CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: October 29, 2026

ALL PLAN LETTER 26-020

SUPERSEDES ALL PLAN LETTER 24-001

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: FIELD MEDICINE PROVIDER: PARTICIPATION IN MANAGED CARE

PURPOSE:

The purpose of this All Plan Letter (APL) is to update policy guidance for Medi-Cal managed care plans (MCPs) on the participation of Field Medicine Providers, in alignment with Assembly Bill (AB) 543 (Chapter 374, Statutes of 2025).[1]

Previous policy guidance utilized "Street Medicine" terminology when referring to such services and Providers. With the chaptering of AB 543, Street Medicine terminology is now statutorily defined as "Field Medicine" and new requirements have been established for MCPs that elect to offer MCP Covered Services through a contracted Field Medicine Network Provider.

This APL outlines requirements and expectations for Network Provider participation, billing, Care Coordination, and presumptive eligibility to support access to care for Members experiencing homelessness.

BACKGROUND:

In recent years, the Department of Health Care Services (DHCS) has taken significant steps to expand access to health care for Medi-Cal members experiencing homelessness through the integration of Street Medicine into Medi-Cal. Street Medicine refers to the provision of health and social services directly in the environments where individuals experiencing homelessness reside—such as encampments, sidewalks/outdoor areas, and other places not intended for human habitation. This model of care is designed to reduce barriers to access by meeting individuals where they are, both physically and in terms of readiness for care, and outside of the four walls of health facilities, clinics, or other traditional care service locations.

[1] Legislation and state law are searchable at: https://leginfo.legislature.ca.gov/.

On November 8, 2022, DHCS issued APL 22-023[2] to provide initial guidance to MCPs on the inclusion of Street Medicine Providers in their Networks. This guidance emphasized the importance of improving access to care by providing services to Members in their lived environment (physical living situation/location), and outlined requirements for Provider participation, Credentialing, and Care Coordination.

On January 12, 2024, DHCS issued APL 24-001 to reflect the adoption of Place of Service (POS) code 27 by the Centers for Medicare & Medicaid Services (CMS), effective October 1, 2023. POS code 27—defined as "Outreach Site/Street"—is used to identify services delivered in non-permanent locations directly to individuals experiencing homelessness. This update enabled more accurate billing and data tracking for Street Medicine services under Medi-Cal.

Building on this foundation, AB 543 codifies the Field Medicine model of care paradigm and the role of Field Medicine Network Providers, and establishes a statutory framework for these Network Providers and their participation in Medi-Cal managed care. Key provisions include:

- Requiring MCPs that elect to offer MCP Covered Services through contracted Field Medicine Network Providers to allow these Network Providers to deliver those services directly to Members experiencing homelessness, regardless of the Member's assigned Primary Care Provider (PCP) or Independent Practice Association (IPA) assignment.
- Requiring MCPs to implement referral and authorization mechanisms to permit and facilitate Field Medicine Network Providers and their ability to directly refer Members for other MCP Covered Services (i.e., specialty, diagnostic, Durable Medical Equipment, etc.) within the appropriate Network of the MCP or IPA.
- Requiring MCPs to establish appropriate mechanisms, procedures, or protocols for the timely communication between Field Medicine Network Providers and the Member's broader health care team for the purposes of Care Coordination and to prevent the duplication of services.

The enactment of AB 543 further reflects California's commitment to reducing barriers to health care and improving health outcomes for individuals experiencing homelessness. This APL updates prior guidance to align with the statutory changes introduced by AB 543, as well as the evolving paradigm and protocols of Field Medicine to not only be performed directly on the street, but also be expanded to other

[2] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

environments that individuals experiencing homelessness inhabit, such as shelters and transitional housing. This wider approach captures the different environments and circumstances individuals experiencing homelessness may find themselves in and promotes a more comprehensive care system for this population. DHCS remains committed to supporting the continued integration of Field Medicine into the Medi-Cal managed care delivery system.

DHCS recognizes that individuals experiencing homelessness have complex needs that may change over time, and the delivery system landscape may vary between localities. As a result, this APL emphasizes flexibility in contracting arrangements, Field Medicine Network Provider roles, and settings of care. Allowable options for each of these aspects of Field Medicine are discussed in more detail in the sections below.

