Date of Hearing: April 20, 2021

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 369 (Kamlager) – As Amended April 12, 2021

SUBJECT: Medi-Cal: persons experiencing homelessness.

SUMMARY: Requires the Department of Health Care Services (DHCS) to implement a Medi-Cal presumptive eligibility (PE) enrollment process for persons experiencing homelessness (PEH). Requires the single streamlined paper and electronic application for Medi-Cal and Covered California to indicate the applicant is a PEH at the time of application. Requires the county, if the county determines that the PEH is eligible for benefits under the Medi-Cal program, to enroll the person in the Medi-Cal program's fee-for-service (FFS) delivery system until they elect, by providing informed consent, to enroll in a Medi-Cal managed care (MCMC) plan. Requires Medi-Cal FFS and a MCMC plan to authorize an enrolled Medi-Cal provider to provide covered services that are otherwise reimbursable to the Medi-Cal provider, but that are provided off the premises of the Medi-Cal provider's office, to a Medi-Cal beneficiary who is a PEH. Requires DHCS to authorize an enrolled Medi-Cal provider to issue a temporary, provider-issued Medi-Cal benefits identification card to a PEH who is a Medi-Cal beneficiary. Specifically, **this bill**:

1) Requires DHCS, to the extent federal financial participation (FFP) is available, to implement a program of PE for PEH. (See Background in Comments below for discussion of PE.)

2) Requires the PE benefits provided to be full-scope Medi-Cal benefits without a share of cost.

3) Requires DHCS, upon implementation of the PE program for PEH, to issue a declaration, which is required to be retained by the Director, stating that implementation of the PE program has commenced.

4) Permits DHCS to implement, interpret, or make specific the above provisions by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. Requires DHCS to thereafter adopt any necessary regulations in accordance with the requirements of the Administrative Procedure Act.

5) Permits an enrolled Medi-Cal provider, including a health facility, such as a hospital or clinic, to make a PE determination for a PEH.

6) Requires the county, if the county determines that the PEH is eligible for benefits under the Medi-Cal program, to enroll the person in the Medi-Cal program's FFS delivery system until they elect, by providing informed consent, to enroll in a MCMC plan.

7) Requires the PEH, if they elect to enroll in a MCMC plan, to complete a Medi-Cal choice form with their chosen primary care provider (PCP) who is present for purposes of completing that form.

8) Prohibits DHCS from assigning a PEH to a PCP without the person's informed consent under any circumstances, including any time beyond the 60-day choice period.

9) Requires the single streamlined paper application for insurance affordability programs (Covered California and Medi-Cal) to include a check box, and the electronic application to include a pull-down menu, for the applicant to indicate if the applicant is homeless at the time of application.

10) Requires DHCS to authorize an enrolled Medi-Cal provider to bill the Medi-Cal program for covered services that are otherwise reimbursable to the Medi-Cal provider, but that are provided off the premises of the Medi-Cal provider's office, to a PEH and who meets one of the following criteria:

    a) Is a Medi-Cal beneficiary who is eligible under PE;

    b) Is exempt from mandatory enrollment in a MCMC plan; or,

    c) Receives services through FFS Medi-Cal before MCMC plan enrollment.

11) Requires a MCMC plan to allow a Medi-Cal beneficiary experiencing homelessness to seek Medi-Cal covered services directly from a participating Medi-Cal provider, as specified below.

12) Requires a MCMC plan to authorize an enrolled Medi-Cal provider to provide covered services that are otherwise reimbursable to the Medi-Cal provider, but that are provided off the premises of the Medi-Cal provider's office, to a Medi-Cal beneficiary who is a PEH.

13) Permits a MCMC to establish reasonable requirements governing utilization protocols and participation in the plan network, if protocols and network participation requirements are consistent with the goal of authorizing services to PEH.

14) Prohibits a Medi-Cal provider providing services under the MCMC requirements of this bill from being required to obtain prior approval from another physician, another provider, a medical group or independent practice association, a clinic, or the MCMC plan before providing services, including specialist services and laboratory services.

15) Requires a MCMC plan to provide a Medi-Cal beneficiary the ability to inform the plan online, in person, or via telephone that they are experiencing homelessness.

