# Homeless Health Advisory Committee

AGENDA
July 16, 2024
9:30 – 11:00am
Zoom link
Meeting ID: 864 2425 1543
Passcode: 122926

| Time | Item—Presenter | Materials |
|---|---|---|
| 9:30am | **Welcome & Introductions** — *Jill Lubin, JWCH* | |
| 9:35am | **Ice Breaker** — *Sarine Pogosyan, CCALAC* | |
| 9:45am | **Homeless Health Policy Updates** — *Erika Rogers, CCALAC*<br>• Local<br>  ○ 2024-25 Recommended Budget<br>  ○ Measure A: Affordable Housing, Homelessness Solutions, and Prevention Now<br>  ○ Greater Los Angeles Homeless Count Results<br>• State<br>  ○ FY 2024-25 Budget<br>  ○ State Legislation<br>  ○ DHCS Street Medicine Advocacy Efforts | • Homeless Heath Policy Slides**<br>• Greater Los Angeles Homeless Count Slides**<br>• State Legislation Tracker**<br>• CPCA Street Medicine Letter |
| 10:20am | **LA County Field Medicine Program** — *All* | • Field Medicine Program Slides** |
| 10:40am | **Open Discussion** — *All*<br>• CARE Court implementation<br>• Street medicine hurdles<br>• Prop 1 MHSA<br>• SCOTUS ruling on Grant's Pass v. Johnson | |
| 11:00am | **Adjourn** — *Jill Lubin, JWCH* | |

**Next meeting: November/December 2024**

Additional Resources

- **Homeless Health Advisory Committee Page**
- **Homeless Health Resource Page**

** provided in final packet of materials

# Homeless Health Advisory Committee

# Ice Breaker

If you could be an instant expert in something, what would it be and why?

# Homeless Health Policy Updates

# Proposed LA County Budget

# $45.4 Billion Recommended Budget

LA County Board of Supervisors released their 2024-25 Recommended Budget, which emphasizes addressing homelessness and bolstering mental health service.

- Adds 835 new positions, over half (452) are in the Department of Mental Health, totaling 116,159 positions in the County workforce.
- $728.2 million to fund the County's multi-layered approach to combating homelessness and facilitate the Homeless Emergency Declaration, including hiring more frontline staff such as outreach workers, housing navigators, mental health clinicians and substance use counselors.
- 452 positions within the Department of Mental Health to support the state's new CARE Court program; the Interim Housing Outreach Program providing services to help mentally ill homeless persons maintain housing stability; and staff an expansion of department-operated clinics and full-service partnership programs; as well as various Mental Health Services Act-funded programs.

# Budget Timeline and Resources

- More information about the County budget can be found here.
- Supplemental/final adopted budget scheduled for October 8.
- Key Resources on the 2024-25 Recommended Budget:
  - PowerPoint
  - Fact Sheet
  - Budget Charts
  - Transmittal Letter

# Measure A: Affordable Housing, Homelessness Solutions and Prevention Now

## Replacing Measure H

- Would terminate and replace the existing ¼ cent sales tax that currently funds the homelessness response system and expires in 2027 (Measure H) with a ½ cent countywide sales tax.
- Tax is estimated to produce $1.2 billion annually.
- If approved, Measure A would have no sunset date and would only be repealable by a future vote.
- Read the measure's language here.

# Goals

The goals of the measure are to significantly reduce and prevent homelessness in Los Angeles County by:

- **Increasing Housing Availability and Affordability:** Accelerate and expand the availability of affordable and interim housing options and preserve currently affordable housing.
- **Enhancing Supportive Services:** Boost mental health and substance abuse treatment for people experiencing homelessness;
- **Addressing Encampments:** Connect people living in large-scale and individual encampments, RVs, automobiles, or public spaces to housing;
- **Preventing Housing Loss:** Implement measures like rental and legal assistance to prevent evictions;
- **Streamlining Processes:** Reduce unnecessary paperwork and barriers to access and build affordable housing, particularly for populations like seniors, families with children, and veterans;
- **Improving Coordination and Funding:** Establish direct local return funding for Los Angeles County's 88 cities, improve coordination with state and federal governments, and reduce bureaucracy to increase funding and efficiency; and
- **Accountability and Transparency:** Implement a Universal Data and Accountability Plan for consistent reporting and conduct independent annual audits to assess progress in reducing homelessness.

# State Budget

# Budget Timeline

- May 10: Governor released his FY 24-25 May Revision budget proposal ($44.9B shortfall for FY24-25; $17.3B solved via "early action;" $27.6B budget "problem" to address in final budget)
- May 29: Senate and Assembly released a proposed joint legislative budget plan
- June 13: Legislature met June 15 deadline by passing AB 107, the Budget Act of 2024 (and SB 154 and SB 167 – additional budget bills, one re Prop 98, one re: corporate net operating loss deductions and tax credits). Bills reflected the Legislature's proposal, *not* a final agreement with the Governor.
- June 14 – 21: Negotiations continued
- June 22: Governor and legislative leaders announce budget agreement. (Assembly summary here; Senate summary here).
- June 22 - 23: 19 budget-related bills emerge in print (in addition to 3 earlier bills)
- June 26 - 27: Legislature passes 18 budget-related bills (one more passed July 1)
- June 26 - 27: Governor signs original 3 budget bills (AB 107, SB 154, SB 167)
- June 29: Governor signs most of the additional bills

# FY 2024-25 $297.9 Billion Budget

- Governor Gavin Newsom approved a $297.9 billion budget for California that will close a state deficit estimated at $46.8 billion.
- The budget addresses the shortfall by cutting state spending, drawing from reserves, and suspending some tax breaks for businesses, among other measures.
- Click here to view the budget summaries and details.

# Budget Adjustments & Reductions

The budget includes $1.25 billion in new funding for and reductions to homelessness programs including:

- **Homeless Housing, Assistance, and Prevention (HHAP) Program Round Six**—$1 billion General Fund in 2024-25 for a sixth round of HHAP grants to eligible cities, counties, and continuums of care.
- **Encampment Resolution Fund (ERF) Grants**—$250 million General Fund for additional rounds of ERF grants ($150 million in 2024-25 and $100 million in 2025-26).
- **Transfer of Homelessness Grant Programs**—provides 26 new positions to the Department of Housing and Community Development (HCD), funded from existing administrative setasides, for HCD to administer homelessness programs that are transferring from the California Interagency Council on Homelessness.
- **HHAP Program Supplemental Funds**—A reduction of $260 million General Fund of HHAP Round Five supplemental funds.
- **Homelessness Program Administrative Funding**—A reversion of $142 million General Fund of unneeded administrative funding for HHAP, ERF grants, and Family Homelessness Challenge Grants.

