California Children's Trust

GIFFORDS CENTER FOR VIOLENCE INTERVENTION

Getting Paid for Treatment to Prevent Homicides

A Practical Guide and Call to Action for Providers to Leverage the New Medi-Cal Benefit for Violence Prevention

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Introduction

Violence is a critical public health issue that profoundly impacts individuals, communities, and society at large. Yet until recently, programs in California working to prevent violence in our communities had no clear path for funding through the health system. **In 2022, the State of California created a benefit to allow "Violence Prevention Professionals" to bill Medi-Cal for the life-saving services they offer.** The goal of this resource guide is to help community-based violence prevention programs, and the advocates working in community with them, to better leverage Medi-Cal as an essential and sustainable funding source to address the public health issue of violence in our communities.

What is a Violence Prevention Professional (VPP)?

- **National Uniform Claims Committee Definition**
  VPPs address specific patient needs "to reduce the risk of relapse, injury, or re-injury of the patient." They "work in a variety of settings and provide appropriate case management, mediation, referral, and mentorship services." They are trained specifically for the population with whom they work.

- **State of California Definition**
  VPPs provide "evidence-based, trauma-informed, and culturally responsive preventive services for the purpose of reducing the incidence of violent injury or reinjury, trauma, and related harms and promoting trauma recovery, stabilization, and improved health outcomes." They are trained by Health Alliance for Violence Intervention (HAVI) or Urban Peace Institute (UPI).

Full list of terms used in this Resource Guide.

Background

In 1985, U.S. Surgeon General C. Everett Koop declared violence a public health issue. And yet in the nearly four decades since, little progress has been made toward embedding violence prevention services into our nation's health system. In 2015, the National Uniform Claims Committee added Violence Prevention Professionals (see the callout box, page 3), or VPPs, to the health care provider taxonomy, and for the first time it became realistic that health insurers could cover these lifesaving services.

U.S. Surgeon General C. Everett Koop

In May 2021, President Biden went as far as to have the Centers for Medicare and Medicaid Services instruct states on including violence prevention in their covered services. Medicaid is important to violence prevention because two out of three gunshot victims are on Medicaid or are uninsured. California data indicates that from 2016 to 2021 Medi-Cal was the expected insurer for 73% of patients hospitalized for nonfatal firearm assaults.

What do violence prevention services look like?

There are several examples of evidence-based violence prevention program models, including:

Hospital-based violence intervention programs, or HVIPs, pioneered by Youth ALIVE! in Oakland, bring trained community members (VPPs) into the hospital to build relationships with recent survivors of violence. These relationships continue once the survivor is back home in the community in order to address retaliation risks and to support recovery from physical and mental trauma. Studies show that HVIPs save lives and money, in particular by reducing patients returning to the hospital with new gunshot wounds.

Street outreach and violence interruption programs deploy trained "credible messengers" (VPPs), who have the respect of the communities they work in, to reach out to people involved in violence to offer them support for a different life path. They also identify and mediate potentially lethal conflicts.

In July 2022, the California State Department of Health Care Services (DHCS) added Violence Prevention Services under the new Community Health Worker (CHW) benefit (see the State Plan Amendment and provider manual), qualifying VPP services to be paid for through Medi-Cal. DHCS sent out a revised All Plan Letter in September 2022 informing all local county managed care plans (MCPs) about what these services are and how they should be implemented. DHCS created the VPP benefit simultaneously with the introduction of AB 1929 (Gabriel), which later passed, codifying elements of the VPP benefit. DHCS is still rolling out the new benefit and has put the onus on the individual county health plans to contract with violence prevention service providers.

Currently, most violence prevention services in California are provided by community-based nonprofit organizations that do not have any experience billing Medi-Cal. This new benefit will be the first time many of the programs providing these critical services are attempting to claim funds through Medi-Cal. This guide is intended largely for that audience of nonprofit programs, to help them understand the opportunities and challenges of billing Medi-Cal.

To prepare this information, in addition to written sources, over two dozen leaders were interviewed—in California and beyond— who work in violence prevention and similar Medicaid-funded fields.

How do Community Health Workers differ from Violence Prevention Professionals?

Both CHWs and VPPs emphasize lived experience and an ability to connect culturally with the people they serve, but they differ. For example, VPPs frequently have histories of incarceration, gang affiliation, and gun violence survivorship.

VPPs specialize in addressing community violence – violence not experienced between family members or intimate partners. CHWs may specialize in any number of areas, including intimate partner violence (IPV), substance abuse, infectious disease, chronic health issues, reproductive health or aging.