16) Requires DHCS to inform the MCMC plan if a Medi-Cal beneficiary has indicated they are experiencing homelessness based on information furnished on the Medi-Cal application.

17) Requires DHCS to seek any federal waivers necessary to implement the above-described requirements, and to implement these requirements only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

18) Requires DHCS to authorize an enrolled Medi-Cal provider, including a health facility, such as a hospital or clinic, to issue a temporary, provider-issued Medi-Cal benefits identification card (PI-BIC) to a PEH who is a Medi-Cal beneficiary or receives full-scope Medi-Cal benefits under PE.

19) Prohibits DHCS from requiring a PEH to present a valid California driver's license or identification card issued by the Department of Motor Vehicles (DMV) in order to receive services under the Medi-Cal program if the Medi-Cal provider verifies Medi-Cal eligibility through telephone or electronic means.

20) Prohibits DHCS from requiring the provider to match the name and signature on any Medi-Cal benefits identification card (BIC), including the initially issued temporary PI-BIC issued by DHCS or a provider to a PEH or that individual's valid California driver's license or California identification card against a signature executed at the time of service, or require a provider to visually verify the likeness of a PEH to the photograph on the identification card or driver's license, if the person does not possess a BIC, temporary benefits identification card, California driver's license, or California identification card.

21) Permits, if a provider is unable to verify eligibility based on a Medi-Cal BIC, including the initially issued temporary card under this bill, the provider to verify eligibility through any other system, including the Medi-Cal Eligibility Data System or the Homeless Management Information System.

22) Defines a "PEH" to mean a person is "homeless" as defined in federal Housing and Urban Development regulation.

23) Makes various legislative findings and declaration regarding PEH, lack of access to care, poor health outcomes, and the role and value of street medicine and shelter-based care.

EXISTING LAW:

1) Establishes the Medi-Cal program, administered by DHCS, under which low income individuals are eligible for medical coverage.

2) Makes adults and parents with incomes up to 138% of the federal poverty level (FPL) eligible for Medi-Cal, and makes children with incomes up to 266% of the FPL eligible for Medi-Cal, including providing full-scope Medi-Cal benefits to undocumented children and young adults through age 25.

3) Requires a single, accessible, standardized paper, electronic, and telephone application for insurance affordability programs to be developed by DHCS, in consultation with Covered California, to be used by all entities authorized to make an eligibility determination for any of the insurance affordability programs and by their agents.

4) Permits, under federal Medicaid regulation, if the state agency provides Medicaid during a PE period to children or to pregnant women, the agency to also apply PE to other groups of individuals, including parents and caretaker relatives, individuals aged 19 through 64, based on the income standard established by the state.

5) Requires, in areas specified by the director for expansion of the MCMC program under particular MCMC models where DHCS is contracting with a plan that is contracting with, governed, owned or operated by a county board of supervisors, a county special commission or county health authority a Medi-Cal or California Work Opportunity and Responsibility for Kids (CalWORKs) applicant or beneficiary to be informed of the health care options

available regarding methods of receiving Medi-Cal benefits. (This process is referred to as the "Health Care Options" process.)

6) Requires each Medi-Cal beneficiary to be informed that if they fail to make a choice, they will be assigned to, and enrolled in, a plan.

7) Requires the Medi-Cal beneficiary to indicate their choice, in writing, from among the available plans in the region and their choice of PCP or clinic contracting with the selected plan.

8) Requires, if a beneficiary or eligible applicant does not choose a PCP or clinic, or does not select any PCP who is available, the plan that was selected by or assigned to the beneficiary to ensure that the beneficiary selects a PCP or clinic within 30 days after enrollment or is assigned to a PCP within 40 days after enrollment.

9) Makes it the responsibility of the provider prior to rendering nonemergency Medi-Cal reimbursable services to persons presenting themselves as Medi-Cal beneficiaries to verify the person's identity by matching the name and signature on their BIC, or their valid California driver's license or California identification card issued by the DMV, against a signature executed at the time of service and further by visually verifying their likeness to the photograph on the identification card or driver's license.

