GOVERNOR'S VETO
AB 369 (Kamlager)
As Enrolled September 7, 2021
2/3 vote

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 include information collection for the applicant to indicate if they are experiencing homelessness at the time of application. Requires Medi-Cal fee-for-service (FFS) and a Medi-Cal managed care (MCMC) plan to reimburse an enrolled Medi-Cal provider for providing 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. Requires DHCS, if Medi-Cal services covered by a MCMC plan 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, to deduct the capitation payments made by DHCS to the plan from subsequent payments due to the plan for the time period from when the PEH was initially enrolled into a MCMC plan until the first receipt of plan-covered services.

Senate Amendments

1) Require DHCS and MCMC plans to reimburse an enrolled provider, instead of authorizing a provider to bill.

2) Require the reimbursement provisions applicable to MCMC plans to include specialist services and diagnostic services without requiring the provider to obtain prior approval from specified entities.

3) Permit any enrolled Medi-Cal provider to refer a Medi-Cal beneficiary who is experiencing homelessness for specialist care and diagnostics.

4) Require DHCS and MCMC plans, if a person experiencing homelessness is assigned a primary care provider (PCP) and receives care by another provider off the premises of the assigned PCP, to notify the assigned PCP that their patient was seen by another provider.

Define the phrase "MCMC plan" and modify the single streamlined application requirement provisions.

Governor's Veto Message
This bill would direct DHCS to establish a PE Program for PEH, authorize all off-premises services under Medi-Cal, remove care authorization and coordination strategies typically provided by Primary Care Physicians, and deduct capitation payments made to MCMC plans if a person experiencing homelessness does not utilize services within 60 days of enrollment.

From day one, my Administration has made treating and housing those experiencing homelessness a top priority. Understanding that homeless individuals face unique challenges in

receiving the health care they need, California designed its PE program so that individuals experiencing homelessness can easily enroll in Medi-Cal and access timely health care. In addition, enrolled Medi-Cal providers can be reimbursed for street-based medicine or services provided outside the office to their patients. Additionally, MCMC plans are responsible for coordinating and providing health care services to their members, including PEH.

We can and must do much better than today. To that end, the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorized in the 2021 Budget, will provide a whole-person approach to care and include expanded benefits to address clinical and non-clinical needs of Medi-Cal beneficiaries. A new enhanced care management benefit and housing support services, delivered by community-based providers, will provide needed services to individuals experiencing homelessness. Creating a "carve out" for persons experiencing homelessness, on the eve of the CalAIM transformation, will cut out these patients from services that are being created specifically to support their health, housing stability, and overall well-being.

Given that providing PEH timely access to critical services and ultimately are permanently housed is a priority, and the timing of CalAIM implementation, I am directing DHCS to identify any interim gaps that can be imminently addressed and act quickly to close these gaps. Such actions may include providing temporary resources to street medicine providers across the state, providing additional technical assistance to street medicine providers who seek to provide services through MCMC plans, and promptly implementing the CalAIM opportunities that will soon be rolling out.

COMMENTS

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.

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 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 compared with people who are adequately housed, and have increased rates of hospitalization for ambulatory care sensitive conditions.

This bill makes several changes to facilitate enrollment into Medi-Cal, enable the provision of services to PEH through "street medicine" providers, and to address barriers to care in the existing MCMC model. For example, this bill would permit a PEH to indicate their status as a PEH on a joint application form, and would provide direct access to "street medicine" health care providers in FFS and in MCMC if the provider is a contracting provider. This bill would address the lack of identification for PEH by authorizing health care providers to issue a temporary, provider-issued Medi-Cal benefits identification card to a PEH, and would prohibit DHCS from requiring a PEH to present a valid California driver's license or identification card issued by the Department of Motor Vehicles in order to receive services under the Medi-Cal program, if the Medi-Cal provider verifies Medi-Cal eligibility through telephone or electronic means.

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.

Arguments in 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 identification 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.

Arguments in Opposition
DHCS writes in opposition to this bill that, given the hospital PE program, it does not believe it is necessary to create a duplicative PE program for people experiencing homelessness. DHCS states the PE program described in this bill would require new federal approvals and changes to the existing State Plan Amendments regarding PE, based on the comparability issues, would not likely be approved by the Centers for Medicare and Medicaid Services, jeopardizing federal financial participation. DHCS argues it supports the practice of street medicine through the enhanced care management (ECM) component of CalAIM and is engaging with community providers who are interested in becoming an ECM provider. DHCS states this bill would circumvent the coordination of care for members identified as homeless by allowing Medi-Cal enrolled providers to provide care that is not coordinated through the comprehensive medical case management provided by the MCMC plan and the primary care provider. This will result in duplication of services and payment as well as inefficient use of services. Further, requiring different utilization controls only for homeless populations creates a comparability issue under federal Medicaid requirements. DHCS states it believes efforts to address the care needs of homeless individuals should be done in conjunction with CalAIM to ensure maximum coordination and effective delivery of services.