In practice, there has been overlap between CHWs and VPPs. For example, Healing Hurt People in Philadelphia, a hospital-based violence intervention program, had their VPPs complete CHW training and Peer Specialist training, then bill Medicaid as Peer Specialists.

What is the New Medi-Cal Benefit for Violence Prevention?

The state is now requiring local health plans (also called Managed Care Plans or MCPs or Managed Care Organizations or MCOs)—the companies providing Medi-Cal health insurance to people—to offer their members access to "health navigation," "health education," "screening and assessment," and "individual support or advocacy" to prevent violent injury or reinjury and promote recovery from trauma. This means many of the direct services already being provided by violence prevention programs—including hospital-based violence intervention, violence-focused street outreach, and violence interruption—can now be covered by MCPs and MCOs. However, these services must be provided by a certified VPP, and can be offered only to Medi-Cal covered patients recommended by a "licensed provider" who meet certain criteria (detailed below) which are broadly inclusive of communities impacted by violence.

A "licensed provider" is a medical clinician with a license, such as a doctor, nurse, or licensed therapist.

In order to bill Medi-Cal, Violence Prevention Professionals must work for a "Supervising Provider" such as a hospital, clinic, local health jurisdiction, or community-based organization (CBO).

While the referral or "recommendation" for services must be approved by a licensed provider, that provider does not need to be employed by the entity. In other words, **you do not need to have a physician or licensed social worker on staff** in order to be able to bill Medi-Cal for violence prevention services.

After 12 "sessions" or six hours of Medi-Cal covered violence prevention services, programs will need to submit a "care plan" for their client in order to continue billing Medi-Cal. The written care plan is developed with, or by, a licensed provider and describes the services to be provided to address client needs. This licensed provider does not need to be the same one who signed off on recommending services, and does not need to be employed by the organization providing the services.

Who can receive Medi-Cal covered violence prevention services?

Recipients must be insured by Medi-Cal, have a licensed provider approve the recommended services, and must be:

- ✔ recently violently injured,
- ✔ at high risk for involvement in violence, or
- ✔ chronically exposed to community violence

Medi-Cal Rates for Violence Prevention Providers

Is the juice worth the squeeze?

The initial rate posted by the State is $26.66 per 30 minutes for direct (face-to-face, telephone, or video call) contact with a client. These are minimum rates that the MCPs can offer service providers. There are already confirmed occurrences of CHW providers negotiating higher rates with their MCPs.

These initial (minimum) rates are insufficient to cover the costs of VPPs or CHWs, although they can provide supplementary income. Frequently, Medicaid reimbursement rates for health services are set with the expectation of 75% productivity. In other words, the notion is that a doctor or other medical provider in a standard hospital or clinic setting is able to spend six out of every eight hours directly treating patients, with the rest of their time spent on activities like documentation, training, and staff meetings. Of course, this definition and expected level of "productivity" is unrealistic for many health workers, including VPPs who spend a great deal of time doing their own outreach to engage clients, setting up their own client appointments, spending time traveling to and from client appointments in the community, attempting to meet with traumatized and hard-to-reach clients who are often late or no-shows, and having "collateral contacts" – speaking with people who are not their client (family members, service providers, employers, landlords, school staff, etc.). For this reason, VPP caseloads tend to be small (15-20) and "productivity" levels (time spent directly with clients) are closer to 25%, with an average of 40 clients served per VPP per year. Based on the percentage of gunshot wound patients on Medi-Cal, it is reasonable to assume only 73% of clients served would even be eligible for this benefit.

STATES THAT COVER VIOLENCE PREVENTION THROUGH MEDICAID

STATE	DATE IN WENT INTO EFFECT	HOURLY RATE
California	7/1/2022	$53.32
Connecticut	7/1/2022	$50.60
Illinois*	5/1/2022	$152.00 (off site) $139.36 (on site)
Maryland	7/1/2023	$65.52
Oregon	1/1/2023	$99.12

*Services by a "Violence Prevention Community Support Team"

Medi-Cal Rates for Violence Prevention Providers *(continued)*

Estimated income must be considered in relationship to overall program cost. A 2015 article cited the average cost of HVIP services provided by VPPs in 2013 as $3,889 per client, or $155,560 per worker. Adjusting for inflation, this is $203,566 in today's dollars. This number is likely a high estimate, because there are often other professionals besides VPPs involved in a client's services, such as therapists or job and housing specialists, who add to the cost of services. But as a reminder, licensed providers are required to be involved in the provision of services under Medi-Cal, which will increase program costs. Leaders who were interviewed believed the cost was closer to $150,000 per VPP for HVIPs. This number could be even lower for VPPs in street outreach programs, where in 2021 most workers made between $30,000 and $50,000. However, even if these low wages persisted and could be considered appropriate for such valuable and highly skilled workers—thereby keeping the overall program costs low—there is reason to believe that the Medi-Cal "productivity" rates for street outreach workers and violence interrupters will be lower than for HVIPs. This is the case given that outreach workers and violence interrupters spend a larger percentage of their time on reaching and engaging clients rather than holding a steady caseload.