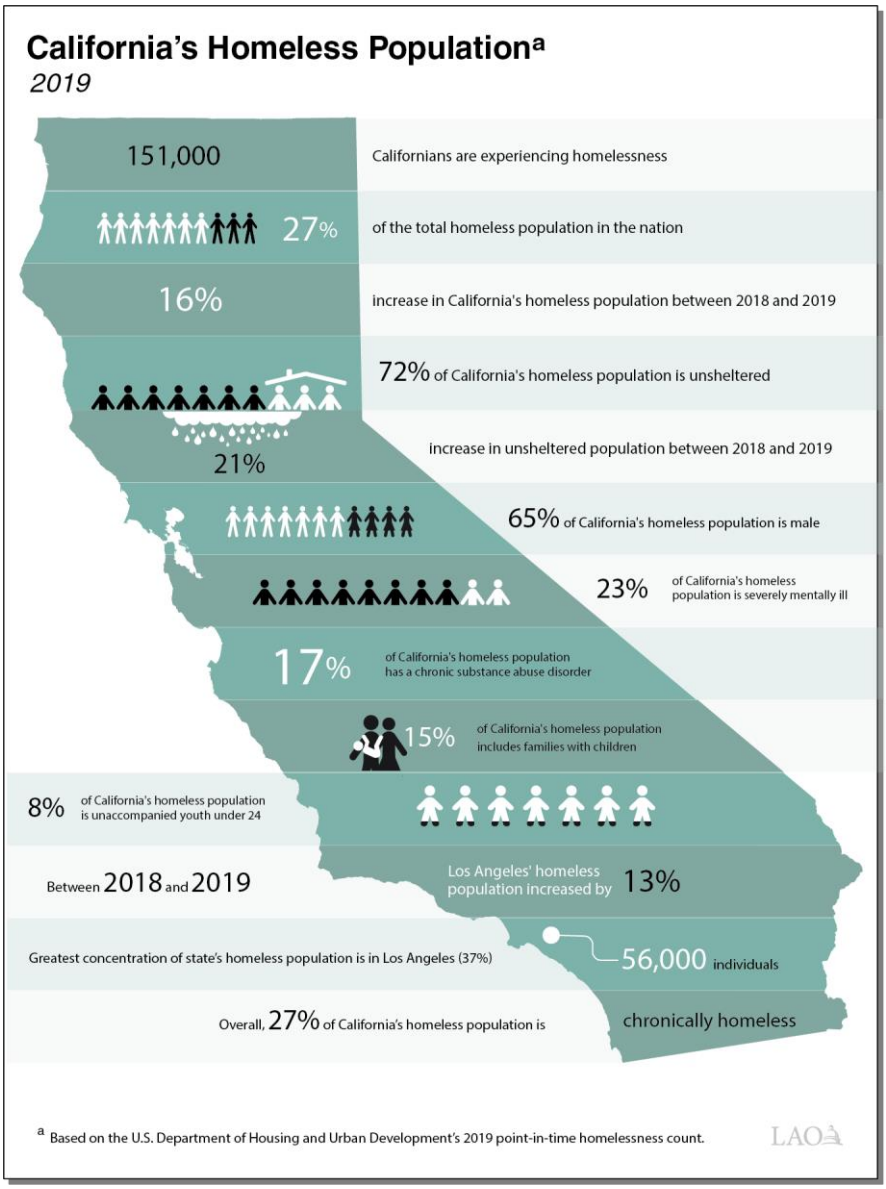
10) Prohibits, if the provider complies in good faith with 9) above, the provider from being held not responsible by having payments withheld by the state.

FISCAL EFFECT: Unknown. This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, California's health care infrastructure does not meet the unique needs and circumstances of our homeless population. Rather than asking PEH to overcome the challenges of accessing care in medical facilities, providers must be able to care for their patients wherever they may reside. Successful delivery models, including mobile clinics and street medicine programs, exist. These programs provide medical and behavioral care, treatment for substance use disorders, enrollment in social services, and assistance with housing transitions.

