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Financing Mechanisms for Street Medicine and Other Low-Barrier Models of Care

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TAKEAWAYS

- Maximizing Medicaid financing is important for the success and sustainability of street medicine programs and other low-barrier models of care.
- Grant funding can support initial program pilots and bridge funding gaps as programs evolve, but Medicaid funding is typically necessary to provide long-term financing.
- Collaboration between provider and health system leaders and state Medicaid leadership can support the development of sustainable financing mechanisms for street medicine programs, with a particular focus on high-risk populations, like people living with HIV.
- This brief offers guidance to help provider organizations establish street medicine programs, including Medicaid financing options, strategies for maximizing funding, action steps for successful implementation, and examples from early innovators.

In recent years, health care providers have implemented innovative models of care to better meet the health and related social needs of people experiencing homelessness. This includes people who do not have a consistent residence or address, including those vulnerable to or living with HIV. Street medicine, harm reduction, and other low-barrier care models have shown that when providers literally "meet people where they are," people experiencing homelessness are more likely to engage in and use services, and experience improved health outcomes.

Although promising, these low-barrier care models often rely on time-limited funding sources, which compromise long-term sustainability and limit opportunities to expand program reach and effectiveness. Sustainable financing is critical for advancing street medicine and other low-barrier forms of care. Medicaid financing mechanisms offer opportunities to sustainably fund programs that move beyond the clinic walls to address health issues commonly faced by people experiencing homelessness.

Developed in collaboration with the HIV Medicine Association.

Drawing from research and interviews conducted between April and November 2024 (see **Acknowledgements**), this brief outlines guidance to support provider organizations in developing street medicine programs. It summarizes the primary Medicaid financing options, strategies that provider organizations can use to maximize funding for these services, action steps providers can take to establish successful programs, and examples of early street medicine innovators. While the guidance is applicable to any street medicine program, it highlights information for programs that focus on people vulnerable to or living with HIV.

Key Terms in this Brief

Low-Barrier Care:

- Seeks to minimize demands placed on clients and make services readily available and easily accessible by reducing barriers, such as transportation and required appointment times.
- Promotes a non-judgmental, welcoming, and accepting environment.
- Provides culturally responsive, person-centered, trauma-informed care.

Street Medicine:

- Provides health and social services for people experiencing unsheltered homelessness* delivered directly in their own environment.
- Engages people exactly where they are and on their own terms to reduce or eliminate barriers to engaging in services, such as travel to clinics.

*The term "**people experiencing homeless**" is used throughout this brief and is intended to be inclusive of people who are unstably housed and people experiencing unsheltered homelessness.

Homelessness Drives Poor Health Outcomes

On a single night in January 2023, 653,104 people in the United States experienced homelessness. This equals about 20 out of every 10,000 people. In addition, certain racial minority groups face disproportionately high rates of homelessness. For instance, people who identify as Black comprise 37 percent of people experiencing homelessness in the United States, even though they represent only 13 percent of the overall population.

People experiencing homelessness have less access to critical health and social services, are more likely to have experienced trauma, and experience poorer health outcomes and lower life expectancy than the general population. For people living with HIV, homelessness can uniquely drive poor health outcomes. Experiencing homelessness limits a person living with HIV's ability to engage in necessary treatment services to achieve viral suppression, which is critical for preventing HIV transmission. Further, experiencing homelessness also increases risk for HIV acquisition, given limitations on accessing critical HIV prevention services known to reduce harm associated with behaviors that drive both HIV acquisition and transmission.

The Role of Medicaid and the Ryan White Program in Supporting People Living with HIV

Medicaid is the largest insurer of people living with HIV in the United States, covering 40 percent of adults under the age of 65 living with HIV. A greater proportion of people living with HIV are currently covered by Medicaid than ever before, largely due to advances in HIV treatment and medication that have led to people with HIV living longer, as well as expanded eligibility available through the Affordable Care Act in the 41 states that have expanded Medicaid. Medicaid covers services critical to people living with or vulnerable to HIV, including inpatient and outpatient medical care, medications, and prevention services. Medicaid also has a critical role to play in achieving the goals outlined in the federal Ending the HIV Epidemic initiative. This effort, launched in 2019 by the U.S. Department of Health and Human Services, aims to reduce new HIV infections in the U.S. by 90 percent by 2030 through targeted strategies like diagnosis, treatment, prevention, and response — with a focus on regions of the country with the highest number of new infections. With recent advances in prevention and long-acting treatment medications, those ambitious goals are more within reach than ever.

