AB-543 Medi-Cal: field medicine. (2025-2026)

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Assembly Bill No. 543

CHAPTER 374

An act to amend Section 15926 of, and to repeal the heading of, and to add, Article 5.7 (commencing with Section 14186) of Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor October 06, 2025. Filed with Secretary of State October 06, 2025.]

LEGISLATIVE COUNSEL'S DIGEST

AB 543, Mark González. Medi-Cal: field medicine.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

Existing law sets forth various provisions for Medi-Cal coverage of community health worker services, enhanced care management, and community supports, subject to any necessary federal approvals. Under existing law, these benefits are designed to, respectively, provide a link between health and social services and the community; address the clinical and nonclinical needs on a whole-person-care basis for certain target populations of Medi-Cal beneficiaries, including individuals experiencing homelessness; and provide housing transition navigation services, among other supports.

This bill would set forth provisions regarding field medicine, as defined, under the Medi-Cal program for persons experiencing homelessness, as defined. The bill would state the intent of the Legislature that the field medicine-related provisions coexist with, and not duplicate, other Medi-Cal provisions, including, but not limited to, those regarding community health worker services, enhanced care management, and community supports.

The bill would authorize a Medi-Cal managed care plan to elect to offer Medi-Cal covered services through a field medicine provider, as defined. Under the bill, a managed care plan that elects to do so would be required to allow a Medi-Cal member who is experiencing homelessness to receive those services directly from an in-network, contracted field medicine provider, regardless of the member's in-network assignment, as specified. The bill would also require the managed care plan to allow an in-network, contracted field medicine provider enrolled in Medi-Cal to directly refer a member who is experiencing homelessness for covered services within the appropriate network, as specified.

The bill would require a managed care plan to have appropriate mechanisms, procedures, or protocols to ensure timely communication between the in-network, contracted field medicine provider, the Medi-Cal member's plan or independent practice association, and the member's primary care provider for purposes of care coordination and to prevent the duplication of services.

The bill would require a managed care plan to provide a method for a Medi-Cal member to inform the managed care plan online, in person, or via telephone that the member is experiencing homelessness. The bill would require the department to inform a

managed care plan if a member has indicated that they are experiencing homelessness based on information furnished on the Medi-Cal application.

In the case of a Medi-Cal beneficiary who is experiencing homelessness and who receives services within the fee-for-service delivery system, the bill would require the department to reimburse a field medicine provider enrolled in Medi-Cal for providing Medi-Cal covered services.

The bill would condition implementation of the above-described provisions on receipt of any necessary federal approvals and the availability of federal financial participation.

The bill would require, on or before January 1, 2027, that the standard application form for insurance affordability programs include an optional question for an applicant to identify whether they are experiencing homelessness. The bill would make conforming changes to related provisions under existing law regarding the application process. The bill would also remove obsolete references within related provisions.

To the extent that the bill would create new duties for counties with regard to data sharing under Medi-Cal, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.
Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares all of the following:

(a) People experiencing homelessness have poorer health outcomes and increased mortality rates compared to the general population. This has been linked to barriers to accessing primary care, such as lack of transportation, lack of government-issued identification, limited means to make appointments, mobility challenges, and competing priorities, including, but not limited to, finding food and maintaining safety.

(b) Poor health outcomes have also been attributed to institutional trauma in the traditional health care system, including experiences of discrimination and exclusion, resulting in distrust of the health care system and hesitation about seeking medical care.

(c) The mortality rate among people experiencing homelessness is 10 times higher than that of housed individuals and continues to rise across California. Deaths of people experiencing homelessness in the County of Los Angeles have increased by over 3.5 times, while the annual mortality rate roughly doubled between 2014 and 2022, according to a 2024 report from the Department of Public Health for the County of Los Angeles.

(d) Homelessness and homeless deaths disproportionately affect people of color, with this population accounting for 68 percent of deaths on the street and demonstrating a gross health inequity.

(e) Poor access to primary care directly contributes to the increased mortality rates observed among people experiencing homelessness. Only 8 percent of people experiencing homelessness have a primary care provider (PCP) versus 82 percent of the general population. This disparity persists, even though 78 percent are insured.

