Sustainability Opportunities for Hospital-based Violence Intervention Programs: A Briefing Paper

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The purpose of this document is to outline opportunities that are available to Hospital-Based Violence Intervention Programs to achieve ongoing long-term fee-for-service revenue streams. In preparing this document, I have focused on funding sources that will support outreach, advocacy, and case management for victims of violence, with a specific focus on serving at-risk youth and young adults who reside in communities in which opportunities for youth are limited. This document is not intended as a detailed guide for getting any particular type of funding; rather, it is intended to give you an overview of your possibilities.

A. Overview

Most state and local funding for outreach and case management has at its base a Federal funding source. States generally have some flexibility in how these funds are administered, but the broad outlines are determined by the Federal regulations. States usually take the Federal funding, then add some funding and some requirements of their own (the "State match"), then pass it along either directly to the service organization or to a local County or City. In the latter case, the County or City will be responsible for selecting the service organizations that will receive the funding. Usually the locality will also be required to put up a "local match". In California, for example, Medicaid funding for adult mental health services is 50% Federal, 25% state, and 25% local.

The funding sources identified in this section have the great advantage of being ongoing. In most cases, once you have obtained the funding, you can count on having it for as long as you are providing a qualified service. However, as wonderful as it sounds to have a dedicated revenue stream, each of these funding sources comes with its own set of costs and compromises. In some cases, you may feel that these compromises threaten the purity and clarity of your organizational mission. In other cases, you may feel that the administrative burden that they impose is too great to justify the potential revenue you would gain. Some of the issues that you will confront:

1. When you write a foundation proposal, you describe exactly the service that you are seeking to provide. When you are funded, you and the funder have already agreed on your service delivery model, and it is one that precisely suits your mission. That will not generally be true of these ongoing funding sources.
    - They may only be willing to pay for portions of what you consider a holistic service. That will mean that you either have to split your program into parts or else painstakingly document which parts you are billing for and which parts you are not.
    - They will impose eligibility requirements that will mean that you will be funded to serve some potential clients but not others. You will need to find other funding to serve non-eligible clients and you will need to document who is served with which funding. There will be a constant gravitational pressure pulling your organization

away from serving everyone in need and toward serving those individuals who are qualified to receive funding.

2. Documentation and charting requirements for these funding sources are very stringent. You may be subjected to Federal or state audits that will require to give funding back if your paperwork is not adequate. This type of funding will require you to establish a quality assurance process, if you do not already have one, and may necessitate your hiring dedicated QA staff to ensure that your charts are always in order.
3. Usually these contracts are fee-for-service based. That means that you will have to prepare a separate invoice (whether paper or electronic) for each client visit. You will need to be sure that your fiscal department is able to do this.
4. Usually these contracts also have a "cost settlement" at the end. The cost settlement will require you to justify your fee-for-service rate based on how much you spent on the program. If you are combining your fee-for-service funding with grant and donation funding, your fiscal staff will need to able to cope with the complexities of justifying the costs you allocate to the Federal funding program.
5. When you have foundation grants, they are generally paid up front. You get a check and then you start spending the money. With these fee-for-service programs, you generally spend the money first, then get reimbursed for it. This means that you have to come up with a pool of money that can support the negative cash flow created by this type of reimbursement mechanism. Sometimes—especially if your funding is passed through your local County government—you may be able to receive a cash advance, but sometimes you cannot.

On the positive side:

1. In addition to stability of these revenues, they can allow you to serve many more individuals that you otherwise could.
2. Charting and quality assurance requirements have a positive side; they help you and your staff to be more rigorous and thoughtful in the provision of services to each client. Good charting is an essential for good case management and can be the foundation for more effective outcome evaluation.
3. This funding is an entrance ticket into a community of other organizations who are providing similar services and facing the same challenges.

B. Crime Victims Funding

The US Department of Justice, Office of Justice Programs, Office for Victims of Crime (OVC) administers the *Crime Victims Fund* (established under the 1984 Victims of Crime Act) to help victims and victim service providers with program funding. There are two main grant types: formula and discretionary. Discretionary grants are offered through RFP, are time-limited, and are worth tracking as they are released. In your search for discretionary grants, www.grants.gov is the website to start. Be aware that these grants are usually more complex and time consuming to prepare and the competition is often intense. You may want to avail yourself of a professional grantwriter if you have never prepared a competitive Federal grant.

