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MEMORANDUM

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Date: May 21, 2026

Subject: Medi-Cal Participation Strategy for Home-Based Primary Care (HBPC) Practice in Sacramento and Placer Counties

Purpose

This memorandum provides a validated, payer-facing overview of Medi-Cal enrollment and managed care network considerations for a home-based primary care (HBPC) practice preparing for initial launch in California. It integrates Medi-Cal managed care provider enrollment requirements, CalAIM Enhanced Care Management (ECM) and Community Supports considerations, and practical payer credentialing and delegation implications.

Background and Operating Context

California relies heavily on Medi-Cal managed care plans (MCPs) to deliver Medicaid services. Recent DHCS eligibility reporting shows Medi-Cal continues to cover more than one-third of California residents, with approximately 14.8 million certified eligibles reported for June 2025 (Note: figures are subject to updates and retroactive adjustments.); DHCS notes that eligibility counts are reported with a lag and are subject to later completion. For an HBPC practice serving frail older adults, dual-eligible members, complex chronic care patients, and home-limited individuals, Medi-Cal enrollment and managed care network readiness are important operational prerequisites for contracting, referrals, care coordination, and participation in risk-based or delegated arrangements.

HBPC capabilities align with several CalAIM priorities, including longitudinal care coordination, in-home care management, interdisciplinary support, and connection to health-related social services. ECM and Community Supports opportunities should be evaluated plan-by-plan and county-by-county because eligibility criteria, referral workflows, and provider participation requirements are established through DHCS policy and individual MCP implementation processes.

Regulatory Foundation

Providers participating in Medi-Cal managed care networks must complete enrollment and screening consistent with federal Medicaid provider screening requirements under 42 CFR Part 455 and DHCS managed care guidance. DHCS All Plan Letter (APL) 22-013 distinguishes provider enrollment and screening from credentialing and re-credentialing. For MCP network providers with an applicable state-level enrollment pathway, enrollment may occur through DHCS Provider Enrollment Division (PED), including PAVE where available, or through an MCP screening and enrollment process recognized under DHCS requirements. Providers enrolled through DHCS may participate in Medi-Cal fee-for-service (if otherwise applicable) and may contract with MCPs; providers enrolled only through an MCP may be limited to Medi-Cal managed care participation. MCPs must monitor ongoing enrollment status and revalidate the enrollment of each network provider at least every five years.

For commercial, Medicare Advantage, delegated IPA, and senior-focused value-based arrangements, Medi-Cal enrollment is not universally required by regulation. However, active Medi-Cal enrollment or proof of a submitted enrollment application is frequently requested or strongly preferred during credentialing, delegation review, PCP assignment, network onboarding, dual-eligible alignment, capitation readiness, and CalAIM-related contracting. This should be presented as a market and contracting readiness issue rather than as a universal commercial or Medicare Advantage requirement.

Processing timelines should be treated as planning ranges, not guarantees. Under DHCS APL 22-013, an MCP that elects to screen and enroll providers must complete that process and provide a written determination within 120 calendar days of receiving a provider application. State law allows DHCS up to 180 calendar days to act on a direct DHCS enrollment application. MCPs may allow certain providers with pending applications to participate in the network for up to 120 calendar days when permitted by applicable requirements, but this is conditional and should not be assumed for go-live planning.

Strategic Recommendations for the HBPC Practice

- **Prioritize Medi-Cal enrollment readiness:** Confirm the correct provider type, entity structure, individual clinician enrollment requirements, NPI structure, service locations, ownership disclosures, and applicable DHCS/PAVE or MCP enrollment pathway. Active or pending Medi-Cal enrollment supports payer discussions but does not guarantee network participation, PCP designation, panel assignment, capitation, or delegation.
- **Pursue MCP-by-MCP network and contracting review:** Submit credentialing and network participation materials to the appropriate MCPs for Sacramento and Placer. For Sacramento, include Anthem Blue Cross Partnership Plan, Health Net Community Solutions Inc., Molina Healthcare of California, and Kaiser Permanente as applicable. For Placer, prioritize Partnership HealthPlan and evaluate Kaiser Permanente pathways for eligible aligned populations where relevant.
- **Evaluate ECM participation:** Position the practice as a potential ECM provider or clinical partner for eligible members with complex needs. ECM is a statewide Medi-Cal managed care benefit that provides eligible members access to a single Lead Care Manager for comprehensive care management and coordination of health and health-related services. MCPs contract with qualified ECM providers, which may include clinical, community-based, and other organizations that meet DHCS and plan requirements.
- **Evaluate Community Supports selectively:** Community Supports are optional, plan-administered services intended to address health-related social needs. Opportunities such as housing navigation, medically tailored meals, respite, or other approved supports should be assessed based on each MCPs elected services, county implementation, provider qualifications, referral process, and reimbursement model. The HBPC practice should not assume every Community Support is available across all target plans or counties.
- **Document HBPC value proposition:** Credentialing and contracting materials should clearly describe home-based primary care model design, clinical protocols, after-hours coverage, care coordination workflows, medication management, hospital avoidance strategy, referral management, quality reporting capacity, compliance infrastructure, and experience with frail, home-limited, chronically ill, and dual-eligible populations.

Recommended Action Steps

1. Confirm provider enrollment pathway through DHCS PED/PAVE or the applicable MCP enrollment process, including provider type, entity ownership, service location, individual clinician requirements, and any ordering/referring/prescribing implications.
2. Prepare core credentialing materials: California licenses, NPIs, malpractice coverage, W-9/EIN, ownership disclosures, organizational policies, HBPC clinical protocols, compliance policies, HIPAA documentation, CLIA status if applicable, and quality reporting capabilities.