How the Ryan White HIV/AIDS Program Supports People Living with HIV

The Ryan White Program is the nation's safety net for people living with HIV who are underinsured or uninsured. Administered by the Health Services and Resources Administration (HRSA), an agency within the U.S. Department of Health and Human Services, this program funds state and local agencies to coordinate HIV care, treatment, and critical support services for people living with HIV in the United States. Each year more than half of these individuals receive some form of assistance through the program. Per federal law, Ryan White Program funding is solely for programs and services supporting people *living with HIV* and may not be used for HIV *prevention* programs and services, which are primarily funded at the federal level by the Centers for Disease Control and Prevention. Ryan White Program funding is intended to be the "payor of last resort," and state and local recipients may not use program funds for services that can be paid for under a private insurance policy or any federal or state health benefits program. Further, Ryan White Program funding recipients, including state and local agencies, are required to consistently assess clients' eligibility for public and private insurance and make efforts to enroll them in plans for which they are deemed eligible.

About one-fifth of Ryan White clients are uninsured but most (approximately 80 percent) have some form of insurance, with Medicaid being the primary source, covering 38 percent of Ryan White clients. The Ryan White Program continues to play an important

role for many who are underinsured or uninsured, filling gaps in coverage and increasing access to critical medical and support services. People living with HIV who use Ryan White Program-funded services and have some form of insurance coverage are more likely to have sustained viral suppression, compared to those who only have some form of insurance, but do not engage in Ryan White Program-funded services (68 vs. 58 percent). This illustrates the importance of accessing both Medicaid coverage and Ryan White Program resources to maximize access to care and critical support services.

Medicaid 101

Medicaid, which is funded by both state and the federal governments, is the largest public health insurance program in the U.S., covering over 80 million people. States administer the program under broad federal guidelines, deciding on benefits, services, and provider reimbursement rates. While the federal government sets a minimum income eligibility at 138 percent of the federal poverty level (FPL), states can expand coverage beyond those requirements. Medicaid also provides coverage for many high-need populations, including 40 percent of all non-elderly adults living with HIV in the U.S. and is the largest source of public spending for HIV care nationally.

Medicaid covers a broad range of services, including those federally required and optional state benefits. Required benefits include, for example, physician visits, inpatient and outpatient hospital services, and laboratory and x-ray services. Examples of optional services include case management, dental services, inpatient psychiatric care, and prescription drug services, with all 50 states currently covering Prescription drug services.

Medicaid Managed Care

Many states contract with managed care organizations (MCOs) to provide health benefits and needed services to Medicaid enrollees. Currently, 74 percent of Medicaid beneficiaries receive care through MCOs, and 52 percent of Medicaid spending is through MCOs. MCOs receive a fixed monthly payment per member enrolled for providing the required services.

MCOs are required to follow state and federal laws to cover specific benefits and maintain network adequacy requirements, ensuring that enrollees have equitable access to required services and sufficient providers. MCOs have some flexibility and can offer additional benefits and services beyond those required by states.

Using Medicaid to Advance Street Medicine and Low-Barrier Models of Care

Medicaid offers three primary financing mechanisms that states can use to support sustainable financing models for street medicine programs — namely maximizing use of existing Medicaid authorities, State Plan Amendments (SPAs), and Section 1115 waivers. All three financing mechanisms offer opportunities for providers to partner with state Medicaid leadership to develop street medicine services that can potentially be reimbursed under Medicaid if approved by federal Medicaid authorities. Given that MCOs often provide Medicaid-covered services, providers can consider partnering closely with MCOs in their street medicine efforts. The following section provides an overview of available Medicaid financing mechanisms.

Existing Medicaid Authority

Provider organizations that have worked primarily in Ryan White or other grant-funded programs may not be familiar with the full suite of services that can be provided and billed for under existing Medicaid authority. Provider organizations can better understand billable services in their respective states via publicly available information on state Medicaid agency websites or through direct communication with state Medicaid agency staff. Providers can ensure that they are billing for any allowable services provided to secure program revenue as well as, in the case of people living with HIV, the availability of Ryan White Program funding for services not covered by other sources.

