



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

MAURA T. HEALEY
Governor

KIMBERLEY DRISCOLL
Lieutenant Governor

KATHLEEN E. WALSH
Secretary

ROBERT GOLDSTEIN, MD, PhD
Commissioner

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December 2, 2024

Maura Healey, Governor
Massachusetts State House, Office of the Governor
Boston, MA 02133

Michael D. Hurley, Clerk
Massachusetts State House, Room 335
Boston, MA 02133

Steven T. James, Clerk
Massachusetts State House, Room 145
Boston, MA 02133

RE: Community Violence Prevention Task Force

Dear Governor Healey, Clerk James, and Clerk Hurley,

On behalf of the Community Violence Prevention Task Force (Task Force), established under Section 151 of Chapter 135 of the Acts of 2024, *An Act Modernizing Firearm Laws*, I am pleased to provide the following letter summarizing the Task Force's recommendations. Please accept this letter as the Task Force's report.

The Community Violence Prevention Task Force was responsible for reviewing the availability of federal funding to support community violence prevention (CVP) programs and making recommendations to maximize federal funding in an equitable manner that supports CVP service delivery across the Commonwealth. Included in its charge was the requirement that the Task Force consider three distinct topics related to supporting CVP programming through federal funding:

- i. whether federal funds may be applied equitably to CVP programs, in clinical and nonclinical settings, across geographic regions;
- ii. the ability of existing CVP and intervention programs to implement any federal requirements to be eligible for funding; and
- iii. any impact federal funding may have on the service delivery model of violence prevention services in the Commonwealth.

The Task Force was given until December 2, 2024 to submit its recommendations to the Governor and the Clerks of the House of Representatives and Senate. Chapter 135 noted that should the Task Force recommend that the Secretary of Health and Human Services pursue an amendment to the Medicaid state plan and seek any federal approval necessary to access federal funds to support equitable access to CVP services, then the Secretary shall pursue such an amendment and shall seek any such federal approval in accordance with the recommendations and findings of the Task Force.

At this time, after extensive deliberations, the Task Force is not able to recommend that the Secretary of Health and Human Services pursue an amendment to the Medicaid state plan due to the following implications related to cost, program model design, and equity:

1. Potential Cost Implications to Providers

Based on guidance from MassHealth and the EOHHS Office of Federal Finance and Revenue, it is anticipated that development and implementation of a Medicaid reimbursement system would require significant up-front costs for CVP providers, for which the current state budget does not provide funding. Some of these costs may be significant and ongoing, including:

- Development or licensing of information technology systems that can verify Medicaid eligibility, and track and report Medicaid claims-related activity.
- Recruitment, hiring, and training of staff and the development and implementation of processes to:
 - Confirm individuals' MassHealth eligibility;
 - Validate and document that allowable services have been provided;
 - Utilize covered codes of payment; and
 - Submit claims using covered codes for payment.
- Participating in state and federal audits, as required, which may include additional auditing and fiscal oversight costs.

In addition, in its deliberations, the Task Force received and reviewed testimony regarding the experiences of the eight states that have pursued Medicaid programs for CVP work – California, Colorado, Connecticut, Illinois, Maryland, New York, North Carolina, and Oregon. Despite several years of effort and cost, these states have received only minimal revenue from Medicaid.

2. Program Model Design Implications

CVP providers have voiced concerns that shifting payment for these services into a Medicaid construct, thereby requiring providers to submit claims for payment to MassHealth, could substantially alter the nature of CVP work, requiring significantly more administrative duties and paperwork and potentially leading to less contact with clients. Utilization of Medicaid rates, instead of existing grant funds to perform the above referenced tasks may require significant restructuring of existing program plans and budgets to account for more administrative capacity.

Many existing models for CVP work are evidence-based and deemed effective. Changing how providers do their work in order to comply with Medicaid requirements could impact the manner in which agencies operate, potentially impacting the effectiveness of services.

3. Equity Implications

As referenced above, providers may be required to invest significant up-front and continuing costs to become a Medicaid provider. While larger, more-established organizations may be able to adapt more easily to the additional administrative and cost requirements, smaller, grass-roots organizations currently

focusing on CVP work may not have sufficient administrative and staffing resources to meet these requirements, creating a barrier to their ability to access Medicaid reimbursements. The potential inability for smaller, grass-roots organizations to commit the resources necessary to become Medicaid providers, could reduce total CVP resources for the people, neighborhoods, and communities where they are needed most.

