TOOLKIT

Financial Planning for Street Medicine Providers in California

Updated September 2024

USC Street Medicine

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ABOUT THIS TOOLKIT

This toolkit was developed in partnership with Katherine Pocock, MHS, PA-C and Brett Feldman, MSPAS, PA-C, **USC Street Medicine**; Alison Klurfeld, MPP, MPH, **Klurfeld Consulting, LLC**; and Meryl Schulman, MPH and Shannon Mead, MHA, **Center for Health Care Strategies**.

Overview

Street medicine is an approach to caring for people who are unsheltered in their own lived environment. In California, street medicine teams are growing in number, and overall, street medicine is establishing as its own clinical field. This is partly due to innovative providers and communities looking to better meet the needs of people experiencing unsheltered homelessness, as well as recent **Medi-Cal reform efforts** that create **program policy** and **funding** opportunities to integrate street medicine teams into the broader continuum of health care services.

Part of these reform efforts include new (one-time and long-term) funding streams that street medicine teams can tap into, as well as clarification of how street medicine providers can contract with Medi-Cal managed care plans (MCPs) to reimburse health care services. As more street medicine teams begin contracting with MCPs, it is important that these teams understand the funding streams they can access to support their programs, as well as the cost of operating their teams, to support rate negotiation with MCPs or other payers.

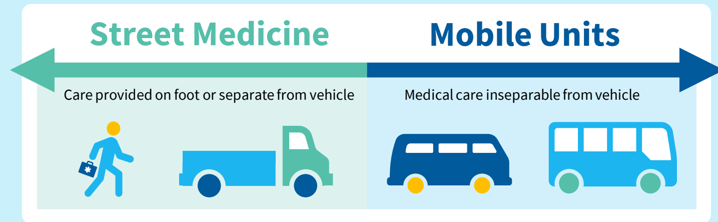
This toolkit is designed to help street medicine providers in California maximize their use of available funding.

What is Street Medicine?

According to the **Street Medicine Institute**, street medicine refers to, "health and social services developed specifically to address the unique needs and circumstances of the unsheltered homeless delivered directly to them in their own environment."

Other forms of medical outreach, such as care provided through a mobile medical unit *(see graphic)*, are not considered street medicine under this definition, but they are effective in engaging people who are unsheltered in care or augmenting the services provided by a street medicine team.

Medical Outreach Continuum*



*Adapted: National Health Care for the Homeless Council. "**Street Medicine or Mobile Medical Unit? Considerations for Expanding Medical Outreach**." February 2022.

Using the Toolkit

Who is this toolkit for? This toolkit can be used by health care providers and community-based organizations seeking to financially support existing street medicine programs, as well as those designing and launching new programs.

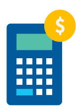
How is the toolkit organized? The toolkit includes the below five sections, each providing practical guidance for financing street medicine programs. This toolkit is designed to grow and evolve over time, and **we welcome feedback** on this resource to support your work in street medicine.

Street Medicine Funding Comparison Chart – Provides a high-level overview of relevant funding streams, details on who is eligible to access funds, allowable uses of funds, and how to access funding.

Roadmap for Accessing Funding for Street Medicine Programs – Offers recommendations for street medicine teams on when to access funding based on time restrictions and other considerations.

Funding Streams to Support Street Medicine Programs: How to Use and Access Them – Expands on the *Street Medicine Funding Comparison Chart* to detail funding that California street medicine programs can access, allowable uses for funds, how to access them, and reporting requirements.

Aligning Street Medicine Funding Sources – Outlines how various funding sources can be used together to maximize opportunities to plan, develop, and launch street medicine programs.



Street Medicine Program Staffing and Revenue Models – Outlines potential staffing and revenue models for street medicine teams based on their program models, as well as offers considerations for each model type. It also includes the **Street Medicine Budget Template and Revenue Planner**, a Microsoft Excel-based tool for street medicine teams to estimate anticipated program expenses and revenue.

Medi-Cal vs. Medicare Funding

This toolkit primarily focuses on Medi-Cal funding streams because most street medicine patients in California have or are eligible for Medi-Cal coverage. This toolkit recommends that street medicine teams that are working to expand and diversify their funding sources first explore Medi-Cal reimbursement. Once Medi-Cal processes are established, teams may consider Medicare billing, especially if they serve a high proportion of Medicare enrollees — including people over age 65 and those who have disabilities that qualify them for **SSDI**. Medicare has a range of billing codes for **care management** and **community health worker** services that may differ from Medi-Cal billing codes and could be applicable to many patients experiencing homelessness.

Additional Resources for California-Based Street Medicine Providers

- **A Game Changer for Street Medicine: Key Takeaways from New Medi-Cal Guidelines**, from the California Health Care Foundation, outlines implications from the policy guidance the California Department of Health Care Services released related to Medi-Cal MCPs contracting with street medicine providers.
- **CA Street Medicine Collaborative**, hosted by USC Street Medicine with support from Health Net, is a free, monthly learning group for street medicine providers. If you have questions or would like to join, reach out to Kaitlin Schwan, PhD, Director, California Street Medicine Collaborative at **Kaitlin.Schwan@med.usc.edu**. Please include your name, job title, and organization.
- **National Health Care for the Homeless Council** works nationally at the intersection of health care and homelessness. The organization provides an array of learning sessions, technical assistance, and training to health care for the homeless providers, including those offering street medicine and mobile outreach.
- **The California Street Medicine Landscape Survey and Report**, from USC Street Medicine and the California Health Care Foundation, details the staffing and care models, populations served, and funding models of 25 street medicine programs in California. A **summary report** is also available.
- **USC Street Medicine** offers high-quality, compassionate care to people who are unsheltered in LA County. The team also offers **workforce development, training, technical assistance, and education** to other street medicine providers.
- **Street Medicine Institute** is a membership organization that offers training, guidance, and support for those looking to establish or further develop their street medicine programs.