2) **BACKGROUND.** In 2019, there were an estimated 151,000 Californians experiencing homelessness, of whom 72% were unsheltered. PEH encounter obstacles in obtaining adequate clothing, food, shelter, and transportation because of limited financial resources. The inability to acquire these basic needs has deleterious consequences on the health of this population. PEH have higher rates of chronic physical health conditions and behavioral health needs compared to the general population. The Legislative Analyst's Office January 21, 2021 presentation entitled "California's Homelessness Challenges in Context" to the Assembly Budget Subcommittee No. 4 and the Assembly Committee on Housing and Community Development contained the following graphic:



A California Health Care Foundation Issue Brief entitled "Homelessness and Health Care: Lessons and Policy Considerations from the COVID-19 Pandemic" cited studies that people who are homeless have higher rates of illness and die on average 12 years sooner than the general US population, that people living in shelters are more than twice as likely to have a disability compared to the general population, and community survey data indicate that over one-quarter of people experiencing homelessness have severe mental illness and nearly 35% have a chronic substance use disorder. The Issue Brief stated that chronic disease such as diabetes, heart disease, respiratory tract conditions, dental disease, and HIV/AIDS are found at high rates among the homeless population, placing people experiencing homelessness at higher risk of serious illness from COVID-19. Additionally, people experiencing homelessness who contract COVID-19 are two to four times more likely to require critical care and two to three times as likely to die compared to the general population.

While eligibility for coverage has expanded after the implementation of the federal Patient Protection and Affordable Care Act (ACA) expansion to adults under age 65 without minor children, providing Medi-Cal coverage does not necessarily translate to access to care as the

traditional MCMC model of assigning a patient to a primary care physician may not work well for PEH. PEH experiencing homelessness have been found to have disproportionate use of the emergency department (ED) compared with people who are adequately housed, and have increased rates of hospitalization for ambulatory care sensitive conditions.

a) PE. This bill requires, to the extent that FFP is available, DHCS to implement a PE program for PEH. PE is a federal Medicaid option that permits time-limited coverage in lieu of a full Medicaid application. California has elected to implement several PE programs, which provide qualified individuals immediate temporary Medi-Cal coverage based on the individual's self-attested preliminary information. Qualified PE providers approved by DHCS make PE determinations under the following programs:

i) Breast and Cervical Cancer Treatment Program;
ii) Child Health and Disability Prevention Program (known as "CHDP Gateway");
iii) Every Woman Counts;
iv) PE for Pregnant Women (PE4PW); and,
v) Hospital PE.

The provider-based PE process enables eligible applicants to receive immediate access to temporary, no-cost Medi-Cal while the individual applies for permanent Medi-Cal coverage or other health coverage. For example, under the Hospital PE, an individual must meet specified eligibility criteria (which include California resident and below Medi-Cal income limits), and visit a hospital that is a qualified Hospital PE Provider. The Hospital PE Provider submits the individual's information via the Hospital PE Medi-Cal Application online portal and eligibility is determined in real-time. Similarly, PE4PW program allows qualified providers to grant immediate, temporary Medi-Cal coverage for ambulatory prenatal care and prescription drugs for conditions related to pregnancy to low-income, pregnant patients, pending their formal Medi-Cal application.

The advantages of extending PE to PEH is that PE provides immediate access to care and enables continuity of care, facilitates enrollment in coverage by establishing new/ additional points of entry to coverage, offers streamlined enrollment and mitigates potential Medi-Cal eligibility processing delays.

b) Medi-Cal application modification. Under the ACA and state law, an individual has the option to apply for insurance affordability programs (Medi-Cal and Covered California) in person, by mail, online, by telephone, or by other commonly available electronic means. There are multiple Medi-Cal applications, including a joint application for Medi-Cal, CalWORKS and CalFresh (known as the "SAWS-2 Plus"), and an ACA-required single, accessible, standardized paper, electronic, and telephone application (known as the "single streamlined application") for insurance affordability programs. The single streamlined application is required by all entities authorized to make an eligibility determination for any of the insurance affordability programs and by their agents.

The SAWS-2 Plus application asks the question "Are you homeless?" with instructions to the applicant to let the county know right away if the individual is a PEH so the county can help the applicant figure out an address to use to accept their application and receive notices from the county about the person's case. This joint application also asks the question because there are additional services through CalWORKs and CalFRESH.

However, the single streamlined application does not contain a question about whether the applicant is homeless, and instead asks the applicant to "Check here if you do not have a home address." This bill would require the single streamlined application to include a question asking the applicant if they are homeless at the time of application.

