PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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<tr><td colspan="4">Original Date: 04/12/2023</td><td colspan="3">Next Review Date: 05/08/2025
Last Review Date: 05/08/2024</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 05/08/2024</td></tr>
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I. RELATED POLICIES:

A. MCCP2032 – CalAIM Enhanced Care Management (ECM)
B. MCUP3142 – CalAIM Community Supports (CS)
C. MCUP3143 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
D. MCCP2033 – Community Health Worker (CHW) Services Benefit
E. MCUP3124 – Referral to Specialists (RAF) Policy
F. MCUP3041 – Treatment Authorization Request (TAR) Review Process
G. MPCR300 – Physician Credentialing and Re-Credentialing Requirements
H. MPCR301 – Non-Physician Clinician Credentialing and Re-Credentialing Requirements
I. MPCR302 – Behavioral and Mental Health Practitioner Credentialing and Re-Credentialing Requirements
J. MPCR17 – Standards for Contracted Primary Care Providers
K. MPCR11 – Credentialing of Community Health Worker (CHW) Supervising Providers
L. MPNET100 – Access Standards and Monitoring
M. MPQP1022 – Site Review Requirements and Guidelines

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Provider Relations
D. Member Services

III. DEFINITIONS:

A. Authorized Representative: An adult Member has the right to designate a friend, family member, or other person to have access to certain protected health information (PHI) to assist the Member with making medical decisions. The Member will need to provide appropriate legal documentation as defined in CMP26 Verification of Caller Identity and Release of Information and submit to Partnership HealthPlan of California for review prior to releasing PHI. Until the form has been submitted and validated by Partnership staff, the Member can give verbal consent to release non-sensitive PHI to a designated person. Verbal consent expires at close of business the following business day. The Member can give additional Verbal Consent when the prior Verbal Consent window of time has expired.
B. Certified Nurse Midwife (CNM): A CNM is licensed as a Registered Nurse and certified as a Nurse Midwife by the California Board of Registered Nursing.
C. Community Health Worker (CHW): Individuals known by a variety of job titles, such as promotors, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, who connect and engage with their community to provide equitable

health care through culturally competent services. CHWs are trusted members of their community who help address chronic conditions, preventive health care needs, and health related social needs within their communities.

D. Community Supports Services (CS): Pursuant to 42 CFR 438.3(e)(2), In-Lieu of Services (ILOS) are optional services or settings that are offered in place of services or settings covered under the California Medicaid State Plan (Medi-Cal) and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. These services or settings require Department of Health Care Services (DHCS)approval. Under CalAIM, these services are known as Community Supports (CS).

E. Community Supports Provider: A contracted provider experienced and/or trained in providing one or more of the Community Supports

F. Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

G. Enhanced Care Management (ECM) Provider: A Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.

H. Managed Care Plan (MCP): Partnership HealthPlan of California is contracted as a DHCS Managed Care Plan (MCP). MCPs are required to provide and cover all medically necessary physical health and non-specialty mental health services.

I. Medical Home: The provider identified as the Member's medical home or primary care provider (PCP) is responsible for managing the Member's primary care needs

J. Mobile Medicine: Health care services provided at shelters, mobile units/recreational vehicles (RV), or other sites with a fixed and specified location. Note that this is not considered street medicine as it requires people experiencing unsheltered homelessness to visit a health care provider at the provider's fixed, specified location.

K. Street Medicine: Street medicine refers to a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment. Note that mobile units/RVs that go to the individual experiencing unsheltered homelessness in their lived environment ("on the street") is considered street medicine.

L. Unsheltered Homelessness: Situations in which individuals are not regularly accessing shelters or transitional housing programs and are instead often sleeping in encampments, under underpasses, in their vehicles, or other locations not meant for human habitation.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the opportunities for providers to address clinical and non-clinical needs of their Medi-Cal Members experiencing unsheltered homelessness.