Street Medicine Funding Comparison Chart

The below table offers an at-a-glance primer to help providers understand the different funding programs currently available in California to support street medicine programs. Available funding, including purpose, timeframe, funding source, and funding flow are listed below. See ***Funding Streams to Support Street Medicine Programs: How to Use and Access Them*** for an expanded version of this chart, which provides additional detail on funding to support programs, including allowable uses for funds, and how to access them.

Program	Purpose	Timeframe	Funding Source	Funding Flow
Homelessness & Housing Incentive Program (HHIP)	Incentive program to help MCPs improve services for members experiencing homelessness, and to reduce/prevent homelessness.	Funds were earned by MCPs by March 2024; can be spent over a longer term	MCP incentive payments	Department of Health Care Services (DHCS) to MCPs; MCPs develop process for investments
Enhanced Care Management (ECM)	Intensive, in-person care management program for Medi-Cal members with health and social challenges, including people experiencing homelessness.	Calendar years 2022 – 2026 *(and beyond)*	Medi-Cal managed care benefit *(administered through MCPs)*	DHCS to MCPs; MCPs to contracted providers
Community Supports (CS)	Non-traditional services to address social determinants of health that MCPs can elect to provide; must be medically appropriate and cost-effective. Services for people experiencing homelessness may include housing navigation, housing deposits, tenancy supportive services, recuperative care, short-term post-hospitalization housing, day habilitation, and others.	Calendar years 2022 – 2026 *(and beyond)*	MCP In Lieu of Services *(optional services, not benefits)*	DHCS to MCPs; MCPs to contracted providers
Providing Access and Transforming Health (PATH)	Supports for implementing ECM, CS, CHW, and for justice-involved capacity building. **Note:** There are various initiatives under PATH (e.g., **PATH CITED**, **PATH Technical Assistance Marketplace**, etc.). For more information, see ***Funding Streams to Support Street Medicine Programs: How to Use and Access Them***.	Calendar years 2022 – 2026	Medi-Cal 1115 Waiver	DHCS to providers and counties through DHCS' Third-Party Administrator (TPA) for PATH

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Program	Purpose	Timeframe	Funding Source	Funding Flow
Incentive Payment Program (IPP)	Incentive program to build MCP and provider capacity to deliver ECM, CS, and community health worker (CHW) services.	January 2022 – June 2024 and may be extended by MCPs with unspent funds.	MCP incentive payments	DHCS to MCPs; MCPs develop application process for providers and other infrastructure investments
Clinical Service Contracts with MCPs	DHCS clarified that Medi-Cal MCPs can pay for street medicine services, including primary care provider services.	Ongoing. Clarified in All Plan Letter (APL) 22-023 in November 2022, updated in APL 24-001 in January 2024.[*]	Existing Medi-Cal benefits delivered by street medicine providers	DHCS to MCPs; MCPs to contracted providers
Community Health Worker Service Contracts with MCPs	Medi-Cal benefit covering some services provided by CHWs to Medi-Cal beneficiaries.	Ongoing from 7/2022	Medi-Cal managed care benefit; Medi-Cal fee-for-service (FFS) benefit	For Medi-Cal managed care beneficiaries: DHCS to MCPs; MCPs to contracted providers For Medi-Cal FFS beneficiaries: DHCS to providers **Note:** CHW services cannot be billed for members enrolled in ECM.

[*] DHCS issued a follow up APL on street medicine in 2024 with minor changes, including DHCS encouraging MCPs to establish a streamlined primary care provider assignment process for street medicine providers and information on when to use the new “Place of Service” code 27 for street medicine.

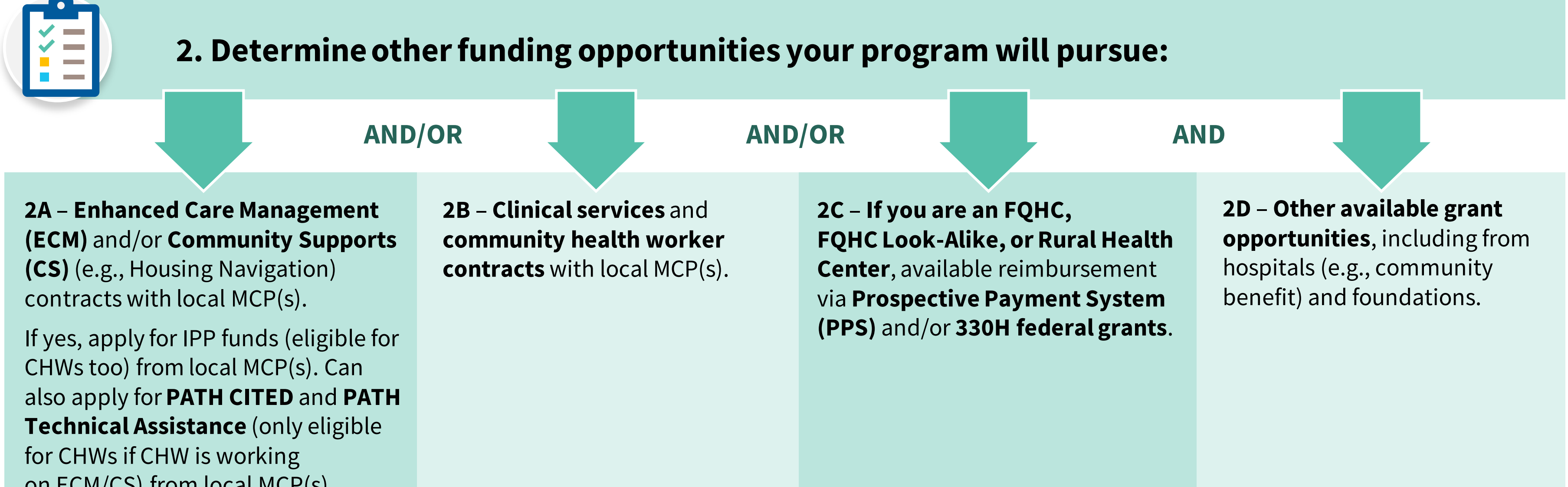
Roadmap for Accessing Funding for Street Medicine Programs

The below diagram and accompanying table *(see next page)* provides guidance for street medicine providers related to when to access funds. As outlined in the ***Street Medicine Funding Comparison Chart***, each funding stream has a unique timeframe for stakeholders to access funds. Programs should keep this in mind to strategically maximize resources available to them.