# Budget Adjustments & Reductions Contiued

- **Behavioral Health Bridge Housing Program**—A reduction of $250 million General Fund and a shift of $90 million to the Mental Health Services Fund. The Budget maintains $1.25 billion ($1.2 billion General Fund) for this program.
- **Behavioral Health Continuum Infrastructure Program**—A reversion of $70 million General Fund in 2024-25 and $380.7 million General Fund in 2025-26.
- **Bringing Families Home Program**—A delay of $80 million General Fund for the Bringing Families Home Program with up to $40 million shifted to 2025-26 and  $40 million to 2026-27.
- **Housing and Disability Advocacy Program**—A reversion of $50 million General Fund for the Housing and Disability Advocacy Program.

# State Legislation

Resource: CCALAC's State Legislation Webpage

# Process

If substantially amended, bill must go back to its House of Origin for concurrence of amendments

**House of Origin**

- Bills must be introduced by Feb. 16, 2024
- Rules Committee
- Policy Committee(s)
- Appropriations (fiscal) Committee
- Floor Vote

**Second House**

- Rules Committee
- Policy Committee(s)
- Appropriations (fiscal) Committee
- Floor Vote

**Governor's Desk**

- Legislature must pass bills by Aug. 31
- Governor signs, approves without signing, or vetoes
- Governor must sign or veto bills by Sept. 30.

Appropriations Committee Suspense File: bill with a cost of over $50K is "placed on suspense" – committee members then make strategic/fiscal/political decisions about what bills to allow to move forward or "pass" out of the committee. Suspense hearings are usually just prior to the deadline for bills to clear fiscal committees.

# Key Dates

- **July 3 - Aug. 5:** Legislature adjourns for summer recess
- Aug. 16: Last day for fiscal committees to meet and report bills
- Aug. 19 - 31: Floor Sessions
- Aug. 23: Last day to amend bills on the Floor
- Aug. 31: Last day for each house to pass bills
- Sept. 30: Last day for Governor to sign or veto bills

Click here to access the 2024 legislative deadlines.

# Bills of Interest: Support

**AB 2498 (Zbur) Housing: the California Housing Security Act**

- Would require the California DMV to establish the Mobile Homeless Connect Pilot Program in specified areas to assist persons experiencing homelessness with obtaining an identification card.
- CCALAC supports

**SB 491 (Durazo) Public social services: county departments: mail programs.**

- Would require counties to develop and implement a program for people experiencing homelessness to receive and pick-up all government-related mail from their county's department of public social services office.
- CCALAC supports, CPCA supports

# Bills of Interest: Watch

**AB 1738 (Carrillo) Mobile Homeless Connect Pilot Program**

- Would require the California DMV to establish the Mobile Homeless Connect Pilot Program in specified areas to assist persons experiencing homelessness with obtaining an identification card.

**AB 1878 (Garcia) Housing programs: tribal housing program**

- Would create the Tribal Housing Advisory Committee within the Business, Consumer Services, and Housing Agency, upon appropriation, and make changes to tribal liaison and technical assistance requirements that apply to the Department of Housing and Community Development.
- CPCA supports

**AB 1948 (Rendon) Homeless multidisciplinary personnel teams**

- Eliminates the sunset date of the provision that allows homeless adult and family multidisciplinary personnel teams (MDT) to serve “individuals at risk of homelessness” in specified counties, including LA County.

**SB 37 (Caballero) Older Adults and Adults with Disabilities Housing Stability Act**

- Would create a targeted housing stabilization grant program for older adults and individuals living with disabilities. Regions in which a high proportion of older adult renters are struggling with high rental costs would first be prioritized for funding.

# Field Medicine Program

# LA County Field Medicine Program (LAC-FMP)

- Joint proposal and RFA from L.A. Care and Health Net; apply by May 24.
- Program goal is to expand access to and improve the quality and scope of health care and social services available to people experiencing homelessness (PEH) in LA County.
- Applicants will be considered for participation in the LAC-FMP as
  - Field Medicine PCP-Regional Anchor Provider,
  - Field Medicine PCP-Floating Provider, or
  - Street Medicine Only Provider.
- RFA documents have been sent to Homeless Health Advisory Committee and LA County Street Medicine Coordination Collaborative members. Health plans also sent RFA to members.

# LAC-FMP Provider Types

<table>
<tr><th>Primary Care Status</th><th>Provider Type</th><th>Description</th></tr>
<tr><td rowspan="2">Takes Primary Care Assignment</td><td>Field Medicine PCP – Regional Anchor</td><td><ul><li>Provides full suite of Field Medicine services, including Street Medicine as well as connection to social services (housing navigation and ECM)</li><li>Is anchored in, and responsible for, a particular geography within Los Angeles County</li><li>Provides care via street teams, mobile units and brick-and-mortar facilities located within the region</li><li>Acts as the default FM-PCP for any given region within Los Angeles County for planning purposes and coordination with government agencies</li></ul></td></tr>
<tr><td>Field Medicine PCP – Floating Provider</td><td><ul><li>Provides full suite of Field Medicine services, including Street Medicine as well as connection to social services (housing navigation and ECM)</li><li>Is NOT anchored to a particular region and instead operates in various regions county-wide based on provider preference and community need</li><li>Provides care via street teams and mobile units</li></ul></td></tr>
<tr><td>Does not Take Primary Care Assignment</td><td>Street Medicine-Only – Floating Provider</td><td><ul><li>Provides Street Medicine services only under direct Street Medicine contract with Managed Care Plans</li><li>Must provide connection to social services (housing navigation and ECM)</li><li>Is NOT anchored to a particular region and instead operates in various regions county-wide based on provider preference and community need</li><li>Must work with the MCP, the member’s PCP, and ECM care manager to ensure member has access to primary and specialty care, behavioral health services, Community Supports and other social services as needed</li></ul></td></tr>
</table>

# LAC-FMP Information & Resources

*Has your organization applied for the LAC-FMP? If so, have you received a response?*

# 2024

# Greater Los Angeles Homeless Count

LOS ANGELES HOMELESS SERVICES AUTHORITY

June 28, 2024

# LAHSA performs the largest annual PIT Count in the United States as required by HUD for Continuums of Care (CoC) nationwide.

## LAHSA's data is then reviewed and validated by HUD.

- The process is designed in partnership with data experts at USC with guidance from HUD to create an accurate census of unhoused people living in the Los Angeles CoC.
- The count is an imprecise estimate. It includes both specific numbers like shelter bed counts, along with estimates, observations, and statistical sampling.

USC

LAHSA

This year, LA region's point-in-time estimate declined slightly – down **0.27% in LA County** and down **2.2% in the City of LA**.