(f) People experiencing homelessness with Medi-Cal coverage rely on referrals from their PCPs to access specialty care and durable medical equipment, such as wheelchairs. Lack of access to primary care furthers lack of access to specialty care.

(g) There are effective, evidence-based models for delivering health care to persons experiencing homelessness, including field medicine, shelter-based care, and care provided in transitional housing. These models were developed specifically to address the unique needs and circumstances of persons experiencing homelessness onsite where they reside.

(h) Through field medicine, shelter-based care, mobile clinics, and related delivery models, providers remove access barriers for persons experiencing homelessness in order to deliver patient-centered care. Services provided include medical care for acute and chronic health conditions, behavioral health care treatment, treatment for substance use disorders, dispensing common medications, and drawing blood.

(i) Less than 30 percent of people experiencing homelessness who are insured have ever seen their primary care physician, versus 70 percent of those treated by field medicine teams, who are actively engaged in primary care within one week of referral.

(j) Providing medical care to persons experiencing homelessness outside of traditional medical settings has demonstrated a decrease in hospital admissions by two-thirds with a hospital-based consultation service.

(k) Persons experiencing homelessness have twice the length of stay while hospitalized compared to the housed population, and spend 740 percent more days in the hospital at a 170-percent greater cost per day than people who are housed. For homeless patients admitted to the hospital, field medicine reduces the length of hospital stays from 12 to 7.9 days.

(l) Providing health care and social services on the street or outside of traditional medical facilities improves housing placement compared to only providing nonmedical outreach services. In the City of Los Angeles, field medicine teams have successfully transitioned 42 percent of their homeless patients into permanent housing, compared to 4 percent when the Los Angeles Homeless Services Authority is the responsible party.

(m) Although field medicine services substantially reduce morbidity and mortality among individuals experiencing homelessness, various policy barriers prevent those living unsheltered from fully accessing the benefits of these services and other supports. These barriers include all of the following:

(1) Individuals experiencing homelessness often face delays in accessing critical health care due to gaps in Medi-Cal coverage. When their Medi-Cal coverage lapses or when they are not enrolled, the process for redetermination or initial enrollment can take weeks, either delaying care or forcing field medicine providers to provide unreimbursed care and medically necessary services.

(2) While field medicine providers can order medically necessary services, such as wheelchairs or diagnostics, Medi-Cal managed care plans continue to deny medically necessary services based on primary care provider (PCP) or independent practice association (IPA) assignment alone. This has profound consequences for patients on the street, contributing to increased morbidity, mortality, and suffering.

(3) Existing administrative systems for accessing benefits for low-income persons, including, but not limited to, the California Statewide Automated Welfare System (CalSAWS) and the California Advancing and Innovating Medi-Cal (CalAIM) initiative within Medi-Cal, lack a definitive identifier for individuals experiencing homelessness, resulting in missed opportunities to connect them to eligible services and making it difficult to determine eligibility, track benefits received, or ensure access to future programs from which they would benefit.

SEC. 2. The heading of Article 5.7 (commencing with Section 14186) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code is repealed.

SEC. 3. Article 5.7 (commencing with Section 14186) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.7. Medi-Cal Field Medicine

14186. For purposes of this article, the following definitions apply:

(a) “Medi-Cal managed care plan” has the same meaning as set forth in Section 14184.101.

(b) “Person experiencing homelessness,” or a variation thereof, means a person who lacks a fixed, regular, and adequate nighttime residence. This may include living in shelters, transitional housing, or places not meant for habitation, like cars or outdoors.

(c) “Field medicine” means a set of health and social services developed specifically to address the unique needs and circumstances of persons experiencing homelessness utilizing a whole-person, patient-centered approach to provide medically necessary health care services, and to address social drivers of health that impede health care access.