4. Other Considerations

The Task Force further discussed that the Commonwealth of Massachusetts has been a leader in the nation in this area, often taking advantage of innovative models of service delivery, and should remain committed to continuously evaluating Medicaid funding for CVP. The Task Force noted that the decision to pursue Medicaid reimbursement for CVP could be made at any point in the future.

Development of an implementation plan that mitigates the risks listed above, including consideration of additional funding for upfront and administrative costs, would be necessary in any future exploration of the use of federal funding for CVP work.

On behalf of the members of the Task Force, we are grateful to the Governor and Legislature for the opportunity to consider this topic and offer our recommendations.

I would be more than happy to make myself available to offer additional details on the Task Force's work and answer any questions you may have.

Sincerely,



Robbie Goldstein, MD, PhD
Commissioner, Department of Public Health
Chair of the Community Violence Prevention Task Force, acting as Secretary Walsh's designee

Cc: Kathleen E. Walsh, Secretary, Executive Office of Health and Human Services
Karen E. Spilka, Senate President
Ronald J. Mariano, House Speaker

Community Violence Prevention Task Force

Legal Authority: Chapter 135 of the Acts of 2024

Section 151

(a) Notwithstanding any general or special law to the contrary, the executive office of health and human services shall establish a task force to review the availability of federal funding to support community violence prevention programs and to make recommendations to maximize federal funding in an equitable manner that supports community violence prevention service delivery across the commonwealth.

The task force shall consist of: the secretary of health and human services or a designee, who shall serve as chair; the commissioner of public health or a designee; the director of Medicaid or a designee; and 9 persons to be appointed by the secretary of health and human services, 2 of whom shall represent organizations that have received a grant through the Safe and Successful Youth Initiative, 2 of whom shall represent recipients of the gun violence prevention grant through the department of public health, 2 of whom shall have lived experience with the impacts of community violence of which at least 1 shall have received services from a community violence intervention or prevention program, 1 of whom represents a hospital that currently operates a hospital-based violence prevention program in the commonwealth, 1 of whom represents a hospital in the commonwealth that does not currently operate a hospital-based violence prevention program and 1 of whom represents behavioral health care clinicians with experience providing trauma informed care.

(b) The task force shall consider: (i) whether federal funds may be applied equitably to community violence prevention programs, in clinical and nonclinical settings, across geographic regions; (ii) the ability of existing community violence prevention and intervention programs to implement any federal requirements to be eligible for funding; and (iii) any impact federal funding may have on the service delivery model of violence prevention services in the commonwealth.

(c) The task force shall submit its recommendations to the governor and the clerks of the house of representatives and senate not later than December 2, 2024.

(d) If the task force recommends that the secretary of health and human services pursue an amendment to the Medicaid state plan and seek any federal approval necessary to access federal funds to support equitable access to community violence prevention services, then the secretary shall pursue such an amendment and shall seek any such federal approval in accordance with the recommendations and findings of the task force.

Community Violence Prevention Task Force Membership

Member	Seat
Robbie Goldstein (<i>Chair</i>) Commissioner, Department of Public Health (DPH)	Secretary of Health and Human Services or a designee
Kevan Barton Executive Director, YouthConnect Program, Boys & Girls Clubs of Boston	Representative of behavioral health care clinicians with experience providing trauma informed care
Paul Brennan Director of EMS and Public Safety, Lawrence General Hospital	Representative of a hospital in the Commonwealth that does not currently operate a hospital-based violence prevention program
Clementina Chéry Founder, President and CEO, Louis D. Brown Peace Institute	Individual #1 with lived experience with the impacts of community violence
Gregg Croteau CEO, United Teen Equality Center (UTEC)	Representative #1 from an organization that has received a grant through the Safe and Successful Youth Initiative (SSYI)
Thea James Director, Violence Intervention Advocacy Program (VIAP), Boston Medical Center	Representative of a hospital that currently operates a hospital-based violence prevention program in the Commonwealth
Keesha LaTulippe Deputy Director, Bureau of Community Health and Prevention, DPH	DPH Commissioner or a designee
Dwight Robson Executive Vice President of Operations, Roca	Representative #2 from an organization that has received a grant through the Safe and Successful Youth Initiative (SSYI)
Monalisa Smith Founder, President, CEO, Mother's for Justice and Equality	Individual #2 with lived experience with the impacts of community violence and has received services from a community violence intervention or prevention program
Laxmi Tierney Director of Federal Finance, MassHealth	Assistant Secretary of Medicaid or a designee
Danayjah Yassen Safe Corners, Old Colony YMCA	Representative #1 of recipient of gun violence prevention grant through DPH
Vacant (<i>member stepped down after 2nd meeting</i>)	Representative #2 of recipient of gun violence prevention grant through DPH