1A. Complete the "Expense" tab of the Street Medicine Budget Template ***(see end of this toolkit).***

1B. Also apply for Housing and Homelessness Incentive Program (HHIP) funding if still available through local MCPs ***(see next page).***

2. Determine other funding opportunities your program will pursue:



AND/OR **AND/OR** **AND**

2A – Enhanced Care Management (ECM) and/or **Community Supports (CS)** (e.g., Housing Navigation) contracts with local MCP(s).

If yes, apply for IPP funds (eligible for CHWs too) from local MCP(s). Can also apply for **PATH CITED** and **PATH Technical Assistance** (only eligible for CHWs if CHW is working on ECM/CS) from local MCP(s).

2B – Clinical services and **community health worker contracts** with local MCP(s).

2C – If you are an FQHC, FQHC Look-Alike, or Rural Health Center, available reimbursement via **Prospective Payment System (PPS)** and/or **330H federal grants**.

2D – Other available grant opportunities, including from hospitals (e.g., community benefit) and foundations.

STEP 1A. Complete the "Expenses Planner" Tab of the *Street Medicine Budget Template and Revenue Planner*.

This tool gives programs a sense of their expenses related to operating their programs, prior to any internal funding conversation or external conversations with Medi-Cal MCPs.

STEP 1B. Apply for HHIP funding.

HHIP is a time-limited funding source that street medicine programs can access. Providers can apply for funding through **their local MCPs**. Each MCP determines how HHIP funds can be used. While HHIP ended on October 31, 2023, MCPs may have remaining funding from the state to invest into local providers.

STEP 2. Determine other funding opportunities your program will pursue:

- **2A. ECM and/or CS Services** – This will be helpful if the organization wants to improve the financial sustainability of care management and/or housing navigation services, which can complement clinical care. The decision to establish ECM and CS services will be program-specific based on patient needs and program bandwidth.

  If yes, also apply for the **Incentive Payment Program**, **PATH CITED**, and access technical assistance resources through the **PATH Technical Assistance Marketplace**. These resources can support capacity building for street medicine providers that offer ECM and/or CS services. Note that the **Incentive Payment Program** is also available to support CHW development. **PATH CITED** and **PATH Technical Assistance** are only available if the CHW is supporting ECM or CS programs/services.
- **2B. Clinical Care and CHW Services Contracts** – Street medicine providers can contract with local MCPs to receive reimbursement for clinical services, and/or preventive services provided by a CHW. It is important to note that contracting between a health plan and a provider organization takes time and requires upfront development of administrative capacity building, especially for billing and documentation. There will also be variability in contracts across MCPs. It is important to note that contracted providers cannot bill for CHW services if a member is enrolled in ECM.
- **2C. PPS and/or 330H Grants** *(Federally qualified health centers (FQHCs), FQHC Look-Alikes, and Rural Health Centers only)* – DHCS stated in **APL 24-001** that FQHCs, FQHC Look-Alikes, and Rural Health Clinics can receive PPS reimbursement for street medicine visits outside of clinics. Guidance on PPS regulations for street medicine is forthcoming.
- **2D. Other available grant opportunities** – Grant funding is an important resource for street medicine programs, as other reimbursement may not cover all care costs. Providers should connect with local hospitals, MCPs, foundations, National Institutes of Health grants, and health systems with support through community benefit, foundations, and others.

Funding Streams to Support Street Medicine Programs: How to Use and Access Them

The below table outlines funding streams that street medicine programs in California can use to support their programs. It provides a more detailed overview of relevant funding streams outlined in the *Street Medicine Funding Comparison Chart*, including information on which provider organizations can access funds, allowable uses of funds, how to access funds, and reporting requirements.

Housing and Homelessness Incentive Program (HHIP)

Description	Incentive program to help MCPs improve services to members experiencing homelessness, and to reduce/ prevent homelessness. Street medicine is a priority initiative for Measure 2.1.
Eligible Providers	Providers awarded by MCPs.
Allowable Uses	• Any budget item(s) that increases the number of MCP beneficiaries seen by street medicine providers; and/or • Additional grant/investment categories per individual MCP guidelines. This can include, but is not limited to: - Personnel (e.g., hiring/salaries/fringe benefits of new team members) - Clinical costs (e.g., medications, clinical supplies) - Technology (e.g., computers, cell phones, software programs) - Vehicles (e.g., purchasing, maintenance, registration, gas/mileage)
How to Obtain	Apply through **local MCP(s)**. **Note:** HHIP funding is time limited and is diverse in allowable use of funds. The final measurement period ended 10/31/2023, but some MCPs will continue allocating funds after this time. Connect with local MCP(s) as a first/early step in funding plan.
Reporting	Varies by MCP. May include regular reporting on the number of MCP members/street medicine patients served, and/or by-name lists of MCP members served, as well as other factors.