Definitions

For purposes of this APL, the following definitions apply:[3]

- "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.
- "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 (SDOH) that impede health care access.
- "Field medicine Provider" means a licensed medical Provider, including, but not limited to, a physician and surgeon, osteopathic physician and surgeon, physician assistant (PA), nurse practitioner (NP), or certified nurse-midwife (CNM), who conducts patient visits outside of the four walls of health facilities, clinics, or other locations, and instead directly on the street and in environments where persons experiencing homelessness might be, such as living in a car, recreational vehicle, encampment, abandoned building, other outdoor areas, shelters, or transitional housing.

[3] AB 543 (Chapter 374, Statutes of 2025)

POLICY:

MCPs that offer MCP Covered Services as part of a Field Medicine program are required to implement policies and procedures (P&Ps) that support the delivery of MCP Covered Services by Field Medicine Network Providers to Members experiencing homelessness, in accordance with the provisions of AB 543, this APL, and any other policy guidance from DHCS. For purposes of this APL and DHCS policy, DHCS utilizes "Field Medicine" terminology to align with state statute; however, DHCS recognizes the historical usage of "Street Medicine" terminology. An MCP may use either term for the purposes of their offered program.

Under AB 543, MCPs may elect to contract with Field Medicine Network Providers, defined as a licensed medical Provider, including, but not limited to, a physician and surgeon, osteopathic physician and surgeon, PA, NP, or CNM to render services to their Members experiencing homelessness. These services must be provided in accordance with Medi-Cal coverage requirements and may include Preventive Care, diagnostic, therapeutic, and Care Coordination services.

MCPs may require appropriate authorization for applicable Field Medicine Network Provider initiated orders and referrals as a component of their Utilization Management protocols to safeguard against Fraud, Waste, and Abuse and/or duplication or fragmentation of services, as well as to enhance care integration and consistency, and support whole-person care strategies. This means if an MCP has a Prior Authorization requirement in place, for example, for an order for Durable Medical Equipment or for a referral for a specialist, the MCP may apply this same requirement to an order or referral initiated by a Field Medicine Network Provider as it would to any other Provider in its Network making such an order or referral. MCPs must process such requests in accordance with federal and state law and contractual requirements and timeframes, and so as not to cause undue denial, limitation, or delay of services.

Key policy requirements include:

- Access to Services: MCPs that contract with Field Medicine Network Providers must allow Members experiencing homelessness to receive MCP Covered Services directly from these Network Providers, regardless of the Member's assigned PCP or IPA. In addition, MCPs must establish and maintain referral and authorization mechanisms in order to facilitate the direct referrals made by Field Medicine Network Providers for Members for other MCP Covered Services within the appropriate Network of the MCP or IPA. This means that MCPs cannot

require a referral or authorization request to originate from a PCP or another Provider in addition to or instead of the Field Medicine Network Provider's referral or authorization request.

- Care Coordination: MCPs must establish and maintain appropriate mechanisms, procedures, or protocols to ensure timely communication and coordination between Field Medicine Network Providers, the MCP or IPA, the Member's PCP (if assigned), and the MCP's care management team. This includes protocols to prevent duplication of services and to support Care Coordination and continuity of care. DHCS expects communications and coordination to be prompt, involved, responsive, and multi-directional from all individuals and Providers engaged in the care delivery and associated administration functions.
- Presumptive Eligibility: Field Medicine Network Providers enrolled in Medi-Cal may conduct Hospital Presumptive Eligibility (HPE) program determinations for individuals experiencing homelessness, enabling immediate access to full-scope Medi-Cal benefits without a share of cost under the Fee-for-Service (FFS) delivery system as outlined in the Medi-Cal Eligibility section below.
- Provider Participation: MCPs must adopt Credentialing and contracting policies that facilitate participation by Field Medicine Network Providers, including flexibility in site review and documentation requirements, while maintaining standards for quality, safety, and program integrity.
- Member Identification: MCPs must provide an accessible method (online, in person, or by telephone) for Members to self-identify as experiencing homelessness. MCPs must also act on information provided by DHCS via eligibility and enrollment files (834 transactions) indicating a Member's homelessness status, as reported on Medi-Cal applications or renewals. Upon receipt of homelessness status, MCPs must update appropriate internal systems to act on such information and ensure access to Medically Necessary benefits, services, and supports, such as, but not limited to, Enhanced Care Management (ECM), Community Supports, Field Medicine, case management, etc. MCPs are also informed if a Member is potentially homeless via the Population Health Management (PHM) Service (Medi-Cal Connect) if indicated on claims or Encounters submitted to DHCS.

