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Comments on the CalAIM Proposal

Breaking the Cycle of Intimate Partner Violence through Medi-Cal Policy

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Preventing IPV through Medi-Cal Policy: Comments on the CalAIM Proposal

Overview

The California Advancing and Innovating Medi-Cal (CalAIM) proposal presents an opportunity to improve the health and well-being of beneficiaries by addressing a major social determinant of health: intimate partner violence (IPV). IPV is a widespread, multigenerational threat that profoundly affects health. Medi-Cal can use the CalAIM proposal to enact policies that prevent IPV and provide health care and social support services for survivors. This brief describes the health impacts and prevalence of IPV among Medi-Cal beneficiaries and details specific policy recommendations that would prevent IPV, identify those at risk, and provide health care and social support services for survivors.

Impact of IPV on Medi-Cal beneficiaries

IPV is pervasive in California. Among California residents, 35 percent of women and 31 percent of men report experiencing IPV or stalking by an intimate partner in their lifetimes.[1] While IPV occurs across racial, ethnic, and socioeconomic groups[2, 3] low-income populations, which Medi-Cal serves, experience greater barriers to leaving violent relationships and may be more vulnerable to poor health outcomes related to IPV.[4, 5]

Experiencing IPV is linked to profound, long-term impacts on the survivor's physical, reproductive, and behavioral health, and overall well-being. More than one in four women injured by an intimate partner require medical care for their injuries.[6] In addition to acute injuries, women and men disclosing IPV are more likely to experience asthma, chronic pain, irritable bowel syndrome, headaches, poor sleep, and activity limitations. Women are more likely to experience sexually transmitted infections, unintended pregnancy, pregnancy complications, and genitourinary problems.[7] Behavioral health conditions that are significantly more common among survivors of IPV than the general population include depression, anxiety, post-traumatic stress disorder, suicidal ideation, and alcohol and drug use.[8] In California specifically, studies suggest adult survivors of IPV were three times more likely to report experiencing serious psychological distress over the previous year than adults who were not exposed, and 33 percent of survivors reported needing help for a mental, emotional, or alcohol or other drug-related problem.[9]

Beyond physical and behavioral health conditions, survivors are more likely to experience a range of social needs. For example, experiencing domestic violence (DV) is a significant contributor to homelessness for women, with about 50 percent of all homeless women reporting DV as the immediate cause of homelessness.[10, 11] Survivors of IPV are at also at high risk for experiencing food insecurity, unemployment, and lack of transportation.[12, 13] In addition, compared to non-survivors, survivors tend to have less social support, such as friends and family members who can provide childcare, financial assistance, or safe places to stay.[14]

IPV is not just an issue that affects adults; many children witness domestic violence, an experience that affects their health and well-being. For example, about one in five children in the United States witness the assault of a parent before age 18.[15] Witnessing DV is associated with adverse behavioral health outcomes in children, including symptoms of post-traumatic stress disorder and difficulty with regulating emotions.[16] Also, strong evidence links experiencing or witnessing violence in childhood to increased likelihood of perpetrating or experiencing IPV later in life, thereby creating a multigenerational cycle that perpetuates the negative sequalae.[17, 18]

Interrupting the cycle of IPV requires effective and meaningful interventions that provide targeted health care and social support services for survivors and their families. These services should intervene at critical periods in the life course and address root causes such as poverty, housing instability, health inequities, and gender perceptions and bias.[19, 20, 21] Successful interventions require building partnerships across health care and social service providers to address the diverse challenges facing people affected by IPV, including physical and behavioral health needs, unstable housing, and unemployment.[22]

Because Medi-Cal insures one-third of California residents and serves low-income populations that are more vulnerable to the impacts of IPV, it is critical that Medi-Cal recognize the effects of IPV and implement evidence-based strategies to support survivors. Over the past several years, Medi-Cal and its partners have increasingly focused on improving quality of care and outcomes for vulnerable populations, including those with high behavioral health needs and those who experience social risk factors and health disparities.[23] Survivors of IPV should also be a focus of these efforts. By preventing IPV, and providing more effective health care and social support services to survivors, Medi-Cal has an opportunity to improve health outcomes and the lives of individuals and to interrupt the intergenerational cycle of IPV.