Enhanced Care Management (ECM)

Description	Intensive, in-person care management for members with health and social needs, including people experiencing or at risk for homelessness.
Eligible Providers	Contracted providers.
Allowable Uses	Direct provision of ECM activities (coordination of services and comprehensive care management) to MCP-enrolled and ECM-eligible members. Read more about allowable use in the **CalAIM ECM Policy Guide**. **Note:** ECM activities provide coordination of care and will supplement the provision of direct medical services that street medicine clinicians deliver.
How to Obtain	Contracted service through local MCP(s).
Reporting	Contracted ECM providers need to provide regular reporting to MCPs via standardized reports and billing: • **Standardized reports** - The **CalAIM Data Guidance: Member-Level Information Sharing Between MCPs and ECM Providers** outlines four regular reports between MCPs and ECM providers: (1) MCP Member Information File; (2) ECM Provider Return Transmission File; (3) ECM Provider Initial Outreach Tracker File; and (4) Potential ECM Member Referral File. MCPs and ECM providers are required to use standardized formats but there may be slight variations in transmission methods and timing between MCPs. MCPs may not impose additional reporting requirements that exceed those “required” and “mandatory” elements listed in this guidance unless mutually agreed upon with the ECM provider, but may require submission of additional member-level documentation such as assessments or care plans. • **Billing** - ECM providers must bill for services according to **DHCS billing and invoicing guidance**. ECM providers either submit standard health care claims or standardized invoices, per their capabilities. Claims must use standard **HCPCS codes** (updated June 2024).

Community Supports (CS)

Description	Non-traditional services for Medi-Cal members to address social determinants of health; must be medically appropriate and cost-effective. MCPs can select which of the 14 CS services they want to offer their beneficiaries.
Eligible Providers	Contracted providers.
Allowable Uses	Direct provision of CS to MCP-enrolled and CS-eligible members. Housing Transition Navigation Services is a common service provided by street medicine teams via housing navigator staff. Read more in the **Medi-Cal Community Supports, or *In Lieu of Services*, Policy Guide**.
How to Obtain	Contracted service through local MCP(s).
Reporting	Similar to ECM providers, contracted CS providers will need to provide regular reporting to MCPs via standardized reports and billing: • **Standardized reports** – The **CalAIM Data Guidance: CS Member Information Sharing Guidance** outlines two reports between MCPs and CS providers: (1) MCP Community Supports Authorization Status File; and (2) CS Provider Return Transmission File. MCPs and providers are required to use standardized formats, but there may be slight variations in transmission methods and timing between MCPs. MCPs may not impose additional reporting requirements that exceed “required” and “mandatory” elements listed in this guidance unless agreed by the provider; but, may require submission of member-level documentation, such as assessments or individual housing support plans. • **Billing** – CS providers must bill according to **DHCS’ billing and invoicing guidance**. Providers will either submit standard healthcare claims or standardized invoices, per their capabilities. Claims must use standard **HCPCS codes** (updated June 2024).

PATH CITED

Description	Initiative that provides funding to support the transition, expansion and development of ECM and CS services capacity and infrastructure.
Eligible Providers	(1) Those contracted with MCPs to provide ECM/CS; or (2) those that have a signed attestation from an MCP or other entity that they intend to contract with to provide ECM/CS. Additional details on who is eligible for funding **are available**. **Note:** PATH CITED funds can be used for CHW support, if the CHW provides ECM or CS.
Allowable Uses	• **Increasing provider workforce** – Organizational needs assessments, hiring and training ECM/CS team members (e.g., ECM director, lead care managers, clinical consultants), among others. • **Infrastructure to support integration into CalAIM** – Health Information Exchanges, referral systems, capacity building for monitoring/data reporting, transitioning from Whole Person Care to ECM and CS. • **Infrastructure to support ECM and CS services** – Hardware, essential office equipment, medical equipment, refrigerators. • **Monitor ECM and CS services** – Staff time dedicated to evaluating/monitoring ECM and CS activities (e.g., conducting a community health needs assessment). • **Outreach to under-resourced or underserved for ECM and CS services** – Staff time for developing/implementing outreach plan, hiring contractors/vendors to assist in outreach plan. ** All PATH CITED funds must support ECM/CS activities.* *Read more about allowable uses for funds at the **PATH CITED** website.*
How to Obtain	**Apply** through Public Consulting Group, DHCS' TPA for PATH CITED. **Note:** There are multiple rounds of PATH CITED funding. Monitor funding rounds that may be forthcoming.
Reporting	Awardees are required to submit quarterly progress reports to the PATH CITED TPA via their online GrantsConnect Portal. Awardees will need to provide narrative and quantitative updates on both the milestones and budgets they submitted. It is recommended (but not required) to also submit supporting documentation, such as finance reports, payroll reports, invoices, quotes, and job descriptions. Report formats and requirements may vary over time. **Access a recent outline**.

PATH Technical Assistance (TA) Marketplace

Description	Program that provides funding for providers, community-based organizations, counties, and others to obtain technical assistance resources to establish the infrastructure needed to implement ECM and CS services.
Eligible Providers	(1) Those contracted with an MCP or other eligible entity to provide ECM/CS services; (2) those planning to contract with an MCP or other eligible entity to provide ECM/CS services or actively exploring that possibility with an MCP or other eligible entity; or (3) those approved by DHCS to receive technical assistance (limited). More details on eligibility for using the PATH TA Marketplace **are available**.
Allowable Uses	• **Building data collection, management, sharing, and use** – Support from vendors on how to best collect, manage, share, and analyze data for ECM/CS services. • **Strengthening services that address the social drivers of health** – Assistance in researching, designing, and implementing any of the 14 CS services. • **Engaging in CalAIM through Medi-Cal managed care** – Training and assistance with MCP relationships, contracting, program applications, compliance, and ECM/CS capacity building. • **Strengthening care for ECM population of focus** – Assistance in developing, implementing, strategizing outreach, workflows, comprehensive assessments, and care plans. • **Promoting health equity** – Guidance on best practices for outreach, engagement, data collection/analysis, cultural competency to increase the care of populations that are underserved and historically marginalized. • **Supporting cross-sector partnerships** – Legal and technical guidance for ECM/CS data sharing across agencies/sectors. • **Developing workforce** – Help with hiring, training, and supporting ECM/CS workforce, in particular frontline providers. • **Supporting cross-cutting competency for rural communities** – Assistance in addressing the unique challenges in providing ECM/CS services for rural populations. *Read more about allowable uses for funds at the **PATH TA Marketplace** website.*
How to Obtain	Apply through Public Consulting Group, DHCS' TPA for the PATH TA Marketplace.
Reporting	Technical assistance recipients are required to submit quarterly reports for any active or completed projects funded through the Marketplace. Recipients can direct questions about reporting to the TA Marketplace at **ta-marketplace@ca-path.com**.

