MEDICAID: ADVANCING EQUITY FOR VICTIMS OF VIOLENCE

All Americans deserve health and safety in their everyday lives. Yet, in the United States, homicide is the leading cause of death among Black males aged 10-19 and 20-44.[1] For Latinx boys and men, it is the second leading cause among those aged 10-19 and the third leading cause among those aged 20-44. The disparate impact of gun violence on communities of color is further illustrated by the findings of a 2014 study, which calculated that compared to white Americans, the rate of non-fatal shootings for young Black Americans is 50 times higher.[2] Likewise, gendered and intimate forms of violence also create significant barriers to health and safety for survivors and communities: 1 in 4 women and 1 in 10 men in the United States will experience violence from an intimate partner, with higher incidence experienced by historically marginalized communities.[3]

In order to heal and thrive, survivors and those at greatest risk of experiencing all forms of violence and abuse—community, intimate partner, child abuse—need a wide range of physical and behavioral health services to address the physical and psychological effects of trauma. These services, which are most effectively delivered through a comprehensive public health approach to violence prevention and intervention, are critical as survivors face considerable health care needs both before violence occurs and to address the immediate and long-term health impacts of violence. Although the immediate physical wounds following injury are most obvious, the psychological needs and long-term health impacts are just as great—including chronic pain, STIs, hypertension, and cancer.[4] One study of patients injured by community violence found that their most frequently cited need was assistance with mental health services.[5] This is not surprising, given the high prevalence of post-traumatic stress disorder among these patients.[6]

Yet for many patients who have experienced violence or abuse, including low-income individuals and those from communities of color, physical and behavioral health care services can be difficult to access and afford. Many are

uninsured and have uneven access to providers—and even less access to trauma-informed and culturally and linguistically appropriate providers—which means critical services are often out of reach.

Health insurance is key to making these services available and affordable. As the largest public insurance program in the United States, Medicaid—which covered approximately 65 million Americans in 2018—is a lifeline for many violently injured patients.[7] Research indicates that among victims of gunshot wounds, nearly two out of three patients are either on Medicaid or uninsured, while only one in six have private insurance.[8] Likewise, gendered and intimate forms of violence have a greater impact on low-income individuals and communities, who are more likely to be on Medicaid or uninsured.[9]

Medicaid's unique federal-state partnership allows the program to provide state-specific, comprehensive coverage designed to meet the needs of each state's population. As a result, it plays an important role in meeting the health care needs, both immediately and over a lifetime, of those who have experienced violence and trauma.

Although the needs of those victimized by and at highest risk of violence are woefully underserved, some services for survivors of violence and abuse are financed through a range of resources based on the services provided and where they are received. The Victims of Crime Act (VOCA) provides direct compensation to those who are injured as well as assistance to certain service providers, while state and local governments directly fund critical services such as sexual assault forensic investigations, housing and other crisis services. While this funding mix is important to maintain, it is insufficient at current levels. Medicaid offers a unique opportunity to deliver much needed health services to survivors in need.

MEDICAID DISPROPORTIONATELY COVERS SURVIVORS OF VIOLENCE

Medicaid is a critical safety net that makes health insurance available and affordable for low-income and working individuals. It inherently advances health equity by providing comprehensive coverage for groups that might otherwise be uninsured, and it has successfully reduced rates of uninsurance in Black and Latinx communities across the country.[10] Given the disproportionate impact of gun violence in communities of color, Medicaid is an important part of the solution to ensure all survivors get the services they need.

Initially created alongside Medicare in 1965, Medicaid was designed to care for poor children and pregnant women. The program has gradually expanded eligibility, most notably following the passage of the Patient Protection and Affordable Care Act (ACA). Since then, all states have had the option to cover individuals who earn less than 138% of the federal poverty level under Medicaid. As of this writing, 39 states and the District of Columbia have opted to expand this coverage.[11]

The expansion of Medicaid under the ACA has proven to be a significant factor in decreasing racial disparities in access to health insurance.[12] However, much work remains to realize the program's full potential. Among the states that have yet to expand Medicaid, many are located in the Southeastern United States, leaving large, disproportionately minority populations uninsured. Additionally, Medicaid's eligibility rules exclude many immigrants from federal reimbursement, leaving them uninsured and creating confusion about eligibility in mixed-status families. With limited exceptions, undocumented individuals are locked out of federal health insurance programs.