This policy aligns with the goals of California Advancing and Innovating Medi-Cal (CalAIM) by supporting whole-person care, reducing barriers to access, and addressing SDOH for individuals experiencing homelessness. MCPs are expected to integrate Field Medicine into their broader care delivery and PHM Strategy.

Field Medicine Network Provider as a Member's Assigned PCP

Field Medicine Network Providers are licensed physicians and non-physician medical practitioners who conduct patient visits outside of the four walls of clinics or hospitals and directly in environments where individuals experiencing homelessness may be, such as a car, abandoned building, outdoor area, shelter, hotel, or transitional/temporary housing. Field Medicine Network Providers are able to bill for services rendered at these types of locations as outlined in the Billing/Reimbursement section below using the appropriate POS codes.

For a non-physician medical practitioner (PA, NP, and CNM), MCPs must ensure compliance with state law and Contract requirements regarding physician supervision of non-physician medical practitioners.[4] Additionally, given the unique and specialized nature of Field Medicine, a supervising Physician must be a practicing Field Medicine Network Provider, with knowledge of and experience in Field Medicine clinical guidelines and protocols. Contracted Field Medicine Network Providers may choose to serve as the Member's assigned PCP upon Member election, similar to how Obstetrician-Gynecologist (OB/GYN) Providers can elect to serve as PCPs. To serve as a PCP, the Field Medicine Network Provider must meet the MCP's eligibility criteria for being a PCP, be qualified and capable of treating the full range of health care issues served by PCPs within their scope of practice, and agree to serve in a PCP role. Field Medicine Network Providers, when elected by Members to act as their assigned PCP, are responsible for providing the full array of Primary Care services, including but not limited to, preventive services, and the treatment of acute and chronic conditions. Thus, Field Medicine Network Providers who choose to act as a Member's assigned PCP must agree to provide the essential components of the Medical Home in order to provide comprehensive and continuous medical care, including but not limited to:[5]

- Basic PHM.
- Care Coordination and health promotion.
- Support for Members, their families, and their authorized representatives.

[4] California Business and Professions Code (B&P) sections 3516, 2836.1, and 2507; Title 22 of the California Code of Regulations (CCR) sections 51240 and 51241; and the MCP Contract. The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index. The MCP Contract is available at: https://www.dhcs.ca.gov/provgovpart/Documents/2024-Managed-Care-Boilerplate-Contract.pdf.

[5] MCP Contract Exhibit A, Attachment I, 1.0 Definitions, Medical Home.

- Referral to Specialists, including Behavioral Health, community, and social support services, when needed.
- The use of Health Information Technology to link services, as feasible and appropriate.
- Provision of primary and preventive services to assigned Members.
- Referral to ECM and Community Supports, as applicable.

If the Field Medicine Network Provider does not have the capability to provide Primary Care services in the field, the Field Medicine Network Provider must be affiliated with a brick-and-mortar facility (e.g., Primary Care medical office, Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or other clinic, etc.). In this scenario, MCPs must assign Members to the affiliated brick-and-mortar facility to which the Field Medicine Network Provider is affiliated. MCPs may assign their Members to the Field Medicine Network Provider as the assigned PCP directly (as appropriate), or to the Field Medicine Network Provider's affiliated brick-and-mortar location. However, the MCP designates the PCP assignment, the MCP must make clear that the Member's care is being overseen by a Field Medicine Network Provider PCP.

If the Field Medicine Network Provider is willing to serve in the Member's assigned PCP capacity, the MCP is responsible for enrolling and Credentialing the Field Medicine Network Provider, in accordance with APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment.

Site Review and Medical Record Review Requirements

Field Medicine Network Providers who are serving in an assigned PCP capacity are required to undergo the appropriate level of Site Review process, which is either a full or a condensed review.

