Office of Senate Floor Analyses
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THIRD READING

Bill No: AB 543
Author: Mark González (D), et al.
Amended: 8/29/25 in Senate
Vote: 21

SENATE HEALTH COMMITTEE: 10-0, 6/18/25
AYES: Menjivar, Valladares, Durazo, Grove, Limón, Padilla, Richardson, Rubio, Weber Pierson, Wiener
NO VOTE RECORDED: Gonzalez

SENATE APPROPRIATIONS COMMITTEE: 7-0, 8/29/25
AYES: Caballero, Seyarto, Cabaldon, Dahle, Grayson, Richardson, Wahab

ASSEMBLY FLOOR: 78-0, 6/2/25 - See last page for vote

SUBJECT: Medi-Cal: street medicine

SOURCE: California Street Medicine Collaborative
University of Southern California

DIGEST: This bill requires the Department of Health Care Services ensure that the California Statewide Automated Welfare System can share data on the status of Medi-Cal recipients experiencing homelessness, as specified, and to update the Medi-Cal application to collect such information. Requires Medi-Cal managed care plans who elect to contract with street medicine providers to allow Medi-Cal recipients experiencing homelessness to receive services from a street medicine provider regardless of network assignment and to allow street medicine providers to make direct referrals for Medi-Cal covered services such as diagnostic services, medications, or durable medical equipment within the managed care network.

ANALYSIS:

Existing law:

1) Establishes the Medi-Cal program, which is administered by the Department of Health Care Services (DHCS), and under which qualified low-income individuals receive health care services. [Welfare and Institutions Code (WIC) § 14000, et seq.]

2) Establishes a schedule of benefits under the Medi-Cal program, which includes benefits required under federal law and benefits provided at the state's option, both of which are funded with federal and state dollars. [WIC § 14132]

3) Authorizes the DHCS Director to contract, on a bid or nonbid basis, with any qualified individual, organization, or entity to provide services to, arrange for, or case manage the care of Medi-Cal recipients and establishes managed care models that DHCS contracts with in each county. [WIC § 14087.3, § 14089, § 14087.98, § 14087.967 and § 14087.5]

4) Defines a Medi-Cal managed care plan (Medi-Cal plan) as any individual, organization, or entity that enters into a comprehensive risk contract with DHCS to provide covered full-scope health care services to enrolled Medi-Cal recipients. [WIC § 14184.101]

5) Requires Medi-Cal plans to adhere to certain network adequacy standards that require them to maintain a network of specialists that are located within a certain time or distance from their enrollees' places of residence, and to offer appointment times in accordance with state law regulating commercial managed care plans. [WIC § 14197]

6) Requires a single, accessible, standardized paper, electronic, and telephone application for insurance affordability programs, including Medi-Cal, that uses simple language and instructions and only requires the information necessary to support the eligibility and enrollment processes for the programs. Permits the form to include voluntary questions with regards to demographic data categories, including race, ethnicity, primary language, disability status, and other categories recognized by the federal Health and Human Services Secretary under the Affordable Care Act. [WIC § 15926]

7) Prohibits, via federal regulation, Medicaid agencies from requiring information on applications that is not necessary to make an eligibility determination or for

a purpose directly connected to the administration of the State plan. [42 Code of Federal Regulations (CFR) § 435.907]

8) Establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative effective from January 1, 2022 until December 31, 2026. The goals of CalAIM are to identify and manage the risk and needs of Medi-Cal recipients through whole-person-care approaches and addressing social determinants of health; transition and transform the Medi-Cal program to a more consistent and seamless system by reducing complexity and increasing flexibility; and improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform. [WIC § 14184.100, et seq.]

9) Defines "homeless" as a) an individual or family who lacks a fixed, regular, and adequate nighttime residence, as specified; b) an individual or family who will imminently lose their primary nighttime residence; c) specified unaccompanied youth under 25 years of age, or families with children and youth; or d) individuals or families who are attempting to flee domestic violence or other related dangerous or life-threatening conditions who have no other residence or resources or support networks to obtain permanent housing. [24 CFR § 91.5]

This bill:

1) Requires DHCS to ensure that the Medi-Cal program and the California Statewide Automated Welfare System (CalSAWS) mutually share data on the status of Medi-Cal applicants and recipients experiencing homelessness, including through codes related to unsheltered status, starting January 1, 2027, or the date DHCS notifies the Legislature that CalSAWS can perform the necessary automation to implement this requirement. Requires the data to be shared to be made available to DHCS, CalSAWS, and the recipient's Medi-Cal plan to the extent not in conflict with any applicable federal or state privacy laws.

2) Requires DHCS to include in the application for insurance affordability programs an optional question to allow the applicant to indicate if they are experiencing homelessness at the time of application by January 1, 2027. Requires DHCS to inform a Medi-Cal plan if a Medi-Cal recipient has indicated that they are experiencing homelessness.

3) Requires DHCS to reimburse enrolled street medicine providers for Medi-Cal services provided to recipient's experiencing homelessness if the recipient is receiving services through the fee-for-service delivery system.