While recognition of the effectiveness of street medicine's approach has grown significantly in recent years, the financing mechanisms necessary to support these programs have not evolved at the same pace. Due to both federal Medicaid and Ryan White Program policy limiting the physical location where billable and allowable services can be provided (e.g., in brick-and-mortar clinics, mobile vans), to date, street medicine programs have primarily relied on more flexible but time-limited grant funding to support their operations. However, as of October 1, 2023, the Centers for Medicare & Medicaid Services (CMS) authorized a new Medicaid "place of service" billing code (#27) that allows health professionals to be reimbursed for "preventive, screening, diagnostic, and/or treatment services provided to unsheltered homeless individuals in a non-permanent location on the street or found environment." To begin using the newly authorized place of service code #27, state Medicaid leadership must request federal approval. A number of states have recently been granted federal approval to use place of service code #27, including California, Hawaii, and Pennsylvania. It is also important for providers to stay updated on new federal billing codes, like the recently released G2211 add-on code, that support care approaches appropriate for unsheltered individuals with complex health and social needs.

In addition to the place of service billing code #27 recently added by CMS, which is applicable to all Medicaid providers, HRSA recently released guidance for federally qualified health centers (FQHCs) on how they can add street medicine to their approved scope of project. This new provision allows FQHCs to provide approved street medicine services and bill Medicaid accordingly.

These critical policy developments create opportunities to maximize the provision of services under existing Medicaid authority for people experiencing homelessness and serve as a foundation for the growth and sustainability of street medicine programs.

State Plan Amendments

To receive federal Medicaid funding, states are required to develop comprehensive state plans that must be approved by the Secretary of the U.S. Department of Health and Human Services. SPAs are required when a state amends its Medicaid program, or when federal or state law changes. For instance, a state might submit a SPA to begin covering optional services or populations.

State Medicaid agencies can use SPAs to expand or enhance covered services. For example, in 2023, New York State's Medicaid agency received federal approval for a SPA that expanded reimbursable harm reduction benefits to better serve people who use drugs. The SPA created coverage and reimbursement for new linkage and navigation services, clarified service definitions for existing services and providers, and further defined which types of organizations are eligible to provide Medicaid harm reduction services. In 2017, North Carolina Medicaid revised its HIV Case Management policy using a SPA, ensuring comprehensive assessments and expanded provider requirements for case managers to increase beneficiary access toa wide range of appropriate services.

Section 1115 Waivers

Under Section 1115 of the Social Security Act, the federal government can waive specific Medicaid requirements to allow states to pilot initiatives that support Medicaid's objectives. These waivers are designed to explore innovative approaches, must be budget neutral, are not intended to reduce costs or bypass federal rules, and are designed to be implemented over a limited, typically five-year, timeframe.

Section 1115 waivers have been broadly used by states to provide enhanced services such as expanded medication coverage, diagnostic testing, and specialized care. Waivers, and SPAs, can also address health-related social needs, offering up to six months of transitional housing, nutrition services (e.g., medically tailored meals), and infrastructure development for social services. However, spending under these waivers must supplement, not replace, coverage of traditional Medicaid services or existing funding.

The Role of Medicaid Managed Care in Operating a Street Medicine Program

Many states contract with MCOs to provide health benefits and needed services to Medicaid enrollees. With 74 percent of Medicaid members receiving care through MCOs, and 55 percent of all Medicaid spending flowing through MCOs, MCOs have a key role in the development and financing of street medicine programs.

Street medicine provider organizations can engage with their local MCOs in multiple ways, the most common of which is through contracting. Provider organizations can apply to be included in an MCO's provider network, which typically includes, but is not limited to, an assessment of provider qualifications, services offered, and geographic coverage area. If approved, provider organizations can contract with MCOs after negotiating key terms and conditions, such as reimbursement rates, and quality standards. Providers can also partner with MCOs through a pay-for-performance system, where the MCO sets health improvement metrics for a priority population and offers incentive payments if performance meets the established criteria. While not common, MCOs may also offer incentive payments to providers that can be used for infrastructure development and equipment purchases that may be beneficial to street medicine programs at an early stage of development.