Here, however, we want to focus on formula grants. Formula grants are distributed to the states (based upon a funding formula) in two separate streams: *Victim Compensation* and *Victim Assistance*.

- Victim Compensation provides reimbursements for medical costs, mental health counseling, funeral and burial costs, lost wages and loss of support
- Victim Assistance Funds support CBOs that serve crime victims—domestic violence shelters, rape crisis centers, child abuse programs, etc.

Victim Assistance funds are distributed through a granting process. In most states, these funds are an ideal source of sustainable revenue, if you can get them, since they tend to be renewed for many years in a row. However, the programs funded often are weighted more toward law enforcement and less toward social service agencies. The table below provides information on how to find out more about these funds.

Victims Compensation funding represents an often untapped source of fee-for-service funds, since it is able to pay for case management and brokerage services. Its major drawback, in California at least, is that it is ferociously late in paying its invoices. To obtain these funds, you will need to assist your clients to apply for funding and you will then need to bill the state or the County (depending on how your state's program is organized) for reimbursement. There are several big advantages to this funding source. First, nearly all your clients will be eligible. Secondly, these funds function like an entitlement, if your client is eligible and your services are appropriately documented, you will be paid. The disadvantages are the delays in payment and the burden of documentation and paperwork.

The table below provides contact information for the Victim Assistance and Compensation programs in each of the states with National Network core programs:

	Victim Assistance	*Victim Compensation*
California	916-324-9100 Web site: http://www.oes.ca.gov	800-777-9229 Fax: 916-491-6420 Web site: http://www.boc.ca.gov/
Illinois	312-793-8550 Fax: 312-793-8422 Web site: www.illinoisattorneygeneral.gov/victims/index.html	312-814-2581 Fax: 312-814-5079 Web site: www.illinoisattorneygeneral.gov/victims/index.html
Pennsylvania	1-800-233-2339 or 1-800-692-7292 (within state) Fax: 717-772-4331 Web site: http://www.portal.state.pa.us/portal/server.pt?open=512&objID=5415&&SortOrder=100&level=2&parentid=5255&css=L2&mode=2	1-800-233-2339 or 1-800-692-7292 (within state) Fax: 717-787-4306 Web site: http://www.portal.state.pa.us/portal/server.pt?open=512&objID=5415&&PageID=495614&level=3&css=L3&mode=2

Wisconsin	608-267-2251 Fax: 608-264-6368 Web site: www.doj.state.wi.us/cvs	1-800-446-6564 or 608-264-6209 Fax: 608-264-6368 Web site: www.doj.state.wi.us/cvs/CVCompensation/Compensation_Brochure.asp
Massachusetts	617-727-5200 Fax: 617-727-6552 website: http://www.mass.gov/mova/page26.html	617-727-2200 Fax: 617-367-3906 Web site: www.mass.gov/?pageID=cagosubtopic&L=2&L0=Home&L1=Victim+and+Witness+Assistance&sid=Cago
Maryland	410-767-7176 Fax: 410-333-0256 Web site: www.dhr.state.md.us/victim	1-888-679-9347 or 410-585-3331 Fax: 410-764-3815 Web site: www.dpscs.state.md.us/victimservs/vs_cicb.shtml

C. Federally Qualified Health Centers funding

A federally qualified health center (FQHC) is a type of health clinic defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and "FQHC Look-alikes". Most larger urban and rural health clinics serving a primarily low-income population are either FQHCs, FQHC look-alikes, or at least have the potential to be certified as such.

All issues related to qualification and reimbursement under FQHCs are ferociously complex. However, the key fact about FQHCs is that they can receive Federal reimbursement for about 80% of their charges, and case management and outreach are covered services. Another advantage is that the unreimbursed 20% can be covered by foundation and donation revenue, something that is not always true for the other revenue sources cited in this report. Finally, FQHC clients are not required to be Medicaid recipients in order for the organization to be reimbursed for services. FQHCs must serve all clients on a sliding fee scale.