Summary of Task Force Meetings

October 10, 2024

Summary: *Oath of office, overview of Open Meeting Law, Conflict of Interest regulations, and discussion of the Task Force’s charge and future priorities for its work*

Members were sworn in and briefed regarding the state’s Open Meeting Law (OML), Conflict of Interest, and Ethics laws and regulations. After reviewing the Task Force’s enabling legislation included within the Acts of 2024, members discussed their goals, expectations, and priorities for the Task Force’s work.

October 25, 2024

Summary: *Presentation on Medicaid for reimbursement for community violence intervention programming from the Health Alliance for Violence Intervention (HAVI)*

Staff from the Health Alliance for Violence Intervention (HAVI), provided a detailed overview of utilizing Medicaid reimbursement funding to support community violence prevention (CVP) programming, summarizing the experiences of the eight states – California, Colorado, Connecticut, Illinois, Maryland, New York, North Carolina, and Oregon – that have implemented such initiatives. Members discussed various aspects of the federal funding opportunity and how it might be implemented in Massachusetts. In their deliberations, members raised various topics, including, rate-setting, equity, stakeholder engagement, payment mechanisms, documentation, reimbursement timing, state Medicaid interagency coordination, social determinants of health, and upstream services. It was noted that since the efforts by other states began in 2021, only minimal, if any, revenue or federal financial participation (FFP) has been generated to date, despite significant investments and effort on behalf of the states and implementing partners.

November 1, 2024

Summary: *Presentation from MassHealth and the EOHHS Office of Federal Finance and Revenue on Medicaid reimbursement requirements and potential impacts of utilizing Medicaid funding to support CVP services in Massachusetts*

Representatives from MassHealth and the EOHHS Office of Federal Finance and Revenue provided an overview of Medicaid reimbursement requirements and the potential impact that utilizing Medicaid funding to support CVP services might have on programming in Massachusetts. Among the topics discussed were the process for the state to obtain legal authority for adding CVP as a new Medicaid service, drawing the distinction between State Plan Amendments (SPA) and 1115 Demonstration “Waivers;” as well as the process for organizations to enroll as MassHealth providers and the

requirements that must be met for enrollment. The use of “certified public expenditures” was discussed as a potential claiming strategy. The experiences of other states were also discussed.

November 8, 2024

Summary: *Continued discussion of the federal funding opportunity, as well as the potential impact on the Safe and Successful Youth Initiative structure*

Members continued discussion of the Medicaid funding opportunity, as well as the potential impact on existing CVP programs such as the Safe and Successful Youth Initiative (SSYI), a youth violence intervention program serving nearly 2,000 youth annually, operating in 14 Massachusetts cities with the highest crime and homicide numbers/rates. Members also discussed some of the up-front costs providers may need to invest to meet Medicaid requirements, including increased staff support, purchase of case management systems, and potential costs associated with audits.

November 22, 2024

Summary: *Review of the draft report and recommendations*

Members reviewed a draft of the report, which had been shared prior to the meeting. During the discussion, members cited multiple factors which influenced their thinking, including the ambiguity about the federal landscape and specifically the priorities of the incoming federal administration. While a vote was not taken on the report’s overall recommendation, members noted that there was consensus that it accurately captured the deliberations of the Task Force and reflected the perspectives of its members.

Note: For additional details on the work of the Task Force, including copies of presentations, resources reviewed, and approved meeting minutes, please visit the Task Force’s Mass.gov webpage:

<https://www.mass.gov/info-details/community-violence-prevention-task-force-meeting-materials>

Written Comments Received from Members Regarding the Draft Report

Note: the responses below have been lightly edited to remove members' contact information.

Paul Brennan:

As a safety net hospital, we would not be significantly burdened with much of the cost and challenges of implementing a Medicaid reimbursement system as these are already in place. Our challenge would be related to the annual salary expense associated with a new position and to what extent those expenses can be offset by funds generated through this program.