Opportunities to address IPV through the CalAIM proposal

CalAIM is a delivery system, program, and payment reform initiative that aims to improve quality of life for all Californians, while implementing targeted approaches to improve outcomes among people enrolled in Medi-Cal with complex needs, such as those experiencing homelessness, those with behavioral health conditions, and those with frequent emergency department visits or hospital stays. Because a large focus of the proposal is improving care for beneficiaries with complex needs, there are opportunities to specifically addresses prevention of IPV and the needs of survivors. For example, the proposal has several features:

- It calls for managed care plans to develop person-centered population health management programs to promote beneficiaries' wellness and identify and respond to the needs of high-risk populations—which would include those experiencing and at risk of IPV.
- It authorizes managed care plans to provide in lieu of services, or nonmedical services as alternatives to standard Medicaid benefits. In lieu of services include housing transition and navigation services, housing deposits, and housing tenancy and sustaining services, and should include other essential services such as economic support, employment support, and family support—which are critical services for survivors seeking to escape a violent home.
- It revises behavioral health medical necessity criteria to provide specialty mental health services to beneficiaries before a diagnosis is made—which would help improve timely access to mental health care for survivors.

Below we discuss policy recommendations related to each of these elements of the proposal. Exhibit 1 is a cross-walk and summary of the waiver provisions and the related policy recommendations.

Exhibit 1. Summary of opportunities to address IPV through the CalAIM proposal

Waiver provision	Recommendations for DHCS
Population health management program **CalAIM would require managed care plans to develop a whole system, person-centered population health management program to promote beneficiaries' wellness and identify and respond to the needs of high-risk populations.** **DHCS will develop a standardized, 10 to 15 question Individual Risk Assessment (IRA) Survey Tool. Medi-Cal managed care plans would use the IRA to assign members to risk tiers.** **Managed care plans' population health management programs would be required to conduct risk assessments, stratify beneficiaries by risk level, and implement strategies such as case management to address identified health-related social needs.**	1. **Specifically include individuals who experience or are at risk for IPV as a high-risk population whose needs should be identified and addressed** • Promote universal education about IPV in health care settings. • Consult with IPV advocacy organizations and service providers to develop guidance for managed care plans and providers about best practices to safely and effectively screen for IPV. • Encourage managed care plans to provide guidance to health care providers on how to safely and effectively screen for IPV in accordance with established best practices. • Partner with IPV advocacy organizations and service providers to develop guidance as to how managed care plans can promote relationships between health care providers and community-based IPV service providers. • Include specific questions about IPV when developing the IRA Survey Tool, which plans will use to stratify beneficiaries into risk tiers.
In lieu of services **The CalAIM proposal would authorize managed care plans to provide in lieu of services, or nonmedical services as alternatives to more costly standard Medicaid benefits.** **Examples of in lieu of services specified in the CalAIM proposal include housing transition and navigation services, housing deposits, and housing tenancy and sustaining services.**	**2. Consider the nonmedical needs of IPV survivors when developing guidance for provision of in lieu of services and/or value added services** • Encourage and provide guidance to managed care plans on how to apply a trauma-informed approach to promote housing stability among beneficiaries experiencing or surviving IPV. • Ensure that IPV service providers are able to participate with managed care organizations by supporting the unique privacy and confidentiality needs of survivors. • Partner with IPV service providers and advocacy organizations to develop guidance for innovative strategies managed care plans can use to safely cover IPV services. • Encourage and provide guidance to managed care plans on how to cover additional non-medical IPV services for survivors. • Encourage managed care plans to cover services for IPV survivors provided by a wide range of community-based, non-medical support providers who have been trained in and use trauma-informed practices, including community health workers (CHWs) and *promotores.*

Revisions to behavioral health medical necessity criteria **DHCS proposes to update and clarify medical necessity criteria for specialty mental health services for adults and children, including allowing reimbursement of treatment before diagnosis.** **DHCS also proposes to clarify Early Periodic Screening, Diagnostic, and Treatment services (EPSDT) protections for beneficiaries younger than 21 by developing criteria for children to access specialty mental health services based on experience of trauma and risk of developing future mental health conditions, such as involvement in child welfare or experience of homelessness.**	**3. Facilitate access to specialty mental health services specifically for adults and children who experience or are at risk for IPV** • Explicitly include experiencing or witnessing IPV as a risk factor that qualifies children to access services through EPSDT.