Below are important considerations for provider organizations when engaging local MCOs.

1. **Identify shared goals between street medicine and managed care programs**. MCOs' approach to serving their members typically vary from entity to entity. Providers can familiarize themselves with their local MCOs' leadership and strategic priorities before exploring potential partnerships. As part of initial discussions and through the contracting process, provider organizations and MCOs can identify shared goals aimed at mutually supporting the development and growth of street medicine programs. Providers should avoid framing benefits as primarily cost saving as there are other priority benefits to MCOs such as providing new access points to care, especially in rural areas, and meeting their required network adequacy, including geographic standards. Provider organizations can follow the Triple Aim Approach in aligning goals with MCO interests:

    - Minimize per capita cost;
    - Meet Healthcare Effectiveness Data and Information Set metrics to improve clinical quality and reduce mortality; and
    - Increase positive clinical experiences of care in both access to and treatment received.

2. **Offer clinical and community subject matter expertise**. MCOs typically have quality management committees that determine covered services and quality standards. Given both their clinical knowledge and familiarity with the communities they serve, street medicine providers have valuable input to offer to MCOs to inform the creation of benefits and services that will drive positive patient outcomes and decreased costs. The chief medical officer at the MCO typically oversees these committees.

3. **Understand current state Medicaid policies**. Medicaid policy varies from state to state. It is important that providers are familiar with their specific state policies — primarily those that drive financial sustainability of programs, including reimbursable services and reimbursement rates. Providers can assess how state policies might impact program financial sustainability models.

Key Steps Street Medicine Providers Can Take Toward Sustainable Financing

In addition to using key Medicaid financing mechanisms to support street medicine services, as described in the prior section, there are important program strategy, strategic planning, and partnership development action steps providers can take to build financial sustainability for their programs.

Facilitate Medicaid Enrollment

A critical step in supporting people experiencing homelessness and the sustainability of street medicine programs is ensuring that people who are eligible are enrolled in Medicaid. However, benefits enrollment for people experiencing homelessness may be a challenging task due to provider mistrust, it is critical that providers take appropriate steps to build trust and enroll eligible patients in Medicaid to be able to bill for services provided through street medicine programs. Using trusted peer staff, such as community health workers, to help facilitate enrollment can be an effective strategy.

Identify and Use Existing Organizational Support

Providers employed by larger, well-resourced health care organizations can cultivate leadership buy-in for street medicine programs. These organizations are often able to provide direct funding, allocated staff time, and other resources necessary to get fledgling street medicine programs "off the ground" while program strategy evolves, and sustainable financing models are developed. Further, health care organizations often have the necessary infrastructure to track data on patient engagement and health outcomes, which can illustrate system cost savings driven by street medicine programs (e.g., averted emergency department visits) and make the case for further investment

and expansion of street medicine programs. Some hospital-based early adopters of street medicine programs have reported significant cost savings.

Develop Relationships with State Medicaid Leadership

Providers and provider organization leadership can identify ways to collaborate and build relationships with state Medicaid and local MCO leadership in their efforts to develop street medicine programs and other low-barrier forms of care. SPAs, 1115 waivers, and other policy actions intended to support innovative models of care can only be requested from federal Medicaid authorities by state Medicaid officials through internal agency processes. However, providers, particularly physicians, have a critical role to play in Medicaid policy advocacy given their subject matter expertise and intimate familiarity with patient needs. State Medicaid officials typically welcome collaboration from provider leaders who can inform their policy and regulatory efforts in the spirit of mutually beneficial partnership. Further, the Affordable Care Act established new rules requiring greater transparency and opportunities for public input on 1115 waivers. These rules require public notice and comment periods at both state and federal levels, before federal authorities approve waivers.

Identify Grants to Use in Braided/Blended Funding

While Medicaid financing is important to the sustainability and growth of street medicine programs, providers can also identify relevant additional state, federal, industry, and philanthropic grant funding that can support the piloting of new initiatives and cover services and populations that are not billable under Medicaid. This approach is particularly important in Medicaid non-expansion states. Street medicine program leadership can seek out grant funding earmarked to address health and social issues common to people experiencing homelessness, like substance use, which may be used in a complementary way to support street medicine services (see **Exhibit 1**, next page). Given recent federal and state investments in addressing the opioid overdose crisis, federal *State Opioid Response* grants and opioid settlement funds are key examples.