4) Requires Medi-Cal plans to provide recipient's with the ability to inform the plan online, in person, or via telephone that they are experiencing homelessness.

5) Requires Medi-Cal plans that are informed by a recipient that they are experiencing homelessness to share that information with the relevant county for inclusion in CalSAWS.

6) Specifies that a Medi-Cal plan may offer Medi-Cal services through a street medicine provider.

7) Requires a Medi-Cal plan that elects to offer Medi-Cal services through a street medicine provider to allow a recipient who is experiencing homelessness to receive those services directly from a contracted street medicine provider, regardless of the recipient's network assignment, such as primary care provider (PCP) or independent practice association (IPA) assignment.

8) Requires Medi-Cal plans that elect to offer Medi-Cal services through a street medicine provider to allow a contracted street medicine provider enrolled in the Medi-Cal program to directly refer a recipient 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 plan or IPA. Requires the Medi-Cal plan or IPA to create referral and authorization mechanisms to facilitate these referrals.

9) Allows a Medi-Cal plan to establish reasonable requirements governing participation in the plan network, if protocols and network participation requirements are consistent with the goal of authorizing services to recipients who are experiencing homelessness.

10) Requires Medi-Cal managed care plans contracting with street medicine providers to have appropriate mechanisms, procedures, or protocols to ensure timely communication between the provider, the Medi-Cal beneficiary's plan or IPA, and the beneficiary's assigned primary care provider for purposes of care coordination.

11) Defines "person experiencing homelessness" according to specified existing federal regulation for "homeless."

12) Defines "street medicine" as a set of health and social services developed specifically to address the unique needs and circumstances of persons experiencing unsheltered homelessness, delivered directly to those persons in their own environment, namely places that are not intended for human habitation, 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.

13) Defines "street medicine provider" as 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 unsheltered homelessness might be, such as living in a car, recreational vehicle, encampment, abandoned building, or other outdoor areas.

14) Requires DHCS to seek any necessary federal approvals to implement this bill and conditions implementation on receipt of such approval and federal financial participation.

15) Permits DHCS to implement via guidance until any necessary regulations are adopted.

16) States the intent of the Legislature that implementation of this bill not be duplicative of other Medi-Cal provisions, including community health worker services, enhanced care management, and community supports services and that the street medicine-related provisions co-exist with these other Medi-Cal benefits to fill gaps within the health care system for persons experiencing homelessness.

17) Includes legislative findings regarding the poor health outcomes and increased mortality of persons experiencing homelessness and the challenges they face in the health care system that can be addressed by street medicine.

Comments

According to the author of this bill:

> Every person in our community deserves compassionate, comprehensive care—this includes the 187,000 people living on the streets in California. People experiencing homelessness face severe health risks and a mortality rates ten times higher than the general population—largely due to barriers in accessing healthcare. Evidence-based models like street medicine have proven to significantly improve access to healthcare, reduce hospitalizations, enhance chronic disease management, and increase housing placements. To address this ongoing homelessness crisis, we must respond with innovation and solutions rooted in humane solutions that work, such as street medicine. These are not just programs; they are lifelines.

Background

All Plan Letter (APL) 24-001. Recent DHCS guidance to plans states that street medicine directly aligns with CalAIM's primary goal to identify and manage comprehensive needs through whole person care approaches and social drivers of health. Street medicine offers an opportunity to provide needed services to individuals who are experiencing unsheltered homelessness by meeting them where they are and utilizing a whole person, patient-centered approach to provide medically necessary health care services, as well as address social drivers of health that impede health care access. The guidance allows Medi-Cal plans to cover services for Medi-Cal recipients experiencing homelessness through street medicine providers in the role of the recipient's assigned primary care provider, as an enhanced care management provider, or through a direct contract with the Medi-Cal plan. Street medicine providers who are physicians may be the assigned primary care provider, as well as other providers who are supervised by physicians who are also street medicine providers. These providers must be able to provide a medical home to provide comprehensive care, which includes care coordination, health promotion, and provision of preventative services. Some of these roles are not feasible for some models of street medicine providers. Another option is for street medicine providers to be an enhanced care management provider, though these services are non-medical, thus doing so without also being a primary care or direct contract provider would not make sense.

For a street medicine direct contract provider, the guidance requirements are similar to the provisions of this bill. The guidance states they must have processes in place to work with the Medi-Cal plan, the primary care provider and the

enhanced care management care managed to ensure the recipient has the appropriate referrals to primary care, community supports, behavioral health services, and other social services as needed. They can bill either the plan or the Medi-Cal fee-for-service system if the recipient is not in a plan. The guidance also states that contracted street medicine providers must comply with all plan data sharing and reporting requirements in accordance with federal and state laws and that they have adequate systems in place for these requirements, such as for encounter, claims and care coordination data. This bill does more explicitly require Medi-Cal plans to allow direct contract street medicine providers themselves to make direct referrals for additional services that recipients experiencing homelessness may need beyond what can be provided in that street medicine encounter.