Given the realities of patients who are most impacted by violence and its effects, Medicaid is the de facto health insurer for this population. This has tremendous downstream consequences for both patients and states. For patients, this means the services and eligibility requirements in each state will largely determine what is available to them as they heal and attempt to break the cycle of violence. For states, this means they are almost the exclusive payer for injuries associated with gun violence. This remains an issue for state budgets as health care spending is traditionally a top line item.

Projections following the passage of the ACA estimated that in the Medicaid expansion population alone, violent injuries would add $397 million dollars of expenditures to the program.[13] Although states share this expense with the federal government, this analysis only projected emergency department visits and hospitalizations and did not include longer term expenses such as mental health, adolescent health, perinatal health services or long-term care. Since Medicaid is the predominant payer of long-term services and supports in the United States, severe injuries related to violence—such as spinal cord and traumatic brain injuries—have lasting effects on state budgets.[14].

HOW MEDICAID SUPPORTS SURVIVORS OF VIOLENCE

Medicaid exists as a partnership between the federal government and the states.[15] For each patient covered under Medicaid, at least 50 percent of the costs are paid by the federal government, with higher percentages paid in states with lower incomes. Under this framework, the federal government has broad rules about the benefits states are required to cover and those that are optional. These rules allow states tremendous flexibility to determine which services are covered and how they are paid for.

In practice, this means each state has its own Medicaid State Plan that specifies benefit packages for patients, requirements for participating health care providers, and payment rules for reimbursement. States have an array of mechanisms to tailor their programs to best meet their citizens' health needs, ranging

AT ITS CORE, FEDERAL MEDICAID POLICY INCLUDES MANY TOOLS THAT STATES CAN USE TO PAY FOR THE TREATMENT OF ACUTE INJURIES, THE RELATED SHORT- AND LONG-TERM HEALTH CONSEQUENCES OF VIOLENCE, AS WELL AS PREVENTIVE HEALTH SERVICES.

from optional services to a variety of waivers that allow states to try new approaches to deliver care.

At its core, federal Medicaid policy includes many tools that states can use to pay for the treatment of acute injuries, the related short- and long-term health consequences of violence, as well as preventive health services. While specific benefit packages vary by state, the federal Essential Health Benefits (EHB) package—a baseline set of benefits that states are required to cover under Medicaid—is designed to provide more comprehensive coverage than is traditionally found in commercial health insurance. This minimum standard of coverage guarantees survivors of violence have access to critical medical services across the lifespan. As a result, Medicaid plays a key role in supporting survivors and ensuring equitable access to services.

FEDERAL ACTION: MEDICAID COVERAGE OF SERVICES TO ADDRESS VIOLENCE AND TRAUMA

As the central payer for violence-related injuries, the Medicaid program has the ability to take a proactive approach in both incentivizing high-quality care for victims of violence as well as promoting strategies that prevent violent reinjury.

Medicaid plays an important role in covering the behavioral and physical health services needed to address the acute care needs of survivors of violence as well as the health consequences of trauma over the lifespan. To leverage this flexibility, states must proactively choose to include the services and supports needed by survivors in their plans. Existing law permits coverage of many services that address trauma and behavioral health, and states are increasingly using their Medicaid programs to address the symptoms of trauma and exposure to violence.