Under these minimum rates, the new benefit covers only a portion of the cost of providing services, with lower end estimates of 10% of expenses being reimbursed, and even the pie-in-the-sky highest estimate at only fifty-eight percent (see chart below). Research seems to indicate that 10% to 20% is most likely. The more pressing question is not whether the benefit covers program costs—it clearly does not—but whether it even covers the administrative costs of billing Medi-Cal. In layman's terms, is the juice worth the squeeze?

Based on discussions with individuals who work in violence prevention programs in other states that bill Medicaid, supporting a billing department is feasible if a program employs at least six VPPs. Starting a billing department can be expensive. The Community Health Worker & Promotor Workforce Capacity Building Collaborative, launched by Health Leads and the California Health Care Foundation (CHCF), has been providing resources to help make community health workers financially sustainable. In a webinar hosted by CHCF with The Jaded Medical Biller, it was shared that on top of needing to have finance and documentation infrastructure, a program will need medical coding and billing staff, whose average salary in California is $49,914, as well as medical billing software that can cost another $7,200 per year. When fringe rates and administrative costs are added, it may easily cost $100,000 a year to start a billing department. Outsourcing medical billing (at a price of 5% to 15% of collections) may be more financially feasible, but even so, programs will need to cover the costs of HIPAA-compliant record keeping, time spent confirming client Medi-Cal eligibility, costs of VPP certification training, and the participation of a licensed provider in the care team.

PORTION OF COSTS COVERED BY MEDI-CAL VIOLENCE PREVENTION BENEFIT AT $53.32/HOUR					
		Productivity rate estimates	25%	50%	75%
		Proportion of clients on Medi-Cal	73%	73%	73%
		Expected income	$19,462	$38,924	$58,385
Annual VPP Cost	Lower estimate	$100,000	**19%**	**39%**	**58%**
	Medium estimate	$150,000	**13%**	**26%**	**39%**
	Higher estimate	$203,566	**10%**	**19%**	**29%**

How to Claim Medi-Cal to Cover the Work of Violence Prevention Professionals

Organizations that want to bill Medi-Cal need to complete the five steps below, not necessarily in this order. We refer to organizations, not individuals, because Violence Prevention Professionals cannot bill for their own work individually. VPPs must bill through a "Supervising Provider" that is a licensed provider, a hospital, an outpatient clinic, a local health jurisdiction (LHJ), or a community-based organization (CBO).

5 Steps to Getting Paid by Medi-Cal

1. The organization is eligible and ready
2. The workers providing violence prevention services are eligible
3. Contract with a Managed Care Plan to provide services
4. The client is eligible
5. The services provided are eligible

Step 1: Ensure your organization is eligible to bill Medi-Cal.

In order to be eligible, your organization must be enrolled with Medi-Cal. You can enroll as a provider via the State's website. However, the State has not yet set up a process for CBOs or local health jurisdictions to enroll. The State plans to roll out that enrollment process by the end of 2023. Because there is no process for a CBO to enroll, the State is leaving it up to each local MCP to determine whether a CBO is an appropriate Medi-Cal services provider. In practice, MCPs have been contracting with CBOs for a number of years for a variety of services, so the lack of an enrollment process is not a barrier. In fact, the existence of an enrollment process may end up being a barrier, because the State can take a number of months to approve an application.

In order to bill for violence prevention services, you are not required to have an NPI (National Provider Identifier) number. However, NPI numbers are provided by the federal government through the Centers for Medicare and Medicaid Services (CMS) through a fairly straightforward process that does not require you to be a Medi-Cal provider, so it is a best practice to go ahead and apply for an NPI number through their website or paper application. (Tip: The "taxonomy code" for Violence Prevention Professionals is 405300000X. For general "Community/Behavioral Health" it is 251S00000X.)

How to Claim Medi-Cal for VPPs *(continued)*

There are other important considerations for an organization to examine before determining if they will bill Medi-Cal for violence prevention services. One is having the capacity to document services using case management software, electronic health records, or another database that includes all the items needed for billing, such as date and duration of contact, whether contacts are face-to-face or telehealth, whether contacts are directly with clients, and the type of services provided. This database must meet the security requirements of HIPAA, the federal law that protects the privacy of people's medical information. Ideally, your system will be able to flag when a case plan is due to be written (after six hours of service). You will need either electronic or paper forms to document client enrollment/registration, consent for services (signed by the client), and the case plan (signed by a licensed clinician). You will need to acquire and record the full name and date of birth or social security number of each client in order to confirm their Medi-Cal status.