Develop a Sustainable Funding Model as Early as Possible

Given the complexities of the health and social issues people experiencing homelessness are facing, and the intense focus of providers operating street medicine on addressing them, it is easy to overlook the importance of developing a sustainable program funding model sooner rather than later. Factors like provider burnout and spending grant funding more rapidly than expected in response to patient needs can compromise the stability of street medicine programs at an early stage. It is critical that street medicine program leadership work to develop a sustainable program funding model as early as possible and partner with health care organization leadership to ensure the future success of effective programs (see **Exhibit 1**, next page).

Exhibit 1. Potential Funding Sources for Street Medicine Programs

FUNDING SOURCES	WHO CAN ACCESS	HOW TO OBTAIN
Federal Funding		
Ryan White Program	States and local government agencies serving people living with HIV	Partner with relevant state and local government agencies
Substance Abuse and Mental Health Services Administration (SAMHSA) grants, such as PATH, SOAR, SOR, and CABHI	State government agencies	Partner with relevant state government agencies **Example**: MaineHealth CONNECT
HRSA (HCH – 330H Grants)	Health centers	Apply directly on HRSA website, must meet specific criteria **Example**: Boston Health Care for the Homeless
HRSA: 340 B	FQHCs, Ryan White Program grantees, hospitals, specialized clinics	Complete registration based on organization type **Example**: University of Miami Health System's Infectious Disease Elimination Act (IDEA Exchange)
Hospital/Health System Funding		
Community benefit funding from nonprofit hospitals	Community and provider organizations	Not-for-profit hospitals are required to engage in activities that benefit their communities (e.g., conduct a community health needs assessment) and adopt an implementation strategy to meet identified community needs **Example**: NY Street Health Outreach and Wellness (SHOW) program
Direct hospital investment/contracts	Street medicine programs	Partner and/or contract with local hospitals/health centers **Examples**: Penn Medicine Street Medicine Program; Vanderbilt Homeless Health Service
Industry		
Pharmaceutical and/or industry-leading organizations	Nonprofit community and provider organizations and academic health systems	Identify relevant funding opportunities and respond to requests for proposals **Example**: ViiV; Gilead
Philanthropic		
Health care foundations	Nonprofit community and provider organizations	Identify relevant funding opportunities and respond to requests for proposals **Example**: amfAR
Managed Care Organizations		
Direct contract	Community and provider organizations	Partnership with local MCOs **Example**: Clinica Sierra Vista Street Medicine Team
Capacity-building grants	Community and provider organizations	Partnership with local MCOs
State/County Public Health Departments Grant Funding		
HIV and infectious disease prevention and screening	Street medicine provider organizations	Outreach/partner with relevant agencies, apply directly for grant opportunities **Example**: Epstein Street Medicine Program
Opioid Settlement Funds		
Awarded to states/localities from opioid related lawsuits	State, county, and municipal government agencies.	Partner with relevant public agency recipients of funds **Example**: Wright State's Dayton Street Medicine Project

Early Street Medicine Innovators: Strategies and Examples

Interviews with early street medicine innovators revealed key themes for building successful street medicine and low-barrier care programs in both Medicaid expansion and non-expansion states. Key themes, outlined below, include building on existing infrastructure, building effective networks, and adapting to changing factors.

Build on Existing Infrastructure to Support Financing Approaches

Developing a low-barrier care model or street medicine program from the ground up is challenging — the time and resources needed to develop the clinical model and secure the necessary funding and personnel are extensive. Building upon existing organizational and program infrastructure can enable a more streamlined and effective process for creating a new program.

An example of this approach is the University of Miami Health System's Infectious Disease Elimination Act (IDEA Exchange) tele-harm reduction initiative, which provides HIV prevention, treatment, and support services through telehealth. The initiative links new tele-harm reduction patient records with the health system's electronic health record, enabling program staff to view relevant patient information while in the field and bill for applicable services and medications. Through the connection with the university health system, the program can ensure compliance and oversight on medical documentation, which can be challenging and costly to develop from scratch or outsource.