The program has acknowledged the role it plays in addressing the symptoms of trauma. In 2013, the Department of Health and Human Services (HHS) released a letter to state officials that specifically addressed trauma-informed care for children and adolescents.[16] The letter outlined various strategies and opportunities for improving care and acknowledged that while no code in the Diagnostic and Statistical Manual of Mental Disorders (DSM) captures the full range of child trauma effects, trauma-related symptoms are identifiable and can be addressed with appropriate interventions:

The HAVI's Executive Director, Fatimah Loren Dreier, and Policy Director, Kyle Fischer, celebrate with Andrew Woods, Executive Director of Hartford Communities that Care, after Connecticut enacts nation's first legislation to ensure violently injured patients have access to HVIP services as a Medicaid benefit.

> Many of these children will demonstrate complex symptoms and/or behaviors that may not map directly to the [DSM] or the [ICD] . . . For example, there is currently no DSM diagnosis that adequately captures the range of child trauma effects . . . Yet, trauma-related symptoms are identifiable, can be clinically significant and can be addressed with appropriate interventions. For these children, appropriate screening, assessment and referral to evidenced-based practices are clearly indicated.

Although no similar letter has been released about the importance of trauma-informed care for adults, many of the Medicaid flexibilities listed can be leveraged to serve adults as well as children.

In addition to its recognition of trauma, federal Medicaid has increasingly provided support to leverage the program to address upstream and downstream impacts of trauma, including social determinants of health such as housing, food insecurity, and in some cases, exposure to violence. The Centers for Medicare and Medicaid Services (CMS) also recently released guidance to support coverage of medically necessary services for individuals with substance use disorders, including those who receive services in the community,[17] as well as an information bulletin on Coordinated Specialty Care designed to help identify and engage individuals with

serious mental illnesses.[18] While these models are defined for specific eligibility categories, they are notable because they demonstrate the willingness of CMS to provide community-based services with care management in a holistic manner.

Today, many states have begun to provide a more holistic bundle of services that address the social determinants of health—including exposure to violence, but also those that allow for safety and healing for survivors of violence, such as housing—and are moving ahead on a range of health care policy and payment reforms, including:

- Building specific bundles of services that address the needs of victims of violence
- Addressing social determinants of health and integrating community-based services and supports into health delivery systems
- Encouraging states to implement best practices and reimbursement strategies to support the needs of individuals who have been exposed to violence or may be experiencing the resulting trauma
- Ensuring that services that prevent further or increased violence are also offered

LEVERAGING CORE BENEFITS

Early and Periodic Screening, Diagnostic, and Treatment Benefit

Medicaid benefits for children and young adults are particularly robust. Specifically, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit ensures that children, adolescents and young adults up to age 21 receive all necessary screenings, diagnostic services, and referrals to treatment. This is a program entitlement (i.e., a legally guaranteed benefit) and applies to both fee-for-service Medicaid and managed care.

EPSDT is a powerful benefit that ensures medically necessary care—even if not covered in the state plan—will be covered by Medicaid. It covers a wide range of behavioral health screenings designed for early detection and intervention, and some state plans even include specific screening for adverse childhood experiences and exposure to violence.

The preventive and curative nature of EPSDT helps to ensure that health problems, including behavioral health issues, are identified and treated early. A wide range of providers—including schools, community health workers, home visitation specialists and more—can conduct initial screenings and assessments and work with pediatricians or other physicians to develop a plan of care. This flexibility allows screening, assessment and navigation to take place outside the traditional physician's office and in locations convenient to where survivors of violence live.

Although it is a powerful benefit, EPSDT does have limitations. Generally, Medicaid only covers "medically necessary" services and treatments for children and adolescents with a diagnosis, including for behavioral health services. This can make coverage difficult for prevention and early intervention services for those with mild diagnoses or who are at risk for developing more serious issues.

To address these limitations, states are exploring new ways to cover services before a diagnosis has been made and for those with mild diagnoses. For example, in 2020, Medi-Cal implemented an expanded policy that allows reimbursement for family therapy services for not only those with a mental health diagnosis, but also for children and adolescents who are at risk for mental health disorders.[19] The definition of "at risk" for mental health disorders includes risk factors such as trauma and other social determinants of health—like food or housing instability—as well as caregiver factors, like substance use or history of incarceration. A range of provider types may bill for this family therapy benefit, including psychologists, Licensed Clinical Social Workers (LCSW), Licensed Professional Clinical Counselors (LPCC), and Marriage and Family Therapists (MFT). Family therapy for treatment of mental health conditions in children and adults is reimbursable under Medicaid, as is family therapy for prevention of mental health conditions in children with specified risk factors.