IPV survivors need a wide array of survivor-centered services

Strategies to address IPV must promote survivor-centered approaches that prioritize survivors' rights and preferences, provide whole-person care, and facilitate access to a range of clinical and non-clinical services to meet survivors' health and social needs. Survivor-centered approaches must include health care and social service providers who are knowledgeable about IPV and trained in providing trauma-informed care. Above all, survivor-centered approaches must promote the dignity and autonomy of survivors by respecting their choices[24] and providing a comprehensive array of services and supports to promote independence and wellbeing, including physical and behavioral health care as well as economic support, employment support, child care and family support. Exhibit 2 presents a list of IPV services—that is, essential services to support survivors of IPV as part of a survivor-centered, whole-person care approach.

Exhibit 2. Essential services to support survivors of IPV
Screening and referral: Universal screening in healthcare settings for IPV, reproductive coercion, and behavioral risk factors such as substance use and depression, and referral to services.
Trauma-informed behavioral health care: Trauma-informed care to address depression, anxiety, PTSD, substance use, and other behavioral health conditions. Evidence-based approaches include Cognitive Behavioral Therapy and Cognitive Trauma Therapy for Battered Women.
Comprehensive health care: Access to medical care to treat and manage survivors' physical health conditions, which may include physical injuries from IPV, sexually transmitted infections, and chronic conditions. Access to reproductive healthcare.
Tailored services for survivors: Access to survivor-centered services such as hotlines, crisis intervention and counseling, and shelters. Navigation services to help survivors access community resources and maintain employment, such as temporary childcare, transportation assistance, and nutrition support.
Housing support: Emergency shelters and transitional housing to support survivors leaving unsafe relationships. Housing navigation services and flexible funds that can be used for security deposits, rent, transportation, and other needs so as to support long-term housing stability.
Economic support, including childcare and nutrition support: Services to promote financial security among survivors, such as income supplements and cash transfers, employment assistance, nutrition assistance including the Supplemental Nutrition Assistance Program (SNAP), childcare subsidies, and tax credits
Legal advocacy services and access to civil legal protections: Legal support to help survivors navigate the criminal and civil legal systems, and promote safety through protective orders, supervised visitation programs, and removal of lethal weapons from perpetrators.
Evidence-based family support interventions: Interventions that provide support and education for families, such as early childhood home visiting programs and prenatal support interventions.

Recommendation 1: Specifically include individuals who experience or are at risk for IPV as a high-risk population whose needs should be identified and addressed in the population health management program

The CalAIM proposal would require managed care plans to develop a whole system, person-centered population health management program to promote beneficiaries' wellness and identify and respond to the needs of high-risk populations. Through the population health management program, managed care plans would conduct risk assessments, stratify beneficiaries by risk level, and implement strategies such as case management to address identified social needs.

Because IPV survivors comprise a high-risk population with a range of health care and social support needs (see Exhibit 2), DHCS should incorporate the needs of survivors into the design of the population health management program requirements.

Specifically, we recommend that DHCS:

- **Promote universal education about IPV in health care settings**.

  DHCS can encourage managed care plans to promote universal education about IPV in health care settings, using a model such as Futures Without Violence's CUES (Confidentiality, Universal Education and Empowerment, Support) intervention. CUES is an evidence-based intervention that teaches health care providers how to provide universal education about violence and healthy relationships, and how to create a patient-centered care plan and warm handoff to IPV services. Providing screening and education to all patients presents opportunities for survivors to receive education and resources, even if they do not choose to disclose their risk, and creates prevention opportunities to interrupt the cycle of violence. Studies of this intervention in primary care settings have shown that (1) women receiving the intervention were 60 percent more likely to end a relationship because it felt unhealthy or unsafe and (2) patients' knowledge of resources and harm reduction strategies increased.[25]

- **Consult with IPV advocacy organizations and service providers to develop guidance for managed care plans and providers about best practices to safely and effectively screen for IPV.**

  DHCS should engage with IPV advocacy organizations and service providers to develop guidance for providers and managed care plans regarding the best practices for screening for IPV and addressing identified safety needs. An example of an IPV advocacy organization that DHCS should engage is the California Partnership to End Domestic Violence (CPEDV). DHCS should also engage local IPV service providers, such as WEAVE in Sacramento, which provides crisis intervention services for IPV survivors along with referrals to community resources for other social support services. The CPEDV website also includes a list of IPV service providers in California that DHCS can engage.

