to do so through a “separate and distinct” contract from a managed care plan that is paid by the state through capitation, or a set amount per member per month. This is intended to prevent federal Medicaid managed care payments from being used for non-emergency services for undocumented people who are ineligible for full Medicaid benefits.³ To comply with the federal guidance, California’s enacted FY 2026–27 budget moved UIS enrollees to FFS, though the legislature considered other proposals before the budget was enacted at the end of June 2026.⁴

Since California phased in full-scope Medi-Cal to immigrants regardless of citizenship status from May 2016 through January 2024, many people are affected. As of March 2026, about 1.4 million people were enrolled through that expansion, accounting for roughly 10% of Medi-Cal’s 14.5 million enrollees, as shown in Table 1.⁵ When enrollees in restricted-scope coverage are counted as well, a total of 1.9 million enrollees with UIS — including 251,000 children under age 21 — will transition to FFS.⁶

Table 1. Medi-Cal Full-Scope Expansion Enrollment, by Age

	ENROLLEES	SHARE
Children (0-18)	178,190	12.5%
Young Adults (19-25)	118,789	8.3%
Adults (26-49)	718,577	50.4%
Older Adults (50+)	410,855	28.8%
TOTAL	1,426,411	100.0%

Source: [Medi-Cal Enrollment Tracking Tool, CHCF, 2026](#). Data reflects March 2026.

To inform this brief, the authors conducted four interviews with managed care, health policy, and consumer advocacy experts in July 2026. The analysis also draws on qualitative and quantitative data. However, since data are limited for the UIS population, this brief uses proxy populations where appropriate, including undocumented people, noncitizens, and Medi-Cal enrollees eligible under the expansion regardless of immigration status. The specific population used is identified throughout the brief.

According to those interviewed, moving this population to FFS is a decision with both political and financial considerations. California is under heightened federal scrutiny and has a Medicaid waiver renewal and other priorities at stake.⁷ This change also lands as a new state administration arrives that must balance policy priorities alongside budgetary constraints. With its lower administrative costs, overall lower utilization in managed care, and reduced utilization due to loss of eligibility for Enhanced Care Management (ECM) and Community Supports, the transition is expected to save the state \$583.8 million (\$471.6 million of which is tied to the General Fund) in FY 2026–27 and about \$1.5 billion annually (\$1.2 billion from the General Fund) going forward. To ease the transition, the budget authorizes up to \$25 million for administrative costs and appropriates \$39 million for transitional services, including \$31 million for care coordination and \$8 million for clinic- and community-based navigation services.⁸

FFS Lacks Structural Protections That Managed Care Requires

To improve care coordination, accountability, and access, Medi-Cal began the shift away from a fee-for-service (FFS) program — where providers billed the state directly for each service, with limited coordination or accountability — to mandatory managed care with the 2010 “Bridge to Reform” Section 1115 waiver.⁹ As of April 2026, approximately 95% of Medi-Cal enrollees are in managed care.¹⁰ Managed care plans are contractually obligated to maintain adequate provider networks that meet time, distance, and other standards; have member call centers and translation services; support providers on claims and billing; report on quality; and deliver CalAIM (California Advancing and Innovating Medi-Cal) benefits such as Enhanced Care Management and Community Supports.

FFS does not include these structural obligations that support and protect enrollees. A high-level, side-by-side comparison of FFS and managed care appears in Appendix A.

Who Is Affected and How

The population moving to FFS is largely Latino/x and of working age. Noncitizen Californians are nearly three times more likely to be uninsured and 1.6 times more likely to be enrolled in Medi-Cal than the overall population. Among women, people over 50 years old, and White Californians, there are the largest gaps in Medi-Cal enrollment for noncitizens compared to the overall population (see [Figures B1-B3](#) in Appendix B).¹¹ The UIS population includes many people with serious and ongoing needs. Local Health Plans of California (LHPC), whose member plans cover approximately 85% of the UIS Medi-Cal population, reports that about 690,000 of the 1.6 million UIS enrollees it serves accessed specialty care in 2025.¹²

Figure 1 (see following page) summarizes the major impacts of the transition on UIS enrollees.