It is important to note that in practice, providers and advocates may face certain challenges to realizing the full potential of EPSDT, including insufficient provider reimbursement, state utilization management techniques (e.g., strong medical necessity definitions), and lack of provider and community education. In order to realize the potential of the benefit, it is critical to enhance and better enforce EPSDT.

STATE OPTIONS FOR VIOLENCE PREVENTION AND CARE FOR SURVIVORS OF VIOLENCE

Health Homes

Medicaid "health homes" are an integrated care model—authorized in Section 1945 of the Social Security Act and created by Section 2703 of the ACA—that states can choose to adopt to coordinate care for adults and children with Medicaid who have certain chronic conditions.

Health homes provide comprehensive care management and coordination as well as a number of other supports and services targeted at the specific needs of the covered population. They are intended to promote the integration of all primary, acute, mental health, and substance-use related care to treat the whole person. As of 2019, 22 states had elected to use the Medicaid health home model to serve various populations and chronic conditions.[20]

In New York, an existing health home program is designed to provide care management for children and adults with serious mental health conditions, including individuals experiencing complex trauma. To participate in the trauma-informed health home, the individual must be enrolled in Medicaid and have one single qualifying condition that includes complex trauma and for which intensive services are appropriate. To determine eligibility, New York uses the CMS/SAMHSA definition of complex trauma, which incorporates:

- Exposure to multiple traumatic events, often of an invasive, interpersonal nature
- The wide-ranging, long-term impacts of the exposure

Once an individual is enrolled in the health home, the care manager identifies the appropriate service needs. The health home pays providers on a tiered rate structure based on the acuity of the patient's condition, and a flat rate is paid for "outreach" activities.

The program has experienced initial success: as of March 2018—15 months after the program began—the state had enrolled 2,730 children with complex trauma into the health home program.[21] Unfortunately, no additional information is currently available to the public about either the types of services delivered or

outcomes, but this is an important model for states to consider.

COVERAGE OF MENTAL HEALTH SERVICES FOR SURVIVORS OF VIOLENCE

Medicaid's Rehabilitative Services Benefit may be used to support survivors of all forms of violence. This benefit provides coverage of "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under state law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level." To operationalize this benefit, each state describes the services it covers and the list of providers who will deliver the services.

Many states use the Rehabilitative Services Benefit to cover individual and group counseling or peer-to-peer support, including for families exposed to violence.[22] Peer support providers are self-identified individuals who are in recovery, such as from mental health or substance use disorders. CMS has clarified that peer-to-peer support is also available to parents when the service is for the benefit of the child.[23] Peer support providers may be the parents or family members of a child with a similar mental illness or substance use disorder. Typically, they are community members with "lived experience" either as a consumer or a caregiver.

One way to extend these benefits is to provide covered services through the "Other Licensed Practitioner Services Benefit," which permits "any medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law." This benefit could be used to cover the services of a range of licensed professionals.

Similarly, for preventive services, states can enable non-licensed providers to deliver care that is recommended by a licensed provider. For example, this could include the domestic violence advocates who administer the screening and/or the brief counseling for domestic violence/interpersonal violence (DV/IPV)—a U.S. Preventive Services Task Force (USPSTF) B service that is covered under the women's health and preventive services packages. Anti-violence programs are consistently underfunded, and being able to seek reimbursement for these services has the potential to significantly expand their reach.