3. Submit or confirm Medi-Cal enrollment status and track all application confirmations, submission dates, pending status notices, requests for information, and approval documentation (including monthly DHCS Open Data Portal checks once enrolled).
4. Contact target MCP provider relations or contracting teams: Anthem Blue Cross Partnership Plan, Health Net Community Solutions Inc., Molina Healthcare of California, and Kaiser Permanente for Sacramento; Partnership HealthPlan of California and Kaiser Permanente pathways as applicable for Placer.
5. Request ECM provider or referral partner requirements from each MCP and confirm plan-specific workflows, referral forms, eligibility screening processes, data expectations, staffing requirements, and contracting terms.
6. Review current plan provider manuals, ECM policy materials, Community Supports elections, home-visit policies, PCP assignment rules, delegation requirements, and directory inclusion criteria before finalizing launch assumptions.
7. Assess network adequacy and unmet need for geriatric, frail, dual-eligible, home-limited, and complex chronic care populations using payer feedback, county-level plan materials, and available market data.

Example Medi-Cal Enrollment Timeline and Checklist

Target planning range: Aim for internal enrollment and payer-readiness work within 60 to 120 days, while recognizing that MCP enrollment determinations may take up to 120 calendar days and direct DHCS enrollment applications may take up to 180 calendar days. Payer credentialing, network contracting, ECM contracting, delegation, and go-live readiness may extend beyond enrollment approval and should be managed as parallel but separate workstreams.

Phase	Planning Timeline	Key Actions and Checklist	Owner / Notes
1. Preparation	~ Days 1-7	Confirm provider type, NPI, CA licensure, malpractice, EIN/W-9, ownership, service locations, HBPC policies, HIPAA, CLIA if applicable, and credentialing files.	Practice Admin / Credentialing Lead
2. Enrollment Submission	~ Days 1-30	Submit or confirm Medi-Cal enrollment through DHCS PED/PAVE or applicable MCP pathway. Track confirmations, submission date, provider type, and pending status.	Credentialing Lead

Phase	Planning Timeline	Key Actions and Checklist	Owner / Notes
3. DHCS / MCP Review	~ Days 15-180	Respond to RFIs. DHCS direct enrollment: up to 180 days; MCP pathway: up to 120 days. Plan for up to 120 days for MCP screening/enrollment and up to 180 days for direct DHCS enrollment, depending on pathway and provider type.	Practice Admin
4. Payer Credentialing	~ Days 30-150	Submit payer credentialing materials with Medi-Cal proof or pending documentation. Confirm plan-specific PCP, directory, home-visit, and network rules.	Contracting Lead
5. ECM / CalAIM	~ Days 45-150	Request ECM/partner requirements. Confirm Populations of Focus, staffing, referral workflows, data-sharing, Community Supports availability, and contracting terms.	Operations / Contracting Lead
6. Delegation / VBC	~ Days 60-180+	Engage MCPs, IPAs, and delegated entities on referrals, panels, delegation, capitation/value-based opportunities, reporting, and readiness.	Leadership
7. Go-Live Readiness	~ Day 90+	Verify enrollment or pending status, payer approvals, directory inclusion, referral workflows, CalAIM pathways, compliance files, and clinical protocols.	Operations

References

1. California Department of Health Care Services (DHCS). All Plan Letter 22-013: Medi-Cal Managed Care Health Plan Guidance on Provider Enrollment, Screening, Credentialing, and Re-credentialing. July 19, 2022. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-013.pdf

2. California Department of Health Care Services (DHCS). All Plan Letter 22-013 Frequently Asked Questions. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-013-FAQ.pdf
3. California Department of Health Care Services (DHCS). 2026 Landscape of Medi-Cal Managed Care Plans and Medi-Medi Plans. September 2025. https://www.dhcs.ca.gov/provgovpart/Documents/2026-Medi-Medi-Plan-List.pdf
3. California Department of Health Care Services (DHCS). Provider Enrollment Division. https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx
4. California Department of Health Care Services (DHCS). Provider Application and Validation for Enrollment (PAVE). https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx
5. California Department of Health Care Services (DHCS). Enhanced Care Management and Community Supports. https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Home.aspx
6. California Department of Health Care Services (DHCS). CalAIM Enhanced Care Management Policy Guide. January 2026. https://www.dhcs.ca.gov/CalAIM/ECM/Documents/CalAIM-ECM-Policy-Guide.pdf
7. California Department of Health Care Services (DHCS). Medi-Cal Eligibility Statistics and Monthly Eligible Fast Facts. https://www.dhcs.ca.gov/dataandstats/Pages/Medi-Cal-Eligibility-Statistics.aspx
8. Electronic Code of Federal Regulations. 42 CFR Part 455 - Program Integrity: Medicaid Provider Screening and Enrollment. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455

This strategy positions the HBPC practice for a more credible and defensible market-entry discussion with Medi-Cal managed care plans, Medi-Medi/D-SNP-aligned plans, delegated entities, and potential ECM/CalAIM partners. Supporting documentation, provider manual excerpts, outreach scripts, or payer-specific contracting trackers can be developed as next-step operational tools.

Disclaimer

This memorandum is intended for strategic and informational purposes only and reflects publicly available regulatory guidance, payer-facing materials, and industry observations as of May 2026. It is not legal, compliance, reimbursement, credentialing, or contracting advice. Medi-Cal enrollment requirements, payer credentialing standards, delegated contracting expectations, ECM participation criteria, Community Supports availability, network requirements, and reimbursement terms may vary by health plan, IPA, medical group, county, provider type, line of business, and contracting model and are subject to change.

The practice should independently confirm all enrollment, contracting, delegation, credentialing, reimbursement, referral, and operational requirements with applicable health plans, delegated entities, DHCS, CMS, legal counsel, compliance advisors, and other appropriate regulatory authorities before implementation or operational reliance.