Is my organization Medi-Cal ready?

- ✔ Can we document services in HIPAA-compliant database?
- ✔ Do we have the capacity to submit billing?
- ✔ Do we have insurance?
- ✔ Do we have access to licensed clinicians?
- ✔ Do we have eligible VPPs on staff, and can we track their certification and continued training?
- ✔ Can we supervise our VPPs?

Another consideration is whether the organization has the capacity to bill Medi-Cal. Building internal capacity is one way to do so, including purchasing billing software, hiring a billing and coding specialist, and planning for QA (quality assurance) review to ensure that bills are submitted correctly and will be paid. You will also need to have a claims reconciliation process to resolve issues when your bills are not paid. Instead of purchasing billing software, billing can be done through a clearinghouse. You may want to reach out to your MCP and see which clearinghouse companies they already work with. Many MCPs also have billing portals set up.

Setting up a billing department if you have none may take as long as a year, and comes at a significant expense. The state of Connecticut passed a law in 2021 allowing Medicaid billing for VPPs, and the only organization in the state that actually bills the state is an organization that already had a department set up to bill Medicaid for behavioral health services. You may instead outsource your contracting with a billing company who will take a percentage of your collections in return. Another way to create billing capacity is to subcontract with another provider who is already contracted with the MCP. Again, this will require negotiating giving up a portion of what you collect from Medi-Cal for your services. A certain type of subcontracting agreement is with an intermediary or "hub" provider. It could be a Management Services Organization or MSO, which is an agency that may provide an array of services to support your program, including providing a database for documentation, offering and tracking training for VPPs, and providing access to licensed clinicians to provide client recommendations and approve care plans. This model has worked for other kinds of nonclinical health services such as Enhanced Care Management (see spotlight on Neighborhood Networks on the following page).

How to Claim Medi-Cal for VPPs *(continued)*

In addition to documentation and billing capacity, an organization needs access to licensed clinicians because of their role in signing off on client referrals and care plans. It does not need to be the same clinician involved in the initial recommendation for services that takes place in the care plan development. MCPs may also require a clinician to sign off on billing claims. Fortunately, a licensed provider (such as a physician, LCSW, etc.) does not need to be an employee of your organization, so you can subcontract or otherwise partner with a clinician to support your team. Potentially paying a clinician is another expense to anticipate, as is the need to purchase (additional) liability insurance for your organization. In addition to insurance, there are many other policies, procedures, and best practices you will need to have in place as a health care provider, such as those on this checklist.

Finally, in order to be ready to bill Medi-Cal, your organization will need a plan for supervision of your VPPs. Line supervision does not need to be done by a clinician, but it does need to happen regularly. You will also need to train, track, and document the certification and continuing education of your VPPs as your organization is responsible for ensuring that the VPP providing services is eligible to bill for them.

Spotlight: Neighborhood Networks

Neighborhood Networks (NN), based in San Diego County, is a nonprofit that is a third party administrator or "hub" for partner CBOs offering Medi-Cal covered services in the community. NN contracts with local MCPs and then subcontracts with CBOs doing work on the ground for a small administrative fee. CBOs are also paid a fee up front based on the number of workers on their team based on successful grant application, such as the Incentive Payment Program. NN offers specialized training for partner CBO staff, a secure centralized online case management system, quality assurance, and reporting.

Step 2: Ensure the worker providing services is an eligible Violence Prevention Professional.

The next step is having the workers on staff. VPPs must have completed their certification training at Health Alliance for Violence Intervention (HAVI) or Urban Peace Institute (UPI) or have already worked as a VPP for 2,000 hours in their career (documented by the Supervising Provider – in other words, by your organization), which is referred to as the "work experience pathway." A VPP certified through the work experience pathway can bill Medi-Cal for up to 18 months before they need to complete one of the allowed VPP trainings.

The HAVI training is 35 hours and is tailored to HVIP model programs. The UPI training is a minimum of 80 hours and is tailored to gang intervention workers. All VPPs need to complete an additional six hours of continuing education per year, so you will need to plan to ensure those training hours are achieved and documented. Some MCPs have expressed interest in directly paying for training and certification services for their providers.

According to the All Plan letter, individual VPPs will need to put their NPI number on their documentation. All VPPs should therefore apply for an individual NPI number. (More information on applying for NPI number is on page 8.)