Looking Ahead

On September 1, 2026, the California Department of Health Care Services (DHCS) released its second UIS transition policy guide (which it promises to update every six weeks); a plain-language, enrollee-facing transition section on its website; enrollee and provider FAQs; a general fact sheet; provider communication templates; a new tool for finding doctors and services; and an FFS telephone service center that operates Monday through Friday from 8:00 AM–5:00 PM (PT).¹³ DHCS also committed to mailing a single member notice in all 19 Medi-Cal threshold languages and alternative formats by December 1, 2026; launching a multilingual text message campaign; developing updated materials for Coverage Ambassadors; and providing complaint and appeals support.¹⁴ These enrollee communication and outreach efforts address several of the gaps identified above, but continued information and guidance will be critical to mitigate risks to continuity of care once managed care plans’ transition duties end.

Efforts to protect high-risk enrollees and ensure continuity of care are also underway. Over 16,000 enrollees who are receiving intensive clinical care from providers not enrolled in FFS and who are at a high risk of losing continuity of care will be prioritized for initial outreach before the transition. Enrollees at lower risk or who have a longer-term risk profile will be contacted after the transition.¹⁵ Enrollees should also receive support from their MCPs in identifying their current providers and understanding whether they will continue providing care under FFS. DHCS has directed MCPs to share enrollee status and prior authorization data and to maintain enrollee services until December 31, 2026.¹⁶

To increase the FFS provider network, DHCS is requiring MCPs to communicate FFS Provider Application and Validation of Enrollment (PAVE) instructions to interested providers and is conducting targeted provider outreach, first prioritizing Los Angeles County and Southern California, where the UIS population is most concentrated. DHCS has also released provider-facing resources, including an FAQ document on how to

Figure 1. Impacts of FFS Transition on UIS Enrollees

A More Limited Provider Network

UIS enrollees will likely have fewer providers to choose from, and those providers may be harder to reach, because FFS has no network adequacy standards and pays comparatively low rates to providers. The 1.9 million enrollees will have to seek care from approximately 373,000 FFS Medi-Cal providers statewide. These providers are primarily concentrated in urban centers, with fewer in rural counties (Table 2). Further, Medi-Cal FFS pays just 87.5% of the Medicare fee rate for primary care, maternity care, and non-specialty mental health services, and a lower rate for most other services. The lower reimbursement rate for Medi-Cal FFS providers makes some less willing or able to accept patients.

Less Continuity of Care

Managed care transition-of-care protections do not apply to enrollees transitioning into FFS. Therefore, care may be disrupted due to logistical challenges with securing new providers, delays in transferring prior authorizations, and a broader loss of benefits. DHCS indicates that 58.7% of UIS enrollees in active treatment currently have non-FFS providers (751,853 out of 1,281,401). These providers cannot be paid for their ongoing services unless they enroll in FFS by December 31, 2026. DHCS has an expedited process to transfer prior authorizations for enrollees whose providers do not enroll but does not guarantee that the transfers will be completed by that date. In FFS, enrollees may be turned away from a point of care if they do not bring a Benefits Identification Card to an appointment. Further, Community Supports and ECM are not available benefits in FFS, so the highest-need enrollees may lose their care managers.

No Oversight to Guarantee Provision of Services

In some instances, FFS enrollees may be less likely to receive services than their managed care peers, which demonstrates the need to monitor access and quality (Table B2). However, the FFS system lacks the reporting requirements, language access accountability, public dashboards, quality measures, and sanctions that govern Medi-Cal managed care and that make this sort of monitoring possible. DHCS intends to strengthen oversight of Medi-Cal FFS beginning in 2027, but building the infrastructure, collecting provider data, and making improvements will take time.

Increased Reliance on Other Safety-Net Providers

Reduced access to preventive and primary care pushes people towards emergency departments and other safety-net providers like Federally Qualified Health Centers (FQHCs). The state estimates a 16% increase in emergency and inpatient care following this transition. Even amid increased demand, FQHCs and Rural Health Clinics will no longer be reimbursed for serving the UIS population beginning July 2027.