COVERAGE OF DYADIC SERVICES

Multi-generational services are critical in offering evidence-based violence prevention programming and could have significant spread and scale with enhanced Medicaid coverage. State Medicaid programs have the flexibility to cover dyadic services— a form of therapy in which an infant or young child and parent are treated together—ensuring that not only children but also their caregivers have access to healing and care. In order to promote attachment and break cycles of violence, states cover a range of services that either a) are for the parent and child together; or b) that would allow services for the parent to take place in a pediatric setting.

The implementation of these strategies can take place in a variety of ways, including by covering specific family interventions in the state Medicaid plan or through other Medicaid authorities. In a 2018 survey of states, 42 reported that their Medicaid plans pay for dyadic treatment of young children and parents, and 18 reported offering the services without a child's diagnosis but where there are potential risk factors in the family.[24] Of these, 11 states that cover dyadic treatment have a specific billing code for this treatment (AR, HI, LA, MA, MD, MI, MN, RI, UT, VT, and WA). Interestingly, in Washington State, providers who use an evidence-based dyadic treatment model use a specific "evidence-based practice code," which was established to help states track the use of specific treatments.

States are permitted to cover interventions in pediatric settings, such as parental education or assessment, as long as these services cannot be considered treatment. If a diagnosis is made, further treatment or services would have to be billed to the mother's Medicaid plan.

INNOVATIONS FOR SURVIVORS

As previously described, Medicaid gives states great flexibility to tailor benefits to best serve the needs of their states—including to support survivors of violence. The "waiver" process provides additional flexibility, allowing states to disregard certain Medicaid program rules to try new or different approaches to health care delivery or payment or to support specific patient populations.[25] In effect, this allows for creativity to advance new and equitable approaches to care.

SOCIAL DETERMINANTS OF HEALTH PILOTS

North Carolina is currently implementing a comprehensive Medicaid transformation project that was approved in October 2018 to test how to integrate and finance evidence-based non-medical services into the delivery of health care.[26] The Healthy Opportunities pilot will provide additional services and support to certain Medicaid enrollees with needs in:

- Housing
- Food
- Transportation
- Interpersonal safety and toxic stress

The Healthy Opportunities pilot is groundbreaking in that it is the first time Medicaid funds will be systematically used to pay for enhanced case management and other nonmedical support services. Through this program, survivors of IPV who are enrolled in Medicaid in certain regions are provided with additional support and nonmedical services that are not typically covered by health insurance. This includes services such as IPV case management, dyadic therapy, and specialized home visiting services.

There are many instances across the United States in which Medicaid is paying for services that address structural root causes of intersecting forms of violence like racism, economic insecurity, and unhealthy gender norms. Similarly there is an immense opportunity for Medicaid to expand coverage to service delivery models such as school-based health, parenting programs, restorative justice, and community health workers.

ADDRESSING COMMUNITY VIOLENCE: HOSPITAL-BASED VIOLENCE INTERVENTION PROGRAMS

Hospital-based Violence Intervention Programs (HVIPs) are multidisciplinary programs

that combine the efforts of medical staff with trusted community-based partners to provide safety planning, services, and trauma-informed care to violently injured people, most of whom are boys and men of color.

By engaging patients during their recovery in the hospital, HVIPs utilize a golden opportunity to improve patients' lives by addressing symptoms of trauma and addressing the upstream social determinants of health. This support goes beyond hospital walls and continues when patients are discharged, creating a pathway for wraparound services and outpatient care. The end result is a reduction in violent retaliation and repeat injuries.

Many high-risk people who have suffered violent injuries are extremely distrustful of mainstream institutions like the health care and criminal justice systems. Using a trauma-informed approach, specially trained violence prevention professionals (VPPs) can often break through this distrust. These highly trained paraprofessionals engage injured patients and their families in the emergency department, at the hospital bedside, or soon after discharge.

After gaining trust and introducing the program, VPPs work with clients and their families to develop a plan for after their discharge that meets their immediate safety needs, provides needed services, and establishes goals. This form of intensive case management promotes survivors' physical and mental recovery while also improving their social and economic conditions.