  In consultation with IPV advocacy organizations and service providers, DHCS can adapt existing screening guidelines. As one example, the Maryland Department of Health developed a guide for health care providers with recommendations for how to screen for IPV and connect patients to appropriate community resources. Recommended practices include screening patients in private without anyone else present, avoiding stigmatizing words such as abuse or battered, and using culturally relevant language. Screening can occur during routine, preventive, and urgent visits. When providers suspect abuse, screenings should include safety assessments—to determine if patients are in immediate danger—and safety planning.[26]

  In consultation with IPV experts, DHCS can use or adapt an existing screening guide for providers, such as the guidance developed by Maryland. Exhibits 3 and 4 also include examples of IPV screening tools that DHCS can use to formulate IPV screening questions.

Exhibit 3. Examples of IPV screening tools

To determine appropriate questions for IPV screening, DHCS can use several tools the U.S. Preventive Services Task Force has determined accurately detect IPV, including Humiliation, Afraid, Rape, Kick (HARK); Hurt, Insult, Threaten, Scream (HITS); Extended–Hurt, Insult, Threaten, Scream (E-HITS); Partner Violence Screen (PVS); and Woman Abuse Screening Tool (WAST).[27]

Exhibit 4. Example of IPV screening questions from North Carolina's Standardized SDOH Screening Questions[28]

Do you feel physically and emotionally safe where you currently live? Yes or no

Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?
Yes or no

Within the past 12 months, have you been humiliated or emotionally abused in otherwise by your partner or ex-partner? Yes or no

- **Encourage managed care plans to provide guidance to health care providers on how to safely and effectively screen for IPV in accordance with established best practices.**

  After developing guidance for screening for IPV in consultation with experts, DHCS should encourage managed care plans to disseminate and promote screening guidance to health care providers. Educating providers is critical because there is evidence that many providers lack the knowledge and training to effectively screen for and follow-up on IPV disclosures or may be uncomfortable doing so.[29] In addition, there are important safety concerns for survivors related to disclosures of abuse that providers need to understand. For example, it is important to screen patients while they are alone; if the perpetrator is present, a patient will be less likely to disclose abuse, and the perpetrator may not allow the patient to return for care.

  Managed care plans should provide trainings emphasizing that screening and universal education are critical, and that disclosure itself is not the end goal. For example, while screening increases disclosures, screening also encourages survivors to seek help outside of the health care system—even in cases where survivors do not disclose to health care providers immediately. Trainings should also emphasize that it generally takes multiple screenings for survivors to disclose to trusted providers and that appropriate responses to disclosures require addressing survivors' varied health and social support needs and coordinating responses across health care and IPV service providers.[30]

- **Partner with IPV advocacy organizations and service providers to develop guidance as to how managed care plans can promote relationships between health care providers and community-based IPV service providers.**

  In addition to appropriately identifying survivors of IPV through screening, we recommend that DHCS encourage providers refer to, and managed care plans to coordinate health care and social support services with, community-based organizations that provide IPV services. To meet federal Medicaid managed care requirements regarding care coordination and continuity of care, managed care plans must coordinate services that beneficiaries receive from community and social support providers. In addition, the CalAIM proposal includes requirements for managed care plans to provide member services, referrals, transportation, health education, system navigation, and warm handoffs to community-based providers or other delivery systems. The proposal would also require managed care plans to mitigate Adverse Childhood Experiences (ACEs) and social determinants of health by using community resources and providing individual social care. IPV service providers serve these roles for survivors by offering trauma-informed services and supports—such as assistance with safety planning and connections to other community resources.[31]

DHCS should engage with IPV advocacy organizations and service providers, such as CPEDV and WEAVE, to develop specific guidance as to how managed care plans can best build relationships with community-based organizations. As DHCS engage with advocacy organizations and service providers, it can also consider examples of partnership building from within California and in other states. Exhibit 5 includes an example of building relationships between California providers and community-based organizations through the Domestic Violence and Health Care Partnerships project. The Oregon Health Care Coordinated Care Organizations, discussed in Exhibit 6, represent another example of building connections between Medicaid managed care and community-based organizations.