## County of LA

| Year | Count |
|---|---|
| 2018 | 52,765 |
| 2019 | 58,936 |
| 2020 | 66,436 |
| 2021 | No Count Conducted |
| 2022 | 69,144 |
| 2023 | 75,518 |
| 2024 | 75,312 |

-0.27%

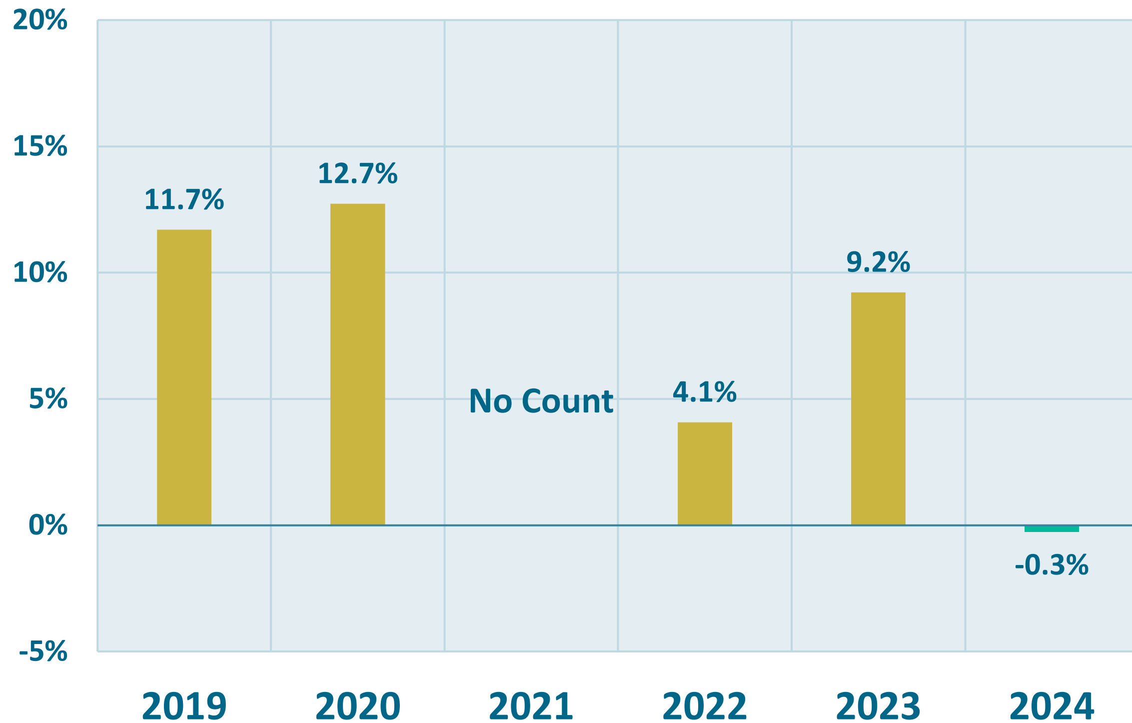
## City of LA

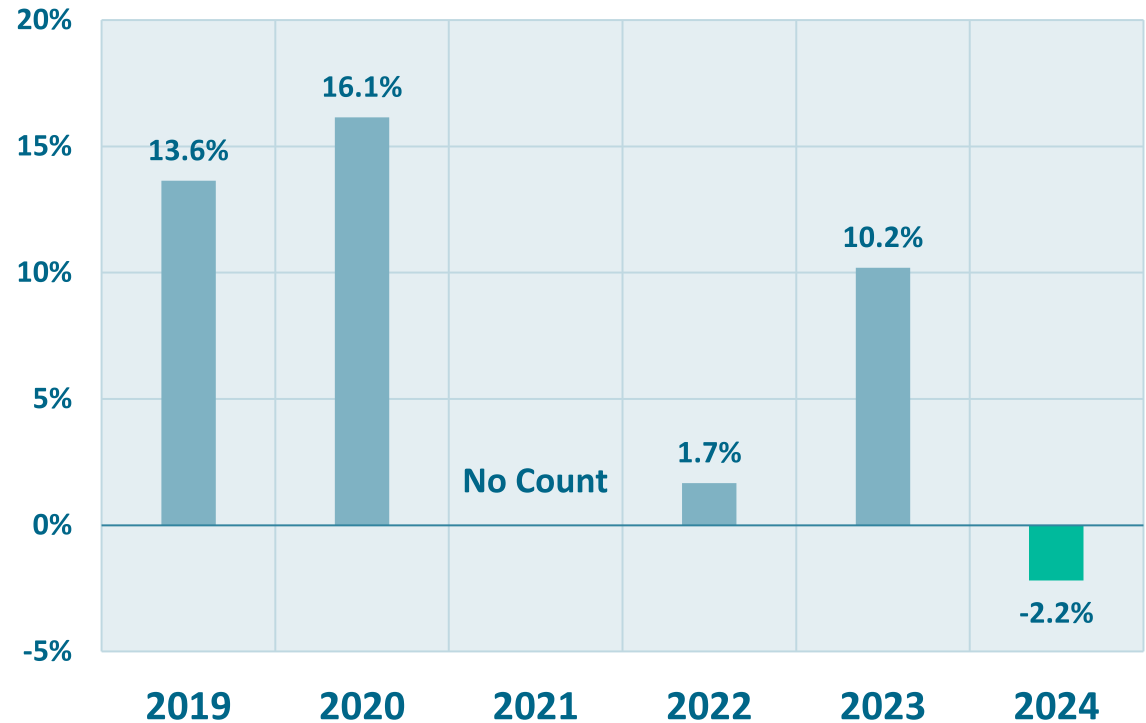
| Year | Count |
|---|---|
| 2018 | 31,285 |
| 2019 | 35,550 |
| 2020 | 41,290 |
| 2021 | No Count Conducted |
| 2022 | 41,980 |
| 2023 | 46,260 |
| 2024 | 45,252 |

-2.2%

Note: The 2023 Homeless Count was conducted on January 23 – 25, 2024.