Research shows that this strategy works. One randomized control trial in Chicago showed that patients who participated in HVIPs had a 60% decrease in their risk of future injury (8.1% of participants, vs 20.3% of non-participants).[27] A similar program in Baltimore also showed substantial decreases in risk of future injury (5% of participants vs 20.3% of non-participants).[28]

HVIP participation has wide-ranging benefits beyond reinjury. Given that violent injury is a psychologically traumatic event, programs are well equipped to address signs and symptoms of trauma.

Philadelphia's Healing Hurt People Program has shown that patients who enroll in HVIPs experience exceedingly high rates of PTSD—as high as 75%.[29] Given such high rates of PTSD among violently injured patients, it is not surprising that a 10-year review of San Francisco's Wraparound Project found that 51% of participants self-reported mental health needs—which the program was able to address in 85% of cases.[30] HVIPs are equipped to assist patients in recovering from PTSD in a range of ways, including by decreasing unhealthy coping behaviors such as intake of alcohol, marijuana, and other drugs.[31]

COVERAGE FOR VIOLENCE PREVENTION PROFESSIONAL SERVICES

Violence Prevention Professionals are the central caregiver in the HVIP model. Typically, these highly specialized health care workers are patients' closest point of contact with the health care system as a whole. As such, they are critical for ensuring patients get the care that they need, when they need it.

Specifically, prevention professionals are defined as the following:

> Prevention Professionals work in programs aimed to address specific patient needs, such as suicide prevention, violence prevention, alcohol avoidance, drug avoidance, and tobacco prevention. The goal of the program is to reduce the risk of relapse, injury, or re-injury of the patient. Prevention Professionals work in a variety of settings and provide appropriate case management, mediation, referral, and mentorship services. Individuals complete prevention professionals training for the population of patients with whom they work.[32]

Violence prevention professionals are typically recruited from the same communities they will serve and often have a history of violent injury, which provides a shared experience to engage with patients. After working for an HVIP for at least six months, they are eligible for training by the Health Alliance for Violence Intervention to become certified as violence prevention professionals.

While state Medicaid agencies have the authority to reimburse VPPs for the services they provide to violently injured patients, most states are unaware of their ability to do so. Reimbursement for VPP services by Medicaid would not only provide financial stability to HVIPs but would also incentivize the provision of trauma-informed care while simultaneously reducing costs associated with reinjury.

The Health Alliance for Violence Intervention and Futures Without Violence have long advocated for Medicaid to reimburse the vital services provided by violence prevention professionals and domestic violence advocates to heal and support violently injured patients. As a result of these efforts, CMS recently hosted a webinar for states that, for the first time, outlined how administrators could include violence prevention services, such as those provided by HVIPs, in their Medicaid benefits packages. Formal guidance on Medicaid reimbursement for community violence intervention services and a toolkit for states are expected later this year.

Several routes exist to achieve reimbursement for VPP services. The first program to do so was an HVIP in Philadelphia, Healing Hurt People (HHP). Since 2017, the program has worked with its local behavioral health agency to provide "trauma-informed services for victims of violence." The Pennsylvania Medicaid program is organized so that behavioral health services are "carved out" from other services. In practice, this means that the local behavioral health insurer (in this case, the City of Philadelphia) retains the flexibility to run its program.

Under this arrangement, the City of Philadelphia's behavioral health provider, Community Behavioral Health, partners with HHP to ensure the mental health needs of violently injured patients are addressed. Specifically, frontline workers at HHP assess the signs and symptoms of trauma while violently injured patients are in the hospital and provide therapeutic interventions to address symptoms. They also work with clients to make plans for their discharge and long-term care. These services are reimbursed using a non-specific "mental health services" code based on 15-minute increments of time spent with clients. This arrangement allows several HHP team members to be reimbursed for services rendered, including their community intervention specialists and community health worker peers.

Recently, both the states of Connecticut and Illinois have elected to add violence prevention services to their state benefit packages. As of this writing, the states have not yet detailed which payment authorities they will utilize to do so. However, CMS has indicated they have multiple options to do so.