Incentive Payment Program (IPP)

Description	Incentive program for MCPs to build capacity to deliver ECM, CS, and CHW services.
Eligible Providers	Contracted/ing ECM, CS, and/or CHW providers
Allowable Uses	Capacity building to support ECM/CS/CHW activities — complementary and non-duplicative with PATH funds.
How to Obtain	Apply through local MCP(s). **Note:** IPP funding will end June 30, 2024; however, some MCPs may continue to allocate unspent funds.
Reporting	Varies by MCP. May include regular reporting on the number of MCP members/street medicine patients served via ECM, CS, and/or CHW programs.

Clinical Service Contracts with MCPs

Description	Agreement between an MCP and a provider organization regarding financial compensation for medical services.
Eligible Providers	Contracted provider organizations in an MCPs network.
Allowable Uses	Primary care provider services, street medicine visits, and/or additional services (e.g., labs, transportation), depending on the MCP contract. Reimbursement models and fees are being negotiated between individual MCPs and providers across the state. *Read more about MCP clinical contracting in* ***APL 24-001***.
How to Obtain	**Contact local MCP(s)** to begin contract discussions.
Reporting	**Billing** - All MCPs will require submission of claims or encounters via standard reimbursement channels. MCPs may request additional information related to quality improvement (e.g., supplemental HEDIS data) or other performance metrics, as well.

CHW Service Contracts with MCPs

Description	Agreement between an MCP and a provider organization regarding financial compensation for services provided by CHWs.
Eligible Providers	Contracted provider organizations in an MCPs network.
Allowable Uses	• CHWs must have lived experience that aligns with the community or population being served. • Examples of preventive services that CHWs can provide include: - **Health education** activities to promote health or address barriers to physical and mental health care (e.g., providing information or guidance on health-related topics); - **Health navigation** providing information, training, referrals, or support to assist individuals in accessing health care, understanding the health care system, and connecting to community resources, among others; - **Screening and assessment** administration of non-licensed tools to connect to appropriate services to improve health; or - **Individual support or advocacy** to help prevent the onset or exacerbation of a health condition or to prevent injury/violence. **Note:** Providers cannot bill CHW services for members enrolled in ECM. *Read more about program coverage for CHWs in the* ***Medi-Cal Provider Manual for the Community Health Worker Benefit.***
How to Obtain	**Contact local MCP(s)** to begin contract discussions. Billing for CHW services is also available through Medi-Cal FFS for people enrolled in Medi-Cal FFS (i.e. not yet in an MCP).
Reporting	• **Service Documentation** – Providers must submit a written recommendation for CHW services from a licensed clinician for members served. CHWs are required to document dates and duration of services, with information on the services provided. • **Billing** – CHW providers must bill for services rendered using the codes outlined in the CHW provider manuals for **preventive services** and for **asthma preventive services**.

Funding Sources Only Accessible to FQHCs, FQHC Look-Alikes, and Rural Health Centers

330H Federal Grants

Description	Federal grant funding to FQHCs to provide high-quality care to people experiencing homelessness.
Eligible Providers	Public and private nonprofit FQHCs.
Allowable Uses	To develop or expand capacity to deliver medical services to uninsured and underinsured people experiencing homelessness.
How to Obtain	Applications **for new access points** can be completed through **HRSA**.
Reporting	In addition to all of the reports listed below under PPS, FQHCs that receive a 330H federal grant must keep records and disclose both receipt and expenditure of all funds. If the award is for $750,000 or more, the FQHC must have a single or program specific audit annually. See the **Compliance manual, chapter 15**, for more.

Prospective Payment System (PPS)

Description	Federally-mandated, cost-based reimbursement for services provided by FQHCs, FQHC Look-Alikes, and Rural Health Clinics.
Eligible Providers	Public and private nonprofit FQHCs, FQHC Look-Alikes, and Rural Health Clinics.
Allowable Uses	Reimbursement for all services provided during a single visit, which may include preventive and primary health care services. May also include other outpatient services or non-medical services included in the organization's approved PPS rate scope of service for the relevant site associated with the street medicine team. *Read more about PPS in the brief **How Health Centers are Paid**. The **California Primary Care Association** is currently addressing street medicine questions for PPS billing providers. Questions should be directed to **Training@cpca.org**.*
How to Obtain	For existing FQHCs, FQHC Look-Alikes, and Rural Health Clinics, applications can be completed through **DHCS**.
Reporting	All eligible providers must complete annual federal and state reporting on spending and utilization. Key requirements are listed below; however, technical assistance is recommended. **Federal reporting requirements:** • FQHCs and FQHC Look-Alikes must report operational and performance measures annually via the **Uniform Data System**. • FQHC Look-Alikes must complete **annual certification**. • All eligible providers must complete a **needs assessment** at least once every 3 years. • Medicare FQHCs must complete cost report form **224-14** and Rural Health Clinics must complete cost report form **222-17**. **State reporting requirements:** • All eligible providers must submit the **DHCS 3097** annual reconciliation for DHCS to confirm that providers are paid an amount equivalent to the PPS rate. • Eligible providers must complete cost and rate setting forms for DHCS when rates or scope of services change. **Access all forms**.

Aligning Street Medicine Funding Sources

The below diagram offers visual guidance for street medicine teams on how they can think about using funding opportunities outlined in this toolkit to support program startup and capacity building costs, as well as ongoing operations for their programs.