- For Field Medicine Network Providers serving as an assigned PCP, and who are affiliated with a brick-and-mortar facility, the MCP must conduct the full review process of the Field Medicine Network Provider and affiliated facility in accordance with federal and state law, as well as the MCP Contract and policy requirements.
- For Field Medicine Network Providers serving as an assigned PCP, and who are not affiliated with a brick-and-mortar facility, the MCP must conduct a condensed Facility Site Review (FSR) and Medical Record Review (MRR) of the Field Medicine Network Provider (including Field Medicine Network Providers that operate a mobile unit) to ensure Member safety. MCPs have flexibility in the design and

scoring of a condensed FSR and MRR with considerations to account for the size and demographics of the Member population served, types of services provided, and place of service; however, the MCP's condensed FSR and MRR requirements must be based on and substantively reflective of the full FSR and MRR review process noted above.

MCPs that use Field Medicine Network Providers as PCPs must develop and maintain protocols for identifying and transferring Members to a higher level of care if needed when the Member's service needs are beyond the capabilities and/or qualifications of the Field Medicine Network Provider. MCPs must ensure protocols include providing access to Urgent Care and emergency care, specialty care, Behavioral Health treatment, ancillary services, and appropriate Non-Emergency Medical and Non-Medical Transportation services. MCPs must also ensure their Field Medicine program protocols allow for expeditious referrals to ECM and Community Supports.

MCPs that use Field Medicine Network Providers as PCPs must develop and maintain protocols for identifying and transferring Members to a higher level of care if needed when the Member's service needs are beyond the capabilities and/or qualifications of the Field Medicine Network Provider. MCPs must ensure protocols include providing access to Urgent Care and emergency care, specialty care, Behavioral Health treatment, ancillary services, and appropriate Non-Emergency Medical and Non-Medical Transportation services. MCPs must also ensure their Field Medicine program protocols allow for expeditious referrals to ECM and Community Supports.

Process for Field Medicine Network Provider to Become Member's Assigned PCP

If an MCP has Field Medicine Network Providers willing to serve in a PCP capacity, MCPs must inform Members through the Member Handbook that contracted Field Medicine Network Providers may be elected to be the Member's assigned PCP so that the Member and the Field Medicine Network Provider can discuss whether this arrangement is appropriate. Additionally, MCPs may distribute population-specific communications about their Field Medicine program (pamphlets, brochures, fact sheets, etc.) approved through the DHCS file and use process. Field Medicine Network Providers are advised to assess and examine the level and quality of the establishment of the treatment relationship at the time of initial engagement when considering an agreement to be a Member's assigned PCP, as DHCS envisions dynamic and effective Provider-Member patient interactions. Field Medicine Network Providers should also be committed to ensuring that the Member is transferred to another PCP in a timely manner in the event

the Field Medicine Network Provider is no longer able or willing to serve as the Member's assigned PCP.

If a Member wants their Field Medicine Network Provider to be their PCP and the Field Medicine Network Provider is willing, then the MCP must have a process in place to complete the Member's election. DHCS encourages MCPs to establish a streamlined PCP assignment process for Field Medicine Network Providers. MCPs must make clear that the Field Medicine Network Provider is the Member's assigned PCP or is overseeing the Member's care. MCPs must inform Field Medicine Network Providers of PCP responsibilities, as well as Credentialing and review requirements, as applicable.

Provider Enrollment and Credentialing

MCP Network Providers, including Field Medicine Providers, are required to enroll as a Medi-Cal Provider if there is a state-level enrollment pathway for them to do so. The Credentialing requirements outlined in APL 22-013 only apply to Field Medicine Network Providers with a state-level enrollment pathway for Medi-Cal enrollment. If there is not a state-level enrollment pathway, the Field Medicine Network Provider is not required to meet the Credentialing requirements in APL 22-013 in order to become a Network Provider. To include Field Medicine Providers in their Networks when there is no state-level Medi-Cal enrollment pathway, MCPs are required to vet the qualifications of the Field Medicine Provider to ensure they can meet the MCP's standards of participation, similar to the Credentialing process and requirements mentioned above. MCPs must create and implement their own processes to do this. Criteria that MCPs may want to consider as part of their vetting processes include, but is not limited to:

- Sufficient experience providing similar services within the Service Area.
- Ability to submit claims or invoices using standardized protocols.
- Business licensing that meets industry standards.
- Capability to comply with all reporting and oversight requirements.
- History of Fraud, Waste, and/or Abuse.[6]
- Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families.
- History of liability claims against the Provider.

[6] MCP Contract Exhibit A, Attachment I, 1.0 Definitions, Fraud. Waste. Abuse.