When I look at it through the lens of a small community service provider, I would have significant reservations about the many unknowns including:

- The cost of instituting, maintaining and future cost of electronic medical records system that meets the requirement of the program.
- The administrative burden required to meet the requirements of the program, including the possible need of additional staff and technologies.
- Unknown monetary benefit. It doesn't appear clear that Medicaid reimbursement is an improvement over funding that is currently received by other means.
- Unknown downstream impact. Would funding of this program result in a reduction of the funding of other programs?

I will defer to the community providers on the task force that will be significantly impacted by these requirements and changes and look forward to Friday's meeting.

Thank you,

Paul

Paul Brennan, B.S, NRP
Director, EMS and Public Safety
1 General Street
PO Box 189
Lawrence, MA 01842

Monalisa Smith:

The letter looks good. I believe this came up when we heard the presentation on the doula services being accepted as billable services, the advocacy reason, and why this is important in equity. The services being rendered to the clients would be billable, if they were being offered in a hospital or clinical setting or by larger nonprofits who have the expertise to do this, because CBOs don't have that option, they are serving clients and not able to get the cost reimbursed which puts a strain on the organization's operations. An example: MJE receives a lot of referrals from hospitals to support clients. The cost of this is covered by grants and contracts. We are not able to bill for these services under Medicare, but the hospitals are billing for the clients that they are referring. I hope this makes sense.

Monalisa Smith
Founder, President, and CEO
Mothers for Justice and Equality

Dwight Robson

Thank you for providing members of the Task Force an opportunity to provide additional feedback on the Task Force's report. I thought Friday's meeting was very productive and am **pleased that the draft report has been revised to note that while the Task Force isn't able to recommend Medicaid expansion for community violence prevention (CVP) at this time, that the group believes this is an idea that merits further evaluation.**

Roca is grateful to have had an opportunity to participate in the Task Force. We appreciate that this a complex matter and we regret that there wasn't more time to explore some of the key issues in greater depth. While we don't claim to be experts—far from it actually—we **continue to believe that Medicaid expansion for violence prevention is an idea that could bring significant additional federal funding to the Commonwealth, support and strengthen a continuum of hospital- and community-based violence prevention services, and, most importantly, save more young people from serious injury and early death.**

I provided substantive feedback prior to and during Friday's meeting, so I won't provide extensive additional comments at this time. Here is a brief summary on where we stand on some of the key issues.

1. Potential Cost Implications to Providers

We understand that there would likely be some cost implications for providers but wonder whether they would be as significant as others might believe. For example, violence prevention programs currently receiving state funding have to have a system to verify participant eligibility and meet certain training requirements. Programs receiving state and/or federal funding also already face auditing requirements. We are not suggesting that nothing would change or that there wouldn't be any additional cost, and that's why the proposal we put forward included an investment of state dollars to allow providers—especially small providers—the ability to develop capacity to participate in the program. **Of course, that would require an upfront investment on the part of the Commonwealth, but we believe that would be a wise investment in a program that could bring millions of dollars in additional federal funds to the state's coffers on an annual basis.**

The report notes that while eight other states have pursued Medicaid expansion for violence prevention work, there has only been minimal Medicaid billing to date. While this statement is accurate, we think it is important to note that what we proposed for Massachusetts was different than what is being done in any other state. Furthermore, while it has taken some time to implement, our understanding is that in a handful of the eight states Medicaid billing for violence prevention is expected to escalate.

2. Program Model Design Implications

There would undoubtedly be some programmatic implications of Medicaid expansion, but their significance would be determined by the design of the program. **We have been advised that existing SSYI providers, which are already contractually obligated to provide outreach, intensive case management and behavioral health care, could meet many of the service requirements that would likely appear if violence prevention were an allowable service under Medicaid.** As a result, our concern has focused on smaller providers who don't currently participate in SSYI. As noted earlier, that's why we proposed a pool of start-up funds for capacity building, which would allow smaller providers greater opportunity to engage in a service delivery system that is already fairly complicated.

