Community-Based Violence Prevention Programs
&
Violence Prevention Providers
HB 4045 -1 Q & A

1. **Are these services reimbursable now?**
   No. The full scope of case management services performed under the Hospital-Based Violence Prevention (HVIP) model does not seamlessly align with existing Medicaid benefits. While some alternative, indirect care services may be covered as health-related services (HRS) by Coordinated Care Organizations (CCOs), accessing HRS benefits is unreliable, discretionary, and runs contrary to this legislation's goals. Further, it is inappropriate to defer benefit coverage of an effective standard of care to HRS coverage. There are no comparative HRS benefits for fee-for-service or "open card" members due to limitations in federal regulations. HB 4045 seeks to provide stability for Oregon providers and communities without disrupting current work.

   The Oregon Health Authority (OHA) will work with affected and knowledgeable parties to structure a benefit aligned with the Hospital-Based Violence Intervention Program (HVIPs) standard of care. The benefit will adequately represent the critical work that trusted community partners perform and appropriately compensate for time and services. Once developed, OHA will seek approval from the Centers for Medicare and Medicaid Services (CMS) to authorize both services and a new provider type (violence prevention providers).

   HB 4045 does not invent a new process for Oregon. There is a broad precedent for narrowly tailored benefit coverage for effective interventions to better serve Oregonians in need. For example, OHA has submitted state plan amendments, and CMS has approved targeted case management services (TCMs). TCM helps specific OHP enrollees gain access to housing, transportation, and medical, social, and educational services. Examples of specific TCM include pregnant women with a history of substance abuse or parents with a history of substance abuse, and enrollees with documented HIV or AIDS diagnoses.[1] Similarly, Oregon could pursue coverage through existing or new preventive services authorities.

2. **Who are violence prevention providers (VPPs)?**
   Violence prevention providers (VPPs) are proposed by HB 4045 to define the role of trusted community messengers who provide intervention services for violently injured individuals under the HVIP model. Like community health workers or peer support workers, VPPs are the best messengers for the individuals who need their services. While this provider definition is new to Oregon, the VPP designation comes from a national framework that has been around since 1994. Recently, in 2014, California recognized Violence Peer Counselor health care providers. In 2015, the National Uniform Claim Committee approved the Violence Prevention Professional recognition. National certifications and training exist now, and community organizations

[1] See OAR 410-138-0007 and OAR 410-138-0060.

leverage best practices from these national frameworks to establish localized trauma-informed VPP certification programs.[2] The bill proposes to adopt the national certification and directs OHA to review and approve community-submitted curriculum, too.

Through HB 4045, Oregon will work to professionalize trusted community messengers as certified VPPs for a specialized case management (or prevention) benefit. Doing so will allow VPPs to bill for their critical services as part of HVIPs across the state. This process will ensure that violently injured Oregonians eligible for intervention services receive the same effective treatment across organizations.

3. **Why Medicaid and is there statewide need?**

National data show that 2/3rds of youth and adults injured by community violence are likely to be uninsured or on Medicaid. Often, the emergency department is the primary interaction with a health care provider for an individual affected by or susceptible to community violence. This experience is especially true for those aged out of pediatric care and who have not established medical care as young adults.

Emergency departments also serve as a revolving door, treating victims of assault with progressively more acute injuries at each encounter. CMS has acknowledged this relationship and encourages states to leverage Medicaid to reduce violence in communities.[3]

Hospital-based violence intervention programs (HVIP) align with Oregon's health care goals. Evidence shows that individuals accessing HVIPs are less likely to be violently reinjured and be admitted to the emergency department. Individuals served are more likely than not to experience improved population health outcomes (e.g., adequate housing and employment).[4] Individuals are more likely to access preventative care, including behavioral health care. Lastly, HVIPs have effectively demonstrated an ability to reduce the likelihood of a victim of a violent crime perpetrating violent crimes.[5]

According to testimony from OHSU, the three years "between 2018 and 2020, there were 290 firearm assaults and 1,026 stabbing-related assaults across Oregon."[6] OHSU researchers were "struck" by how community violence extended to ER rooms outside the metro area in Keizer and

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[2] The HAVI — Violence Prevention Professional Training. (2022, January 14). The HAVI. https://www.thehavi.org/violence-prevention-professional-training

[3] Centers for Medicare & Medicaid Services. (2021, April). All-State Medicaid & CHIP Call [Webinar]. https://www.medicaid.gov/state-resource-center/downloads/allstatecall-20210427.pdf

[4] Juillard, C., Cooperman, L., Allen, I., Pirracchio, R., Henderson, T., Marquez, R., Orellana, J., Texada, M., & Dicker, R. A. (2016). A decade of hospital-based violence intervention. Journal of Trauma and Acute Care Surgery, 81(6), 1156–1161. https://doi.org/10.1097/ta.0000000000001261

[5] Purtle, J., Dicker, R., Cooper, C., Corbin, T., B. Greene, M., Marks, A., Creaser, D., Topp, D., & Moreland, D. (2013). Hospital-based violence intervention programs save lives and money. Journal of Trauma and Acute Care Surgery, 75(2), 331–333. https://doi.org/10.1097/ta.0b013e318294f518

[6] Carlson, K. (2022, January). Testimony to the Interim House Health Care Committee. https://olis.oregonlegislature.gov/liz/mediaplayer?clientID=4879615486&eventID=2022011011&startStreamAt=4520&stopStreamAt=6431 (1:28:00 – 1:32:44).