(d) “Field medicine provider” means a licensed medical provider, including, but not limited to, a physician and surgeon, osteopathic physician and surgeon, physician assistant, nurse practitioner, or certified nurse-midwife, who conducts patient visits outside of the four walls of health facilities, clinics, or other locations, and instead directly on the street, in environments where persons experiencing homelessness might be, such as living in a car, recreational vehicle, encampment, abandoned building, or other outdoor areas.

14186.1. (a) (1) The department shall seek any federal approvals necessary to implement this article.

(2) Each section of this article shall be implemented only to the extent that any necessary federal approvals are obtained and that federal financial participation is available and is not otherwise jeopardized.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this article by means of all-county letters, plan letters, plan or provider

bulletins, or similar instructions until any necessary regulations are adopted.

14186.2. It is the intent of the Legislature that implementation of this article not be duplicative of implementation of other Medi-Cal provisions, including, but not limited to, those regarding community health worker services, enhanced care management, and community supports, as described in Sections 14132.36, 14184.205, and 14184.206, respectively. It is the intent of the Legislature that the field medicine-related provisions set forth in this article coexist with those other Medi-Cal benefits in order to fill significant gaps within the health care system for persons experiencing homelessness.

14186.3. (a) A Medi-Cal managed care plan may elect to offer Medi-Cal covered services through an in-network, contracted field medicine provider pursuant to this article.

(b) A Medi-Cal managed care plan that elects to offer Medi-Cal covered services through an in-network, contracted field medicine provider shall allow a Medi-Cal member who is experiencing homelessness to receive those services directly from an in-network, contracted field medicine provider, regardless of the member's in-network assignment, such as primary care provider (PCP) or independent practice association (IPA) assignment.

(c) (1) A Medi-Cal managed care plan that elects to offer Medi-Cal covered services through an in-network, contracted field medicine provider shall allow an in-network, contracted field medicine provider enrolled in the Medi-Cal program to directly refer a member who is experiencing homelessness for covered services, including specialist, diagnostic services, medications, durable medical equipment, transportation, or other medically necessary covered services, within the appropriate network of the Medi-Cal managed care plan or in-network IPA.

(2) The Medi-Cal managed care plan or IPA shall create referral and authorization mechanisms in order to facilitate the referrals described in paragraph (1).

(d) Medi-Cal managed care plans contracting with field medicine providers pursuant to this section shall have appropriate mechanisms, procedures, or protocols to ensure timely communication between the in-network, contracted field medicine provider, the Medi-Cal member's plan or IPA, and the member's assigned primary care provider for purposes of care coordination and to prevent the duplication of services.

(e) (1) A Medi-Cal managed care plan shall provide a method for a Medi-Cal member to inform the Medi-Cal managed care plan online, in person, or via telephone that the member is experiencing homelessness.

(2) The department shall inform a Medi-Cal managed care plan if a Medi-Cal member has indicated that they are experiencing homelessness based on information furnished on the Medi-Cal application.

(f) In the case of a Medi-Cal beneficiary who is experiencing homelessness and who receives services within the fee-for-service delivery system, the department shall reimburse a field medicine provider enrolled in the Medi-Cal program for providing Medi-Cal covered services.

SEC. 4. Section 15926 of the Welfare and Institutions Code is amended to read:

15926. (a) The following definitions apply for purposes of this part:

(1) "Accessible" means in compliance with Section 11135 of the Government Code, Section 1557 of the PPACA, and regulations or guidance adopted pursuant to these statutes.

(2) "Limited-English-proficient" means not speaking English as one's primary language and having a limited ability to read, speak, write, or understand English.

(3) "Insurance affordability program" means a program that is one of the following:

(A) The Medi-Cal program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(B) The state's children's health insurance program (CHIP) under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(C) A program that makes available to qualified individuals coverage in a qualified health plan through the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code with advance payment of the premium tax credit established under Section 36B of the Internal Revenue Code.

(D) A program that makes available coverage in a qualified health plan through the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code with cost-sharing reductions established under Section 1402 of PPACA and any subsequent amendments to that act.

(b) An individual shall have the option to apply for insurance affordability programs in person, by mail, online, by telephone, or by other commonly available electronic means.