As a part of this relationship-building, DHCS should identify ways for managed care plans to compensate IPV service providers and should engage IPV service providers in identifying appropriate payment methods that protect the safety and privacy of survivors. In consultation with IPV service providers, DHCS can promote use of payment methods that North Carolina's Medicaid program will employ in the Healthy Opportunity Pilots. Specifically, under the pilots, IPV community-based organizations would receive a per-member-per-month payment for IPV case management and violence intervention services, whereas dyadic therapy for survivors and their children and linkages to legal supports would be reimbursed per occurrence (see Exhibit 8 for more detail). As another option, DHCS could encourage Medi-Cal managed care plans to pursue similar arrangements as those that they have previously used with Community Health Workers (CHWs), such as directly employing IPV service providers or contracting with community partners that employ IPV service providers.

Exhibit 5. Example of building connections between providers and community-based organizations: The Domestic Violence and Health Care Partnerships

A model for building provider capacity and relationships with community organizations is the Domestic Violence and Health Care Partnerships, a collaboration of the Blue Shield of California Foundation and Futures Without Violence. This project partnered health care safety net providers with DV service providers and included training for health care providers regarding how to screen for DV, discuss these topics with patients, and provide referrals to the partnered DV organizations. The program showed an increase in the number of providers who screened for and discussed DV with their patients. Health care providers and DV service providers also reported greater confidence in referring clients to one another.[32] The evaluation of this project found establishing communication protocols and referral processes between health care providers and DV organizations to be critical for building collaboration and integration across settings. Specific communication protocols included formal agreements regarding the referral processes and written protocols for health care providers regarding assessment and response to DV.

Exhibit 6. Example of building connections between managed care and community-based organizations: Oregon Health Care Coordinated Care Organizations[33]

One model for linking Medicaid managed care with community organizations is the Oregon Health Care Coordinated Care Organizations (CCOs). CCOs are regional entities that are responsible for the whole well-being of Oregon Medicaid managed care beneficiaries. CCOs coordinate mental and physical health care and focus on preventive care. Oregon law mandates they work with traditional health workers, which includes Community Health Workers (CHWs), peer support specialists, and doulas. As part of their mission to address upstream health issues, CCOs may offer "flexible services funding," which pays for nontraditional medical services, such as advocacy services, and "community benefit initiatives," which are investments at the community level in care management or provider capacity. For example, one CCO granted community investment funds to a local women's resource center to enable the center to expand its advocacy and build its health care partnerships. CCOs also have local advisory councils to which they are accountable, which IPV organizations can join.

- **Include specific questions about IPV when developing the IRA Survey Tool, which plans will use to stratify beneficiaries into risk tiers.**

  While developing the guidance for conducting population risk assessments, DHCS can encourage managed care plans to promote screening to identify beneficiaries experiencing or living in a household with IPV.[1] In addition, given the substantial health risks associated with experiencing and witnessing IPV, when constructing algorithms for risk stratification or segmentation, DHCS should encourage managed care plans to consider IPV as a factor for placing beneficiaries into a higher risk tier.

  When DHCS develops the IRA Survey Tool that plans will use to validate risk tier placement, the survey should include specific questions about experiencing IPV. Some of the suggested categories for the IRA to cover, including emergency department use, access to basic needs, housing assessment, and availability of social supports, align with the needs of survivors of IPV, but the tool should also include an explicit question about experiencing or witnessing violence—such as from one of the screening tools listed in Exhibit 3. DHCS should provide plans with similar guidance to that which is given to providers regarding best practices for conducting screenings for IPV to ensure that plans' care managers conduct risk assessments, screenings and referrals without causing harm to survivors or putting them in danger.