Unless your organization is already operating a primary care clinic, it would not be feasible to set up your own FQHC. The best strategy is to find an existing FQHC and establish a subcontractual relationship with them. Members of the network who are affiliated with a hospital may find that the hospital already operates an FQHC.

It is a general misconception that all service providers at FQHCs must be professionals, such as psychologists or social workers. That is not true. Your peer and paraprofessional staff can provide case management and outreach services. However, your paraprofessional staff will need to have their work supervised by a licensed professional (usually a psychologist, LCSW, nurse practitioner, or physician). As with all other fee-for-service funding sources, charting requirements are fairly burdensome and will need to be completed with great care, or your organization risks major audit-related repayments.

If you are interested in proceeding down this track, start by educating yourselves about FQHCs. The Rural Assistance Center generally has the most understandable introductory

information about FQHCs. Their website is http://www.raconline.org/info_guides/clinics/fqhc.php. (Rural Health Clinics have similar funding characteristics and would also be able to fund similar services.) If FQHC funding seems right for you, you should reach out to FQHCs in your area to initiate discussions. At some point in the process, you will certainly need a consultant who understands this topic fully. It might be reasonable to engage an consultant right at the start to help to facilitate these discussions.

D. Medicaid Mental Health funding

All states except Kentucky, Louisiana, and South Carolina provide mental health benefits under their Medicaid plans. (In California, Medicaid is called "Medi-Cal".) There are a bewildering variety of ways in which states choose to organize their mental health services. In California, each County is designated as the Medi-Cal mental health provider. Most counties then subcontract with non-profits to provide some or all of the actual mental health services on a fee-for-service basis. In other states, organizations (which may be non-profits, for-profits, counties, coalitions of counties, etc.) are designated as managed care mental health providers. They are then given a fixed monthly fee with which they have to provide for all the mental health needs of all the Medicaid recipients in their jurisdiction.

Outreach and case management are allowable services under Medicaid. The positive side of this funding stream is that it will generally pay for a lot more intensive service than other funding sources. It also pays at a better rate—up to $150 per hour for most mental health services (and more for psychiatry). However, it has a lot of restrictions that make this a funding source to be only undertaken with careful planning and the assistance of a local expert:

1. Recipients need to meet "medical necessity" criteria, which means that they have to have a diagnosable mental illness. The bar for meeting medical necessity is not very high. Most young adults who have been shot would quality under a trauma diagnosis at least.
2. Recipients need to be Medicaid recipients. In most states, merely being poor does not qualify you. Generally, being blind or disabled, pregnant/postpartum, a young child, or a TANF recipient is a categorical qualification for Medicaid. Some states expand eligibility to other groups using a mix of state and federal funding.
3. The provider of services needs to be a "licensed practitioner of the healing arts". In most states, paraprofessional, unlicensed case managers can provide outreach and case management, provided that they are supervised by, and every document is co-signed by, a licensed mental health professional. This is a tricky area and levels of required supervision can vary from state to state and county to county. Often there are different requirements for diagnosis and care planning than there are for service provision. In some places, the supervising professional can be on contract, while other jurisdictions will require that they be employed by your program. Normally, supervision required will be one hour of individual supervision and one hour of group supervision per week per person being supervised. You will need to be sure to have understood all these requirements correctly before proceeding.

4. Documentation requirements are very rigid. Federal and state auditors frequently conduct audits that amount to raiding expeditions, looking to recover revenue already paid as a way of controlling costs. Consequently documentation needs to be very carefully attended to and an audit reserve should be established.
5. Generally, the facility needs to be licensed and the organization needs to be licensed, with annual renewals being typical. Who does the licensing varies from state to state and often multiple types of licenses and certifications will be required from entities ranging from the State Department of Mental Health to the local fire marshal.
6. The local match generally must be local tax revenues and can't be foundation or private donations. That will mean having to persuade your local county or city to provide the match.

E. EPSDT

EPSDT stands for "Early Periodic Diagnosis, Screening, and Treatment". EPSDT is the funding stream that pays for Medicaid services to youth under age 18, including mental health, case management, and outreach services. In all states, it has the virtue that the services it covers are much broader than the services Medicaid covers for adult clients. Essentially, almost any issue that can fall under a DSM diagnosis will be eligible for appropriate services. This makes EPSDT a particularly attractive funding source for serving youth (under 18) and families with complex histories and high levels of need.