Sources: “Stakeholder Advisory Committee & Behavioral Health Stakeholder Advisory Committee Meeting” (PDF), PowerPoint presentation, DHCS, September 22, 2026; “Enrolled Medi-Cal FFS Providers,” DHCS, last updated September 25, 2026; “Medi-Cal Targeted Provider Rate Increases and Investments,” DHCS, accessed August 6, 2026; *Policy Guide for Transition of the Unsatisfactory Immigration Status Population From Managed Care to Medi-Cal Fee-For-Service* (PDF), DHCS, September 1, 2026; *The 2025-26 Budget: CalAIM Enhanced Care Management and Community Supports Implementation Update*, Legislative Analyst’s Office (LAO), March 6, 2025; *Los Angeles County Child-Welfare Involved Population Medi-Cal Analysis: Comparative Analysis of the Engagement in Care for Children in Medi-Cal Fee-for-Service vs. Managed Care and Learnings from Enhanced Care Management Early Implementation*, Health Management Associates, May 2025; Miranda Dietz et al., *Over Two Million More Californians Projected to Lack Health Insurance By 2030*, UC Berkeley Labor Center and UCLA Center for Health Policy Research, May 25, 2026; *Medi-Cal FFS for UIS Population Jeopardizes Critical Health Care Services & Access* (PDF), Local Health Plans of California, accessed July 31, 2026; *Eliminate Prospective Payment System Reimbursement for State-Only Services* (PDF), DHCS, 2025; *The 2025-26 California Spending Plan: Health*, LAO, October 16, 2025; and author calculations based on preliminary data shared in September 2026 by DHCS in the Stakeholder Advisory Committee & Behavioral Health Stakeholder Advisory Committee Meeting.

Notes: UIS is unsatisfactory immigration status; FFS is fee-for-service; DHCS is the California Department of Health Care Services; ECM is Enhanced Care Management.

Table 2. Medi-Cal FFS Providers, by California County

COUNTY	FFS PROVIDERS	COUNTY	FFS PROVIDERS	COUNTY	FFS PROVIDERS
Alameda County	11,929	Modoc County	43	Sonoma County	3,844
Alpine County	8	Mono County	82	Stanislaus County	4,149
Amador County	253	Monterey County	2,124	Sutter County	624
Butte County	1,523	Napa County	738	Tehama County	260
Calaveras County	135	Nevada County	758	Trinity County	41
Colusa County	85	Orange County	20,269	Tulare County	1,955
Contra Costa County	7,455	Placer County	3,483	Tuolumne County	327
Del Norte County	129	Plumas County	77	Ventura County	4,805
El Dorado County	826	Riverside County	13,267	Yolo County	1,078
Fresno County	6,368	Sacramento County	14,079	Yuba County	302
Glenn County	73	San Benito County	179		
Humboldt County	1,111	San Bernardino County	14,781	UNKNOWN	7,934
Imperial County	751	San Diego County	21,580	N/A	89,345
Inyo County	190	San Francisco County	14,472		
Kern County	4,874	San Joaquin County	4,394		
Kings County	622	San Luis Obispo County	1,430		
Lake County	303	San Mateo County	5,178		
Lassen County	111	Santa Barbara County	2,530		
Los Angeles County	70,269	Santa Clara County	21,071		
Madera County	637	Santa Cruz County	2,104		
Marin County	1,716	Shasta County	1,455		
Mariposa County	80	Sierra County	12		
Mendocino County	568	Siskiyou County	255		
Merced County	1,105	Solano County	3,221		

Notes: Authors used data for "FL_Provider_Type" and "FL_Provider_County" from source dataset. Total counts of providers does not include roughly 100,000 providers who did not have related county data (Unknown = 7,934 and N/A = 89,345).