There are multiple policy reasons for including such a question on the Medi-Cal application.

i) PEH may be receiving mail at a location that they do not visit regularly (such as a charity or social services/welfare office) and MCMC plans and providers could be made aware that attempting to contact the individual via mail may result in a delayed or non-response, and that other forms of communication would be more effective;

ii) An affirmative answer to the question will identify beneficiaries as a PEH who will have "direct access" to health care providers treating PEH outside the four walls of the provider's office under this bill;

iii) MCMC plans would be aware of PEH in determining auto-assignment of a beneficiary to a primary care physician or a clinic; and,

iv) MCMC plans could enroll the PEH in additional benefits currently available in MCMC (case management) and expected to be available under CalAIM (such as enhanced case management and in lieu of services).

c) Direct access to "street medicine" providers for persons experiencing homelessness. Existing law requires, if a Medi-Cal beneficiary does not choose a PCP or clinic, or does not select any PCP who is available, the MCMC plan to ensure that the beneficiary selects a PCP or clinic within 30 days after enrollment or is assigned to a PCP within 40 days after enrollment.

The assignment of a beneficiary to a PCP affects the care a patient receives because of the payment arrangements between MCMC plans and PCPs, which vary from plan to plan. Some PCPs are members of an independent practice association (IPA), medical group or clinic which are capitated (a capitated provider or group receives receive a per member per month payment) for primary care services, while other plans reimburse PCPs on a FFS basis. If a patient is assigned and receives care from an unassigned PCP, or a PCP who does not contract with either the MCMC plan, IPA, medical group or clinic to which the patient is assigned, the PCP can be denied payment for those services.

The language in this bill on these provisions is modeled on the state direct access law for obstetrician/ gynecologist (OB/GYN) services, and the provisions authorizing clinics to provide services "outside the four walls" during a state of emergency. Under the state's OB-GYN direct access law, health plans must allow an enrollee the option to seek obstetrical and gynecological physician services directly from a participating obstetrician and gynecologist or directly from a participating family physician and surgeon designated by the plan as providing obstetrical and gynecological services, and an enrollee is prohibited from being required to obtain prior approval before obtaining direct access. The existing law provisions applicable to clinics during a state of emergency permit a clinic to provide Medi-Cal covered services that are otherwise reimbursable, but that are provided somewhere off the premises (at an address other than the address listed on the

provider's license or in the provider master file), including, but not limited to, at a temporary shelter, a Medi-Cal beneficiary's home, or any location other than the premises. This arrangement in effect provides a workaround from the patient assignment to a capitated group that the patient to receive primary care services from an assigned PCP in a capitated group by allowing a PEH to see a contracted provider who provides services "outside the four walls" of the provider's office.

Referred to as "street medicine," this bill would allow health care providers to provide services to people where they live, including in shelters, on streets and sidewalks, and under bridges. Care is able to be provided on site, thereby improving access to primary and preventive services, reducing the need for referrals to other health providers, and reducing unnecessary hospital ED visits, reducing the duration of hospitalization, and decreasing health care costs.

d) Exemption from mandatory enrollment in MCMC plans. The Medi-Cal program provides benefits through both a FFS and managed care delivery system. Enrollment in FFS delivery system or the managed care delivery system is based upon specific geographic areas, the health plan model, and/or the beneficiary's aid code. In some cases, enrolling in MCMC is optional for beneficiaries but most Medi-Cal beneficiaries are required to enroll in a MCMC plan. More than 80% of the over 14 million people enrolled in Medi-Cal each month are currently served through the managed care delivery system.

Instead of being required to enroll in a MCMC plan, this bill requires a PEH person to be enrolled in the Medi-Cal program's FFS delivery system until they elect, by providing informed consent, to enroll in a MCMC plan. If the PEH elects to enroll in a MCMC plan, the individual must complete a Medi-Cal choice form (known as the Health Care Options process) with their chosen PCP who is present for purposes of completing that form. This provisions is intended to prevent the state from incurring state costs for payments made to MCMC plans and their capitated providers for individuals who are not receiving services, and to ensure the PEH makes an informed choice on their PCP.

e) PI-BIC for PEH. This bill requires DHCS to authorize an enrolled Medi-Cal provider, including a health facility, such as a hospital or clinic, to issue a temporary, provider-issued Medi-Cal benefits identification card to a PEH who is a Medi-Cal beneficiary or receives full-scope Medi-Cal benefits under PE.

