For policy development only
October 22, 2024

Medicaid for Violence Prevention Services

Background

Frontline violence intervention workers, also known as Violence Prevention Professionals (VPPs), are public health professionals who play a crucial role in addressing the ongoing violence epidemic. VPPs, many of whom are highly trained, offer trauma-informed care to survivors of violence through various means, such as Hospital-based Violence Intervention Programs (HVIPs), street outreach, violence interruption, and other community violence intervention services. VPPs utilize evidence-informed strategies to improve health outcomes and trauma recovery, reduce repeat visits to emergency departments with subsequent injuries, disrupt cycles of community violence and improve access to culturally relevant and trauma-informed services.

Violence prevention services effectively and demonstrably (a) improve the quality of care by connecting hard-to-reach patients to physical and behavioral health services, (b) increase health equity because firearm injuries are concentrated in poor communities of color and violence prevention addresses social drivers of health like poverty and trauma, and (c) reduce health care costs, most noticeably by preventing hospitalizations for firearm injuries.

A violence preventive services benefit allows violence prevention professionals to receive financial reimbursement through Medicaid to provide services to existing Medicaid patients who have been personally injured, chronically exposed to violence, or those at significant risk of violent injury as determined by licensed health care provider.

Current Status

As of 2024, California, Illinois, Connecticut, Oregon, Maryland, New York, and Colorado have passed laws to authorize Medicaid funding for violence intervention services. The following chart provides the current implementation status, as well as the success and challenges the respective States have experienced. For more details including training, reimbursement rates, patient eligibility, and provider resources, visit HAVI CVI Smart Hub for a comprehensive tracker:

State	Successes	Challenges	Current Status
California (2022)	-California set up a CBO hub for enrollment as a Medicaid provider.	-California's county-based MCO system has been a challenge for many CBOs who have no experience or prior connection to the MCOs. -Reimbursement rates are low.	- One program has enrolled and established software for Medicaid billing. Several programs are looking to take advantage of this benefit. They are assessing their ability to bill and collaborating with their local health departments and offices of violence prevention for assistance with their billing capabilities. -The health department in Monterrey County is beginning to develop its billing capacity.

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State	Successes	Challenges	Current Status
Connecticut (2021)	-The state had a strong stakeholder engagement process at the launch.	-Reimbursement rates are below the cost of doing business, so the only program that has enrolled has not yet started billing. -Out of concern for the benefit spending too much, the state mandated that programs were only eligible to bill if they had an affiliation with a hospital, which has cut off some community-based organizations.	-No programs are currently billing for services due to low rates. Local groups plan to advocate for higher rates and changes to the rules to include non-HVIP programs in the next legislative cycle. -This was the first state in the country to release a benefit. To date, there is only one program enrolled as a Medicaid provider and they have not submitted a claim yet.
Illinois (2021)		-The mental health requirements come with significant barriers, such as the completion of very complex, lengthy psychological intake assessment that was not created for this purpose. -Illinois did not consider how to handle background checks of frontline violence prevention professionals prior to releasing its regulations. Given that most program recruit individuals who have lived experience surviving gun violence, this oversight created challenges for many providers.	-There are programs currently enrolled in billing and receiving reimbursement for their services. Even though groups have raised the issue of the mental health requirement with the health department, no actions have been taken to make changes to the benefit to include HVIP programs. -Illinois' regulatory framework is different from all other states. It is a team-based model based out of community mental health centers, rather than an individual provider. While the rates are higher than other states, it is difficult to compare.

State	Successes	Challenges	Current Status
New York (2024)		-They lacked a stakeholder engagement process in their benefit design. As a result, they created an exceedingly low benefit restriction (four hours of care per patient) that only allows practitioners to be reimbursed for a small portion of care delivered.	-The New York City Department of Health and Mental Hygiene is working with programs in their crisis responder system to enroll in this benefit. However, no program has completed enrollment yet. There seems to be a lack of communication between the state health department, which designed the benefit, and the local city department that works closely with the programs. -No program has submitted billing for services.
Oregon (2023)	-They held robust stakeholder engagement processes during the benefit design process. -They included a technical assistance fund to help programs prepare to bill and offset start-up costs (such as documentation systems). -Reimbursement rates are better compared to other states.		- Portland Opportunities Industrialization Center (POIC) has been registered and is preparing to invoice soon. The implementation process has been progressing well. -Going Well, the primary violence prevention program in Oregon, is currently enrolling in the system for billing.

Considerations

To date, states have not received substantial reimbursement from Medicaid. There are two primary considerations for effective development and implementation of the Medicaid benefit for violence prevention services.

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1. Stakeholder engagement

A lesson learned from working with other states, is that implementing this benefit requires proper planning and thoughtful consideration to ensure successful execution. Due to the technical nature and unique requirements of this work, state administrators cannot do it alone and must engage stakeholders throughout the process. It is essential to invest the time to develop the benefit through a structured stakeholder engagement group.

For example, in Pennsylvania, HAVI is facilitating a stakeholder engagement series, with each meeting lasting approximately 90 minutes. This structured process ensures alignment and clarity around key elements needed to create and implement the benefit. Session topics include identifying appropriate training and certification entities for violence prevention professionals, identifying billable services, developing a reimbursement structure, and identifying or creating provider billing codes. This intentional approach supports informed decision-making and fosters collaboration.

2. Reimbursement rates

Low reimbursement rates hinder the sustainability and effectiveness of services. They also fail to reflect the complexity and time-intensive nature of CVI work, which can ultimately undermine program outcomes and reduce the positive impact on community health and safety. When reimbursement is insufficient, programs struggle to cover essential costs, such as staff salaries, training, and the implementation of comprehensive interventions that address the root causes of violence. Unlike most other medical services, the beneficiary population is almost exclusively insured by Medicaid, with minimal coverage by private insurers or Medicare. In practice, this precludes programs from balancing their budgets with higher reimbursement from commercial insurers.