Source: [Enrolled Medi-Cal FFS Providers, California Department of Health Care Services](#), last updated September 25, 2026.

prepare and what to tell patients, a provider bulletin, and a “Providers and Partners” page on the DHCS website.¹⁷

These DHCS efforts and resources lay important groundwork, but some elements of the transition need further defining and development to ensure the UIS population maintains access to care. At the time of writing this policy brief, DHCS resources and materials were current as of September 2026. DHCS plans to continuously update materials as the transition approaches. The following opportunities would further protect the UIS population before the 2027 transition:

- **Develop a detailed transition plan for enrollees with complex care needs.** UIS enrollees who are currently in treatment or who have a complex medical need (e.g., dialysis, organ transplant) are a high-priority population that could benefit from a more detailed care transition plan. DHCS plans to conduct targeted outreach based on risk-stratified enrollee groups but could provide additional detail to and support for these enrollees as well as clear, accountable escalation pathways. There are roles across the delivery system, including providers, community-based organizations, along with health plans, which can play a pivotal role in supporting complex care transitions.
- **Define and fund an FFS care management program.** Defining a pathway for care management by ensuring warm handoffs when possible, providing enrollees with clear points of contact, and utilizing referral pathways to engage high-risk enrollees could help mitigate some of the effects of losing ECM and Community Supports. DHCS plans to do this through a hybrid model, where a statewide vendor leverages existing local networks (e.g., community health workers, FQHCs) to provide care coordination, with a separate clinical nurse advice line, beginning January 1, 2027. However, specific details around the FFS care management pathway and its billing codes remain forthcoming. DHCS could finalize and publish the codes before January 1, 2027, so flagged enrollees have a defined pathway to receive care management.
- **Guarantee continuity beyond the December 31 wind-down.** To ensure that enrollees can continue accessing services they are already receiving, DHCS could actively honor prior authorizations for a defined period after January 1, 2027, as well as monitor enrollees in active treatment during the transition.
- **Complete the front door and secure language access.** Approximately 47% of noncitizens in California have limited English proficiency, and UIS Medi-Cal enrollees with limited English proficiency may face challenges locating providers participating in FFS.¹⁸ The DHCS search tool does not yet show whether a provider is accepting new patients, and language interpretation services at FFS visits will be uncertain without MCP-level obligations.¹⁹ DHCS plans to expand its helpline, as it is likely strained under high volume, but has not yet provided concrete details. To expand information sharing efforts with enrollees, DHCS could indicate in its tool which providers are accepting new patients, fund interpretation services for FFS providers, and use the \$8 million in recently allocated funds to sustain outreach through community navigators and county eligibility workers.²⁰
- **Convert provider communication into participation.** To help broaden the FFS provider network, DHCS could add enrollment and rate incentives for high-demand specialties and safety-net providers. DHCS also plans to publicly monitor access through data points like provider capacity and appointment availability, but this will take time to set up.²¹
- **Enhance data and reporting.** California could develop a dashboard to help the state and stakeholders understand how this population is accessing care, so the transition does not go unmeasured. Such a tool would also help policymakers address challenges as they emerge.

Conclusion

As nearly two million Medi-Cal enrollees with UIS transition from managed care to FFS, what matters most is protecting their access to care and continuity of treatment.²² In practice, that means keeping enrollees connected to their current providers, tracking the care they receive, and preserving the ability to reconnect them to MCPs in the future. These choices are the most likely to limit harm now and protect the state's ability to rebuild later.

The stakes are significant. The transition moves Medi-Cal away from the managed care protections and supports that the state spent years developing. Many enrollees currently receiving care will face difficulties keeping their providers, continuing treatment, and navigating the system without a care manager. Others still may be discouraged from seeking care at all, given the current political climate and the impact of all the coming Medi-Cal coverage changes.²³

A return to managed care for the UIS population is possible. One option proposed by stakeholders but rejected during the most recent budget negotiations was to pay for certain services, such as emergency care, through fee-for-service while allowing enrollees with UIS to remain in managed care for other services. However, the political and fiscal headwinds are steep, and any reversal would require another disruptive transition. That makes the mechanisms of this transition especially consequential. The decisions made now will determine both the extent to which UIS enrollees keep their access to care today and how easily they may be able to regain access to the benefits of managed care should the climate shift.

About the Authors

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About the Foundation

The [California Health Care Foundation](#) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with the changemakers to create a more responsive, patient-centered health care system.