Build Effective Coalitions

Interviewees noted the importance of building coalitions with relevant provider stakeholders and community partners to make the case to state Medicaid leadership and legislators for investing in innovative clinical care approaches. This can be done through direct advocacy with state leaders or responding during open comment periods when new program rules and state budgets are up for review and approval.

For example, the California Street Medicine Collaborative formed a coalition of over 175 organizations representing street medicine providers, health plans, community-based organizations, and local and state governments. The goal of the group was to raise awareness about the challenges faced by people experiencing homelessness and to explore potential policy and program strategies to address these issues.

Adapt to Changing Environments to Maintain Service Provision

The environments in which people experiencing homelessness live are inherently fluid. Street medicine providers need to take an adaptive approach to continue to meet people where they are, provide services, and bill for services delivered to keep program revenue stable and consistent.

For example, when the COVID-19 pandemic began, the Boston Health Care for the Homeless HIV program (BHCHP) adapted their outreach and follow-up practices and took steps to safely visit local encampment sites to be able to reach patients and provide care. When increasing encampment sweeps took place in their area, causing patients to relocate, they again adjusted their follow-up practices to reach individuals who moved further from their previous locations. They also adjusted their outreach model to allow for the additional time needed to provide more in-depth outreach and care linkage approaches. BHCHP's model was supported by a combination of grant support as well as, when applicable, billing through Medicaid and other insurance programs.

Conclusion

Street medicine and other low barrier forms of care offer great potential to better serve the health and social needs of people experiencing homelessness, including people living with HIV. Provider innovators have demonstrated the impact of their early-stage street medicine efforts in recent years. Developing sustainable financing approaches for street medicine programs allows providers to evolve, scale, and spread their programs to meet the often-changing needs of the people they serve. Provider organizations can assess how both Medicaid and grant funding can better sustain their programs through braided and blended funding approaches. They can also leverage partnerships with state Medicaid officials and health system partners to further the development of street medicine programs and other low-barrier forms of care that meet people experiencing homelessness "where they are."

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Resources

Following are helpful resources for developing street medicine programs:

- **Adding Street Medicine to Scope of Project for Federally Qualified Health Centers –** Provides a step-by-step guidance to help FQHCs incorporate street medicine services into their scope of project, to be eligible for Medicaid and Medicare reimbursement.
- **GileadFOCUS** – Public health initiative enabling partners to share best practices in routine blood-borne virus (HIV, HCV, HBV) screening, diagnosis and care linkages (see funding opportunities).
- **HIV Medicine Association Podcast Series** – Covers relevant topics for providers on the role Medicaid can plan in coverage, access to medication, and other relevant services for people living with HIV (see direct links below).
  - → Engaging Medicaid Managed Care Plans on HIV
  - → Understanding Why Medicaid Matters for People with HIV
  - → Helping Medicaid Patients Access Their HIV Medications
  - → Reimagining Medicaid, How Medicaid Can Help Address Social Determinants of Health
- **National Health Care for the Homeless Council** – National organization providing resources to support improved health services for people experiencing homelessness.
- **Street Medicine Institute** – Global nonprofit that provides communities and clinicians with expert training and guidance to develop and grow their own street medicine programs.
  - → **Street Medicine ECHO** – Monthly webinar series provides peer support and best practices, and knowledge about the key concepts for a street medicine program.
- **Primary Care Training and Enhancement: Residency Training in Street Medicine** – HRSA funding for physician residency programs looking to integrate street medicine in primary care training.
- **Street Medicine Financing Toolkit** – Can support new and existing street medicine programs in designing and refining their financial model (created for California, but helpful for other states).
- **USC Street Medicine** – University of Southern California program offering a range of resources to support street medicine program development.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit **www.chcs.org**.

ABOUT THE HIV MEDICINE ASSOCIATION

Housed within the Infectious Diseases Society of America (IDSA), the HIV Medicine Association (HIVMA) represents medical providers and researchers working on the front lines of HIV. More than 13,000 IDSA and HIVMA members work across the United States and in nearly 100 other countries on six different continents. For more information visit **idsociety.org** and **hivma.org**.