VI. POLICY / PROCEDURE:

A. The fundamental approach of street medicine is to engage people experiencing unsheltered homelessness exactly where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through. The Department of Health Care Services (DHCS) recognizes the benefit that street medicine can provide, and with this in mind, encourages Managed Care Plans (MCPs) to adopt requirements for street medicine providers as outlined in APL 24-001

Street Medicine Provider: Definitions and Participation In Managed Care that allow for maximum provider participation while maintaining high quality care.

1. The Department of Health Care Services (DHCS) does not require a street medicine provider to be affiliated with a brick-and- mortar facility.
2. DHCS does not prescribe any particular contracting type for MCPs (i.e. Partnership) and street medicine providers.
3. There is no required effective start date for the operations of a street medicine program since utilization of street medicine providers is voluntary for MCPs.

B. Partnership covers the provision of medical services for their Members experiencing unsheltered homelessness through street medicine providers acting in the following ways:
   1. In the role of the Member's assigned primary care provider (PCP)
   2. In a direct contracting arrangement with Partnership
   3. As a referring or treating contracted provider directly contracted with Partnership
   4. As an ECM provider (as defined in III.F. and G.) or as a Community Supports Provider (as defined in III.D. and E.)

C. DHCS has outlined provisions for various street medicine scenarios as follows:
   1. Street Medicine Provider as a Member's Assigned Primary Care Provider (PCP)
      a. "Street medicine provider" refers to a licensed medical provider (e.g., Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNM)) who conducts patient visits outside of the four walls of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be (such as those living in a car, RV, abandoned building, or other outdoor areas).
         1) A non-physician medical practitioner (PA, NP, and CNM), must have a supervising Physician who is a practicing street medicine provider.
      b. Contracted street medicine providers may choose to serve as the Member's assigned PCP upon Member election. In order to serve as a PCP, the street medicine Provider must meet Partnership's eligibility criteria for being a PCP per policy MPCR17 Standards for Contracted Primary Care Providers, be qualified and capable of treating the full range of health care issues served by PCPs within their scope of practice, and agree to serve in a PCP role.
         1) Street medicine providers willing to serve in a PCP capacity are advised to assess and examine the level and quality of the establishment of the treatment relationship at the time of initial engagement when considering an agreement to be a Member's assigned PCP, as DHCS envisions dynamic and exceptional Provider-Member patient interactions.
         2) If the street medicine provider is willing to be the Member's assigned PCP, the provider must initiate the request via telephone call to Partnership's Member Services department (800) 863-4155 with the Member on the line, and both parties must confirm to Partnership the Member's choice in selecting the street medicine provider to be their assigned PCP. The street medicine provider will then be assigned as the Member's PCP and will be responsible for overseeing the Member's care.
      c. Street medicine providers, when elected by Members to act as their assigned PCP, are responsible for providing the full array of primary care services, including but not limited to, preventive services, and the treatment of acute and chronic conditions. Thus, street medicine providers who choose to act as a Member's assigned PCP must agree to provide the essential components of the Medical Home in order to provide comprehensive and continuous medical care, including but not limited to:
         1) Care coordination and health promotion, such as those services offered under Basic

Population Health Management (BPHM)
2) Support for Members, their families, and their authorized representatives
3) Referral to specialists, including behavioral health, community, and social support services, when needed
4) The use of health information technology to link services, as feasible and appropriate; and
5) Provision of primary and preventative services to assigned Members