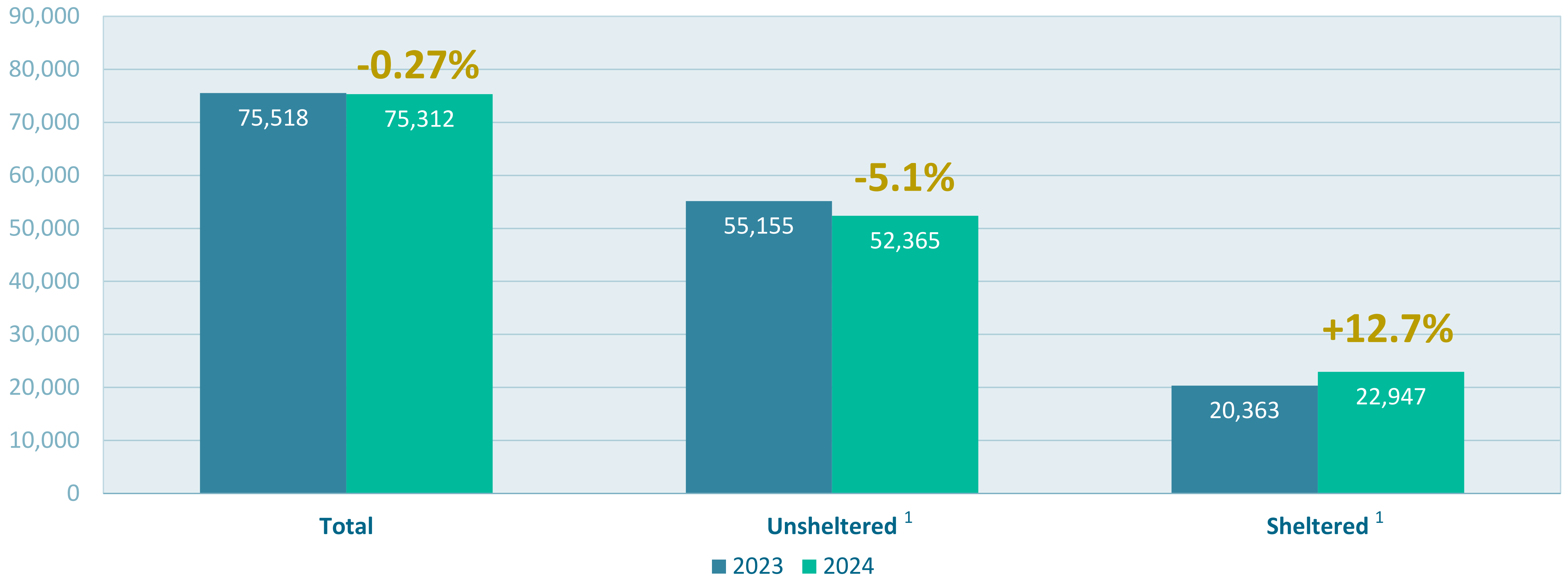
# Our unified response to unsheltered homelessness is contributing to meaningful change.



Note: The 2024 Homeless Count was conducted on January 23 – 25, 2024.

# Across the County*, unsheltered homelessness dropped by 5.1%, while the number of people in shelter rose by 12.7%.

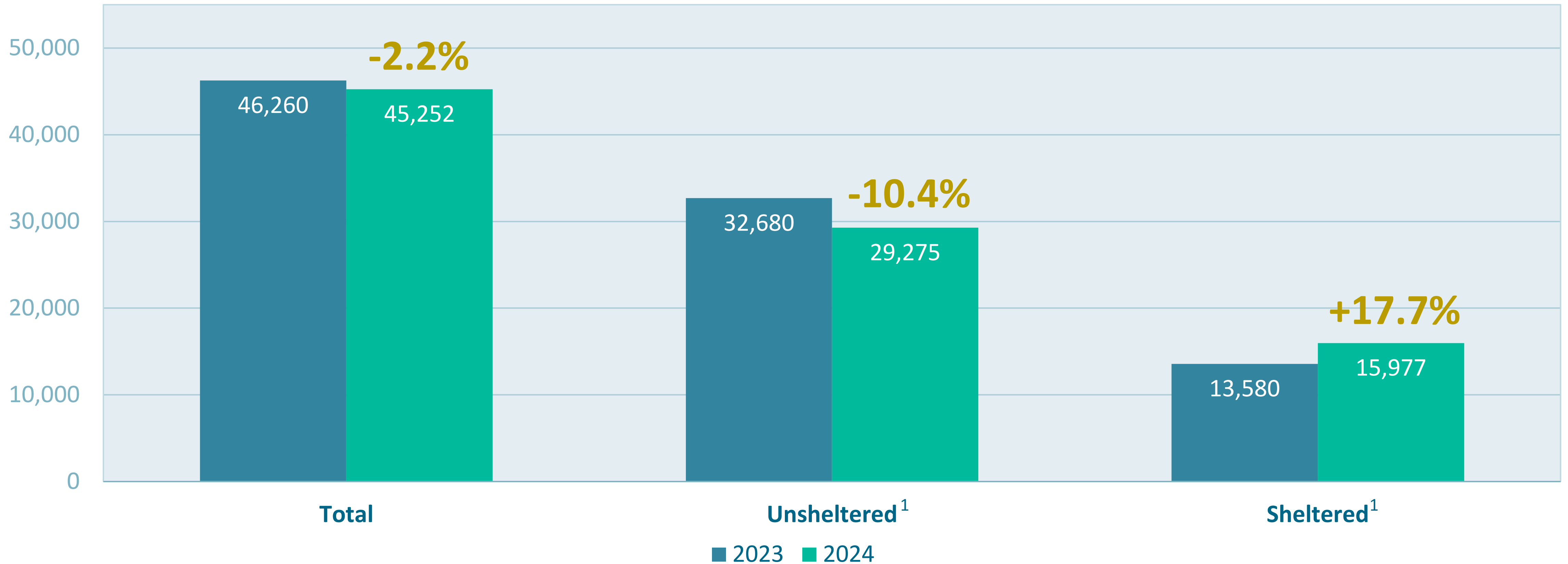



*Including data from Glendale CoC, Pasadena Coc, and Long Beach CoC.

[1] Unsheltered numbers are an estimate, while Sheltered numbers have been counted.

LAHSA

# In the City of LA, unsheltered homelessness dropped by 10.4%, while the number of people in shelter rose by 17.7%.




LAHSA

[1] Unsheltered numbers are an estimate, while Sheltered numbers have been counted.

# Service Planning Areas (SPAs) Estimates

| SPA | 2023 | | | 2024 | | | Unsheltered Change | Sheltered Change | Total Change |
|---|---|---|---|---|---|---|---|---|---|
| | Unsheltered People | Sheltered People | Total People | Unsheltered People | Sheltered People | Total People | | | |
| **SPA 1** Antelope Valley | 3,833 | 853 | **4,686** | 5,538 | 1,134 | **6,672** | **1,705** | **281** | **1,986** |
| **SPA 2** San Fernando Valley | 8,064 | 2,379 | **10,443** | 6,997 | 3,704 | **10,701** | **-1,067** | **1,325** | **258** |
| **SPA 3** San Gabriel Valley | 3,458 | 1,551 | **5,009** | 3,630 | 1,213 | **4,843** | **172** | **-338** | **-166** |
| **SPA 4** Metro | 12,846 | 5,685 | **18,531** | 12,185 | 6,204 | **18,389** | **-661** | **519** | **-142** |
| **SPA 5** West | 5,235 | 1,434 | **6,669** | 4,143 | 1,240 | **5,383** | **-1,092** | **-194** | **-1,286** |
| **SPA 6** South | 8,431 | 4,564 | **12,995** | 8,682 | 5,204 | **13,886** | **251** | **640** | **891** |
| **SPA 7** East | 5,070 | 1,441 | **6,511** | 4,342 | 1,557 | **5,899** | **-728** | **116** | **-612** |
| **SPA 8** South Bay | 5,370 | 1,106 | **6,476** | 3,992 | 1,436 | **5,428** | **-1,378** | **330** | **-1,048** |