Arguments to negotiate higher VPP service fees with MCPs

- ✔ MCPs must provide VPP services and there are limited qualified providers
- ✔ VPPs improve overall health care
- ✔ VPPs save the MCP money
- ✔ VPP services address health equity and the social drivers of health

Step 3: Contract with a Managed Care Plan.

You cannot bill the State directly for Medi-Cal covered violence prevention services. Instead, services are billed through a local managed care plan (MCP). Depending on where you provide services, there may be several MCPs, which means that you will need to be in contract with all of them in order to ensure that you can bill all the Medi-Cal covered people you serve, since billing claims need to be submitted to the MCP where your client is a member. You can look up the MCPs in your county via the State's website. When you reach out to the MCP, you may start with their government or public affairs staff if they are listed, or simply the administrative or provider contact provided, then share with them the All Plan Letter to remind them that they are required by the State to offer violence prevention services and what the requirements are.

When negotiating your contract with the MCP, you may consider requesting a higher rate than the $26.66 per 30 minutes minimum. Some MCPs have already settled on a higher rate for CHW services. A MCP may want to pay a higher rate in order to ensure they are contracted with a local provider that employs certified VPPs. Violence prevention programs can also point out the cost savings to the health system by reducing the number of firearm injuries treated. In fact, in order to help MCPs realize the cost savings of programs working with populations most likely to be treated for firearm injuries, a program could argue for a case or bundled rate (lump sum payment per client) or a capitated rate (such as a monthly rate per person). Enhanced Care Management uses a capitated rate based on a minimum number of contacts per month.

In New York, Medicaid covered "Assertive Community Treatment" with a monthly payment based on a minimum number of outreach attempts, even if no contact was made with the client. There are more innovative payment plans available at the discretion of the MCP, such as a lump sum plus an incentive payment for milestones such as not returning to the hospital with a subsequent injury. There are in fact many alternative payment models (APMs) that an MCP can consider using. Not all payment models are based on cost or cost saving. Violence prevention programs help to eliminate health disparities. MCPs are interested in doing that because they are held accountable for health equity as well as cost. It is important to learn, if possible, what is in the MCP's contract with the State in order to understand the goals for which they are being held accountable. Violence prevention services can help the MCP achieve those goals.

Step 4: Ensure clients are eligible for the services provided to be billed to Medi-Cal.

To be eligible for services, someone must either (a) have recently been violently injured, (b) be at risk for violence, or (c) be chronically exposed to violence. This is verified by a licensed provider who recommends someone for services. However, it is up to your organization to also verify that someone is on Medi-Cal in order to be able to bill for services. There is an Automated Eligibility Verification System (AEVS) available via the California Medi-Cal provider portal that you can use to verify client Medi-Cal coverage. You will need an NPI number to sign up. You can also call Medi-Cal's help line at 800-541-5555 or reach out to your county's Medi-Cal office.

Step 5: Ensure services provided are eligible.

As described above and in the provider manual, certain types of services are eligible. More importantly, only direct contact with a client fits into existing billable codes. No more than two hours (or four "units") of services can be billed per day per client, and a written plan of care must be completed to bill more than 6 hours (or 12 units).

Opportunities

Despite the hoops to jump through in order to be able to bill and get paid, the new Medi-Cal benefit for violence prevention services is an opportunity for programs to earn supplemental income on existing grant-funded violence prevention programs, allowing for marginal program expansion or increases in worker pay and other expenses. Once the reimbursement system is created, this will most likely become a permanent and scalable funding source.

Outsourcing billing to another company like an MSO, or subcontracting altogether with another organization as an intermediary might make financial sense for programs at a smaller scale, and produce income that could grow over time as programs individually and collectively negotiate higher pay and different payment structures at both the MCP level and at the State level.

Once programs do wade into the world of Medi-Cal, you may look into other Medi-Cal funding streams including Medicaid Administrative Activities (MAA) and Enhanced Care Management (ECM), the latter of which is newly available to the reentry population. These can provide braided funding streams to grow your services.

There may also be grant opportunities with your MCP to help cover start-up costs. At least one MCP in California is using Incentive Payment Program (IPP) funds to provide grants to VPP (and CHW) providers to help them build capacity to provide Medi-Cal funded services. IPP funds come to each MCP from the State DHCS for the purpose of being given out to providers. If not through IPP, it is still worth inquiring about grants with your local MCP, as they do have good reason to give out grants to help providers work with them in order to comply with the new VPP benefit.

A Tip to Increase Billing Productivity

Train your staff to do collaborative documentation, an emerging practice that can increase trust with clients by doing documentation with them present. It also increases billable time.

Barriers

The rate is low—AKA "the money is funny."