d. Street medicine providers who are serving in an assigned PCP capacity are required to undergo the appropriate level of site review process, which is either a full or a condensed review as follows:
   1) For street medicine providers serving as an assigned PCP, and that are affiliated with a brick-and-mortar facility or that operate a mobile unit/RV, Partnership will conduct the full review process of the street medicine provider and affiliated facility in accordance with APL 22-017: Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review and policy MPQP1022, Site Review Requirements and Guidelines.
   2) For street medicine providers serving as an assigned PCP in the unsheltered environments, and that are not affiliated with a brick-and-mortar facility or mobile unit/RV, Partnership will conduct a condensed Facility Site Review (FSR) and Medical Record Review (MRR) of the street medicine provider to ensure Member safety. The condensed FSR and MRR requirements will be based on, and reflective of, the full FSR and MRR requirements as outlined in APL 22-017.
e. Street medicine providers who elect to be PCPs are required to develop and maintain protocols for identifying and transferring Members to a higher level of care if needed when the Member's service needs are beyond the capabilities and/or qualifications of the street medicine Provider. This includes access to urgent and emergency care, specialty care, mental health and substance use disorder treatment, ancillary services, and appropriate Non-Emergency medical and Non-Medical Transportation services as well as expeditious referrals to ECM and Community Supports.
f. Licensed providers must follow Partnership credentialing requirements as per Partnership policies MPCR300 Physician Credentialing and Re-Credentialing Requirements, MPCR301 Non-Physician Clinician Credentialing and Re-Credentialing Requirements, and MPCR302 Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements.
g. Licensed providers must be enrolled as a Medi-Cal provider in accordance with APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment.
   1) If there is not a state-level enrollment pathway, the street medicine provider is not required to meet the credentialing requirements in APL 22-013 in order to become an "in-network" Provider. But in that case, Partnership must vet the qualifications of the street medicine provider to ensure they can meet Partnership's standards of participation, similar to the credentialing process and requirements outlined in APL 22-013 and in accordance with Partnership policies MPCR300 Physician Credentialing and Re-Credentialing Requirements, MPCR301 Non-Physician Clinician Credentialing and Re-Credentialing Requirements, and MPCR302 Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements.
h. Providers elected as a Member's assigned PCP are exempt from PCP time and distance standards (as part of Annual Network Certification requirements) because the Member does not have a permanent residential address and the street medicine provider is meeting the Member at their lived environment. Additionally, service location requirement for PCPs, as specified in the MCP Contract, is not applicable to street medicine providers serving as PCPs, as they are not rendering services at a brick-and-mortar location

2. Street Medicine Provider in a Direct Contracting Arrangement with Partnership
    a. To facilitate direct access, DHCS encourages Partnership to contract directly with street medicine providers. This is an option even if the provision of health care services is delegated to a Subcontractor.
        1) Direct contracts with street medicine providers can allow ready access to health care services for individuals experiencing unsheltered homelessness and reduce contracting complexity for street medicine providers.
        2) The street medicine provider would be subject to the same Partnership administrative processes (e.g. billing protocols, credentialing requirements, authorization guidelines, etc.) rather than having multiple processes and requirements under each subcontracting entity.
        3) The payment arrangement would be between the MCP and the street medicine Provider.
        4) Under a direct contracting arrangement, the street medicine provider must have the ability to refer Members to medically necessary covered services within Partnership's network, and must coordinate care with Partnership, the Subcontractor, and/or Independent Physician/Provider Association (IPA) as appropriate.
3. Street Medicine Providers Serving Solely as Referring or Treating Contracted Provider
    a. The contracted street medicine provider has the right to decline the additional responsibilities of an assigned PCP, and instead, care for Members in a non-PCP capacity as a referring or treating contracted provider working with individuals experiencing unsheltered homelessness. To provide care in this capacity, street medicine providers must have processes in place to work with Partnership, the Member's PCP, and/or the ECM Care Manager to ensure the Member has referrals to primary care, Community Supports, behavioral health services, and other social services as needed.
    b. Licensed providers must follow Partnership credentialing requirements as per Partnership policies MPCR300 Physician Credentialing and Re-Credentialing Requirements, MPCR301 Non-Physician Clinician Credentialing and Re-Credentialing Requirements, and MPCR302 Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements.
    c. Licensed providers must be enrolled as a Medi-Cal provider in accordance with APL 22-013 Provider Credentialing/Re-Credentialing and Screening/Enrollment.
4. Street Medicine Provider as an ECM and/or Community Supports Provider
    a. A street medicine provider can be contracted to provide both PCP and ECM or Community Supports services to a Member but must avoid duplication of services. Street medicine providers that are also ECM or Community Support providers are required to do the following:
        1) Enroll in Medi-Cal if there is a state-level enrollment pathway
        2) Fulfill all ECM or Community Supports requirements per policies MCCP2032 CalAIM Enhanced Care Management (ECM), MCUP3142 CalAIM Community Supports (CS) and MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
        3) Have the capacity to provide culturally appropriate and timely in-person care management activities; and
        4) Have formal agreements, data systems, and processes in place with entities across sectors to support care coordination and care management

