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CHCF Issue Brief

A Game Changer for Street Medicine:
Key Takeaways from New Medi-Cal Guidelines

Street medicine is a critical but underutilized model for delivering health care to people experiencing unsheltered homelessness and connecting them to social services, including housing. In November 2022, California's Department of Health Care Services (DHCS) released an All Plan Letter that provides new guidance to Medi-Cal managed care plans that will make it easier for communities to establish, maintain, and fully leverage street medicine programs. This issue brief lays out the major implications of this new policy, as well as key issues that remain.

What Is Street Medicine?

Established in the early 1990s, street medicine is the provision of health care and social services directly to people who are unsheltered in their own environment and outside of the four walls of a traditional brick-and-mortar clinic or hospital setting.

As the **Street Medicine Institute** explains, "The fundamental approach of street medicine is to engage people experiencing homelessness exactly where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through. Visiting people where they live — in alleyways, under bridges, or within urban encampments — is a necessary strategy to facilitate trust-building with this socially marginalized and highly vulnerable population. In this way, street medicine is the first essential step in achieving higher levels of medical, mental health, and social care through assertive, coordinated, and collaborative care management."

Street medicine exists on a **broader continuum of medical outreach** that also includes care provided at shelters, mobile medical units, and medical RVs. While each of these approaches is important in its own right, this brief focuses specifically on street medicine and new opportunities to expand that model of care in California.

Street Medicine in California

Over the past few decades, street medicine has evolved from a grassroots movement to an established area of medicine, with programs in existence both nationally and internationally. In California, there are at least 25 street medicine programs in operation. These programs are primarily clustered around the San Francisco Bay Area and Los Angeles, though other programs exist in communities such as San Diego, Bakersfield, and Redding.

Nearly half of these existing programs are associated with a Federally Qualified Health Center (FQHC). The rest have a variety of sponsoring organizations from hospitals, health plans, academic institutions, and local governments.

COMING SOON. In early 2023, CHCF will publish a new landscape report on street medicine in California from authors Brett J. Feldman, MSPAS, PA-C; Corinne T. Feldman, MMS, PA-C; Alexis Coulourides-Kogan PhD, Sonali Saluja MD, MPH, FACP; and Michael Cousineau DrPH at the Keck School of Medicine of the University of Southern California, Division of Street Medicine.

Variation exists across California's street medicine programs. Each has created unique ways to reflect local circumstances and meet the needs of people experiencing homelessness within their communities. Most programs use team-based approaches to provide a mix of primary care, urgent care, and care focused on unmet social needs. There is also widespread use of peer professionals and community health workers to help with outreach, engagement, and care coordination.

To date, most programs in California have relied on grant funding to cover the cost of providing services. That is true even of health center-based programs, where Medi-Cal reimbursement for street-based services continues to be the exception rather than the norm. Historically, there was no Place of Service Codes[1] that providers could use for care delivered outside a facility. In addition, street medicine providers had no clear guidance or precedent for how to contract with Medi-Cal managed care plans and bill for services.

Two big changes have the potential to help providers of all types develop and sustain street medicine programs. First, in late 2021, DHCS released a **new billing notice** for street medicine providers that clarified that both enrollment in Medi-Cal and delivery of service could happen outside of traditional health care settings in fee-for-service Medi-Cal. This helps people get enrolled in Medi-Cal and means that services provided by street medicine providers can be reimbursed before someone is enrolled in managed care. Second, the agency provided guidance in the form of an All Plan Letter, to help Medi-Cal managed care health plans and local providers take advantage of opportunities to deliver street medicine in their region.

All Plan Letter: A Game Changer for Street Medicine

On November 8, 2022, DHCS released an **All Plan Letter** (PDF) to Medi-Cal managed care health plans on the use of street medicine to address the health needs of Medi-Cal members experiencing unsheltered homelessness. The purpose of an All Plan Letter is to provide clarification and guidance to managed care plans affected by any Medi-Cal policy change. All Plan Letters are the means by which DHCS conveys information or interpretation of changes in policy or procedure at the federal or state level. It provides instruction to managed care contractors on how to implement these changes on an operational basis. In this case, it clarifies for street medicine providers exactly what they need to do to participate in Medi-Cal managed care.