[1] The CalAIM proposal would require population health management programs to include preventative health visits for all adults in accordance with U.S. Preventive Services Task Force Grade "A" and "B," which include a recommendation for screening women of reproductive age for IPV.

Recommendation 2: Consider the nonmedical needs of IPV survivors when developing guidance for provision of **in lieu of services** and/or value added services.

The CalAIM proposal includes a list of 14 non-medical in lieu of services as alternatives to standard Medicaid benefits that managed care plans can choose to provide. Examples of in lieu of services specified in the CalAIM proposal include housing transition and navigation services, housing deposits, and housing tenancy and sustaining services. DHCS should include additional services and encourage managed care plans to provide these as in lieu of or value added services that address the needs of IPV survivors, especially transportation support, job placement services, childcare subsidies, financial services, home visiting and parenting programs, and navigation and peer support services provided by community health workers (CHWs) and promotores.

Given IPV survivors' particular need for housing supports and increased risk for health and behavioral health conditions, DHCS can develop specific guidance related to addressing IPV survivors' housing and social support needs through a trauma-informed lens and to covering these support services as in lieu of and/or value added services. The eligibility criteria for housing services specified in the CalAIM proposal include being "homeless," "chronically homeless" or "at risk of homelessness," as defined in Section 91.5 of Title 24 of the Code of Federal Regulations and receiving enhanced care management, having one or more serious chronic condition(s) and/or serious mental illness (SMI) and/or being at risk of institutionalization or requiring residential services as a result of a substance use disorder (SUD). These criteria represent risks that are elevated among IPV survivors. For example, in California, women who have experienced DV are four times as likely to report housing insecurity than those who have not.[34] In 2020, HUD Continuums of Care in California reported 1,960 victims of DV were in emergency shelter, 819 were in transitional housing, and 7,996 were unsheltered.[35]

To address the needs of survivors, DHCS should:

- Encourage and provide guidance to managed care plans on how to apply a trauma-informed approach to promote housing stability among beneficiaries experiencing or surviving IPV.

  DHCS should provide managed care plans with guidance on how to provide and tailored housing services to support survivors who are at risk of or experiencing homelessness. Guidance from DHCS should include important components of housing assistance for IPV survivors, such as providing trauma-informed and survivor-driven services with flexible financial assistance to enable survivors to meet their housing needs. Exhibit 7 highlights the DV Housing First pilot programs in California and Washington State as examples of survivor-driven housing assistance programs which managed care plans can connect survivors to or replicate.

Exhibit 7. Examples of addressing housing instability for DV survivors: The DV Housing First Pilots

The DV Housing First Pilots implemented in Washington State and California are evidence-based models that increase access to permanent and affordable housing as a foundational step for empowering survivors to leave violent environments and rebuild their lives. The Washington State program, funded by the Bill & Melinda Gates Foundation, included 13 agencies serving more than 500 survivors across the state.[36] The California pilot, funded by the California Office of Emergency Services, was implemented in 33 nonprofit agencies across the state by 2017 to support survivors in need of housing and supportive services. Participants received funds that they could use for rental assistance, move-in costs, transportation, and debt assistance. An evaluation of 925 survivors who received flexible funds found that the majority of participants (58 percent) used their funds to prevent homelessness.[37] Currently, California has over 65 sites that have received grants for DV Housing First, and California's DV Housing First Program served over 10,000 new individuals in FY 2019-2020.[38] The evaluations of the California and Washington models emphasized the importance of flexible funding to meet each survivor's unique needs.

- **Ensure that IPV service providers are able to participate with managed care organizations by supporting the unique privacy and confidentiality needs of survivors.**

  Given the safety issues regarding disclosure of IPV, there is a need for special consideration regarding payment of IPV services, related documentation of services, and reporting requirements. Managed care plans should support survivors' use of and trust in the health care system by training providers on several key protections including: robust and informed patient consent about sharing of health care data; patient control over how their data is shared and with whom; transparency over who has access to their data and when data is shared; and enforceable penalties for violations of privacy. In addition, health plans must consider how information is shared on explanation of benefit forms so that information about the receipt of sensitive services or providers is not included and potentially accessible to perpetrators.