[1] SPA 2 excludes data from Glendale CoC
[2] SPA 3 excludes data from Pasadena CoCs
[3] SPA 8 excludes data from Long Beach CoC

LAHSA

# The effects of the encampment resolutions led to a decrease in makeshift shelters.

| Dwelling Types | 2023 | 2024 | % Change |
|---|---|---|---|
| **Cars** | 3,918 | 3,709 | -5.33% |
| **Vans** | 3,364 | 2,986 | -11.24% |
| **RVs** | 6,814 | 6,854 | 0.59% |
| **Tents** | 4,293 | 4,232 | -1.42% |
| **Makeshift shelters** | 5,049 | 3,507 | -30.54% |
| **Total** | **23,438** | **21,288** | **-9.17%** |

LAHSA

**This year's homeless count numbers suggest that our unprecedented coordinated emergency response is making a difference.**

# LAHSA's Key Performance Indicators show people are moving through our rehousing system faster.

From 2022-2023, year over year, LA County increased street to interim housing placements through outreach by almost 50%.

Additionally, in the same timeframe, the number of people moving from interim housing to permanent housing increased by 25%.

**From Street to IH**

**+47%**

**From IH to PH**

**+25%**

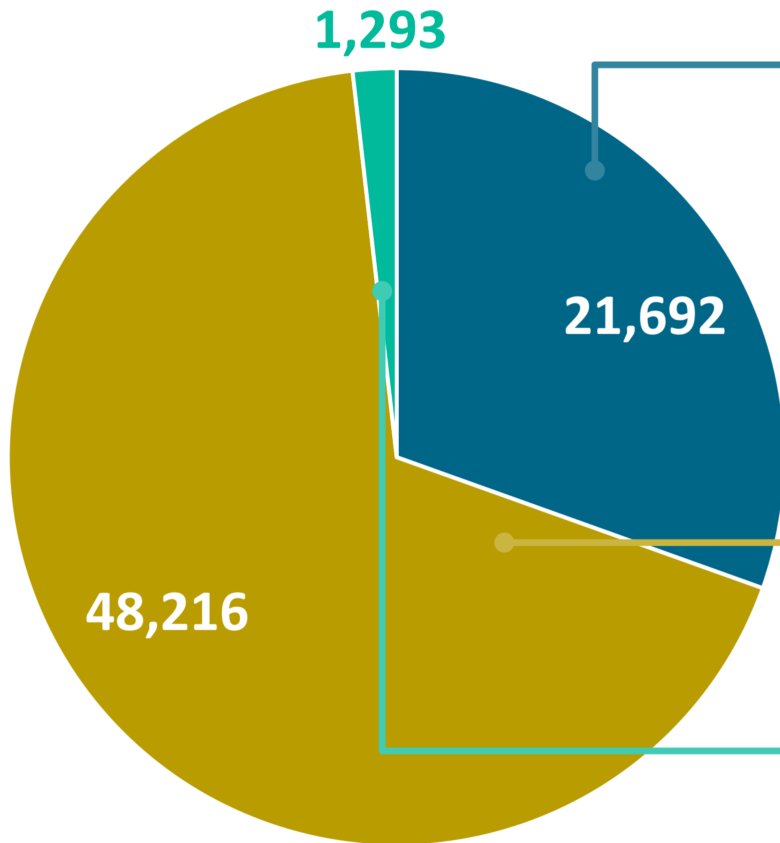
# In 2023, the rehousing system recorded an all-time high number of permanent housing placements.*

| Year | Permanent housing placements |
| --- | --- |
| 2017 | 14,252 |
| 2018 | 19,846 |
| 2019 | 19,437 |
| 2020 | 21,073 |
| 2021 | 22,659 |
| 2022 | 22,540 |
| 2023 | 27,300 |

*Note: Data provided courtesy of County Information Office. It is possible for one person to have multiple permanent housing placements in a year.

# The LA CoC* PIT Count methodology has 3 components

**Overall Estimate: 71,201** (+/- 1,592)




**Sheltered adults & youth (30.5%):**

- Shelter count
- Administrative data (HMIS)

**Unsheltered adults (67.7%):**

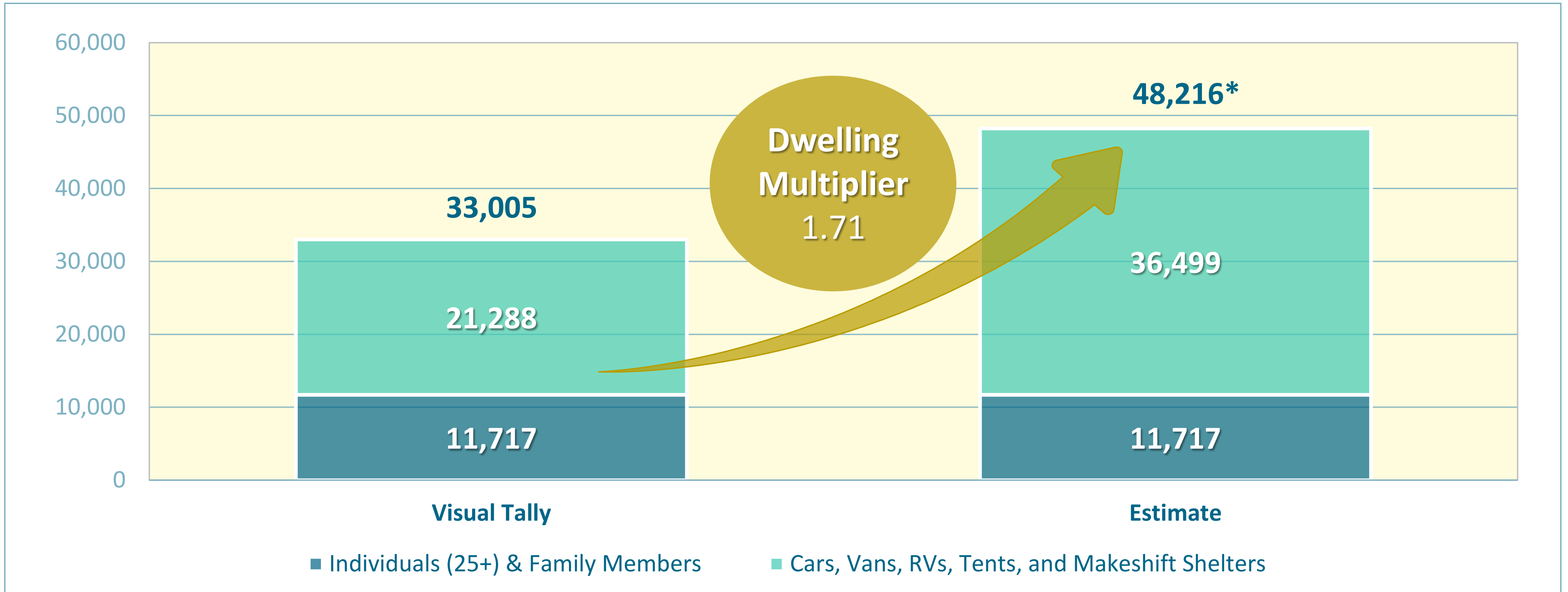
- Street count (visual tally)
- Demographic surveys

**Unsheltered youth (1.8%):**

- Survey-based count

*Note: Estimates do not include Glendale, Long Beach, and Pasadena.