Health care providers require identification as a condition of services, but PEH often do not have photo identification because it has been lost or stolen (IDs have monetary value when re-sold). Allowing Medi-Cal enrolled providers to issue temporary provider -issued benefit identification card (PI-BIC) and to verify eligibility via the Homeless Management Information System (HMIS) or Medi-Cal Eligibility Data System (MEDS) is intended to ensure PEH can access health care, even if their identification cards is lost or stolen, eliminating a significant barrier for those wanting to participate in care.

DHCS issues a plastic BIC to each Medi-Cal recipient for identification purposes. The BIC is used to access the Point of Service (POS) network to determine a recipient's eligibility and scope of benefits. The BIC is composed of a nine-character Client Identification Number, a check digit and a four-digit date that matches the date of issue.

The BIC issue date is used to deactivate a card when reported as lost or stolen. DHCS indicates that, in some cases, Medi-Cal beneficiaries are issued temporary paper Medi-Cal ID cards from either the county welfare department or a PE Provider. The card contains a 14-digit BIC ID number and is used just like a plastic BIC. Temporary paper identification cards are issued to the following:

i) Recipients new to Medi-Cal who have an immediate need for health care services;
ii) Recipients currently eligible for Medi-Cal who have an immediate need for replacement ID card;
iii) Eligible minors who wish to receive confidential care for services; and,
iv) Recipients that are enrolled in a PE program.

f) Provider Verification of Medi-Cal Eligibility. This bill prohibits DHCS from requiring a PEH to present a valid California driver's license or identification card issued by the DMV in order to receive services under the Medi-Cal program if the Medi-Cal provider verifies Medi-Cal eligibility through telephone or electronic means. This bill also prohibits DHCS from requiring the provider to match the name and signature on any Medi-Cal BIC, including the initially issued temporary provider-issued Medi-Cal benefits identification card of a PEH, or that individual's valid California driver's license or California identification card against a signature or the likeness of a PEH to the photograph on a specified cards. Finally, this bill permits, if a provider is unable to verify eligibility based on a Medi-Cal BIC, including the initially issued temporary card under this bill, the provider to verify eligibility through any other system, including MEDS or the HMIS.

State law requirements related to BICs are focused on the provider verifying information as a condition of payment. For example, existing law makes it the responsibility of the health care provider (prior to rendering Medi-Cal reimbursable services to persons presenting themselves as Medi-Cal beneficiaries) to make a good faith effort to verify the person's identity, if the person is not known to the provider, by matching the name and signature on his or her Medi-Cal BIC against the signature on a valid California driver's license, or California identification card issued by the DMV, or another type of picture identification card or other credible document of identification.

When the provider verifies the beneficiary's identity with a signed Medi-Cal card and one of the documents described above, the state deems this to be a good faith effort. If the provider does not make a good faith effort of reasonable identification prior to rendering Medi-Cal reimbursable services and renders services to a presenting person who is ineligible for those Medi-Cal services, payment for those services may later be disallowed. These provisions do not apply to:

i) Persons 17 years of age and under;
ii) Persons in long-term care; and,
iii) Persons receiving emergency services;

Medi-Cal providers with a valid provider number and Provider Identification Number can use a POS network via the internet (through the DHCS Medi-Cal provider website), through third-party software or through the Automated Eligibility Verification System via telephone or internet.

3) **SUPPORT.** This bill is supported by housing advocates, patient advocates and substance use treatment providers, who argue this bill will increase access to health and social services for PEH by requiring DHCS to incorporate street medicine into existing health care infrastructure, grant PE for Medi-Cal, and waive ID requirements for providing care to unsheltered populations. Supporters state these changes will remove barriers to accessing care for people experiencing homelessness by providing direct, comprehensive care Californians on streets and under bridges where they reside. Supporters write that people experiencing homelessness, who are disproportionately people of color, suffer from poorer health and have life expectancies 30 years shorter than the general population. Alarmingly, in California, homeless deaths have doubled over the last five years, and the COVID-19 pandemic has exacerbated these existing health disparities.