Salem, Eugene, Medford, and Grants Pass. With consistent health care funding, Oregon can prevent these expensive ED interactions, reduce violent injury, and promote community safety across the state.

4. **What about costs?**
   Of the assault data shared by OHSU, "more than half [of violent injuries] were billed to Medicaid, at an average of about 150-250k per assault, for just these hospital costs alone."[7]

   Hartford Communities That Cares, a HVIP partner in Connecticut, requested an economic evaluation of their HVIP program. The analysis focused on a cohort of 82 young men. They found health care delivery savings of $3.42 for every $1.00 invested in intervention and cost avoidance of $5 for every $1.00 invested by reducing interactions with the criminal justice system. [8]

   In 2019 the California Health Benefits Review Program (CHBRP) projected the costs and benefits of qualified VPPs on the Medi-Cal system. The CHBRP estimated an average of 50 client contact hours per intervention and a total program estimate of $575,000 for over 700 contacts. A Milliman analysis of Medi-Cal enrollee patient discharge and emergency department data showed that 14% of violently injured Medi-Cal enrollees experienced another violent injury in less than 12 months. The CHBRP conservatively estimated a 50% reduction in reinjury using qualified VPPs, estimating a savings of $4,300 per contact. The same study projected growth of 20% in total services by the second year of program implementation at a total program cost of $626,000. [9]

5. **What about the 1115 Waiver?**
   Community organizations will need to build administrative competency and familiarity with Medicaid. The 1115 waiver submission includes critical changes to the THW, CHW, and peer support framework that complements the goals of HB 4045, including:
   - Expanded infrastructure to support access to services using providers outside of the medical model.
   - Obtain expenditure authority to support implementation capacity at the community level, including payments for provider and community-based organizations (CBO) infrastructure and capacity building.
   - Other SDOH transition services authorization.

   However, we do not have certainty of federal approval for Oregon's 1115 waiver request, and the 1115 waiver does not cover fee-for-service members. The Legislature must acknowledge that these new waiver-requested policy changes will require an implementation process if

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[7] Carlson, K. (2022, January). Testimony to the Interim House Health Care Committee. https://olis.oregonlegislature.gov/liz/mediaplayer?clientID=4879615486&eventID=2022011011&startStreamAt=4520&stopStreamAt=6431 (1:28:00 – 1:32:44).

[8] Social Capital Valuations document dated March 23, 2021 provided by Hartford Communities that Cares (HCTC) on January 13, 2022.

[9] California Health Benefits Review Program. (2019, April). Analysis of California Assembly Bill 166 Violence Preventive Services: A Report to the 2019–2020 California State Legislature.

approved and pose a significant learning curve for many. Community-based organizations with limited Medicaid experience will benefit from certainty and clarity. HB 4045 envisions two or three years of successful claims data on fee-for-service. The goal is to transition service billing through the CCO model once there is more certainty for how CBOs will interact with this system.

6. **What are the steps to define a Medicaid benefit?**
   Once authorized by HB 4045, the Oregon Health Authority will convene an advisory group of providers and organizations who participate in Oregon-based HVIPs, national technical experts in the HVIP standard of care, and Medicaid stakeholders to: [10]
   - Further define the scope of benefits (e.g., limitations, coding, services covered, billing criteria).
   - Further refine the provider definition, including identifying the national training necessary to bill for these services.
   - Develop a rate structure.
   - Build backend system changes necessary to "see" this provider in the MMIS.
   - Perform a full review, including public notice and comment regarding submitting a State Plan Amendment to CMS.
   - Issue provider guidance once approved.

7. **Why not ask for a state Medicaid match this session?**
   HB 4045 authorizes a process to develop a formal request of CMS for approval of this provider type and services. There is a significant amount of work to complete before submitting a request to CMS. HB 4045 makes a general fund request of $5 million in the 2022 session. This funding will build critical capacity for the existing Healing Hurt People program to address the inordinate need for services. Grant dollars will also grow capacity among smaller organizations that perform related violence prevention work and street outreach. Lastly, grant dollars will provide seed money for a community-based organization and hospital partnership to develop an HVIP program outside of Multnomah County. The funding package intends to grow and continue this critical work while the agency works with stakeholders to submit an ask of CMS. OHA's important interim work and CMS guidance will inform additional statutory changes and a future state-match request in 2023.

[10] List adapted from Connecticut Department of Social Services presentation received December 28, 2021.