Related/Prior Legislation

AB 369 (Kamlager of 2021) would have required DHCS to implement a presumptive eligibility program for persons experiencing homelessness. It also would have allowed Medi-Cal recipients experiencing homelessness to seek services from any participating Medi-Cal provider and required DHCS to deduct from capitation payments to Medi-Cal plans the cost of providing services to these recipients if they do not provide Medi-Cal covered services within the first 60 days of enrollment. The bill was vetoed by Governor Newsom.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee, this bill would have the following fiscal impact:

- Unknown potential costs (General Fund and federal funds) related to the delivery of street medicine services and data sharing, including state administration for DHCS, county administration, increased utilization of Medi-Cal services, and automation system changes.

- Cost to counties would be potentially reimbursable by the state, subject to a determination by the Commission on State Mandates.

SUPPORT: (Verified 8/29/25)

California Street Medicine Collaborative (Co-source)
University of Southern California (Co-source)
Adventist Health
Alameda County Families Advocating for the Seriously Mentally Ill

Blue Shield of California
California Chapter of the American College of Emergency Physicians
California Community Foundation
California State Association of Psychiatrists
Capital Compassion
City and County of San Francisco
Coalition to Abolish Slavery and Trafficking
County Behavioral Health Directors Association
County of Alameda
County of San Diego
Courage California
Drug Policy Alliance
East Bay Housing Organizations
Housing California
LA Family Housing
League of California Cities
Liver Coalition of San Diego
Los Angeles County Business Federation
Los Angeles Network for Enhanced Networks
National Alliance to End Homelessness
National Healthcare & Housing Advisors
National Health Care for the Homeless Council
People Assisting the Homeless
Smart Justice California, a Project of Tides Advocacy
Steinberg Institute
USC Street Medicine
Wellness Equity Alliance
Western Center on Law & Poverty
Whole Person Care Clinic
Three individuals

OPPOSITION: (Verified 8/29/25)

Health Care LA, IPA
Saban Community Clinic
St. John's Community Health

ARGUMENTS IN SUPPORT: Sponsors, the California Street Medicine Collaborative, a collaborative of 66 street medicine programs and other stakeholders hosted at the University of Southern California, write that street medicine has been proven to reduce hospital stays, readmission rates, and

unnecessary emergency department visits, improve engagement with primary care providers and improve housing placements for a population facing poorer health outcomes and higher mortality. Nonetheless, street medicine providers face barriers in helping unhoused individuals access needed referrals for specialty care, diagnostics, or medical equipment due to network assignment restrictions. They also state that the presumptive eligibility program should be expanded to the most vulnerable Medi-Cal population to expedite enrollment and that a homelessness identifier code in state Medi-Cal and welfare systems would enable better data tracking, care coordination, and access to benefits such as CalAIM services, behavioral health supports, and housing assistance. Removing these administrative barriers would ensure people experiencing homelessness can access the healthcare to which they are entitled.

ARGUMENTS IN OPPOSITION: The Community Clinic Association of Los Angeles County writes an oppose unless amended letter on behalf of their 66 nonprofit community health centers. They write that health centers agree with the intent of this bill to remove barriers to care for people experiencing homelessness, especially those being served via street medicine and agree with the presumptive eligibility and data sharing provisions of the bill. However, the managed care and medical home models rely on timely communication and information sharing between the providers. Primary care providers play a critical role in managing their assigned patients' care and it is essential they obtain information when services are rendered by other provider to enable outreach and follow-up, monitoring of chronic conditions and medications, and avoiding duplication of services. They seek an amendment that would require DHCS to issue guidance to Medi-Cal plans that contract with street medicine providers requiring the plans to develop and maintain protocols for timely sharing of information between street medicine providers, subcontractors, and primary care providers.

ASSEMBLY FLOOR: 78-0, 6/2/25
AYES: Addis, Aguiar-Curry, Ahrens, Alanis, Alvarez, Arambula, Ávila Farías, Bains, Bauer-Kahan, Bennett, Berman, Boerner, Bonta, Bryan, Calderon, Caloza, Carrillo, Castillo, Chen, Connolly, Davies, DeMaio, Dixon, Elhawary, Ellis, Flora, Fong, Gabriel, Gallagher, Garcia, Gipson, Jeff Gonzalez, Mark González, Hadwick, Haney, Harabedian, Hart, Hoover, Irwin, Jackson, Kalra, Krell, Lackey, Lee, Lowenthal, Macedo, McKinnor, Muratsuchi, Nguyen, Ortega, Pacheco, Papan, Patel, Patterson, Pellerin, Petrie-Norris, Quirk-Silva, Ramos, Ransom, Celeste Rodriguez, Michelle Rodriguez, Rogers, Blanca Rubio, Sanchez, Schiavo, Schultz, Sharp-Collins, Solache, Soria, Stefani, Ta, Valencia, Wallis, Ward, Wicks, Wilson, Zbur, Rivas

NO VOTE RECORDED: Tangipa

Prepared by: Jen Flory / HEALTH / (916) 651-4111
9/2/25 17:59:54

****** END ******