	STARTUP & CAPACITY BUILDING	ONGOING OPERATIONS
GENERAL USE	• **Housing and Homelessness Incentive Program (HHIP)* offers flexible funding that can be used for infrastructure, startup, capacity building, and/or ongoing operations, depending on each MCPs' guidelines**	
CARE MANAGEMENT AND HOUSING NAVIGATION	• **Incentive Payment Program (IPP)**	• **Enhanced Care Management (ECM) contracts with managed care plan(s) (MCP)** • **Community Support (CS) contracts with MCP(s)** • **Community health worker (CHW) contracts with MCP(s) and fee-for-service (FFS)**
	• **PATH CITED** • **PATH Technical Assistance**	• **ECM contracts with MCP(s)** • **CS contracts with MCP(s)** • **CHW contracts *only* if CHW is supporting ECM/CS programs/services**
CLINICAL CARE		• **Provider contracts with MCP(s)** • **Prospective Payment System (PPS) rate and/or Section 330H federal grants** *(for FQHCs, FQHC Look-Alikes, and Rural Health Clinics)*

Codes for Billing for Street Outreach and Medicine

CMS added Place of Service (POS) code 27 for street medicine (“outreach site/street”) in October 2023. This is the first code that is specific to street medicine services delivered to people experiencing unsheltered homelessness in their lived environment. The code allows payers and government entities to better track care delivered on the street and further establishes the important role of street medicine in the continuum of health care delivery. Additional codes, such as POS codes 04, 15, and 16, allow providers to bill for services provided to people experiencing homelessness in settings outside of a traditional health care clinic, including at homeless shelters, mobile clinics, and temporary lodging (e.g., hotels).

Providers need to assess when it is appropriate to use POS code 27 versus other codes to bill for the services they provide. FQHC and FQHC Look-Alike providers should ensure that they use the POS code associated with their PPS billing site if claiming their PPS rate.

Code	Name	Description
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short-term accommodation such as a hotel, campground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.
27	Outreach Site/ Street	A non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered homeless individuals.

Table source: Centers for Medicare & Medicaid Services. “**Place of Service Code Set**.” May 2024.

Street Medicine Program Staffing and Revenue Models

In California and across the country, street medicine providers have built teams that meet needs and fit the context of their patient population. This means that street medicine teams look different. They can have different staffing models, service offerings, and affiliations with varying types of supporting institutions (e.g., hospital systems, FQHCs, medical institutions). As such, street medicine teams have different expenses and have access to different sources of revenue to support their programs.

This section outlines staffing and revenue models for street medicine teams based on program model and offers considerations for each model type. It also provides teams with access to a **budget and revenue planner tool**. The models are informed by the authors' experiences working in street medicine, as well as conversations with street medicine programs with similar care models.

Multidisciplinary

Description	Includes a mix of clinical treatment and support services staff.
Example Staffing Model	• 1 full-time equivalent (FTE)medical doctor (MD)/doctor of osteopathic medicine (DO) • 0.6 FTE nurse practitioner (NP) • 1 FTE registered nurse (RN) • 1 FTE CHW • 0.5 FTE housing navigator • 1 FTE administrative staff See "Multidisciplinary Team" tab of the **Street Medicine Budget Template and Revenue Planner** for an example.
Revenue Model	• Mix of clinical reimbursement, CalAIM services (ECM, CS), and CHW contracts from local Medi-Cal MCPs • CalAIM startup funds, contracts with city/county/hospitals/Continuums of Care, and grants to fill funding gaps • Example: 18% of reimbursement from clinical services vs. 23% from CalAIM (see "Revenue Example – Multidisciplinary Team Model" in the **Street Medicine Budget Template and Revenue Planner** for an example).
Considerations	• Requires significant administrative effort to manage program regulations, reporting, and billing, potentially with multiple MCPs • Most MCP billing is retrospective, so a team needs startup funding and sufficient cash reserves to cover initial and ongoing expenses • Able to cross-subsidize across services (e.g., if ECM revenue is higher than service delivery cost and CHW revenue is lower) • Can offer services to patients without referring externally, enabling more control over patient care and services • Need a care management documentation system for ECM and Housing Navigation, as well as an electronic health record (EHR) • More mature model, which requires time to build program infrastructure • Dependent on ability to recruit and retain each workforce position

Enhanced Care Management-Focused

Description	Includes high FTEs for care management staff and low FTEs for clinical treatment staff.
Example Staffing Model	• 0.1 FTE MD/DO • 0.5 FTE NP • 2 FTE care manager • 1 FTE CHW (with ECM caseload) • 0.5 FTE administrative staff See "ECM-focused" tab of the **Street Medicine Budget Template and Revenue Planner** for an example.
Revenue Model	• Largest expected revenue source is ECM reimbursement from local MCPs • Use ECM reimbursement to cross-subsidize clinical treatment provider time • CalAIM startup funds, contracts with city/county/hospitals/Continuums of Care, and grants to fill revenue gaps; high potential for IPP and PATH due to ECM focus (especially startup/expansion) • Example: 4% of reimbursement from clinical services vs. 49% from CalAIM (see "Revenue Example – ECM-focused" of the **Street Medicine Budget Template and Revenue Planner** for an example).
Considerations	• Revenue from ECM needs to be high enough to subsidize the costs of care provided by clinical treatment staff • Helpful to have ECM contracts with all local MCPs so that the team can be reimbursed for services regardless of the patient's MCP • Need to ensure ECM case load expectations are realistic for homeless population; if actual Case Manager-ECM-enrolled member ratio is lower than the ratio assumed in the MCP's rates, then revenue may not be sufficient. For example, some MCPs assume a 1:60 ECM ratio, which would be too high for this population. • Requires administrative support for ECM billing • Most MCP billing is retrospective, so a team needs startup funding and sufficient cash reserves to cover initial and ongoing expenses • More referral-based approach; need for strong local partnerships with physical and mental health providers, hospitals, and other clinical partners • May need to limit acuity for clinical treatment patients due to limited clinical treatment provider time • May have higher transportation costs for patient accompaniment as part of ECM • Need a care management documentation system as well as an EHR • Need strong communication between care management staff and patient's Primary Care and other treatment providers • Teams can consider adding Housing Navigation Transition Services (CS) as a complementary service with an additional revenue stream