D. Billing/Reimbursement Street medicine
1. Contracted street medicine providers rendering services to Medi-Cal eligible individuals are to bill Partnership based on the eligibility of the individual, for appropriate and applicable services within their scope of practice. Street medicine providers rendering services to beneficiaries eligible for fee-for-service (FFS) Medi-Cal, not assigned to Partnership, should bill Medi-Call FFS consistent with the requirements set forth in the FFS provider manual.

2. Street medicine providers must comply with the billing provisions for street medicine providers as applicable to Partnership policies and procedures.
3. If a street medicine provider is a Federally Qualified Health Clinic (FQHC), they can still be reimbursed at their applicable Prospective Payment System (PPS) rate when such services are being provided outside the four walls and where the Member is located. The FQHC would be paid their applicable PPS rate when the street medicine provider is a billable clinic provider.
4. Street medicine providers can also be reimbursed for providing other State Plan benefits (e.g . Community Health Worker (CHW) services are often provided in street medicine programs and can be billed by the contracted CHW supervising provider organization).
    a. Partnership is responsible for ensuring non-duplication of services with any other covered benefit, program, and/or delivery system.

E. Medi-Cal Eligibility
1. Street medicine Providers are required to verify the Medi-Cal eligibility with Partnership of individuals they encounter in the provision of health care services.

F. Authorizations
1. No Prior Authorization is needed for a Member to see a street medicine provider if the Member seeks services directly from a street medicine provider related to the Member's primary care. This means that a Partnership-contracted street medicine provider that meets all of Partnership's required administrative processes could provide services to a Member and receive payment for those services, even if the Member is assigned to another PCP.
2. If a Member needs medical services that do require prior authorization, all Partnership contracted street medicine providers must follow the requirements of Partnership policies MCUP3124 Referral to Specialists (RAF) Policy and MCUP3041 Treatment Authorization Request (TAR) Review Process.

G. Data Sharing, Reporting and Administration
1. Contracted street medicine providers must comply with all applicable Partnership administration requirements in accordance with federal and state laws as well as Partnership data sharing and reporting requirements and the provider's contract with Partnership, based on provider contracting type.
2. Partnership ensures street medicine providers are given the necessary provider training and manuals and have adequate systems in place to adhere to administration requirements, such as grievances and appeals, referrals, after-hours and timely access, prior authorizations, quality improvement, performance measures, and electronic health records.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-001 Street Medicine Provider: Definitions and Participation in Managed Care (01/12/2024)
B. DHCS APL 22-017 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review (09/22/2022)
C. DHCS APL 22-013 Provider Credentialing/Re-Credentialing and Screening/Enrollment (07/19/2022)
D. DHCS APL 22-016 *Revised* Community Health Worker Services Benefit (09/09/2022)
E. State Plan Amendment (SPA) 22-0001
F. Title 42 Code of Federal Regulations (CFR) Section 440.130(c)
G. Medi-Cal Provider Manual/ Guidelines: Community Health Worker (CHW) Preventive Services (*chw prev*)
H. Street Medicine Institute: https://www.streetmedicine.org/
I. "Addressing Unsheltered Homelessness in California" (August 2021): A report by the Division of Social Work and the Center for Health Practice, Policy & Research at the California State University, Sacramento prepared for the Homelessness Coordinating and Financing Council in the California Business, Consumer Services, and Housing Agency

https://bcsh.ca.gov/calich/documents/2021_heap_case_study1.pdf

VIII. DISTRIBUTION:

B. Partnership Department Directors
C. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 05/08/24

PREVIOUSLY APPLIED TO: N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.