CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: September 30, 2026

ALL PLAN LETTER 26-018

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: FEDERAL REIMBURSEMENT LIMITATION ON GENDER-AFFIRMING CARE SERVICES FOR YOUTH

PURPOSE:

The purpose of this All Plan Letter (APL) is for the Department of Health Care Services (DHCS) to provide guidance to Medi-Cal managed care plans (MCPs) about requirements for gender-affirming care services for youth in relation to a newly promulgated Final Rule.

BACKGROUND:

On August 13, 2026, the federal Centers for Medicare & Medicaid Services (CMS) published a Final Rule, titled "Medicaid Program; Prohibition on Federal Medicaid and Children's Health Insurance Program [(CHIP)] Funding for Sex-Rejecting Procedures Furnished to Children" (CMS-2451-F). Effective October 13, 2026[1], this Final Rule prohibits states from claiming federal Medicaid and CHIP matching funds for specified gender-affirming care services (referred to in the Final Rule as "sex-rejecting procedures" and defined in 42 Code of Federal Regulations (CFR) section 441.801[2]) furnished to Medi-Cal Members under age 18, and CHIP Members under age 19. This Final Rule does not apply to Medi-Cal Members ages 18 or older.

POLICY:

Reimbursement for Services: Gender Affirming Care Indications

[1] The Medicaid Program; Prohibition on Federal Medicaid and CHIP Funding for Sex-Rejecting Procedures Furnished to Children Final Rule (CMS-2451-F) is available at: https://www.federalregister.gov/d/2026-16508. The Final Rule amends Title 42, Code of Federal Regulations (CFR) Parts 441 and 457.
[2] See CMS-2451-F, 42 CFR sections 441.802, 457.476 (effective October 13, 2026).

Effective for dates of service (DOS) on or after October 13, 2026, Medi-Cal and MCPs will no longer reimburse the following services for Medi-Cal Members under the age of 18 or for CHIP Members under the age of 19 when provided as part of gender-affirming care[3]:

- Surgical interventions (e.g., mastectomy or breast augmentation)
- Puberty blockers and associated professional services (e.g., gonadotropin-releasing hormone agonists and their injection or implantation)
- Hormone therapy and associated professional services (e.g., estrogen, testosterone and their injection or implantation)
    - Note: Medi-Cal and CHIP Members who are already taking gender-affirming hormones (referred to in the Final Rule as "cross-sex hormone therapy") as of October 13, 2026, may continue to have these medications reimbursed by Medi-Cal and MCPs through April 12, 2027. The Final Rule allows for this time-limited "transition period" of up to six months. MCPs are responsible for this coverage for impacted MCP Members when covered under the medical benefit only (i.e., when billed as a medical claim). After April 12, 2027, these medications will be reimbursed with state-only funding from the Department of Health Care Access and Information's (HCAI) grant program, as described below.

This transition period does not apply to puberty blocking medications or surgical interventions. It also does not apply to Medi-Cal Members who are newly starting hormone therapy on or after October 13, 2026.

[3] See Medi-Cal Provider Manual, Part 2 – Medical Services, Gender Affirming Care Services (gender) section for additional detail on impacted services. Please note that this federal Medicaid/CHIP reimbursement limitation does not prevent MCPs from voluntarily making payments to Providers, at their own discretion, for gender affirming care services impacted by the Final Rule for their Members with non-Medicaid/CHIP funds.

Non-Gender Affirming Care Indications and Other, Ancillary Services

MCPs must continue to cover the services outlined above for Medi-Cal Members under the age of 18 and for CHIP Members under the age of 19 when Medically Necessary to treat medical conditions other than gender dysphoria.[4]

MCPs remain responsible for covering all other Medically Necessary services for Medi-Cal Members under the age of 18 and for CHIP Members under the age of 19 that fall outside of the categories specified above, including office visits, laboratory tests, speech therapy and psychotherapy as these services do not fall within the scope of the Final Rule, regardless of their purpose or whether they are associated with the treatment of gender dysphoria. MCPs must also cover the services listed above when Medically Necessary to treat complications, including any infection, injury, disease, or disorder that has been caused by or exacerbated by the provision of the non-reimbursable services listed on page 2 of this APL.[5]

Populations and Services Outside of the Scope of the Final Rule

There are no policy changes for gender-affirming care services with DOS on or before October 12, 2026. MCPs must therefore continue to cover and process any claims or Encounters for Medically Necessary gender-affirming care services provided to Members with DOS on or before October 12, 2026. Coverage requirements also remain unchanged for Members who fall outside of the age ranges affected by the federal regulations. MCPs must continue to cover and process any claims or Encounters for Medically Necessary gender-affirming care services for Medi-Cal Members aged 18 and older as they are not impacted by the Final Rule. MCPs continue to be responsible for adhering to all policy and requirements for staff who perform services or are in contact with Members, including those Members impacted by the Final Rule, related to transgender, gender diverse or intersex cultural competency training and ensuring access to transgender services as outlined in APL 24-017 and APL 20-018 respectively.