(c) (1) A single, accessible, standardized paper, electronic, and telephone application for insurance affordability programs shall be developed by the department, in consultation with the board governing the Exchange, as part of the stakeholder process described in subdivision (b) of Section 15925. The application shall be used by all entities authorized to make an eligibility determination for any of the insurance affordability programs and by their agents.

(2) The department may develop and require the use of supplemental forms to collect additional information needed to determine eligibility on a basis other than the financial methodologies described in Section 1396a(e)(14) of Title 42 of the United States Code, as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148), and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments, as provided under Section 435.907(c) of Title 42 of the Code of Federal Regulations.

(3) The application shall be tested and operational by the date as required by the federal Secretary of Health and Human Services.

(4) The application form shall, to the extent not inconsistent with federal statutes, regulations, and guidance, satisfy all of the following criteria:

(A) The form shall include simple, user-friendly language and instructions.

(B) The form may not ask for information related to a nonapplicant that is not necessary to determine eligibility in the applicant's particular circumstances.

(C) The form may require only information necessary to support the eligibility and enrollment processes for insurance affordability programs.

(D) The form may be used for, but shall not be limited to, screening.

(E) The form may ask, or be used otherwise to identify, if the mother of an infant applicant under one year of age had coverage through an insurance affordability program for the infant's birth, for the purpose of automatically enrolling the infant into the applicable program without the family having to complete the application process for the infant.

(F) The form may include questions that are voluntary for applicants to answer regarding demographic data categories, including race, ethnicity, primary language, disability status, and other categories recognized by the federal Secretary of Health and Human Services under Section 4302 of the PPACA.

(G) Notwithstanding subparagraphs (B) and (C), on or before January 1, 2027, the form shall include an optional question for an applicant to identify whether they are experiencing homelessness.

(H) Until January 1, 2016, the department shall instruct counties to not reject an application that was in existence prior to January 1, 2014, but to accept the application and request any additional information needed from the applicant in order to complete the eligibility determination process. The department shall work with counties and consumer advocates to develop the supplemental questions.

(d) Nothing in this section shall preclude the use of a provider-based application form or enrollment procedures for insurance affordability programs or other health programs that differs from the application form described in subdivision (c), and related enrollment procedures. Nothing in this section shall preclude the use of a joint application, developed by the department and the State Department of Social Services, that allows for an application to be made for multiple programs, including, but not limited to, CalWORKs, CalFresh, and insurance affordability programs.

(e) The entity making the eligibility determination shall grant eligibility immediately whenever possible and with the consent of the applicant in accordance with the state and federal rules governing insurance affordability programs.

(f) (1) If the eligibility, enrollment, and retention system has the ability to prepopulate an application form for insurance affordability programs with personal information from available electronic databases, an applicant shall be given the option, with their informed consent, to have the application form prepopulated. Before a prepopulated application is submitted to the entity authorized to make eligibility determinations, the individual shall be given the opportunity to provide additional eligibility information and to correct any information retrieved from a database.

(2) All insurance affordability programs may accept self-attestation, instead of requiring an individual to produce a document, for age, date of birth, family size, household income, state residence, pregnancy, and any other applicable criteria needed to determine the eligibility of an applicant or recipient, to the extent permitted by state and federal law.

(3) An applicant or recipient shall have their information electronically verified in the manner required by the PPACA and implementing federal regulations and guidance and state law.

(4) Before an eligibility determination is made, the individual shall be given the opportunity to provide additional eligibility information and to correct information.

(5) The eligibility of an applicant shall not be delayed beyond the timeliness standards as provided in Section 435.912 of Title 42 of the Code of Federal Regulations or denied for any insurance affordability program unless the applicant is given a reasonable opportunity, of at least the kind provided for under the Medi-Cal program pursuant to Section 14007.5 and paragraph (7) of subdivision (e) of Section 14011.2, to resolve discrepancies concerning any information provided by a verifying entity.

(6) To the extent federal financial participation is available, an applicant shall be provided benefits in accordance with the rules of the insurance affordability program, as implemented in federal regulations and guidance, for which the applicant otherwise qualifies until a determination is made that the applicant is not eligible and all applicable notices have been provided. Nothing in this section shall be interpreted to grant presumptive eligibility if it is not otherwise required by state law, and, if so required, then only to the extent permitted by federal law.