The most significant barrier to taking advantage of the new Medi-Cal benefit is that the return on the investment is currently very low. As detailed above, this benefit is likely to generate less than $20,000 per VPP per year. Unless you have more than six to eight VPPs on staff, creating billing capacity internally at your organization may cost more than the revenue you will bring in initially. The (minimum) rate of $53.32 per hour is low, particularly since it does not cover many of the critical activities that VPPs do, such as travel, outreach, engage with collateral contacts, hold client meetings longer than two hours, etc.

Reimbursement rates and methods are faulty.

Not only is the rate low, but it incentivizes working with clients with fewer barriers. In order to maximize billing "productivity" – time spent directly with clients – VPPs would need to travel less, work fewer hours in the community, work more with clients who have their own transportation, and stop reaching out to clients who are no-shows for appointments. However, it is exactly those clients who are most in need of violence prevention services. MCPs will not see the full cost benefit of reductions in future hospitalizations for gun injuries unless the new VPP benefit encourages programs to work with people most likely to get shot. For that reason, we are encouraging MCPs to consider alternative payment structures such as bundled or capitated rates.

Payment can come slowly or not at all.

Even when programs submit claims for the VPP benefit, they may have to wait up to 90 days for payment. There is also the risk that claims will be rejected. Some providers have not only been concerned with money lost when estimating 5% of claims would be denied, but they were also concerned about potential financial penalties for submitted claims that were deemed to be in error.

Avoid double dipping and losing existing program funding.

Although it sounds delicious, "double dipping" in Medi-Cal terminology is something that must be avoided. Medi-Cal cannot be used to supplant or pay for services already funded with federal dollars, or with state dollars that are already being used to match federal Medi-Cal dollars through "certified public expenditures" or CPE. In practice, this only impacts programs whose VPP salaries are entirely funded by a federal grant (such as a Department of Justice Community Violence Intervention grant) or by a state grant that uses federal dollars (such as Victim Services grants that come from federal Victim of Crime Assistance, or VOCA, funds). It might also impact public hospitals with VPPs if their violence prevention program is part of what the county public health department is claiming as a CPE, which is possible but not likely.

Another concern from programs is that their state and local government funders will treat any Medi-Cal dollars leveraged from work done by VPPs funded through those sources as double-dipping. Public and private funders should be made aware of both how marginal the income from Medi-Cal is likely to be, and how important it is to have existing grants to leverage those dollars.

Some programs fear that funders will hear about the Medi-Cal funding for violence prevention and drop their grant programs altogether under the false assumption that the new Medi-Cal benefit is accessible and sufficient to cover our state's substantial need for violence prevention services. Even if it came anywhere close, we know that one-third of those in need of these services are not covered by Medi-Cal.

Another double-dipping concern is specific to violence prevention programs who bill victim compensation for reimbursement of mental health counseling. They have a disincentive to become a Medi-Cal provider because then they would have to bill Medi-Cal first before billing victim compensation, which is a "payer of last resort."

The costs of billing may exceed the income— that is, "the juice may not be worth the squeeze."

The costs associated with billing Medi-Cal may not be offset, in some instances, by the funds being brought in. Not only does an organization need to develop a HIPAA-compliant documentation and billing infrastructure, it also needs to plan for additional staff time for documentation, confirmation of Medi-Cal enrollment status, training to acquire and maintain VPP certification, and coordination with licensed providers on care plans. Another potential expense for violence prevention programs is the addition of part-time or contracted licensed clinicians to support referral, care planning, and billing. When you add these costs along with other hidden costs like additional insurance, written policies and procedures, HIPAA-related information technology, etc., it is clear why a number of violence prevention programs are looking to Managed Services Organizations to cover these costs and risks.

FQHCs cannot bill.

Because violence prevention professionals provide a type of nonclinical health care service, we have heard that local MCPs are treating the new VPP (and CHW) benefits like an extension of existing Enhanced Care Management (ECM) and Community Supports (CS) programs, and are reaching out to those contracted providers for this new benefit. One issue with this is that violence prevention specifically, and community health work generally, are different from ECM and CS, although they may complement each other. But it is also the case that many ECM and CS providers, and some VPP providers, are federally qualified health centers (FQHCs) which are prohibited under the "Prospective Payment System" model from billing Medi-Cal directly for time spent by nonclinical staff such as community health workers and VPPs.

Medi-Cal provider enrollment

While the State does not yet have a process for enrolling CBOs or local health jurisdictions as Medi-Cal providers, there is a plan to create that process. As individuals, clinics, and hospitals already know, the process to enroll is complicated and opaque. It may take six months to a year to complete. (As a reminder: Currently, without a State enrollment process, it is left to the individual MCPs to determine if a CBO is a qualified Medi-Cal service provider.)