One route to coverage is through existing regulations stemming from the ACA. The ACA's preventive service rule authorizes states to reimburse non-physician providers to deliver

preventive services.[33] Under this arrangement, a physician or other licensed health care provider must recommend specific services for patients prior to care by the VPP. Since the HVIP model is based on a multidisciplinary care team, this mechanism could be easily implemented into the regular workflow.

In addition to the preventive service rule, CMS has outlined several other mechanisms to support violence prevention services, such as 1115 Demonstration Waivers, various constructs of the 1915 home and community-based services (HCBS) waivers, and health home authorities.

ADDRESSING INTIMATE PARTNER VIOLENCE: UNIVERSAL EDUCATION

Under the ACA, and in response to the known health impacts of IPV, health insurance companies are required to reimburse for brief counseling for IPV. Clinicians, social workers, health and peer navigators, promotoras, and health-based domestic violence advocates across the country are looking for comprehensive and effective ways to address and prevent IPV in the lives of their patients. Unlike traditional disclosure-based screening approaches for IPV, Adverse Childhood Experiences (ACEs), and other forms of trauma, the universal education approach, "CUES," offers health professionals the opportunity to share information and resources with all patients—not just those who feel safe enough to disclose violence or who happen to exhibit "red flags." "CUES" is an evidence-based approach that has been demonstrated to decrease risk for violence and coercion and associated poor health outcomes. This approach also encourages providers to normalize conversations about healthy relationships and supporting friends—including with people who are not experiencing violence—and to offer resources and support to people who may be using violence in their relationships. Programs with health and social service professionals and paraprofessionals who utilize universal education for IPV, violence, and trauma have the opportunity to sustain this work through Medicaid reimbursement for services that go beyond identifying victims to offer support to all patients and clients.

CONCLUSION

The Medicaid program allows states the opportunity to advance equitable care for survivors of violence. Although the life experiences of this population are diverse—from children recovering from abuse to people surviving intimate partner and sexual violence to young men of color impacted by community violence—their needs are often similar. All survivors of violence require comprehensive, longitudinal care to address the profound effects of trauma, and Medicaid can provide the necessary services through the Essential Health Benefits package and state options. Additionally, the waiver process provides opportunities for further innovation.

It is important to note that making changes to Medicaid can be challenging and take time. Adding services to state Medicaid programs may have implications for state budgets and may require states to work closely with CMS or to pass legislation. However, given that investments in violence prevention and the healing of those who have been violently injured have been shown to improve both short- and long-term health outcomes, states would be wise to consider ways to utilize and modernize their existing Medicaid programs to best support survivors of violence.

DIVERSIFYING FUNDING STREAMS TO SUPPORT SURVIVORS

Stable funding is a critical prerequisite to provide long-lasting, high-quality support for survivors of violence. While Medicaid offers stable reimbursement, best practices suggest service providers should have multiple sources of funding. One such source is the Victims of Crime Act (VOCA). Disbursed through the Crime Victims Fund, this funding stream dispenses dollars from the federal government through state administering agencies in two forms. The first, VOCA Compensation, provides reimbursement to victims of crime to cover expenses such as medical costs, mental health counseling, and lost wages. The second, VOCA Assistance Grants, fund organizations that support victims of crime, including survivors of violence.

The size of the Crime Victims Fund has fluctuated in recent years due to its dependence on money recouped from criminal fines. To address this instability, recent legislation—commonly referred to as the "VOCA Fix" Act—enacted several financial fixes to replenish the fund, which will mean increased and more reliable funding for victim assistance and compensation. The legislation also includes several provisions intended to increase flexibility for both state administering agencies and grantees. These include allowing states to eliminate financial match requirements, making grant funds available for longer periods of time, and giving states the option to eliminate barriers to victim compensation, such as requiring documentation of law enforcement cooperation. Combined, these VOCA reforms create a strong opportunity to pair with Medicaid reimbursement to more reliably fund support services for survivors of violence.

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