The All Plan Letter from DHCS has the potential to dramatically expand the scale and spread of street medicine in California. There are three key reasons why DHCS' latest guidance has the potential to be a game-changer for street medicine in the state. The All Plan Letter:

- Provides a stable and flexible source of funding for street medicine programs
- Enables street medicine teams to deliver whole-person care
- Makes it easier for people experiencing homelessness to access their full range of Medi-Cal benefits

Providing a Stable and Flexible Source of Funding

Until now, street medicine programs had to cobble together funding to cover their costs. That lack of predictable, stable funding made it hard for established programs to sustain and grow and for new programs to launch. With the All Plan Letter guidance, there is now clarity on the multiple ways providers, community-based organizations, and local governments can get reimbursed for street medicine in partnership with Medi-Cal managed care plans in their region.

Plans can now contract with different types of street medicine teams and allow them to bill for providing care in the streets. Previously, a provider delivering street medicine had to be part of a brick-and-mortar primary care facility, like an FQHC, in order to even consider billing for their care. That is no longer the case. This guidance now enables street medicine teams affiliated with academic centers, hospitals, and community-based organizations to bill for primary care even if they aren't affiliated with a traditional brick-and-mortar primary care clinic. Notably, a street medicine provider will not have to be the primary care provider assigned to the member by the managed care plan in order to provide care and get paid. The person can now become a referring or treating provider and will not need a specific authorization to provide services. This provision also helps in cases where street medicine teams do not want the responsibility of delivering all the requirements of a primary care medical home,[2] as outlined in the All Plan Letter.

Another change is that in the past a Medi-Cal member experiencing homelessness had to personally call and request to be assigned to a particular primary care provider. Under the All Plan Letter, a street medicine primary care provider can call the plan together with the member, and both make the request to become that person's assigned primary care provider. For providers contracted as both a referring and a primary provider, this change makes it much easier to ensure that they are getting reimbursed for patients they are treating in the streets, especially given that it can take up to 30 days for a new primary care assignment to start.

Enabling Street Medicine Teams to Deliver Whole-Person Care

Under **CalAIM**, Enhanced Care Management is a new statewide Medi-Cal benefit designed to facilitate whole-person care. Specifically, it enables Medi-Cal to cover the cost of a care manager to coordinate clinical and nonclinical care and services across multiple systems (namely physical, behavioral, dental, developmental, and social services), making it easier for patients to get the right care at the right time. People experiencing homelessness are one of the populations of focus for Enhanced Care Management.

Under the new policy, managed care plans may now contract with street medicine providers to become an Enhanced Care Management provider. This change will allow street medicine programs to get reimbursed for important functions like care coordination and to cover the cost of important nonclinical members of street medicine care teams, like community health workers, neither of which have historically been billable services. That in turn will give street medicine teams the tools and capacity to not only provide direct primary care but to also manage their patients' full range of needs, including specialty physical or behavioral health, pharmacy, housing supports, and other social services.

Making It Easier for People Experiencing Homelessness to Access the Full Range of Medi-Cal Benefits

Before this new policy, street medicine providers could provide direct care, but many did not have the full scope that a designated primary care provider would have under managed care rules. For example, they could not refer patients they care for on the street to physical or behavioral health specialists or for important diagnostic tests. Instead, they would need to call the primary care provider assigned to the patient by the managed care plan and ask them to put through the referral. If the primary care provider did not know the patient, they would ask the patient to come see them before intervening, inevitably leading to delays in diagnosis or treatment.

By allowing street medicine providers to become designated primary care providers, unhoused Medi-Cal members will now have easier access to the full range of their Medi-Cal benefits, beyond direct primary care on-site. This opens up the possibility for street medicine patients to have many more of their needs met in a timely manner and in a much more person-centered, responsive way.

Areas to Watch

DHCS's new guidance removes many barriers and creates new opportunities for the sustainability and spread of street medicine. Still, there are several areas to watch as implementation unfolds.