In California, there is a special advantage in that the local match is only 7.5% for these services. That has made it very inexpensive for local jurisdictions to serve youth who are Medi-Cal recipients, so there has been a very significant growth of services in this arena.

As with regular Medicaid mental health services, the challenge will be persuading a local jurisdiction to provide their share of the match so that you are able to provide services. Even more than regular Medicaid, EPSDT auditors will check every jot and tittle of your documentation, looking for errors.

F. Targeted Case Management funding

The TCM program reimburses participating counties for the federal share of costs (typically 50%) for case management services provided to Medicaid beneficiaries in six specific target populations. The target populations include: 1) Public Health; 2) Outpatient Clinics; 3) Public Guardian; 4) Aging and Adult Services; 5) Adult Probation; and 6) Community. Each local jurisdiction will have a TCM Plan on file with the state that details what target populations and services they will cover.

All states except Texas, Delaware, and Florida provide targeted case management although some states restrict the target populations. TCM has a particular advantage in that it will reimburse you for both outreach and case management provided in the hospital provided that the client is within 14 days of discharge. Again, as with other Medicaid-based funding sources,

it will only reimburse you for services to Medicaid recipients, and the Federal reimbursement rate is only 50% of charges.

States determine what types of programs are eligible to offer TCM services and what types of practitioners are eligible to provide these services.

The table below illustrates the vast diversity of target populations and services covered by TCM by state for Network states.

State	Process	Special Considerations	Payment Information
California	There are two types of case management benefits to serve Medi-Cal recipients. The Targeted Case Management program serves individuals who would benefit from a case manager's direct support to ensure the person receives appropriate care and to encourage the person to follow an established plan of care. See next column for eligible groups. The Medical Case Management (MCM) program provides short-term case management to Medi-Cal beneficiaries who have no other health care coverage. Individuals eligible for MCM services generally have complex, chronic and/or catastrophic medical conditions. MCM assists in planning the discharge from an acute hospital to a home setting. MCM typically approves home health care services and other related medical services. MCM staff follow-up with the Medi-Cal beneficiary to ensure services are meeting their needs.	The following groups are eligible for Targeted Case Management: • Individuals age 18 and older who are in frail health and who would otherwise need institutional care; • Individuals age 18 and older who are on probation and who have medical and/or mental needs; • Individuals age 18 and older who are unable to handle personal, medical or other affairs or who are under a conservator; • Persons who have been identified as needing public health case management such as women, infants, children, pregnant women, persons with HIV/AIDS or reportable communicable diseases, persons who use medical technological devices, and persons with multiple diagnoses; • Individuals who need outpatient clinic services and case management who have not followed a medical regime; and • Individuals who have language barriers or other communication barriers that result in difficulties complying with a medical plan. There is a separate case management program called	These services are reimbursed according to the Medi-Cal fee schedule. DHS establishes rates for each provider type on a fee-for-service basis.

		California Children Services (CCS) for children under age 21 who are residentially, financially and medically eligible. Eligible children are required by law to be referred to this program.	
Illinois	Family Case Management – All infants and pregnant women who are enrolled in medical assistance programs are referred to the Department of Human Services (DHS) for family case management. Case management services are also provided to high-risk infants up to age two who are: • Identified through Illinois Department of Public Health's Adverse Pregnancy Outcome Reporting System (APORS); or • Wards of Illinois Department of Children and Family Services (DCFS) identified as high risk children.		These services are reimbursed according to the Medicaid Fee Schedule for case management.
Massachusetts	Targeted case management services are provided to individuals infected with HIV/AIDS.	Setting of service – staffed congregate, residential housing programs that meet the Department of Public Health's AIDS Bureau funding requirements.	The national procedure code for Targeted Case Management is T1017 – Targeted Case Management, Each 15 Minutes. This code is for services to Mass Health members who have been diagnosed with AIDS and who are living in congregate AIDS housing. The maximum number of units that can be billed for each member per day is four.
Pennsylvania	Targeted Case Management (TCM) Services in Pennsylvania are provided to: • Categorically and medically needy recipients who have contracted AIDS or symptomatic HIV;	Pennsylvania has also included in their state plan targeted case management services for eligible recipients with mental retardation. The state has established a certification procedure for case managers.	The Department of Public Welfare's coverage for TCM services is limited to a specified number of hours per 30-day period as determined by the Department as appropriate for the specific