Access Requirements

Field Medicine Network Providers elected as a Member's assigned PCP are exempt from PCP time or distance standards as the Member does not have a permanent residential address and the Field Medicine Network Provider is meeting the Member at their lived environment. MCPs are not expected to contract with Field Medicine Network Providers in order to meet time or distance standards as part of Annual Network Certification requirements. Additionally, the Service Location requirement for PCPs, as specified in the MCP Contract, is not applicable to Field Medicine Network Providers serving as PCPs, as Field Medicine Network Providers are not required to render services at a brick-and-mortar location. MCPs must submit P&Ps detailing at a minimum:

- Process for Field Medicine Network Providers to contract with the MCP as a PCP, if desired, and not requiring contracted Field Medicine Network Providers to be PCPs
- Process to ensure Members have timely access to traditional PCPs and Specialists in the MCP's Network
- Process to provide transportation to a traditional PCP who is outside of time or distance standards, upon the Member's request

Direct Contracting Arrangement

DHCS encourages MCPs to directly contract with Field Medicine Network Providers given their allowance to directly refer Members to MCP Covered Services, even though the Field Medicine Network Provider is not designated as the Member's PCP. Even if the MCP delegates the provision of health care services to a Subcontractor or Downstream Subcontractor entity, herein referred to as Subcontractor, MCPs have an option to directly contract with Field Medicine Network Providers. MCPs that directly contract with Field Medicine Network Providers must allow ready access to health care services for individuals experiencing homelessness and reduce contracting complexity for Field Medicine Network Providers. For example, rather than having to contract with each subcontracted IPA in the MCP's Network, the Field Medicine Network Provider could directly contract with the MCP. In addition, under this arrangement, the Field Medicine Network Provider is subject to the same MCP administrative processes (e.g., billing protocols, Credentialing requirements, authorization guidelines, etc.) rather than multiple processes and requirements under each Subcontractor. The payment arrangement is between the MCP and the Field Medicine Network Provider. Moreover, Prior Authorization to see a Field Medicine Network Provider would not be needed if the Member seeks services directly from a Field Medicine Network Provider related to the

Member's Primary Care. This means that an MCP contracted Field Medicine Network Provider, that meets all MCP-required administrative processes, can provide services to an MCP Member and receive payment for those services, even if the Member is assigned to a traditional PCP or Subcontractor, such as a medical group or IPA.

When an MCP directly contracts with the Field Medicine Network Provider, the Field Medicine Network Provider must have the ability to directly refer Members to MCP Covered Services within the proper MCP Network, and must coordinate care with the MCP, PCP, Subcontractor, and/or IPA as appropriate. MCPs must ensure Members have access to all MCP Covered Services and have appropriate referral and authorization mechanisms in place to facilitate access to needed services in the MCP's Network. Additionally, delivery of MCP Covered Services without authorization from the Member's PCP is an operational component that must be worked out between the MCP and Field Medicine Network Provider in accordance with AB 543. DHCS recognizes the important function PCPs have in Utilization Management and their need to have visibility and involvement in the overall Care Coordination of Members.

Field Medicine Network Provider as an ECM Provider

ECM is delivered primarily by community-based ECM Providers that enter into contracts with MCPs. MCPs may contract with Field Medicine Network Providers to become an ECM Provider. When a Field Medicine Network Provider is contracted to provide ECM, MCPs are required to allow that Provider to implement streamlined authorization procedures, which allow delivery of ECM services while a formal authorization request pends.[7]

A Field Medicine Network Provider can be contracted to provide both PCP and ECM services to a Member. ECM is primarily in-person based, and as such, ECM Providers are poised to build trust and facilitate coordinated care management with Members experiencing homelessness. Field Medicine Network Providers who are also ECM Providers are required to enroll in Medi-Cal if there is a state-level enrollment pathway; fulfill all ECM requirements; have the capacity to provide culturally appropriate and timely in-person care management activities; and have formal agreements, data systems, and processes in place with entities across sectors to support Care

[7] The ECM streamlined authorization requirements are outlined in the DHCS ECM Policy Guide in section VIII, subsection E https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf.

Coordination and care management.[8] MCPs are responsible for ensuring non-duplication of services provided through ECM and any other covered benefit, program, and/or delivery system.