Consistent with the final Budget Act of 2026 (Assembly Bill 113, Statutes of 2026), HCAI will oversee a grant program, funded with State General Funds only, to support continued access to gender-affirming care services for Medi-Cal and CHIP Members subject to the Final Rule. MCPs must encourage their Network Providers with surgical interventions scheduled on or after October 13, 2026, and with Prior Authorization

[4] See Medi-Cal Provider Manual, Part 2 – Medical Services, Gender Affirming Care Services (gender) for additional detail on ICD-10-CM codes.
[5] See CMS-2451-F; 42 CFR section 441.801 (effective October 13, 2026).

approved before that date, to contact HCAI to ensure uninterrupted access and funding for the services provided. HCAI will accept previously approved authorizations as sufficient supporting documentation from DHCS or individual MCPs.[6] HCAI will also have additional information soon regarding on or after October 13, 2026 access to medications (including hormone therapy and puberty blockers).[7] DHCS will be working closely with HCAI to provide technical assistance in the form of information sharing and outreach to support MCPs and Medi-Cal and CHIP Members seeking gender-affirming care services that are no longer reimbursable under Medi-Cal as a result of the Final Rule. In the interim, Network Providers should not cancel services or redirect Members. More details on HCAI grant program reimbursement for these services are forthcoming, and DHCS will share information as soon as it becomes available through future APL updates.

For the affected population, MCPs should still assist these Members in receiving gender-affirming care as appropriate (e.g., through care management) and partner with Network Providers to leverage state-only funding sources to pay for the care that is no longer reimbursed by Medi-Cal.

Member Notification Requirements

MCPs must notify Members of this change in benefits in accordance with the MCP Contract and 42 CFR section 438.10. Since the affected gender-affirming care services will no longer be reimbursable by Medi-Cal for affected Members beginning October 13, 2026, MCPs must provide Members advance notice of the change in services. MCPs are required to do so as soon as feasible. Specifically, MCPs must update the applicable Member Handbook/Evidence of Coverage (EOC) to reflect the reimbursement limitation described above and may communicate the change through an applicable Member Handbook/EOC errata or other permissible method consistent with 42 CFR section 438.10(g)(3). This notice requirement applies independently of whether an individual Member is currently receiving a gender-affirming care service or whether they are an affected Member. MCPs must distribute the DHCS-approved 2026 Member Handbook Errata, Attachment A, without substantive modification. See Attachment A for the DHCS Approved Errata template.

[6] For further details, including contact information, please visit the HCAI webpage
[7] For further details, including information regarding the upcoming Request for Information (RFI) and contact information for HCAI, please visit the HCAI webpage.

In addition, MCPs must provide an individualized Notice of Action (NOA) to Members for whom implementation of this federal reimbursement limitation results in an adverse benefit determination, including the termination, suspension, or reduction of a previously authorized affected service. For a Prior Authorization that extends beyond October 13, 2026, the MCP must provide the required notice at least ten (10) days before the effective date of the termination or reduction, absent an applicable exception. The NOA must identify the adverse benefit determination and clearly explain the reason for the determination, including that the affected service will no longer be reimbursed by Medi-Cal for the Member on or after October 13, 2026, pursuant to the applicable Final Rule, and must include all other information required under applicable federal and state notice requirements, including information regarding Appeal and State Hearing rights and, where applicable, continuation of benefits.

MCP Responsibilities for Policies and Procedures, Subcontractors, and Enforcement Actions

The requirements in this APL necessitate revisions to MCPs' contractually required Policies and Procedures (P&Ps). MCPs must update their P&Ps within 90 calendar days of the release of this APL. MCPs must submit an attestation to DHCS and a copy of the updated P&Ps to the Managed Care Operations Division (MCOD)-MCP Submission Portal within 90 calendar days of the release of this APL confirming that the required P&P revisions have been completed.[8] DHCS approval after submission is not required.

MCPs are responsible for ensuring that their Subcontractors, Downstream Subcontractors, and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all Subcontractors, Downstream Subcontractors, and Network Providers. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. MCPs should review their Network Provider, Subcontractor, and/or Downstream Subcontractor Agreements, including Division of Financial Responsibility provisions as appropriate, to ensure compliance with this APL. For additional information regarding administrative and monetary sanctions, see APL 25-007, and any subsequent iterations on this topic. Any failure to meet the requirements of this APL may result in a CAP and subsequent enforcement actions.

[8] The MCOD-MCP Submission Portal can be found at: https://cadhcs.sharepoint.com/sites/MCOD-MCPSubmissionPortal/SitePages/Home.aspx

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Dennis Hsieh

Dennis Hsieh, M.D., J.D.

Division Chief, Managed Care Quality and Monitoring Division