The Local Health Plans of California (LHPC), in an oppose unless amended position, objects to the requirement that DHCS deduct capitation from MCMC plans if they have not provided a service within 60 days of enrollment to a Medi-Cal beneficiary who is experiencing homelessness. LHPC writes this approach is fundamentally misaligned with the purpose of capitation wherein the plan assumes full risk for all members, and that there are many reasons why an unhoused beneficiary may not receive services within the first 60 days of enrollment, perhaps most significantly is the fact that individuals who are unhoused may be difficult to locate and successful outreach is challenging. Ultimately, the requirement to deduct capitation from plans if services are not provided within a certain period does not resolve the larger issue of reducing barriers to street medicine providers contracting with MCMC plans to be reimbursed for the care they provide.

FISCAL COMMENTS

According to the Senate Appropriations Committee, DHCS estimates the following costs to implement this bill:

1) Fiscal year (FY) 2022-23 - One-time total funds cost of $39.586 million ($20.229 million General Fund (GF) and $19.793 million federal funds (FF).

2) FY 2023-24 and annually thereafter total funds $46.6 million ($23.3 million GF and $23.3 million FF.

VOTES

ASM HEALTH: 14-0-1

YES: Wood, Mayes, Aguiar-Curry, Bonta, Burke, Carrillo, Flora, Maienschein, McCarty, Nazarian, Luz Rivas, Rodriguez, Santiago, Waldron
ABS, ABST OR NV: Bigelow

ASM APPROPRIATIONS: 15-0-1
YES: Lorena Gonzalez, Calderon, Carrillo, Chau, Megan Dahle, Davies, Fong, Gabriel, Eduardo Garcia, Levine, Quirk, Robert Rivas, Akilah Weber, Holden, Luz Rivas
ABS, ABST OR NV: Bigelow

ASSEMBLY FLOOR: 74-0-4
YES: Aguiar-Curry, Arambula, Bauer-Kahan, Bennett, Berman, Bloom, Boerner Horvath, Burke, Calderon, Carrillo, Cervantes, Chau, Chen, Chiu, Choi, Cooley, Cooper, Cunningham, Megan Dahle, Daly, Davies, Flora, Fong, Frazier, Friedman, Gabriel, Gallagher, Cristina Garcia, Eduardo Garcia, Gipson, Lorena Gonzalez, Gray, Grayson, Holden, Irwin, Jones-Sawyer, Kalra, Lackey, Lee, Levine, Low, Maienschein, Mathis, Mayes, McCarty, Medina, Mullin, Muratsuchi, Nazarian, Nguyen, O'Donnell, Patterson, Petrie-Norris, Quirk, Quirk-Silva, Ramos, Reyes, Luz Rivas, Robert Rivas, Rodriguez, Blanca Rubio, Salas, Santiago, Stone, Ting, Valladares, Villapudua, Voepel, Waldron, Ward, Akilah Weber, Wicks, Wood, Rendon
ABS, ABST OR NV: Bigelow, Kiley, Seyarto, Smith

SENATE FLOOR: 32-0-8
YES: Allen, Archuleta, Atkins, Becker, Bradford, Caballero, Cortese, Dodd, Durazo, Eggman, Glazer, Gonzalez, Grove, Hertzberg, Hueso, Hurtado, Kamlager, Laird, Leyva, Limón, McGuire, Min, Newman, Ochoa Bogh, Portantino, Roth, Rubio, Skinner, Umberg, Wieckowski, Wiener, Wilk
ABS, ABST OR NV: Bates, Borgeas, Dahle, Jones, Melendez, Nielsen, Pan, Stern

ASSEMBLY FLOOR: 72-0-7
YES: Aguiar-Curry, Arambula, Bauer-Kahan, Bennett, Berman, Bloom, Boerner Horvath, Bryan, Burke, Calderon, Carrillo, Cervantes, Chau, Chen, Chiu, Cooley, Cooper, Cunningham, Megan Dahle, Daly, Davies, Flora, Fong, Frazier, Friedman, Gabriel, Gallagher, Cristina Garcia, Eduardo Garcia, Gipson, Lorena Gonzalez, Gray, Grayson, Holden, Irwin, Jones-Sawyer, Kalra, Lackey, Lee, Levine, Low, Maienschein, Mathis, Mayes, McCarty, Medina, Mullin, Muratsuchi, Nazarian, O'Donnell, Patterson, Petrie-Norris, Quirk, Quirk-Silva, Ramos, Reyes, Luz Rivas, Robert Rivas, Rodriguez, Blanca Rubio, Salas, Santiago, Stone, Ting, Valladares, Villapudua, Voepel, Waldron, Ward, Akilah Weber, Wicks, Wood
ABS, ABST OR NV: Bigelow, Choi, Kiley, Nguyen, Seyarto, Smith, Rendon

UPDATED

VERSION: September 7, 2021

CONSULTANT: Scott Bain / HEALTH / (916) 319-2097 FN: 0002034