Nurse-Led

Description	Includes a RN/BSN/MSN as the lead clinical provider for the care team.
Example Staffing Model	• 1 FTE RN • 1 FTE CHW • Ideally, will also have additional prescribing support provided by a clinician via consultation and/or telehealth
Revenue Model	• Primarily grant funded • Little to no clinical reimbursement expected from MCPs (few RN codes are billable) • Can potentially add ECM contracts if nurse and/or other staff time allows for ongoing care management activities
Considerations	• Lower cost model that is a common startup option for new teams, especially ones connected to a home organization with other clinical and programmatic resources, (e.g., hospital, FQHC) and/or for rural areas • For FQHCs/FQHC Look-Alikes, RN visits are not billable under PPS • Teams without a prescriber (e.g., MD, DO, NP) do not meet the DHCS definition of street medicine in APL 24-001 • Telehealth can offer some prescribing provider access (and may also be a billable service) • To add ECM billing, see above for “ECM-focused” model

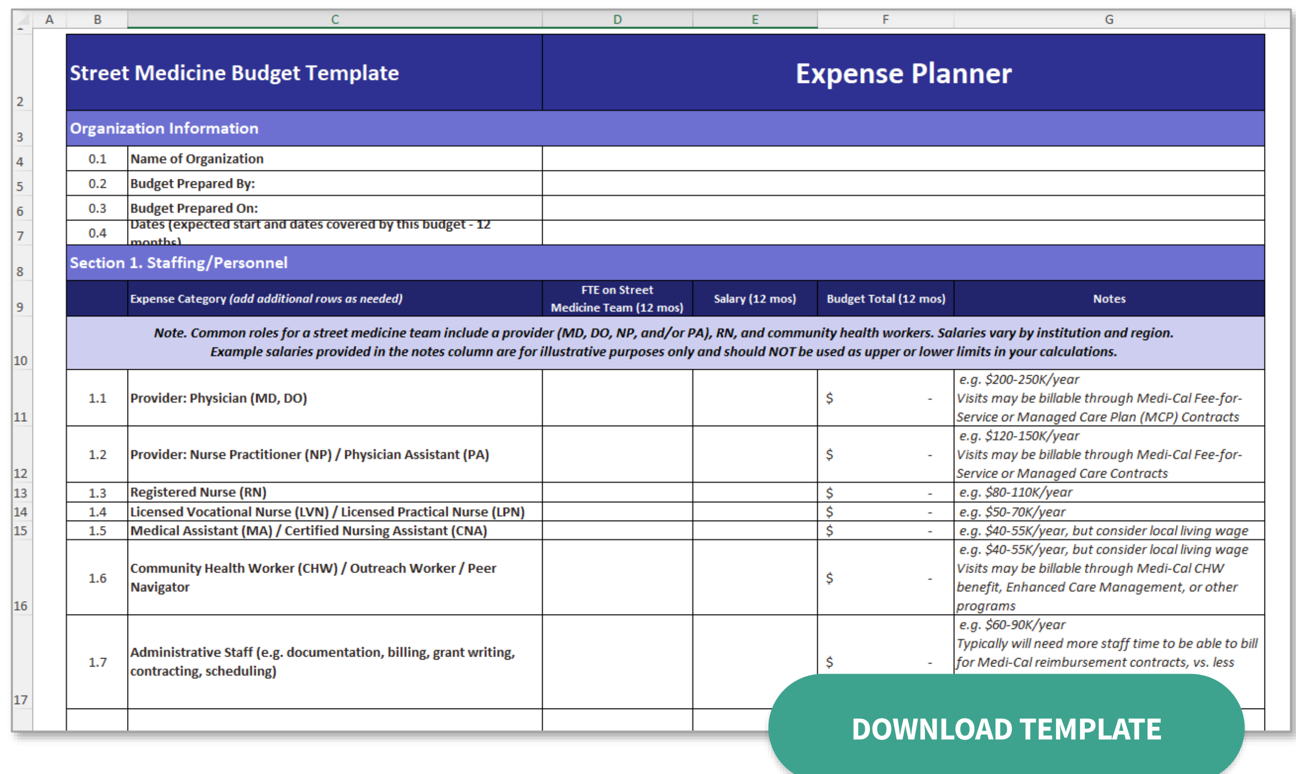
Resident-Staffed

Description	A regular or rotating team of medical residents who usually deliver street medicine as part of a larger care team.
Example Staffing Model	• Variable resident FTEs (paid and/or volunteer) • Variable attending physician FTEs (paid and/or volunteer) • For-hired staff supporting the team, roles like RN, CHW, and program administrator are common, but vary significantly
Revenue Model	• Can do clinical billing through a sponsoring organization (e.g., hospital, sometimes also an FQHC/FQHC Look-Alike) • Graduate Medical Education (GME) dollars may be available for residency training support • Primarily funded by grants and/or by the Graduate Medical institution
Considerations	• Paid MD/DO residents have much lower staffing costs; residency program may cover cost or pass it to the street medicine program • Need for attending physician supervision for residents to deliver clinical services • Continuity of care can be difficult due to residents’ rotations and the time limited nature of residency • Residents can bill for clinical services • Opportunities for learning among new providers and field-building opportunities for street medicine • Family and emergency medicine residency programs are common sources for staffing, but many other specialties can benefit from/add value to teams • For family medicine residencies, participating in street medicine programs may help residents build a consistent patient caseload (which is a requirement for that specialty), and may help with continuity of care for homeless patients at a brick-and-mortar clinic

Street Medicine Budget Template and Revenue Planner

This Microsoft Excel-based budget and revenue planner tool was created to help street medicine teams estimate their anticipated expenses and revenue using available information. It provides categories that are applicable to many street medicine teams, but providers can customize as needed. It also provides expense and revenue examples for two common staffing models for street medicine teams — multidisciplinary teams and teams that focus on ECM with fewer clinical services for the patients they serve.