Acknowledgments

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Appendix A. Fee-for-Service vs. Managed Care: High-Level Comparison

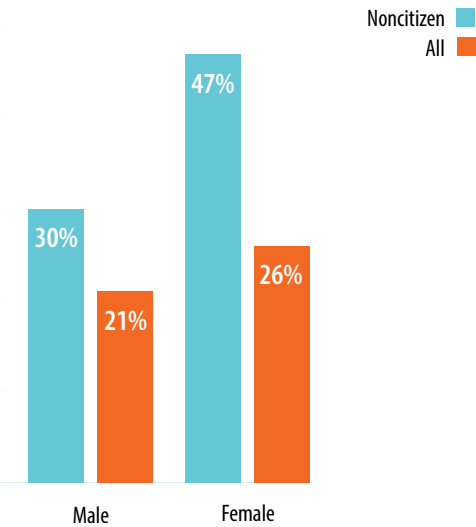
FEATURE	MANAGED CARE	FEE-FOR-SERVICE
Provider network	Contracted network held to network adequacy standards and time and distance requirements	No network adequacy standards; any enrolled provider willing to accept FFS rates
Finding a provider	Searchable, member-facing provider directory required	New “Find Doctors & Services” tool searches by name, location, type, and specialty, but advises calling to confirm accuracy and status on accepting new patients
Care coordination	Member services, care management, and navigation built in	None inherent; limited navigation funded for the transition, and implementation remains forthcoming as of September 2026
CalAIM benefits	Enhanced Care Management and Community Supports available	No equivalent
Provider payment	Contracted rates with managed care plans	State FFS fee schedule; at least 87.5% of Medicare fee schedule even after targeted increases
Oversight & quality	Reporting, dashboards, quality measures, sanctions	Limited data reporting
Member appeals	Knox-Keene independent medical review plus state fair hearing	State fair hearing before an administrative law judge
Language services	Free interpretation services, arranged by the health plans, in all languages and translated member materials	Providers must meet federal meaningful-access requirements

Notes: CalAIM is California Advancing and Innovating Medi-Cal. FFS is fee-for-service.

Source: Authors’ analysis, Aurrera Health Group, 2026.

Appendix B. UIS Enrollee Impact Reference Data

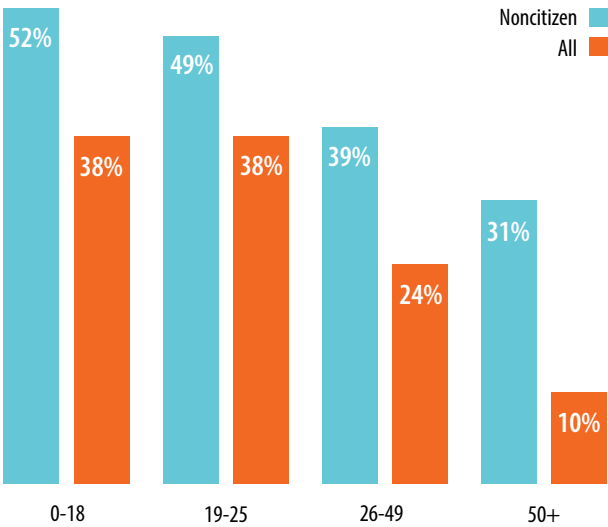
Figure B1. Medi-Cal Enrollment Among Noncitizens and All Californians, by Gender



Note: The data show the share of noncitizens enrolled in Medi-Cal compared to all Californians enrolled in Medi-Cal by select demographics.

Source: "AskCHIS," UCLA Center for Health Policy Research, 2024 data, accessed August 1, 2026.

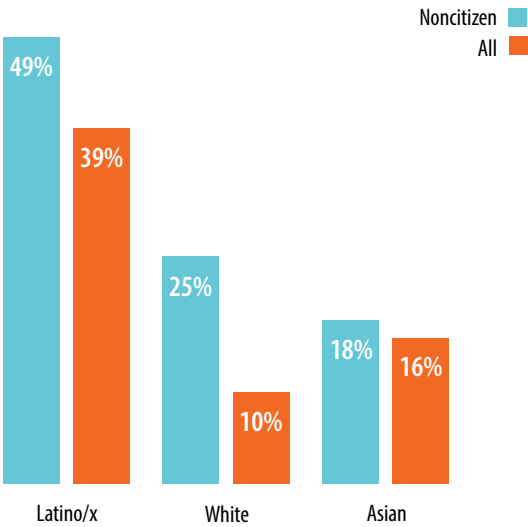
Figure B2. Medi-Cal Enrollment Among Noncitizens and All Californians, by Age



Note: The data show the share of noncitizens enrolled in Medi-Cal compared to all Californians enrolled in Medi-Cal by select demographics.