- **Partner with IPV service providers and advocacy organizations to develop guidance for innovative strategies managed care plans can use to safely cover IPV services.**

  IPV service providers offer critical services to survivors, including trained IPV advocates who assist with safety planning and who provide connections to community supports such as housing and employment services. Studies have shown IPV service providers help improve survivors' quality of life and reduce instances of abuse.[39] DHCS can seek recommendations from IPV service providers for innovative strategies Medi-Cal can employ to pay for DV services without compromising beneficiaries' safety. Payment models, such as monthly flat fees that cover services for an assumed number of survivors, rather than payment tied to billing based on services rendered to individual beneficiaries, could help protect the privacy and ensure the safety of survivors. The North Carolina Healthy Opportunities Pilots, described in Exhibit 8, are one state Medicaid agency's approach to creating a mechanism that integrates and pays for nonmedical social support services, including IPV services provided by community-based organizations. DHCS should engage with IPV service providers in California to develop a similar approach or identify other innovative strategies for Medi-Cal to fund the services of IPV services.

Exhibit 8. Covering interpersonal violence advocacy services under the North Carolina Healthy Opportunities Pilots[40, 41]

North Carolina is pursuing direct reimbursement for interpersonal violence advocacy services under its Health Opportunities Pilots. These pilots are part of the state's Medicaid Section 1115 demonstration and its transition to Medicaid managed care. Within these pilots, a local lead entity will facilitate relationships between local human services organizations, including organizations providing services that address interpersonal violence. The state managed care plans will pay the local lead entities, which in turn will pay local human services organizations for covered services. Payment rates will depend on a fee schedule generated by the state and approved by the Centers for Medicare & Medicaid Services (CMS). Two services, Interpersonal Violence Case Management Services for survivors and Violence Intervention Services for perpetrators, will be paid for on a per-member-per-month basis, whereas parenting support programs, evidence-based home visiting services, and dyadic therapy will be reimbursed on a fee-for-service basis.

Note: This pilot program was put on hold due to the COVID-19 public health emergency; the North Carolina Department of Health and Human Services has resumed reviewing proposals for the pilots as of January 2021 but has yet to post information regarding selected contract awards or a new start date of the pilots on its website.

- **Encourage and provide guidance to managed care plans on how to cover additional non-medical IPV services for survivors.**

  Because survivors are at higher risk for experiencing unmet social support needs including DHCS should encourage managed care plans to cover additional in lieu of and/or value-added services to help survivors access the service they need. For example, IPV is not limited to physical abuse; perpetrators may engage in financial abuse (such as withholding money or sabotaging employment) or use their relationship or custody of children to harm the survivors and limit their ability to access both medical and social support services. Survivors should receive assistance navigating job placement services, transportation services, and financial services that can allow them to attain financial independence. Legal services are also essential for survivors who may need personal protection orders, help with dissolving marriages or domestic partnerships, or assistance in securing custody of children. In addition, survivors with children need access to childcare and parenting support, such as secure places to send their children while they pursue employments, housing, or attempt to meet other social needs. Parenting programs can also help to end the cycle of violence by teaching positive parent practices and increasing prosocial behaviors in children.[42] DHCS should encourage managed care plans to cover these critical services as in lieu of service or value-added services.

  DHCS should consult with IPV service providers to develop guidance regarding appropriate payment methods for in lieu of and value-added services. For example, as described above, DHCS and experts may consider following the model of the North Carolina's Healthy Opportunities Pilots—which include per-member-per-month payment and per occurrence payments depending on the specific service types (see Exhibit 8 for more detail).

- **Encourage managed care plans to cover services for IPV survivors provided by a wide range of community-based, non-medical social support providers who have been trained in and use trauma-informed practices, including community health workers (CHWs) and *promotores*.**