Medicalization of a community-based program

Are we weakening the profession by medicalizing it? A large part of why VPPs are effective is that they are people with shared lived experiences offering services out in the community. The same is true of professions like doulas and CHWs, who are also newly funded through Medi-Cal. While Medi-Cal presents new opportunities for sustainable funding, it creates significant barriers for community members and CBOs. Several people pointed out that many health providers are jumping into these fields now that there is money, but they do not share the same social justice values or community roots. For example, there are now doulas who are entirely hospital-based, even though home and community visits are central to how doula work began. The required involvement of licensed clinicians, who in most cases are less knowledgeable about community violence than the VPPs for whom they must approve referrals and care plans, discourages community participation. If we are successful in advocating for higher reimbursement rates for VPPs (and CHWs and doulas and other community-based professions), we run the risk of making the program lucrative enough that MCPs will provide the services directly, as some have already considered doing. It has been mentioned that MCPs do not even consider CBOs as health providers, and therefore do not reach out to them for opportunities like the Medi-Cal VPP benefit.

A Call to Action: Opportunities for Future Advocacy and Learning

Increase the rate.

In order for the new VPP benefit to be effective in expanding access to life-saving services for the people who need them, the benefit at least needs to more than cover the costs of billing Medi-Cal, and ideally cover the full cost of these services at an appropriate living wage for those doing the frontline work in our communities. One way to make this argument can be taken from the doula negotiations (see sidebar). The rate for doulas is the same rate paid to physicians, nurses, and midwives under Medi-Cal for perinatal visits and for labor and delivery, despite acknowledging that doulas offer different services. This equivalency argument means that Medi-Cal rates for VPPs should similarly be much higher and equal or close to rates paid to licensed professionals in similar settings, such as licensed therapists providing post-traumatic support.

Increase the number of services covered.

Currently, the number of 30-minute sessions is capped at four per day. However, often VPPs meet with their clients for longer periods in order to do relationship-building and to accompany them to appointments at places like court or the DMV that take longer than two hours. Removing the cap on sessions per day makes sense in the context of what the work actually looks like. Similarly, the 12-session (six hour) limit prior to the development of a care plan is unrealistic given that it might take longer than that to build rapport with traumatized community members in order for them to even be ready to discuss future goals and needs.

Additionally, there are other activities besides direct client contact that are valuable components of violence prevention services and should be covered. In order to encourage community-based services to be delivered in the community, DHCS should consider reimbursement of travel time. In the Philadelphia example, Medicaid reimbursed travel time to appointments with clients. Collateral contacts are also a valuable component of violence prevention programs; in fact, the State specifically names advocacy as part of the services covered, so it only makes sense that the benefit should cover contact made with medical and other service providers, schools, employers, etc., on the client's behalf. Finally, in order to incentivize working with people most at risk for involvement in violence and therefore hardest to reach, the state should find a way to reimburse outreach attempts where no client contact is made.

Spotlight: Medi-Cal Doula Rate

The initial Medi-Cal rate for doula services was extremely low, at only $450 per pregnancy. Through advocacy, it was increased substantially to $1,095. The change was the result of advocacy by the doula community, in part through a series of doula implementation stakeholder meetings with DHCS to help the state understand the actual expenses and barriers to offering doula services through Medi-Cal. A second doula implementation workgroup started meeting in March 2023 as required by the passage of a law, SB 65.

Use alternative payment models.

As described above, fee-for-service reimbursement of time spent with patients is not an ideal payment model for violence prevention. While MCPs can individually choose to use other payment models like bundled or capitated payments, there can be advocacy at the state level to encourage or require that type of payment.

Reconsider the role of licensed clinicians.

The requirement for licensed providers to be involved in so many aspects of the VPP benefit is a barrier to providing services. It is expensive and undermines the expertise of VPPs.

Develop hub providers.

Because of the significant barriers to entry for community-based violence prevention programs that are not already billing Medi-Cal, hubs can play a critical intermediary role between programs (the VPPs) and payers (the MCPs). This may be a role for county health departments and city offices of violence prevention, to either become the hub organization themselves or coordinate with providers to develop a hub for violence prevention services in their area. Some health departments in California are already working on this.