Field Medicine Network Provider Serving Solely as a Referring or Treating Contracted Provider

The contracted Field Medicine Network Provider has the right to decline the additional responsibilities of an assigned PCP, and instead, care for Members in a non-PCP capacity as a direct referring or treating contracted Provider working with Members experiencing homelessness. To provide care in this capacity, MCPs must have appropriate communication processes in place to work with the Field Medicine Network Provider, the Member's PCP and/or IPA, and ECM Lead Care Manager (if applicable) to ensure the Member has referrals to Primary Care, Community Supports, Behavioral Health services, and other social services as needed. Field Medicine Network Providers in this capacity need to be communicative about and responsive to Care Coordination and monitoring activities with other care service entities.

Decoupling from Primary Care Provider Assignment

In accordance with AB 543, MCPs must allow contracted Field Medicine Network Providers to directly deliver MCP Covered Services to Members experiencing homelessness regardless of the Member's assigned PCP.

MCPs are not required to reassign the Member's PCP to the Field Medicine Network Provider, unless such an arrangement has been established as outlined above. However, MCPs must ensure that:

- Field Medicine Network Providers have access to the Member's care plan and relevant health records, as appropriate.
- There are protocols in place for bidirectional communication between the Field Medicine Network Provider and the Member's assigned PCP or care team.

[8] For further details, see the ECM and Community Supports Provider Standard Terms and Conditions at: https://www.dhcs.ca.gov/services/Documents/MCQMD/ECM-and-Community-Supports-Standard-Provider-Terms-and-Conditions.pdf; the CalAIM ECM Policy Guide; APL 23-032: Enhanced Care Management Requirements; and the CalAIM Enhanced Care Management and Community Supports Contract Template Provisions at: https://www.dhcs.ca.gov/Documents/MCQMD/MCP-ECM-and-ILOS-Contract-Template-Provisions.pdf.

- Services provided by Field Medicine Network Providers are coordinated and non-duplicative, particularly in relation to ECM, Community Supports, and other Medi-Cal benefits and services.

Prevention of Service and Payment Duplication

In accordance with AB 543, MCPs must implement oversight mechanisms to ensure that the services delivered by contracted Field Medicine Network Providers:

- Do not duplicate services already provided under other Medi-Cal benefits.
- Are coordinated with the Member's assigned PCP, IPA, ECM Provider (if applicable), and other care team members to ensure integration and avoid fragmentation.
- Are documented and reported in a manner that supports accurate Encounter Data submission and prevents duplicate billing or payment.

MCPs must establish protocols for:

- Real-time or near real-time communication between Field Medicine Network Providers and the Member's care team.
- Claims review and reconciliation processes to identify and prevent overlapping or duplicative payments.
- Training and technical assistance for Field Medicine Network Providers on Medi-Cal billing standards, documentation, and coordination expectations.

Medi-Cal Eligibility

Field Medicine Network Providers are required to verify the Medi-Cal eligibility of individuals they encounter in the provision of health care services. Medi-Cal eligible individuals will be covered by either the Medi-Cal FFS or Medi-Cal managed care (with a corresponding MCP) delivery system. For those individuals without Medi-Cal coverage, the HPE program is one pathway for qualified HPE Providers to determine Medi-Cal eligibility. HPE provides qualified individuals immediate access to temporary Medi-Cal services while individuals apply for permanent Medi-Cal coverage. DHCS allows qualified HPE Providers to determine presumptive eligibility under the HPE program off the premises of hospitals and clinics, such as in mobile clinics, field teams, or other locations.[9] Field Medicine Network Providers are not required to participate in the HPE

[9] For additional information on HPE Off-Premise flexibilities, see Medi-Cal NewsFlash: HPE Off-Premise Flexibilities at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/news/31240.

program, but may do so if they meet and fulfill all qualifications and requirements of the HPE program.

Billing/Reimbursement

Field Medicine Providers rendering services to Medi-Cal eligible individuals are to bill Medi-Cal based on the eligibility of the individual, for appropriate and applicable services within their scope of practice; with billings directed to Medi-Cal FFS, or the MCP if contracted. Field Medicine Providers must comply with the billing provisions for Field Medicine Providers as applicable in FFS, including but not limited to, the Medi-Cal Provider publications.[10] For managed care Members, Field Medicine Network Providers must comply with the billing provisions for Field Medicine Network Providers as applicable to MCP policies and procedures.

Field Medicine Network Providers can also be reimbursed for providing other California Medicaid State Plan benefits. MCPs are responsible for ensuring non-duplication of services with any other covered benefit, program, and/or delivery system.