	• Categorically needy adult recipients with severe and persistent mental illness and children with a severe mental illness or emotional disturbance; and • Those pregnant women with a high incidence of medical and/or social problems that could constitute a serious hazard and may result in complication, prolonged hospitalization or death of the mother and/or the fetus.		target group, and included in the MA Program Fee Schedule. Payment will be made for TCM services provided by only one MA case manager per recipient for a given period of time determined by the Department.
Wisconsin	TCM is available to the following populations: • Persons age 65 or over; • Persons with a diagnosis of Alzheimer's disease or related dementia; • Persons with a developmental disability • Persons who are age 21 or older with a chronic mental illness; • Persons with a physical or sensory disability; • Persons having an alcohol or drug dependency; • Persons diagnosed as having HIV infection; • Persons who are severely emotionally disturbed and under age 21; • Persons diagnosed with asthma and under age 21 • Persons infected with tuberculosis • Women 45 to 64 years old • Children enrolled in a Birth to 3 Program; and • Families with a child(ren) under age 21 who is at	These services may only be provided by certified case management agencies. Wisconsin Medicaid covers case management services on a FFS basis for recipients enrolled in Medicaid-contracted HMOs. The following special managed care program include case management as a covered service; therefore, case management may not be billed separately to Wisconsin Medicaid for individuals enrolled in these programs: • Children Come First (CCF); • Community Care for the Elderly; • Community Health Partnership; • Community Living Alliance; • Elder Care Options; and • Wraparound Milwaukee(WAM).	DHFS establishes contracted hourly rates for all covered services provided by certified case management agencies. The contracted hourly rates are based on various factors, including a review of budgetary constraints and other relevant economic limitations. Providers are required to bill their usual and customary charge. For providers using a sliding fee scale, the usual and customary charge is the median of the provider's charge for the service when provided to non-Medicaid patients. For each covered service, DHFS pays the federal Medicaid share of the contracted hourly rate. Medicaid reimbursement, less appropriate copayments and payments by other insurers will be considered payment in full. Providers are reimbursed by Medicaid only for that portion of allowable costs

	risk of a physical, mental or emotional dysfunction.		for which federal financial participation (FFP) is available. The State share shall come from non-federal funds available to case management agencies.

G. SCHIP funding

SCHIP is the Federal supplement to Medicaid that covers families who are poor, but not categorically eligible for Medicaid. Like Medicaid, SCHIP is a partnership between federal and state governments. The programs are run by the individual states according to requirements set by the federal Centers for Medicare and Medicaid Services. States may design their SCHIP programs as an independent program separate from Medicaid (separate child health programs), use SCHIP funds to expand their Medicaid program (SCHIP Medicaid expansion programs), or combine these approaches (SCHIP combination programs). States receive enhanced federal funds for their SCHIP programs at a rate above the regular Medicaid match. Although SCHIP should be a promising funding source, in most states, mental health (and associated case management) services are bundled in with the regular Medicaid mental health services and are provided by the authorized Medicaid mental health providers.

The table below provides a summary of SCHIP eligibility and coverage for Network states.

State	SCHIP Income Limits	Inpatient Service Limits	Outpatient Service Limits
California	Age <1, 200-250% FPL Age 1-5, 133-250% FPL Age 6-18, 100-250% FPL	1. Inpatient services are provided without limit for serious mental illnesses. 2. For members with an SED, plan will provide up to 30 days inpatient; after 30 days responsibility for providing inpatient care shifts to county mental health department. 3.Non-SMI/SED limited to 30 days inpatient mental health care per benefit year. If appropriate 1 day of inpatient care may be substituted by: 2 days residential, 3 days day care, or 4 outpatient visits	1.Outpateint services provided without limit for serious mental illness 2. For members with an SED, outpatient visits pertaining to the SED condition will be provided by the county mental health department. 3. Outpatient treatment for all non-SMI/SED conditions limited to 20 outpatient services/benefit year 4. Participants must meet coverage requirements established by their health plan
Illinois	KidCare Share: Age 1-18, 133-150% FPL KidCare Premium: Age 1-18, 150-200% FPL. KidCare Rebate:	Medicaid limits	Medicaid limits