3. Equity Implications

Whether or not the Commonwealth pursues Medicaid expansion for violence prevention, we believe more should be done to help small providers build their capacity so that they are better positioned to access SSYI, GVP and other state funding. It was with the smaller providers in mind that our Medicaid proposal included the aforementioned pool of funding for capacity building. Lastly, we noted the statement in draft report that equity implications could reduce total community violence prevention "...resources for the people, neighborhoods, and communities where they are needed most." **It was exactly those people, neighborhoods, and communities we had in mind when we proposed Medicaid expansion for violence prevention with the goal of bringing more resources—not fewer—to those who need it most and promoting health equity for the highest-risk young people.**

On another note, we appreciate that the draft report doesn't suggest that it might be financially disadvantageous for the Commonwealth to expand Medicaid for violence prevention due to the inclusion of SSYI in CHIP, as was suggested at the meeting before last. As we discussed during and after that meeting, our understanding of the facts suggests to us that the entire SSYI expenditure of \$11 million could draw a match under Medicaid (at least to the degree it is spent on a Medicaid member for eligible services) without reducing the reimbursement the Commonwealth receives under CHIP.

In closing, Massachusetts has much to be proud of as a national leader in gun safety and public health, and much of the Commonwealth's success can be traced to progressive leadership that has always believed we can do better than accept the status quo, even when the data suggests we are already performing well relative to other states. As an SSYI provider, we are extremely proud of the program and wouldn't want to do anything to undermine its impact. However, we also wouldn't want to miss an opportunity to build on its success by pursuing Medicaid expansion for violence prevention and provide another opportunity for the Commonwealth to affirm its position of national leadership. In that spirit, **perhaps the Commonwealth would consider testing the impact of Medicaid expansion for violence prevention by collaborating with a provider or two willing to participate in a pilot program while continuing to hold all other providers harmless.** If that is of interest to EOHHS, Roca would certainly be willing to discuss our potential participation in such a pilot.

Finally, I would underscore that while any significant policy change—no matter how promising—invites some level of risk, there are no assurances with the status quo either. To address an economic downturn, the Legislature and the Administration could make the tough decision to reduce funding levels. In addition, the upcoming change in the White House could lead to significant shifts in policy and/or reductions in federal funding for community violence prevention.

Thank you again, Gabe. While I wish that the Task Force hadn't had to work under such a compressed time frame, **I appreciate the effort you and Commissioner Goldstein have made to organize the group and facilitate our learning and a productive discussion.**

Best,

Dwight

Dwight Robson
EVP, Operations

Thea James:

Thank you for the extremely well- organized process we have been engaged in to meet the charge of the task force. This has been quite impressive.

Please see bullets below.

- There are challenges for some existing programs as documented in the draft, (smaller programs, lack of existing resources to meet new requirements for Medicaid funding, etc)) However a decision to not accept this opportunity for Medicaid funding to impact and positively alter the quality and outcome of life course trajectory would truly be a missed opportunity. This opportunity could possibly not ever become available again given recent and present future political circumstances.
- The opportunity for transformation of program clients is a longitudinal societal investment-this is not based in theory, it is based in witnessed, program experience. The transformation that can occur in clients enables a shift in mindset and setting of goals. Positive outcomes are rooted in program strategy and design. Intentionality to design for specific, intended outcomes, and additionally, accountability in operations, are foundational to transformation.
- We should engage in thoughtful options or provisions for under-resourced programs to be able to participate meaningfully and contribute to the opportunity for transformation. Perhaps, incorporating a preparation runway could be possible.
- In my opinion, the Medicaid funding opportunity is a worthwhile bet to make and a true value proposition if structured to achieve goals.

Thea James, MD, MBA
VP of Mission | Associate CMO
Co-Executive Director, Health Equity Accelerator
Boston Medical Center Health System
85 E Concord St, Boston, MA 02118

Kevan Barton:

Thank you both for the opportunity to have YouthConnect weigh in on this complex decision with fellow taskforce partners. I am in agreement with the letter as written and appreciate the time, care and diligence that went into this process and deliberations. I do believe MA has been a leader in so much including within CVP work. I am hopeful we will have a chance to reconvene again in the future to explore this further and to find additional ways of supporting this work financially that allows for sustainability and mitigates burden for any organization choosing to access Federal funds.

There are many organizations (YouthConnect included) engaged in this CVP (CVIP) ecosystem doing critical and invaluable work and having funds to support the necessary infrastructure for receiving state and federal funds at the front end (non- reimbursement model) would be ideal and out of the box thinking in my opinion - making it much more equitable across the Commonwealth.

With gratitude,
Kevan

Kevan A. Barton, MSW, LICSW
Executive Director
YouthConnect