CMS created a new POS code 27 (Outreach Site/Street), that became effective October 1, 2023. Field Medicine Network Providers should bill POS code 27 to MCPs when rendering services for Field Medicine in a non-permanent location on the street or other uninhabitable environment, not described by any other POS code.

POS codes 04 (Homeless Shelter), 15 (Mobile Unit), and 16 (Temporary Lodging) should continue to be utilized for services provided in those respective settings by Field Medicine Network Providers. DHCS would like to reiterate that Field Medicine is reimbursable in accordance with billing protocols and a Provider's scope of practice across a range of appropriate settings.

Please note that mobile units/RVs that go to the individual experiencing homelessness in their lived environment is considered Field Medicine and should use POS code 27.

If the Field Medicine Network Provider is an FQHC or RHC, they are entitled to the MCP contracted rate and the Prospective Payment System (PPS) differential "wrap" payment through Medi-Cal's fiscal intermediary when such services are being provided by a

[10] For additional information, see DHCS Medi-Cal Bulletin: Reminders and Updated Billing Guidelines for Street Medicine at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/news/33375.01.

billable clinic practitioner outside the service facility four walls and where the Member is located.[11]

FQHC or RHC Providers can bill for Field Medicine services when using the Accredited Standards Committee (ASC) X12N 837I electronic institution claim or UB-04 paper claim form by providing the specific revenue and procedure codes established by the MCP. When FQHCs or RHC Providers submit claims to the DHCS fiscal intermediary to receive the PPS differential "wrap" reimbursement for Field Medicine services, they must include the Type of Bill 71X. Additionally, FQHCs or RHCs should include Z59.00 (Homelessness, unspecified), Z59.01 (Sheltered homelessness), and/or Z59.02 (Unsheltered homelessness), as appropriate, on the wrap claim's informational line.[12] It is essential to use the appropriate Z59.0x procedure code on the informational line of the claim to clearly identify the service as part of Field Medicine.

It remains the expectation of DHCS that individuals experiencing homelessness will be able to receive appropriate and applicable services in their lived environment as a part of an MCP's Field Medicine program.

Data Sharing, Reporting and Administration Requirements

Contracted Field Medicine Network Providers must comply with all applicable MCP data sharing and reporting requirements in accordance with federal and state laws and the MCP Contract based on Provider contracting type. MCPs are to ensure Field Medicine Network Providers have adequate systems in place to adhere to data sharing and reporting requirements, such as for Encounter, claims, and Care Coordination data. Additionally, Field Medicine Network Providers must comply with all applicable MCP administration requirements in accordance with federal and state laws and the MCP Contract based on Provider contracting type. MCPs are to ensure Field Medicine Network Providers receive appropriate Provider training and manuals and adhere to administration requirements, such as Grievances and Appeals, referrals, after-hours and timely access, Prior Authorizations, Quality Improvement, performance measures, and electronic health records.

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[11] Effective July 1, 2026, only FQHC and RHC services "that are eligible for federal financial participation shall be reimbursed" at the PPS rate, meaning services outside those that are eligible for FFP will be paid at the contracted rate and will not be eligible for the "wrap" payment. (Welfare & Institutions Code (W&I), section 14132.100(c).

[12] For the billing instructions for wrap payments see Provider Manual: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): Billing Codes at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/2D80A3B6-A32B-4131-BE63-12EE7243A849/ruralcd.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

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

For MCPs that elect to offer Field Medicine, the requirements in this APL necessitate revisions to the MCP's contractually required P&Ps. MCPs must submit their P&Ps to the Managed Care Operations Division (MCOD)-MCP Submission Portal[13] for DHCS' review and approval within 90 calendar days of the release of this APL. DHCS will provide a P&P Review Tool for this APL. For MCPs that do not elect to offer Field Medicine, the MCP must attach an attestation to the Portal within 90 calendar days of the release of this APL, stating that the MCP does not offer Field Medicine. The attestation must include the title of this APL as well as the applicable APL release date in the subject line.

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 and/or 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. Any failure to meet the requirements of this APL may result in enforcement actions.

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

[13] The MCOD-MCP Submission Portal is located at: https://cadhcs.sharepoint.com/sites/MCODMCPSubmissionPortal/SitePages/Home.aspx.