# L.A. Care Health Plan: AB 369 Analysis

**Bill Text**: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB369

L.A. Care Health Plan supports the overall goals of Street Medicine models to bring care directly to People Experiencing Homelessness (PEH). We appreciate the opportunity to provide feedback on AB 369 and look forward to collaborating on efforts to improve access to health care services for PEH. We are very excited about the potential of this bill and would like to share some of our initial thoughts and questions on the proposed provisions.

Overall, we are very interested in identifying and proposing policy solutions which will expand access and remove barriers to care for PEH and the providers who serve them. While this bill seeks to address some of the ongoing challenges for PEH seeking health care services, we believe that there may be potential unintended consequences associated with some of the proposed changes. We have outlined key concerns and questions below and hope to collaborate further on this important policy strategy to improve care for PEH.

## L.A. Care Health Plan AB 369 Summary of Questions and Comments

**A. AB 369 would mandate no prior authorizations for any COVID-19 testing or treatment through 2026.**

- L.A. Care would like clarification on the purpose of this provision and its potential impact on the health of people experiencing homelessness (PEH).

**B. L.A. Care supports the concept of adding PEH as a new group for Presumptive Eligibility.**

- We suggest narrowing down the list of qualified Medi-Cal providers who are able to determine PE to those who are likely to serve PEH, such as FQHCs, FQHC look-alikes, public hospitals, hospitals, and street medicine providers.
- **Questions**:
    i. Are there federal limits on who can make PE determination for Medicaid? Is there a federal approval process for adding another group to PE?
    ii. How long would PE last – is it the standard time frame (60 days)? Should there be a minimum timeframe for PEH PE?

**C. L.A. Care is concerned that enrolling PEH into FFS until individual makes a choice of Managed Care Plan and PCP would lead to unintended consequences. L.A. Care would like to work with the Senator's office to explore alternate solutions.**

- We are concerned that authorizing PEH to remain in FFS will create unintended consequences that will limit access to care.
    i. Today, access is worse for specialty, laboratory, ancillary, and SNF/LTC services in Medi-Cal FFS as compared with Medi-Cal Managed Care. We are worried about creating a two-tier system that could inadvertently end up with worse access to care for PEH.
    ii. Many benefits are only available in Medi-Cal Managed Care and not available in FFS, including CalAIM ECM/ILOS, mild-moderate BH services, etc. We are also worried that this would counteract the efforts to improve care for PEH under CalAIM (especially ECM and ILOS).
- We are concerned that enrolling a PEH into Medi-Cal FFS does not establish a connection to a PCP.
    i. This bill proposes an enrollment process solution but does not address connection/access to health care services. The bill doesn't provide resources or funding for street medicine teams/ homeless health providers to do the work of outreach & engagement to help members connect to a PCP.

- We think adding PEH as a group to PE could go a long way toward helping street medicine teams/homeless health providers be able to serve the members during the PE time period. During that time, providers should help PEH establish the new PCP.
- **Feasibility considerations**:
    i. It is not feasible to require all PEH to actively choose MCP and not have a backup system (like current system of default assignment to MCP w/in 45 days if no choice form is received). What if PE provider loses track of homeless member due to transience? Does the beneficiary stay in FFS forever?
        1. In the current Medi-Cal enrollment process, members who do not select a plan and/or provider via the HCO choice form or phone line are auto-assigned by the state to a health plan within 30-45 days, taking effect on the first of a month. Members can then switch health plan and/or PCP once per month thereafter
    ii. What if a PEH wants to choose a plan but not choose a PCP? We may not want to require PEH to choose a PCP in order to access managed care delivery system, since no other members are required to do so.
    iii. At the time of initial assignment to Medi-Cal Managed Care Plans, plans do not receive information on the member's homeless status on the DHCS 834 eligibility file.
        1. Instead, we receive member name, Social Security Number, basic demographics, and address info (which may or may not be accurate, based on the information that was provided when applying to Medi-Cal).
        2. It is not feasible to ask plans to match homeless members to homeless specialty providers initially because homeless status information is not available at the member level, nor is there a current designation on which Medi-Cal providers specialize in serving PEH.
- **Questions:**
    i. What is the purpose of authorizing PEH to remain in FFS?
    ii. Is it to solve the problem of PEH being initially assigned to PCPs they did not pick & may not be aware of?
        1. If so, potential solutions could be allowing PEH to have a same month change/immediate change of PCP within first year of enrollment.
    iii. If the issue is around the fact that all the Health Care Option choice forms for Medi-Cal are mailed, could we collaborate on solutions to improve the current system?
    iv. Is the problem that the street medicine providers who meet the member can't serve them and get paid? Could we address that through a payment solution instead, which might allow street medicine providers to get paid even if they aren't assigned as the member's PCP (similar to how current sexual and reproductive health services are paid regardless of PCP assignment in Medi-Cal)?
    v. Can we untangle the MCP assignment issues from the PCP assignment issues?
    vi. Can we untangle the initial Plan and PCP assignment issues from the Plan & PCP change process issues?

**D. The bill proposes a very wide scope of reimbursable services & eligible providers for PEH, which could also have unintended consequences.**

- L.A. Care has concerns about including all Medi-Cal providers serving PEH outside of traditional medical facilities as reimbursable.
    i. We would like to avoid any possible abuse by unscrupulous actors who may prey on this population for unneeded care.
    ii. Another unintended consequence could be further fragmentation of care, with no one provider or health plan responsible for the patient.
- **Feasibility considerations**:

i. While the bill proposes allowing PEH to get specialty and diagnostic care from anywhere, in practice, this would not be feasible to operationalize because referral pathways usually do not exist to access that care outside the existing Medi-Cal referral systems.

- **Questions**:
  i. Would it be possible to limit the proposed expansion of payable services to street medicine, shelter-based care and interim housing care, vs. all providers in Medi-Cal?
  ii. Would the bill allow Medi-Cal members experiencing homelessness to get any care from any provider – or just from street medicine, shelter, & interim housing providers?
  iii. Is the goal to ensure providers can be paid regardless of PCP or plan assignment? If so, again, we recommend looking at an alternate solution such as a FFS payment to specific homeless specialty provider types.
  iv. Who will be responsible for oversight of the quality of care provided by these providers – DHCS or Managed Care plans or both?

**E. Verifying Medi-Cal eligibility would likely not be feasible through HMIS systems without additional changes.**

- Medi-Cal providers can already verify eligibility in AEVS (the Automated eligibility verification system for Medi-Cal).
- **Feasibility considerations:**
  i. Medi-Cal eligibility information from AEVS is not shared with any local HMIS systems today by the state. A larger change would be needed to be able to do this, and all HMIS systems would need to be HIPAA compliant.
  ii. Most health care providers are not allowed / able to access the HMIS systems in their region – would this also be a new requirement for all Homeless Continuums of Care?
  iii. Proposed alternative: Ask that the state use the new HMIS statewide database (being created now: https://www.bcsh.ca.gov/hcfc/hdis.html) to exchange -Cal data with Medi bi-directionally. This may require additional analysis and longer timeframes to execute.
- **Questions:**
  i. What specific AEVS and HMIS system changes are being proposed by this bill?

**F. Additional Questions**:

- What is the source of the statistic on 30% of PEH have seen their PCP vs 70% of street medicine providers? This may not translate to all street medicine everywhere.
- What is the source for the statistic on housing placement numbers for Street medicine vs. LAHSA? Is this for a specific Street Medicine team, such as USC?