Medi-Cal & HHIP Coverage for Street Medicine

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Background

The Department of Health Care Services (DHCS) prioritizes street medicine in both its Housing and Homelessness Incentive Program (HHIP) and the new Medi-Cal CalAIM initiative.

CoCs should be aware of a potential increase or expansion of street medicine programs in their communities, as well as the opportunities for leveraging street-based services (e.g., coordination with homeless outreach teams, ensuring all areas of a CoC are covered, connecting street medicine patients to Coordinated Entry, etc.) This handout provides information about how DHCS defines Street Medicine for purposes of Medi-Cal coverage and HHIP so CoCs can discuss street medicine needs, programs, and coordination opportunities with their local MCPs with this critical context in mind.

In November 2022, DHCS released an All Plan Letter[1] (APL 22-023) that governs Medi-Cal coverage for street medicine. The APL removes many of the barriers that prevented street medicine teams from providing comprehensive care to people living unsheltered.

Before APL 22-023, there was no policy that allowed medical providers to get reimbursed for providing or referring patients to services that people living unsheltered need, unless those services were provided in their clinics, federally-qualified health centers (FQHCs), hospitals, or medical offices. Services provided where people lived with their belongings were most likely uncompensated or paid for through private foundations.

HHIP incentivizes Medi-Cal managed care plans (MCPs) to provide support for street medicine. The one-time HHIP funds can be used to provide resources to communities that wish to stand up a new, robust street medicine program or expand existing programs.

Street Medicine Under CalAIM

The new policies reflected in APL 22-023 serve to address the "clinical and non-clinical needs" of people experiencing unsheltered homelessness. Of utmost importance, Medi-Cal will ***pay street medicine providers for their on-site medical visits*** to care for people living unsheltered.

If medical or social services are provided at shelters, mobile units or RVs, or other sites with a ***fixed, specific location***, they do not qualify as street medicine for purposes of CalAIM (they may be reimbursable through other Medi-Cal initiatives). Services provided in such situations are covered as "mobile medicine," because they require the person experiencing homelessness to visit a health care provider at the fixed location.

Mobile medicine provides care to people experiencing homelessness who live in shelters or who receive their health care some place other than their own personal "lived environment," such as a day center or an emergency shelter.

However, if the mobile unit/RV goes to the individual experiencing unsheltered homelessness in their "lived environment" (e.g., on the street, at an encampment, in their tent by a river), it would be considered "street medicine." Under the DHCS definition, delivery of medical services at a safe parking site, which is not meant for human habitation, would fit the definition of street medicine since the medical provider is providing services to an individual in their lived environment (their car). Street medicine programs are not required to be associated with a brick-and-mortar facility.

DHCS encourages MCPs to adopt their own street medicine guidelines and engage as many providers as possible in street medicine, while still maintaining high quality of care standards.

APL 22-023 allows street medicine providers to become Medi-Cal providers directly. While they recognize the value of mobile medicine, DHCS clearly states that they expect the majority of health and social services provided to individuals experiencing unsheltered homelessness will be through street medicine.

Street medicine includes "[h]ealth and social services developed specifically to address the unique needs and circumstances of unsheltered homeless individuals delivered directly to these individuals in their own environment." Street medicine is provided to an individual experiencing unsheltered homelessness in their "lived environment, places that are not intended for human habitation."

While the provision of medical services on the street will be covered by Medi-Cal, the APL is silent regarding the reimbursement rates. Street medicine may be reimbursed at the same rate as services on site at a facility or medical office.

[1] DHCS shares information or interpretation of changes in policies or procedures through All Plan Letters (APLs). APLs communicate how to operationalize federal or state law changes.

Managed Care Plans & Street Medicine Options

There are multiple ways that MCPs can cover medical services to unsheltered individuals through street medicine:

- Street medicine providers assigned as the primary care providers (PCP) for the individual receiving services;
- Through a direct contract with the MCP as an Enhanced Care Management (ECM) provider;
- As a referring or treating contract provider.

Street medicine provider as PCP

Street medicine providers are licensed medical providers[2] who conduct patient visits outside a clinic or hospital, "directly on the street, in environments where unsheltered individuals may be (such as those living in a car, RV, abandoned building, or other outdoor areas)." They can opt to serve as the individual's PCP in a similar fashion that ob/gyns act as PCPs. They must also:

- Meet 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.[3]

Street medicine providers are responsible for all the medical services that would be provided as a Medi-Cal PCP, including preventive services and the treatment of acute and chronic conditions. The range of services includes:

- Basic case management;
- Care coordination and health promotion;
- Support for members, their families, and their authorized representatives;
- Referral to specialists, including behavioral health, community, and social support services, when needed;
- The use of health IT to link services; and
- Provision of primary and preventative services to assigned members.