What Are the Practical Realities of Launching New Street Medicine Programs?

Existing street medicine programs are best positioned to take advantage of the new street medicine guidance. Without Medi-Cal reimbursement, it has been difficult to sustain those programs, let alone grow their reach. The new policy largely solves that sustainability problem. Starting a new program, however, is a much bigger lift. Providers and communities that want to launch new street medicine programs will need more intensive, up-front capacity-building support. Under the American Rescue Plan Act, California has $1.3 billion in Housing and Homelessness Incentive Program (HHIP) dollars to incentivize Medi-Cal managed care plans to invest in new homeless service programs. Plans should consider using some of those funds to develop new street medicine programs. CalAIM's **PATH CITED** dollars could also be leveraged for street medicine teams that contract with or intend to contract with managed care plans to provide Enhanced Care Management contract with or intend to contract with managed care plans to provide Enhanced Care Management.

What Can Be Done to Reduce the Administrative Burden?

Street medicine providers will have to clear several administrative hurdles before they can take advantage of these new Medi-Cal reimbursement opportunities. For example, they will have to set up billing systems, as well as systems for data collection and data sharing. While these steps might be easier for hospitals, FQHCs and academic medical centers, they could pose a bigger challenge for independent providers and community-based organizations. It is worth exploring how funding programs like HHIP and PATH could be used to provide technical and financial assistance to help street medicine programs solve their administrative challenges.

What If an Unsheltered Patient Is Already Assigned to Another Primary Care Provider?

In the rules embedded in many claims systems, only the designated primary care provider can get paid for primary care services. In many cases, Medi-Cal members are auto-assigned to a provider. If a street medicine provider tries to treat that person and wants to get reimbursed for it, the provider would either need to get paid without being the primary care provider of record, or get that person to call their plan to have their provider changed (and that often doesn't even take effect until the first of the next month). The All Plan Letter suggests a workaround: encouraging plans to set up street medicine providers as contracted or referring providers through direct contracts that supersede any delegated arrangements. Even with the fix, one could argue that this arrangement is needlessly complicated and that the added complexity itself could be a barrier to the effective deployment of street medicine.

Will Reimbursement Rates Cover the Actual Cost of Street Medicine?

Delivering street medicine is more expensive than providing care in a health care facility. Street medicine providers also tend to a greater array of health and social needs than traditional primary care providers do. The All Plan Letter does not include guidance on rates, but existing reimbursement rates may not be enough to cover the costs of street medicine. It may be, however, that this rate shortfall could be mitigated if street medicine providers also signed up to be an Enhanced Care Management provider. This action would help offset the costs of the types of coordination and support that come from other team members, like community health workers and care coordinators.

What Are the Particular Implications for Street Medicine and FQHCs?

Due to **specific payment rules for FQHCs**, it is possible that the rate that FQHCs would receive for a primary care visit at their facilities is higher than the rate they would receive for a street medicine visit. The difference could inadvertently create a disincentive for FQHCs to deploy or grow street medicine programs. The **Alternative Payment Methodology** under development may offer a solution, given that it grants FQHCs more flexibility in who delivers services and where they are delivered. The issue is worth monitoring as the street medicine guidance and payment reforms for FQHCs are implemented over time.

How Will the All Plan Letter Impact Other Models of Care for People Who Are Unsheltered?

Providing care to unsheltered Californians will necessitate an approach that includes a panoply of different health care delivery models, like mobile medical units and medical RVs. DHCS's new guidance, while a game changer for street medicine, does not address contracting and billing for other mobile health models. It will be important to track the growth and impact of the various models and ensure that those with the most potential to improve health and housing outcomes have every opportunity to grow and scale.

About the Foundation

The **California Health Care Foundation** (CHCF) is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

1. Place of Service Codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. POS information is often needed to determine the acceptability of direct billing of Medicare, Medicaid, and private insurance services provided by a given provider.
2. The primary requirements of a medical home are: basic case management (with transition to basic population health management when effective); 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 information technology to link services, as feasible and appropriate; and provision of primary and preventative services to assigned members.