# Survey data is used to determine how many people are living within each vehicle, tent and makeshift shelter




*The 95% confidence interval is 46,651 to 49,781.

## The data continues to show that historic exclusionary racist policies still result in a disproportionate amount of black people experiencing homelessness.

## Latinos remain the largest ethnic group experiencing homelessness.

| Race / Ethnicity | Homeless Pop. single race category only | Homeless Pop. race category and Hispanic/Latino/a/e | Grand Total | Percent of Total |
|---|---|---|---|---|
| American Indian, Alaskan Native, or Indigenous | 1,056 | 476 | 1,532 | 2.2% |
| Asian or Asian American | 927 | 200 | 1,127 | 1.6% |
| Black, African American, or African | 21,160 | 881 | 22,041 | 31% |
| Hispanic/Latino/a/e alone | | 23,103 | 23,103 | *see below** |
| Middle Eastern or North African | 95 | 5 | 100 | 0.1% |
| Native Hawaiian/Other Pacific Islander | 288 | 81 | 369 | 0.5% |
| White | 14,905 | 5,762 | 20,667 | 29.0% |
| Multiple Races | 1,889 | 373 | 2,262 | 3.2% |
| **Total** | 40,320 | 30,881 | 71,201 | |
| Hispanic/Latino/a/e alone plus Hispanic/Latino/a/e and any other category | *n/a* | 30,881 | *n/a* | 43%* |

*Respondents can select Hispanic/Latino/a/e alone or in combination with another category, so the total adds up to more than 100%.

**54% of newly homeless unsheltered persons reported that economic hardship as a reason for falling into homelessness.***

| Percent of newly homeless population (First Time (<=1 yr.) | |
|---|---|
| Economic hardship | 54% |
| Weakened social network | 38% |
| Disabling health condition | 17% |
| System discharge | 14% |
| Violence | 4% |
| Other | 10% |

*Respondents can report more than one reason for homelessness, so the totals can add up to more than 100%. Also, data is self-reported.

LAHSA

New provider payment model
Master leasing & increasing efficiency
Together we must make systemic changes
Housing location & quicker placements
Data transparency

# What's different about this moment?

- Los Angeles has a coordinated path forward.
- LA area stakeholders , including providers, are coordinating.
- City and County of LA remain in a state of emergency.
- The State of California has financially supported encampment resolution efforts and enacted AB 977.
- The Biden/Harris Administration is supporting through ALL-Inside and HUD's focus on encampment resolution.

**This level of alignment to address unsheltered homelessness is unprecedented.**

LAHSA

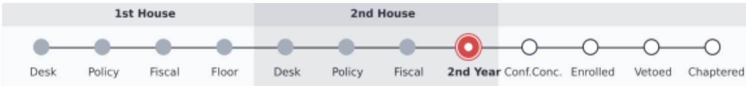
# Homeless Health Advisory Committee

Friday, 07/12/2024
Sorted by: Measure

**AB 1738** **Carrillo, Wendy (D)** HTML PDF

**Mobile Homeless Connect Pilot Program.**

**Progress bar**




Tracking form

| CCALAC Position | CCALAC Staff Lead(s) |
| --- | --- |
| Watch | Erika Rogers |

**Bill information**

**Status:** 09/14/2023 - Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/12/2023)(May be acted upon Jan 2024)

**Summary:** Would require the California DMV to establish the Mobile Homeless Connect Pilot Program in specified areas to assist persons experiencing homelessness with obtaining an identification card. (Based on bill dated 9/14/23)

**Location:** 09/14/2023 - Senate 2 YEAR

**Last Amend:** 06/15/2023

**AB 1878** **Garcia (D)** HTML PDF

**Housing programs: tribal housing program.**

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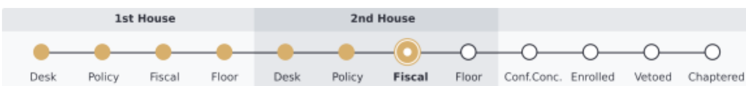



Tracking form

| CCALAC Position | CCALAC Staff Lead(s) |
| --- | --- |
| Watch | Erika Rogers |

**Bill information**

**Status:** 07/03/2024 - From committee: Do pass and re-refer to Com. on APPR with recommendation: To Consent Calendar. (Ayes 11. Noes 0.) (July 2). Re-referred to Com. on APPR.

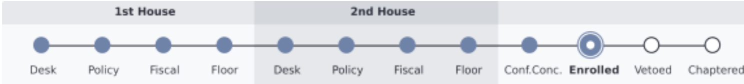
**Summary:** Would create the Tribal Housing Advisory Committee within the Business, Consumer Services, and Housing Agency, upon appropriation, and make changes to tribal liaison and technical assistance requirements that apply to the Department of Housing and Community Development. (Based on bill dated 7/3/24)

| **Location:** | 07/03/2024 - Senate APPR. | **Last Amend:** | 06/17/2024 |
|---|---|---|---|

**AB 1948** **Rendon (D)** HTML PDF

**Homeless multidisciplinary personnel teams.**

**Progress bar**




Tracking form

| CCALAC Position | CCALAC Staff Lead(s) |
|---|---|
| Watch | Erika Rogers |

**Bill information**

**Status:** 07/01/2024 - Enrolled and presented to the Governor at 4 p.m.

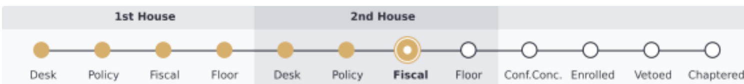
**Summary:** Eliminates the sunset date of the provision that allows homeless adult and family multidisciplinary personnel teams (MDT) to serve “individuals at risk of homelessness” in specified counties, including LA County. (Based on bill dated 7/1/24)

| **Location:** | 07/01/2024 - Assembly ENROLLED | **Last Amend:** | 03/12/2024 |
|---|---|---|---|

**AB 2498** **Zbur (D)** HTML PDF

**Housing: the California Housing Security Act.**

**Progress bar**




Tracking form

| CCALAC Position | CCALAC Staff Lead(s) |
|---|---|
| Support | Erika Rogers |

**Bill information**

**Status:** 06/25/2024 - From committee: Do pass and re-refer to Com. on APPR. (Ayes 8. Noes 1.) (June 24). Re-referred to Com. on APPR.