Source: "AskCHIS," UCLA Center for Health Policy Research, 2024 data, accessed August 1, 2026.

Figure B3. Medi-Cal Enrollment Among Noncitizens and All Californians, by Race/Ethnicity



Notes: The data show the share of noncitizens enrolled in Medi-Cal compared to all Californians enrolled in Medi-Cal by select demographics. Several racial/ethnic groups are omitted due to small sample size and/or statistically unstable data.

Source: "AskCHIS," UCLA Center for Health Policy Research, 2024 data, accessed August 1, 2026.

Table B1. Number of Medi-Cal FFS Providers, by Type and Specialty

	COUNT	%
Provider Type		
Physicians	159,680	42.8%
Unknown	41,268	11.1%
Marriage & Family Therapists	21,928	5.9%
Physician Groups	17,711	4.7%
Certified Nurse Practitioners	17,013	4.6%
Licensed Clinical Social Workers	16,430	4.4%
Psychologists	8,497	2.3%
Physical Therapists	7,914	2.1%
Provider Specialty		
Unknown/Not Applicable	237,863	63.7%
Internal Medicine	25,415	6.8%
Pediatrics	11,597	3.1%
Family Practice	11,320	3.0%
Emergency Medicine/Urgent Care	11,029	3.0%
General Practice	8,563	2.3%
Anesthesiology	7,370	2.0%
Radiology	6,872	1.8%
Obstetrics-Gynecology	6,807	1.8%
Total	373,367	100.0%

Notes: Authors used data for "FL_Provider_Type" and "FL_Provider_Specialty" from source dataset. Unknown combines "unknown" and "NA" data. FFS is fee-for-service.

Source: Authors' analysis of [Enrolled Medi-Cal FFS Providers, California Department of Health Care Services](#), last updated September 25, 2026.

Table B2. Care Received by Children and Youth in Los Angeles County, by Medi-Cal Delivery System

VISIT TYPE	FFS	MANAGED CARE
Well-child visits	11%	38%
Behavioral health visits	14%	26%
Dental visits	8%	29%
Social determinants of health screening	3%	10%

Notes: Health Management Associates analyzed Transformed Medicaid Statistical Information System (T-MSIS) data for Medi-Cal enrollees age 26 and under who were enrolled in December 2022 and resided in Los Angeles County.

Source: [Los Angeles County Child Welfare-Involved Population Medi-Cal Analysis](#), Health Management Associates, May 2025.

Endnotes

1. [“Immigration Status and Changes to Medi-Cal Eligibility,”](#) California Department of Health Care Services (DHCS), December 30, 2025; and [FY 2026–27 May Revision Highlights](#) (PDF), DHCS, May 2026; and Miranda Dietz et al., [“Over Two Million More Californians Projected to Lack Health Insurance By 2030,”](#) UC Berkeley Labor Center and UCLA Center for Health Policy Research, May 25, 2026.
2. Miranda Dietz et al., [“Over Two Million More Californians Projected to Lack Health Insurance By 2030,”](#) UC Berkeley Labor Center and UCLA Center for Health Policy Research, May 25, 2026.
3. Caprice Knapp (acting deputy administrator and director, Department of Health & Human Services, US Centers for Medicare & Medicaid Services) to all state Medicaid directors, [“Medicaid Managed Care Payments and Emergency Medical Condition Coverage for Aliens Ineligible for Full Medicaid Benefits”](#) (PDF), SMD #25-003, September 30, 2025.
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23. Michele Cordoba et al. [In Their Own Words: How Undocumented Californians Are Navigating Medi-Cal Changes and Immigration Enforcement](#), CHCF, June 2026.