  Many Medi-Cal managed care plans, particularly those participating in the Health Homes Program and the Whole Person Care Pilot, employ or contract with CHWs and *promotores* to provide outreach, navigation, and peer support services to beneficiaries with complex needs.[43] CHWs and *promotores* are typically trusted community members and/or individuals with a particularly strong understanding of the communities they serve; thus, CHWs and *promotores* can be uniquely positioned to build trust with survivors, identify health and social needs, and help survivors navigate services.[44, 45] Evidence suggests CHWs and *promotores* increase patients' engagement with the health care system and improve a variety of health outcomes, including chronic disease management and cervical cancer screening. Of note, there is evidence that CHWs and *promotores* are effective in improving outcomes among populations that face cultural, linguistic, and geographic barriers to care.[46] There is also some evidence that CHWs can successfully engage IPV survivors in services and help improve survivors' feelings of safety.[47] As one example of a Medi-Cal managed care plan using CHWs, the Inland Empire Health Plan has deployed more than 100 CHWs to provide care management for beneficiaries with chronic physical and behavioral health conditions. Inland Empire Health Plan provides intensive training for CHWs, covering topics such as trauma-informed care, motivational interviewing, and linkage to community resources.[48]

Recommendation 3: Facilitate access to **specialty mental health services** specifically for adults and children who experience or are at risk for IPV

Given the substantial psychological trauma and risks associated with IPV, many survivors have considerable need for mental health services. The proposed changes to medical necessity criteria in the CalAIM proposal—specifically allowing reimbursement for services before receipt of diagnosis and expanding access to specialty mental health services for children, adolescents, and young adults based on experience of trauma and risk of developing future mental health conditions—can remove barriers to care for beneficiaries experiencing or witnessing IPV. For example, many survivors have not engaged with a behavioral health provider or received a behavioral health diagnosis; barriers may include perceived stigma, lack of affordable or linguistically appropriate services, or coercive behavior from a perpetrator who prohibits access to services. Allowing reimbursement for treatment before diagnosis can help survivors who are in immediate need of care and potentially prevent development or progression of chronic mental health conditions. Expanding access to mental health services for adults and for children at risk of IPV can help families heal and play a role in breaking the intergenerational cycle of violence.[49]

DHCS should:

- Explicitly include experiencing or witnessing IPV as a risk factor that qualifies children to access services through EPSDT.

  Enabling children who need specialty mental health services to receive them on the basis of IPV exposure is an important mechanism for intervening at critical junctures in their development and disrupting the intergenerational cycle of IPV. The proposed clarification to the EPSDT protections criteria will allow children to access specialty mental health services based on experience of trauma, such as IPV, and can help ensure children receive care that can prevent future mental health conditions. Screening children specifically for exposure to IPV is critical

given the increased risk of emotional and behavioral problems as well as emotional, physical, and sexual abuse among children who experience or witness IPV.[50]

When clarifying the EPSDT criteria, DHCS should explicitly include exposure to IPV as a risk factor that qualifies children as scoring in the high-risk range on the DHCS-approved trauma screening tool and, therefore, eligible to access specialty mental health services. The Pediatric Adverse Childhood Experiences (ACEs) and Related Life Events Screener (PEARLS), the screening tool for ACEs that Medi-Cal providers currently use as part of the ACEs Aware Initiative, includes a screening question related to children's exposure to violence.[51] DHCS should promote managed care plans' use of the PEARLS screening tool as an approved trauma screening tool.

Conclusion

The CalAIM proposal presents an opportunity for Medi-Cal to help beneficiaries who currently experience IPV. While IPV occurs across income levels, low income survivors and their families are less likely to have access to the resources they need to leave violent environments and improve their lives. By encouraging appropriate screening for IPV, building community connections to IPV service providers, and connecting survivors to important resources—including housing support, CHWs, and *promotores*—DHCS can enable survivors to get the support they need to improve health and wellbeing for themselves and their children. To ensure clinical and non-clinical services are survivor driven, DHCS should engage with IPV service providers— and with advocacy organizations and survivors—to develop guidance for health care provider's regarding screening and referral to services, and managed care plans' coverage of in lieu of and value-add services. CalAIM also presents an opportunity to help break the intergenerational cycle of violence by promoting universal education about healthy relationships and safety resources, helping to reduce children's exposure to violence within the home, and helping to ensure that children and adults who have experienced IPV can access the services they need to heal. The recommendations in this brief will help address the needs of some of the most vulnerable Californians and support attainment of CalAIM's goals: to manage beneficiaries' risk, improve health care quality and outcomes, and reduce health disparities.

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