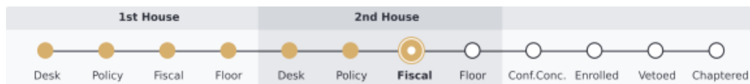
**Summary:** Would establish a statewide housing subsidy program to reduce housing insecurity for low- income individuals and families. The California Housing Security Program would provide housing subsidies to eligible low-income individuals and families to not exceed $2,000 a month. The program would target populations that are at high risk of experiencing homelessness, including older adults, adults with disabilities, and individuals experiencing homelessness regardless of their immigration status. Sponsored by Los Angeles County Board. (Based on bill dated 4/25/24)

| **Location:** | 06/25/2024 - Senate APPR. | **Last Amend:** | 06/19/2024 |
|---|---|---|---|

**SB 37** **Caballero (D)** HTML PDF

**Older Adults and Adults with Disabilities Housing Stability Act.**

**Progress bar**




Tracking form

| CCALAC Position | CCALAC Staff Lead(s) |
|---|---|
| Watch | Erika Rogers |

**Bill information**

**Status:** 07/02/2024 - July 2 set for first hearing. Placed on suspense file.

**Summary:** Would create a targeted housing stabilization grant program for older adults and individuals living with disabilities. Regions in which a high proportion of older adult renters are struggling with high rental costs would first be prioritized for funding. Sponsors: Corporation for Supportive Housing, Justice in Aging, United Way of Greater LA. (Based on bill dated 1/22/24)

**Location:** 07/02/2024 - Assembly APPR. SUSPENSE FILE

**Last Amend:** 01/22/2024

SB 491 Durazo (D) HTML PDF

**Public social services: county departments: mail programs.**

**Progress bar**

Tracking form

| CCALAC Position | CCALAC Staff Lead(s) |
|---|---|
| Support | Erika Rogers |

**Bill information**

**Status:** 09/01/2023 - Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/16/2023)(May be acted upon Jan 2024)

**Summary:** Would require counties to develop and implement a program for people experiencing homelessness to receive and pick-up all government-related mail from their county's department of public social services office. CPCA Supports. Sponsors include Western Center on Law and Poverty and Coalition of California Welfare Rights Organizations (Based on bill dated 9/1/23)

**Location:** 09/01/2023 - Assembly 2 YEAR

**Last Amend:** 07/03/2023

**Total Measures: 6**
**Total Tracking Forms: 6**

June 5, 2024

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*submitted via email to: glenn.tsang@dhcs.ca.gov*

**RE: Comments on the All-Plan Letter 24-001 Street Medicine Provider**

Dear Mr. Tsang,
On behalf of our nearly 1,300 community health centers (CHCs), the California Primary Care Association (CPCA) would like to thank you for your continued engagement in clarifying State policy related to operationalizing street medicine. CHCs provide high-quality, comprehensive, coordinated, accessible, equitable, patient-centered care to 1 in 3 Medi-Cal patients, including 338,000 persons experiencing homelessness[1].

California's network of CHCs has been a front-line provider of health care for the homeless since their inception in the 1960's. Health centers were born out of the social justice and health equity movements and have remained true to their mission of supporting vulnerable populations. For decades prior to a statewide street medicine concept and before Medicaid expansion - which increased health care coverage for thousands of low-income persons who otherwise would not be eligible, including the unhoused - health centers were the primary source of care for persons experiencing homelessness. CHCs are in every California community, providing services in their communities without regard to payment and often without consistent reimbursement.

We applaud the Department of Health Care Services (DHCS) for articulating a design for Medi-Cal Managed Care Plans (MCPs) to offer street medicine services. The purpose of our continued administrative engagement with DHCS is to highlight the CHC implementation experience with All-Plan Letter 24-001 Street Medicine Provider. Health center operational and reimbursement policy is complicated and merits specific consideration when promulgating regulations. In this letter, we outline the most pressing issues and recommend policies to alleviate these issues so health centers can continue their efforts to provide comprehensive health and wrap around care to persons who are homeless.

**Issue 1: Direct Access to Medically Necessary Covered Services**

[1] Data source: Health Resource Services Administration Uniform Data System, California Aggregate, Reporting Year 2022.

CPCA shares the concerns expressed by the California Street Medicine Collaborative about the barriers street medicine providers face in operationalizing direct access. Direct Access refers to a system that allows individuals experiencing homelessness to immediately access services without extensive prerequisites or barriers. This approach aims to streamline the process of getting help by minimizing the steps and requirements typically involved in accessing support. Direct access is the intention of APL 24-001, which states that:

> "Under a direct contracting arrangement, the street medicine provider must have the ability to refer Members to Medically Necessary Covered Services (MNCS) within the proper MCP network, and must coordinate care with the MCP, Subcontractor, and/or IPA as appropriate. MCPs would need to ensure Members have access to all Medically Necessary Covered Services and have appropriate referral and authorization mechanisms in place to facilitate access to needed services in the MCP's Network."

CPCA interprets this to mean providers directly contracted with the MCP for street medicine services must have the ability to order MNCS, including prescriptions, durable medical equipment, diagnostic studies, and refer to specialty care. While several MCP's are making progress toward operationalizing direct access, and many affirm its importance, the implementation approach and level of progress varies. This has profound consequences for patients on the street, contributing to increased morbidity, mortality, and suffering.

> **RECOMMENDATION: Clarify for MCPs DHCS' position that any street medicine provider, in accordance with their appropriate license and credentialling status may order MNCS' for patients, regardless of their network and patient assignment status; and support MCPs to operationalize direct access consistent with DHCS' policy guidance.**

**Issue 2: Street medicine services for "out of network" or unassigned managed care patients**
The Medi-Cal Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) Provider Manual states that an FQHC/RHC facility is "required to redirect the unassigned patient to their "in-network" managed care provider and document this referral in the patient's medical/dental records (page 9)."[2] In a brick-and-mortar facility, it may be reasonable to expect providers to look up in real time the patient's assigned managed care provider and refer the patient accordingly. In the field, the mechanism for doing this is more complicated and health centers have various workflows to verify eligibility and PCP for unknown patients, including: contacting their affiliated brick-and-mortar site to verify eligibility using the Automated Eligibility Verification System (AEVS), directly calling AEVS, asking patients to complete intake paperwork that is later used to verify eligibility, and capturing any Medi-Cal eligibility documentation (e.g. identification card) using HIPPA-compliant mobile charting.

Health centers will not deny services to patients encountered during street medicine, regardless of eligibility status and will only bill Medi-Cal for enrolled patients. Given the nature of the patient population, and complications inherent with field-based medicine, it is unlikely that street medicine providers universally have mechanism for reliably verifying eligibility and assigned primary care provider prior to or during an encounter. For health centers, it is not practical and counter intuitive to the

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[2]Medi-Cal Manual: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

concept of direct access to refer a patient to their assigned PCP at each encounter with an unassigned street medicine provider.