(g) The eligibility, enrollment, and retention system shall offer an applicant and recipient assistance with their application or renewal for an insurance affordability program in person, over the telephone, by mail, online, or through other commonly available electronic means and in a manner that is accessible to individuals with disabilities and those who are limited English proficient.

(h) (1) During the processing of an application, renewal, or a transition due to a change in circumstances, an entity making eligibility determinations for an insurance affordability program shall ensure that an eligible applicant and recipient of insurance affordability programs that meets all program eligibility requirements and complies with all necessary requests for information moves between programs without any breaks in coverage and without being required to provide any forms, documents, or other information or undergo verification that is duplicative or otherwise unnecessary. The individual shall be informed about how to obtain information about the status of their application, renewal, or transfer to another program at any time, and the information shall be promptly provided when requested.

(2) The application or case of an individual screened as not eligible for Medi-Cal on the basis of Modified Adjusted Gross Income (MAGI) household income but who may be eligible on the basis of being 65 years of age or older, or on the basis of blindness or disability, shall be forwarded to the Medi-Cal program for an eligibility determination. During the period this application or case is processed for a non-MAGI Medi-Cal eligibility determination, if the applicant or recipient is otherwise eligible for an insurance affordability program, the applicant or recipient shall be determined eligible for that program.

(3) Renewal procedures shall include all available methods for reporting renewal information, including, but not limited to, face-to-face, telephone, mail, and online renewal or renewal through other commonly available electronic means.

(4) An applicant who is not eligible for an insurance affordability program for a reason other than income eligibility, or for any reason in the case of applicants and recipients residing in a county that offers a health coverage program for individuals with income above the maximum allowed for the Exchange premium tax credits, shall be referred to the county health coverage program in their county of residence.

(i) Notwithstanding subdivisions (e), (f), and (j), before an online applicant who appears to be eligible for the Exchange with a premium tax credit or reduction in cost sharing, or both, may be enrolled in the Exchange, both of the following shall occur:

(1) The applicant shall be informed of the overpayment penalties under the federal Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (Public Law 112-9), if the individual's annual family income increases by a specified amount or more, calculated on the basis of the individual's current family size and current income, and that penalties are avoided by prompt reporting of income increases throughout the year.

(2) The applicant shall be informed of the penalty for failure to have minimum essential health coverage.

(j) The department shall, in coordination with the Exchange board, streamline and coordinate all eligibility rules and requirements among insurance affordability programs using the least restrictive rules and requirements permitted by federal and state law. This process shall include the consideration of methodologies for determining income levels, assets, rules for household size, citizenship and immigration status, and self-attestation and verification requirements.

(k) (1) Forms and notices developed pursuant to this section shall be accessible and standardized, as appropriate, and shall comply with federal and state laws, regulations, and guidance prohibiting discrimination.

(2) Forms and notices developed pursuant to this section shall be developed using plain language and shall be provided in a manner that affords meaningful access to limited-English-proficient individuals, in accordance with applicable state and federal

law, and at a minimum, provided in the same threshold languages as required for Medi-Cal managed care plans.

(l) The department, the California Health and Human Services Agency, and the Exchange board shall establish a process for receiving and acting on stakeholder suggestions regarding the functionality of the eligibility systems supporting the Exchange, including the activities of all entities providing eligibility screening to ensure the correct eligibility rules and requirements are being used. This process shall include consumers and their advocates, be conducted no less than quarterly, and include the recording, review, and analysis of potential defects or enhancements of the eligibility systems. The process shall also include regular updates on the work to analyze, prioritize, and implement corrections to confirmed defects and proposed enhancements, and to monitor screening.

(m) In designing and implementing the eligibility, enrollment, and retention system, the department and the Exchange board shall ensure that all privacy and confidentiality rights under the PPACA and other federal and state laws are incorporated and followed, including responses to security breaches.

SEC. 5. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.