Recommended Next Steps for Violence Prevention Service Providers

If you are a violence prevention program looking to take advantage of the new Medi-Cal VPP benefit, you may not know where to start. Here are some suggested initial steps:

- ✔ Submit Medi-Cal provider enrollment applications as soon as possible (currently not possible for CBOs).
- ✔ Apply for an NPI number if you do not have one. VPP staff need to apply for NPI numbers as well
- ✔ Contact HAVI and/or UPI about certifying your workers as VPPs, if they are not already certified.
- ✔ Calculate the cost of doing billing to determine if you want to:
  - Build your own internal department,
  - Outsource billing to a separate company, or
  - Subcontract with another organization such as a hub, an MSO or another provider.
- ✔ Reach out to the MCP(s) in your area to start the contracting process and:
  - Ask them about IPP or other grants to cover startup costs,
  - Discuss the need for a higher hourly rate or alternative payment model,
  - Learn which clearinghouses and billing companies they currently work with.
  - Make the argument for VPP services on the basis of (a) cost savings, (b) quality of care, and (c) health equity.

Resource Guide Glossary

AEVS - Automated Eligibility Verification System. The State of California online database that providers use to verify Medi-Cal enrollment.

APM - Alternative Payment Model (or Method). A federal government-recognized approach to paying for health services in different ways other than fee-for-service, and can include incentive payments/shared savings arrangements, paying for data, paying for infrastructure, and capitation.

CBO – Community-based organization. Nonprofit organizations—including violence prevention service providers—that work at the local level to provide services to communities and specific target audiences which improve a community's health and well-being.

CHW – Community Health Worker. A community health worker is a frontline public health worker who shares lived experience with the community served.

CMS - Centers for Medicare & Medicaid Services. The federal government entity that administers Medicaid and other public health insurance programs.

CVI – Community Violence Intervention. An umbrella term for programs that intervene, interrupt and prevent community violence, such as gang and group violence.

DHCS – California Department of Health Care Services. This is the body that administers Medi-Cal.

ECM – Enhanced Care Management. A statewide Medi-Cal benefit that provides high-need populations with case managers who coordinate and connect them to care.

FQHC – Federally Qualified Health Center. A community health clinic recognized by the government that has a special type of cost-payment structure.

HAVI – The Health Alliance for Violence Intervention. The membership organization for hospital-based violence intervention programs, and an organization that provides credentialing to frontline workers under the new Medi-Cal benefit for violence prevention services.

HIPAA - The Health Insurance Portability and Accountability Act of 1996. The federal law that protects the privacy of people's medical information.

HVIP – Hospital-based Violence Intervention Program. This is an evidence-informed model program where community-based frontline workers (Violence Prevention Professionals) work with patients and their families in the immediate aftermath of a shooting or other violent injury.

LCSW - Licensed Clinical Social Worker.
A Licensed Provider under Medi-Cal.

LMFT - Licensed Marriage and Family Therapist.
A Licensed Provider under Medi-Cal.

LPCC - Licensed Professional Clinical Counselor.
A Licensed Provider under Medi-Cal.

MAA – Medi-Cal (or Medicaid) Administrative Activities. Reimbursed administrative work to assist Medi-Cal patients in enrolling in insurance and receiving care.

Resource Guide Glossary *(continued)*

MCO - Managed Care Organization. A health plan that insures and provides coverage.

MCP - Managed Care Plan. A health plan that insures and provides coverage to Medi-Cal recipients.

Medi-Cal – California's Medicaid program.

MSO – Management Services Organization. A company that offers an array of non-clinical administrative services to a health services provider.

NPI Number - National Provider Identifier Number provided through a federal government registry to health services providers.

NUCC - National Uniform Claims Committee. The national group of health insurers, including Medicare and Medicaid, who define which health care professions are recognized and can receive payment.

UPI – Urban Peace Institute. An organization that provides credentialing to frontline workers under the new Medi-Cal benefit for violence prevention services.

VOCA – Victim of Crime Assistance. Refers to the law or to the funds that come from the federal Department of Justice to states to support victim-serving organizations.

VPP – Violence Prevention Professional. A frontline worker in a community violence intervention program. California defines VPPs as professionals who provide evidence-based, trauma-informed, and culturally responsive preventive services for the purpose of reducing the incidence of violent injury or reinjury, trauma, and related harms and promoting trauma recovery, stabilization, and improved health outcomes.

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GIFFORDS CENTER FOR
VIOLENCE INTERVENTION

Giffords Center for Violence Intervention champions the strategies that break cycles of violence and the community organizations working on the ground to save lives. American gun violence is a complex problem, but we know what the solutions are—we just need to commit to them.

giffords.org/intervention

California Children's Trust

The California Children's Trust (CCT) is a statewide initiative to reimagine our state's approach to children's social, emotional, and developmental health. We work to transform the administration, delivery, and financing of child-serving systems to ensure that they are equity driven and accountable for improved outcomes. CCT regularly presents its Framework for Solutions and policy recommendations in statewide and national forums.

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Framework for Solutions