We understand the state's intention with this policy is to connect patients to a consistent and available provider, especially vulnerable patients who would be well served by medical homes. However, the traditional assigned PCP concept is not well-suited for persons experiencing homelessness because this population is highly transient and has fragmented and episodic healthcare usage. Individuals experiencing homelessness require a more flexible, out-reach oriented, direct access approach. Health centers bear an outsized administrative documentation burden with this policy.

> **RECOMMENDATION: Clarify that for claims rendered using street medicine place of service codes, FQHCs are not required to redirect unassigned patients to in-network providers and not required to document the referral.**

**Issue 3: Optional Service**

The utilization of street medicine providers is voluntary for MCPs. It is unclear if health centers may be reimbursed for PPS-eligible street medicine services provided to patients enrolled in a non-participating or non-contracted MCP, per the following examples:

> 1) *Example 1: Non-participating MCP*. Health center operates in a geographic managed care plan county and is contracted an MCP that doesn't offer street medicine services. The health center street team then encounters a patient in the community who is enrolled in that MCP.
>
> 2) *Example 2: Non-contracted MCP.* A street medicine FQHC encounters a patient enrolled in a MCP participating in street medicine who is now living outside of their MCP jurisdiction. The MCP and the health center are not contracted for any services.

Street medicine is essentially Medi-Cal authorization for providers to bill Medi-Cal state plan services outside traditional brick-and-mortar facilities using POS code 27[3]. APL 24-001 is guidance from DHCS to MCPs about operational requirements. Given that the Medi-Cal manual allows for FQHCs to provide services to unassigned and non-contracted patients, our understanding is that health centers will be made whole to their PPS rate via reconciliation, regardless of MCP participation in street medicine services or the CHC/MCP contractual relationship.

> **RECCOMENDATION: Clarify that health centers will be made whole in reconciliation for street medicine services provided by a billable provider to a Medi-Cal Managed Care patient whose MCP is not offering street medicine or with whom the health center does not have a contractual relationship.**

**Issue 4: Billing and Reimbursement Standardization**

MCPs have discretion in setting their own encounter documentation requirements for street medicine services, resulting in disparate requirements when billing for services to patients who are housed versus unhoused. Health centers report they have experienced different documentation standards across MCPs that do not comport with DHCS' Evaluation and Management procedures. For example, one MCP requires street medicine providers to include a modifier for all service lines billed with POS 27. Disparate

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[3] DHCS Medi-Cal Provider Bulletin. *Place of Service Code '27" may be used for street medicine*.

documentation requirements result in unnecessary complexity and administrative burdens for providers, especially for providers working in multi-Plan counties or within multiple counties.

Additionally, FQHCs have identified that some MCPs require documentation codes that are not covered by Medicare, resulting in denied claims when the patient is dually enrolled in Medicare and Medi-Cal. For example, one MCP requires primary diagnosis codes Z00.8 or Z.0189 on the service line. However, Medicare will not reimburse for z-codes as the primary diagnosis, rendering the Medicare portion of these services non-reimbursable for the provider.

> **RECCOMENDATION: Require all MCPs in the same county to standardize documentation requirements that align with State and Federal requirements and definitions. Require MCPs to adopt claim standards consistent with existing Medicare and Medi-Cal billing guidelines for primary care services.**

**Issue 5: Place of Service**

The adoption of street medicine services represents a marked shift in the State's approach to providing healthcare to persons experiencing homelessness. The Keck School of Medicine of the University of Southern California's Division of Street Medicine conducted a landscape analysis of street medicine in the state[4]. The data confirm that street medicine exists along a robust continuum of homeless health care, which includes traditional, mobile, and shelter-based clinics.

Effective October 1, 2023, CMS updated POS codes to include the following codes: 04 (Homeless shelter), 15 (Mobile unit), 16 (Temporary lodging), and 27 (street medicine/outreach). The State's position on allowing health center reimbursement outside the four walls of the licensed or intermittent health center site is ambiguous. In 2018, CPCA and DHCS worked on a State Plan Amendment (SPA) to codify policy on four walls. At the time, DHCS was cognizant of the need to allow flexibility for FQHCs to support the provision of services outside of the four walls to persons experiencing homelessness. The SPA was never finalized, and health centers lack official guidance that FQHCs can bill using the full continuum of homeless healthcare including homeless shelters, temporary lodging, and permanent supportive housing.

Health centers have interpreted APL 24-001 billing/reimbursement section to mean that FQHCs can be reimbursed at PPS for services provided outside the four walls for POS code 27 only. We are hopeful that the State's intention is for health centers to sustainably provide services to patients along the continuum of homelessness (i.e. currently residing in temporary lodging or homeless shelters). Health centers also recognize that care continuity and health outcomes would be greatly improved if care teams could also deploy into permanent supportive housing once the patient is stabilized. Allowing health centers to reimburse for these codes would improve continuity, health outcomes, and support DHCS to demonstrate the utilization of street-based services accurately.

> **RECCOMENDATION: Clarify Medi-Cal policy to allow FQHCs to be reimbursed for PPS-eligible services provided in homeless shelters (POS 04), temporary lodging (POS 16), and permanent supportive housing (POS 12).**

**Issue 6: Presumptive Eligibility**

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[4] Feldman, B. et all. The California Street Medicine Landscape Survey and Report. March 2023.

Presumptive eligibility is an excellent opportunity to support patients to access Medi-Cal benefits and services immediately and get on the path to full and consistent coverage. APL 24-001 states that "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, street teams, or other locations." CPCA wants to ensure that DHCS understands that most FQHC mobile clinics and street teams are not hospital based and therefore unable to presumptively enroll patients into Medi-Cal. We hope DHCS will consider effective and efficient mechanisms to extend presumptive eligibility to the providers, like non-hospital-based health centers, who most encounter this target population in real-time. Providers seeing patients are the most equipped to support patient enrollment in real-time.

> **RECCOMENDATION: Work with providers to identify a pathway for FQHC street medicine providers to efficiently and effectively presumptively enroll patients into Medi-Cal that is not restricted to hospital-based providers.**

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Thank you for the opportunity to provide you with information about the health center experience with the implementation of APL 24-001 and street medicine services. We are heartened to learn that DHCS intends to issue additional guidance and clarification to MCPs on many of the issues we identify. We hope you will consider our recommendations and we look forward to discussing solutions in more detail. Please do not hesitate to reach out to me at abudenz@cpca.org in response to these comments.

Respectfully,

Allie Budenz
Vice President of Health Center Optimization

Cc: Alek Klimek
Bambi Cisneros
Rafael Davtian

Attachment: California Street Medicine Collaborative Direct Access Memo June 2024 – Final