   PEH are unable to follow stay at home orders, wash hands regularly, or wear clean masks to slow the spread of COVID-19. This puts their lives, and their communities' lives, at risk. Supporters argue "street medicine" has proven to be an essential service during this time, and has been the driver of COVID-19 testing efforts, surveillance, contact tracing, and education on the best way to follow health recommendations even while living on the street. Street medicine was developed specifically to address the unique needs and circumstances of unsheltered homeless individuals. Street medicine teams provide people experiencing homelessness with medical and behavioral health care, treatment for substance use disorders, assistance with housing transitions, and living necessities such as sanitary products and clean water.

   Studies of street medicine programs indicate increased access to care, increased housing placement, improved health outcomes, and significant cost savings for Medi-Cal and hospital systems. Despite these benefits, the existing health care infrastructure does not recognize the "street" as a location for providing care. As a result, people experiencing homelessness are denied medical treatment, social services, housing assistance, addiction treatment, and other benefits normally covered by Medi-Cal. Supporters conclude this bill will increase access to comprehensive care and is a significant step in achieving health justice, equity and inclusion for Californians experiencing homelessness.

4) **PREVIOUS LEGISLATION.** AB 1494 (Aguiar-Curry), Chapter 829, Statutes of 2019, among other provisions, prohibits face-to-face contact or a patient's physical presence on the premises of an enrolled community clinic, as specified, to be required for services provided to a Medi-Cal beneficiary during or immediately following a state of emergency.

   AB 770 (Eduardo Garcia) of 2019, among other provisions, would have required federally qualified health centers (FQHC) and rural health clinic (RHC) services rendered to a Medi-Cal beneficiary at premises such as a temporary shelter, a beneficiary's residence, a location of another provider, or any location other than the location identified on the primary care clinic license or in the provider master file, to be billed by the FQHC or RHC, and reimbursed at the FQHC or RHC's contracted rate when specified conditions applied. AB 770 was held on the Assembly Appropriations Committee suspense file.

5) **TECHNICAL AMENDMENTS.** This bill requires DHCS to seek any federal waivers necessary to implement several different sections of this bill. Because a waiver may not be required but federal approval of Medi-Cal changes generally are, staff recommends "waivers'

be changed to federal approval, and to make the PE changes proposed by this subject to federal approval, consistent with the other provisions of this bill.

6) **POLICY ISSUE: Exemption from mandatory MCMC plan enrollment.** This bill exempts a PEH from mandatory enrollment in a MCMC plan unless the person provides informed consent to enroll. Beginning in the mid-1990s, the state has expanded the mandatory enrollment into managed care and the geographic areas with plans. Mandatory managed care enrollment began with women and children in urban areas and has expanded to seniors and persons with disabilities across the state. The advantage of MCMC enrollment is a beneficiary has a central point of contact, the state has imposed appointment availability and time and distance standards for PCPs, specialists and hospitals, additional benefits will likely be authorized as part of the CalAIM proposal targeted specifically at PEH, and plans often pay above FFS rates in order to maintain a provider network. The argument made by the author is the state is paying MCMC plans, which in turn are paying capitated providers, for PEH who are not receiving services from those providers, and the state could achieve taxpayer savings by not enrolling PEH in a plan that is failing to provide services. Should this change to default enrollment be made?

7) **PROPOSED AMENDMENTS.** Following discussions between committee staff, the author's office and proponents, the exemption from mandatory MCMC plan enrollment will be deleted. This bill will instead be amended to prevent payments from DHCS to MCMC plans unless PEH are receiving services. Specifically, if Medi-Cal covered health care services that are the responsibility of the MCMC are not provided within the first 60 calendar days of enrollment to a Medi-Cal beneficiary who has indicated that they are a PEH at the time of application, DHCS would be required to deduct the capitation payments made to the plan from subsequent payments due to the plan.

REGISTERED SUPPORT / OPPOSITION:

Support

Mayor Eric Garcetti, City of Los Angeles
California Association of Alcohol and Drug Program Executives, Inc.
California Chronic Care Coalition
California Pharmacists Association
California State Treasurer Fiona Ma
Corporation for Supportive Housing
Health Net
Housing California
Keck Medicine of University of Southern California
People Assisting the Homeless

Opposition

None on file.

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