If an individual street medicine provider meets the PCP qualifications, it is up to the MCP to enroll and establish credentials for the street medicine provider.[4] (There also are additional administrative requirements.)

MCPs must also develop protocols that govern when PCPs identify and transfer members to a higher level of care when the member's needs are higher than the PCP can provide through the street medicine program (e.g., access to emergency medicine, specialty care, mental health services, substance use services, transportation). They need to have protocols in place for "expeditious" referrals to ECM and Community Supports. They must have policies and procedures in place that articulate their 1) process for contracting with street medicine providers; 2) process for ensuring timely access to traditional PCPs and/or specialists; and 3) process to provide transportation to traditional PCPs upon member request.

Other requirements

All street medicine providers serving as PCPs must meet site review and medical record review requirements. If they are associated with a brick-and-mortar facility or a mobile/RV clinic, they must go through a full review. If they are not affiliated with a brick-and-mortar facility, they go through condensed review.

Enrolling a Patient with a Street Medicine Provider

MCPs must clearly communicate with members that street medicine providers are available as PCPs. Street medicine providers must be able to call the MCP while in the company of their member/patient. The MCP must allow the member to choose the street provider as their PCP. The new process potentially overcomes a barrier that existed in the past, which required PCP approval to access a street medicine provider. However, the process of calling together to change the name of the PCP and allow for immediate coverage for services may not be as smooth practically as it is envisioned in the APL.

[2] Doctor (MD/OD), Physician Assistant (PA), Nurse Practitioner (NP), or Certified Nurse Midwife (CNM). For non-physicians, MCPs must ensure compliance with state law/contract requirements re: physician supervision (e.g., supervisor must be a practicing street medicine provider, with knowledge of and experience in street medicine clinical guidelines and protocols).
[3] Street medicine providers are exempt from meeting Medi-Cal time and distance standards, as well as the service location requirement.
[4] Please note that there may be some providers unable to enroll in DHCS's state-level enrollment pathway (APL 22-013) for credentialling. In those circumstances, to become an in-network provider, they must meet alternative criteria for credentialling. See APL 22-023 pages 5-6.

DHCS encourages MCPs to directly contract with street medicine providers. Direct contracts enable providers to skip having to contract with intermediary independent physician/provider associations (IPAs). The street medicine provider would also be able to directly process claims with the MCP (again, skipping the middle administrative agencies). Payments would be between the street medicine provider and the MCP; they would not have to go through a prior authorization process even if the member is assigned to an IPA or medical group for other services.

The main requirement for direct contracting is that the street medicine provider must have the ability to directly authorize and refer their patients to other medically necessary services through the members' appropriate network.

Street medicine providers who are also ECM providers

MCPs can contract with street medicine providers to be ECM providers. When providers are both street medicine and ECM providers, they can directly provide care management, rather than have to refer back to a PCP to do so. They can manage their patients' housing-related supports, social services, mental health services, etc. in addition to their medical care.

If providers opt to be both ECM and street medicine providers, they must be enrolled as Medi-Cal providers and meet all of the ECM provider requirements (have the capacity to provide culturally appropriate and timely in-person care management activities; have formal agreements, IT and data systems/processes to support care coordination/care management).

Street medicine providers who serve only as referring or treating contracted providers

Street medicine providers are not required to take on additional roles as PCPs. They can opt to simply refer or treat through a street medicine program. To refer or treat only, the street medicine provider must have a relationship with the member's PCP or ECM manager so that the member can get referrals to primary care, behavioral health services, and other services as needed. They also must have the ability to communicate and be responsive to care coordination and monitoring of care.

Allowing non-PCP providers to offer street medicine is a significant change, in that the provider does not have to be the assigned PCP of an individual experiencing homelessness to provide care to the individual and get paid for the services.

Housing & Homelessness Incentive Program (HHIP) & Street Medicine

One of the seven priority metrics DHCS defined for HHIP relates to street medicine: Metric 2.1 – Connection with street medicine team providing health care for people who are homeless. The definition of what services are considered "street medicine" is the same as in APL 20-023.

DHCS will provide incentive fund points to MCPs who are able to report progress on street medicine efforts. Specifically, MCPs must report an increase in the proportion of their members receiving street medicine services during the first ten months of 2023 as compared to the last eight months of 2022. See *Understanding HHIP Performance Metrics* in this Toolkit.

For more in-depth information about street medicine efforts in California, please see The California Street Medicine Landscape Survey and Report.