There are six tabs in the tool: **Expenses Planner**, **Expenses Example – Multidisciplinary**, **Expenses Example – Enhanced Care Management (ECM)-Focused**, **Revenue Planner**, **Revenue Example – Multidisciplinary,** and **Revenue Example – ECM-Focused**.
All tabs are based on a single year budget. To download the tool, visit chcs.org/media/Street-Medicine-Toolkit-Budget-Template.xlsx.



Street Medicine Budget Template		Expense Planner			
Organization Information					
0.1	Name of Organization				
0.2	Budget Prepared By:				
0.3	Budget Prepared On:				
0.4	Dates (expected start and dates covered by this budget - 12 months)				
Section 1. Staffing/Personnel					
	Expense Category *(add additional rows as needed)*	FTE on Street Medicine Team (12 mos)	Salary (12 mos)	Budget Total (12 mos)	Notes
Note. Common roles for a street medicine team include a provider (MD, DO, NP, and/or PA), RN, and community health workers. Salaries vary by institution and region. Example salaries provided in the notes column are for illustrative purposes only and should NOT be used as upper or lower limits in your calculations.					
1.1	Provider: Physician (MD, DO)			$ -	*e.g. $200-250K/year Visits may be billable through Medi-Cal Fee-for-Service or Managed Care Plan (MCP) Contracts*
1.2	Provider: Nurse Practitioner (NP) / Physician Assistant (PA)			$ -	*e.g. $120-150K/year Visits may be billable through Medi-Cal Fee-for-Service or Managed Care Contracts*
1.3	Registered Nurse (RN)			$ -	*e.g. $80-110K/year*
1.4	Licensed Vocational Nurse (LVN) / Licensed Practical Nurse (LPN)			$ -	*e.g. $50-70K/year*
1.5	Medical Assistant (MA) / Certified Nursing Assistant (CNA)			$ -	*e.g. $40-55K/year, but consider local living wage*
1.6	Community Health Worker (CHW) / Outreach Worker / Peer Navigator			$ -	*e.g. $40-55K/year, but consider local living wage Visits may be billable through Medi-Cal CHW benefit, Enhanced Care Management, or other programs*
1.7	Administrative Staff (e.g. documentation, billing, grant writing, contracting, scheduling)			$ -	*e.g. $60-90K/year Typically will need more staff time to be able to bill for Medi-Cal reimbursement contracts, vs. less*

DOWNLOAD TEMPLATE

Glossary of Key Terms

TERM	ACRONYM	DEFINITION
All Plan Letter	APL	DHCS uses APLs to provide guidance to MCPs. The 2022 and updated 2024 APLs from DHCS provide guidance to MCPs on the street medicine provider workforce and the use of street medicine to address the unmet needs of unsheltered homeless Medi-Cal members.
California Advancing and Innovating Medi-Cal	CalAIM	Coordinated series of programs and initiatives designed to overhaul and improve the delivery of Medi-Cal services to members, with a focus on people with complex health and social needs.
Capacity and Infrastructure Transition Expansion and Development	PATH-CITED	Funding to support on-the-ground partners to transition, expand, and develop ECM and CS programs.
Collaborative Planning and Implementation Program	PATH-CPI	Funding to a facilitator to support organized planning meetings between stakeholder groups to establish ECM and CS programs in each California county.
Community Health Worker	CHW	Member of a care team who has lived experience and knowledge of the community that is being served and assists in the navigation of services for patients.
Community Supports	CS	A la carte menu of 14 services (also known as *In Lieu of Services*) that MCPs can offer to their Medi-Cal beneficiaries to assist with important health-related social needs (e.g., nutrition, housing, among others), implemented as part of CalAIM.
Department of Health Care Services	DHCS	State government agency that finances and manages health service delivery in California, including Medi-Cal, the state's Medicaid program.
Electronic Health Record	EHR	Technology-based system used to maintain patients' medical notes, rather than a paper-based system.
Federally Qualified Health Center	FQHC	Federally funded health centers that serve Medi-Cal, Medicare, and uninsured patients. Sometimes referred to as Community Health Centers.
Fee-for-Service	FFS	Payments to providers for each service provided to a patient, regardless of the quality or outcome of the service provided.
Housing and Homelessness Incentive Program	HHIP	Incentives paid to MCPs to address homelessness and housing insecurity for their beneficiaries. Street medicine is a designated initiative for each MCP to include in their plan.
Incentive Payment Program	IPP	Incentives paid to MCPs to establish their ECM, CS, and CHW programs.
Managed Care Plan	MCP	A Medi-Cal health plan that organizes, manages, and is the payer for the provision of health services to the plan's members (e.g., Anthem Blue Cross, Kaiser Permanente, Health Net, Partnership Health Plan).
Prospective Payment System	PPS	Payments to FQHCs and FQHC Look-Alike providers based on a predetermined, fixed amount per patient.
Providing Access and Transforming Health	PATH	Funding to support on-the-ground providers in establishing ECM and CS programs.
Public Consulting Group	PCG	The Third-Party Administrator for PATH, including PATH-CITED, PATH-TA, and PATH-CPI.
Technical Assistance Marketplace	TA Marketplace	Funding for vendors to offer support services to current and prospective ECM and CS providers and/or intermediary organizations to build their infrastructure. TA is free to those who access it.
Third Party Administrator	TPA	Organization contracted to assist in the delivery of programming. PCG is the TPA for PATH.