	insured, Age 1-18, 133-185% FPL. This program reimburses part of the cost for private health insurance for children. -- 1115 waiver covers parents of Medicaid & SCHIP-eligible children from families, <= 133% FPL who do not qualify for Medicaid. Note: Illinois HIFA waiver allows separate SCHIP coverage of insured children.		
Massachusetts	Age 1-18, 150-200% FPL	Medicaid limits	Medicaid limits
Maryland	Age 1-5, 133-185% FPL Age 6-18, 100-185% FPL4 Age 1-18, 185-200% FPL	Medicaid limits	Medicaid limits
Pennsylvania	Age <1, 185-200% FPL Age 1-5, 133-200% FPL Age 6-18, 100-200% FPL	Participants may receive no more than a combined total of 90 day per year of inpatient hospital services, including mental health and substance abuse admissions.	1. Participants may receive no more than a combined total of 50 outpatient visits per year of mental health and/or substance abuse services. 2. Up to 50 visits/outpatient mental health services can be exchanged for inpatient hospital days.
Wisconsin	No Program	No Program	No Program

H. Medicaid Administrative Claiming/Medi-Cal Administrative Activities

Federal matching funds under Medicaid are available for the cost of administrative activities that directly support efforts to identify and enroll potential eligibles into Medicaid and that directly support the provision of medical services covered under the state Medicaid plan. In California, this program is called “Medi-Cal Administrative Activities” (or MAA) while in most other states it is called Medicaid Administrative Claiming, or MAC. MAC/MAA provides a 50% reimbursement for a broad range of services relating to assistance to individuals to enroll in or obtain services from a Medicaid service provider. What is particularly advantageous for Network members is that organizations can claim MAC/MAA even if they are not themselves Medicaid/Medi-Cal providers, so long as they are assisting their clients to obtain services from a

Medicaid/Medi-Cal provider. Additionally, it is much easier to obtain reimbursement for services provided by paraprofessionals and unlicensed staff than it is with most of the other funding sources identified above.

Services eligible for reimbursement include:

- Outreach: Providing Medicaid/Medi-Cal information to prospective applicants. Making initial referrals to Medicaid/Medi-Cal.
- Facilitating Applications
- Monitoring, Coordination, or Referral to Covered Services
- Arranging Transportation to medical services within the community
- Translation
- Program Planning, Policy Development & Interagency Coordination

Services can be provided over the phone (e.g. by a receptionist) as well as in person. Usually, MAC reimbursements are tracked using a "time-study" in which staff record and code all of their daily activities (usually in 15 minute increments) to ascertain which activities are MAC-reimburseable. Reimbursements are usually 50% of actual costs and can be treated as unrestricted revenue.

It is most likely that you will claim MAC/MAA through your local County Health Department, although claiming can also proceed through local school districts and various state departments. In any case, the best place to go for initial information about how to begin MAC/MAA claiming will be your local health department.

About the Author

Since 2005, Bob Bennett has been CEO of Family Service Agency of San Francisco, San Francisco's oldest and largest provider of outpatient social services. Under Mr. Bennett's leadership, FSA has developed an National Institute of Mental Health funded research center—in collaboration with the University of California, San Francisco—devoted to improving mental health treatment for low income elders and elders of color. In addition, FSA has developed the nation's most extensive model program for early diagnosis, treatment, and rehabilitation for schizophrenia. This project is currently initiating a three-county evaluation study to determine if this treatment approach can stably remit schizophrenia. FSA is also a major participant in the Back on Track Program, which is listed by the Department of Justice as a model program.

For 20 years, Mr. Bennett was CEO of Resource Development Associates, a national consulting firm focusing on transformation of large social service networks to make them more effective, more accountable, more culturally competent, and better funded. This strategic planning and evaluation firm was devoted to strengthening community-based social services in low-income communities and communities of color.

Mr. Bennett has consulted extensively for NIMH, the Department of Housing and Urban Development, US Justice Department, and SAMHSA, and was key in the development of California's perinatal substance abuse programs, California's Children's Systems of Care, and HUD's Supportive Housing Program.