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breaking the cycle of intimate partner violence

States Leverage Medicaid to Address and Prevent Intimate Partner Violence

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Executive Summary

Intimate partner violence (IPV) is a public health crisis in California. Among California residents, 35 percent of women and 31 percent of men report experiencing violence from their partner at some point in their lives. In 2022, Medi-Cal began the five-year CalAIM initiative[1] to transform Medi-Cal into a health delivery system that, among other objectives, supports whole person care and the social drivers of health.[2] CalAIM presents many opportunities for Medi-Cal to adopt evidence-based strategies to meet IPV survivors' needs, prevent IPV, and interrupt the intergenerational cycle of violence. At the request of Blue Shield of California Foundation, Mathematica conducted an environmental scan of state Medicaid agencies and their efforts to prevent IPV among Medicaid enrollees and provide support services to IPV survivors in Medicaid.

Our research identified eight states implementing policies to address and prevent IPV by using contracts with managed care plans and/or through Section 1115 demonstrations. Two states featured in this report, North Carolina and Rhode Island, use 1115 Medicaid demonstrations to create comprehensive programs that test methods to address a range of SDOH, including IPV. This brief presents the results of the environmental scan and highlights key practices that Medi-Cal should consider as it works to implement CalAIM and address IPV in California, including recommendations in the following areas: program authorities and monitoring, health-related social needs (HRSN) screening and trust, referral networks and platform privacy, covered services and supports.

I. Introduction

IPV is a public health crisis in California.[3] Among California residents, 35 percent of women and 31 percent of men report experiencing violence from their partner at some point in their lives.[4] These figures are particularly alarming given that experiencing IPV is linked to long-term negative effects on women's and men's physical, behavioral, and environmental health across the life course.[5, 6, 7, 8, 9]

The physical consequences of IPV are profound. More than one in four female IPV survivors require medical care for their injuries, and frequently, those injuries lead to chronic pain and activity limitations.[10,11] The physical effects of IPV are not limited to acute injuries but to chronic conditions as well, including asthma, persistent headaches, irritable bowel syndrome, sexually transmitted infections, unintended pregnancies, and obstetric complications, such as pre-term birth, low birth weight, and pregnancy-associated death.[12,13]

Experiencing IPV is also known to increase the likelihood of developing behavioral health conditions, such as depression, anxiety, post-traumatic stress disorder (PTSD), somatic pain, and substance use.[14, 15,16] A study of adult women living in California, for example, found that IPV survivors were three times more likely to experience serious psychological distress than women who were not exposed to IPV.[17] Of these survivors, 33 percent reported needing assistance with a mental, emotional, or substance misuse issue.[18]

IPV has lasting consequences for children and adults. A study showed that approximately 20 percent of children in the United States witnesses the assault of a parent before age 18.[19] Witnessing or surviving IPV during childhood can result in PTSD and difficulties with emotional regulation.[20] In addition, children exposed to IPV are more likely to perpetrate or experience violence later in life, resulting in an intergenerational cycle.[21,22]

The consequences of IPV extend beyond physical and behavioral health conditions. IPV survivors are more likely to experience substantial environmental and social disruptions that threaten overall quality of life. For instance, experiencing IPV is a contributor to homelessness; about half of all unhoused women report IPV as the immediate cause of their homelessness.[23,24] IPV survivors are also at high risk for experiencing food insecurity, unemployment, and lack of transportation.[25,26] In addition, compared with non-survivors, IPV survivors tend to have fewer deep social connections to friends and family who can provide childcare, financial assistance, safe places to stay, and emotional support during difficult times.[27]

IPV occurs across racial, ethnic, and socioeconomic groups. People experiencing poverty, however, often encounter more significant barriers to leaving violent relationships and are more vulnerable to the poor health outcomes related to IPV.[28,29,30,31] Given that Medi-Cal insures individuals and families with low income —and that Medi-Cal insures one-third of all Californians —the program can make a significant impact on the problem of IPV.[32]

In 2022, Medi-Cal launched the five-year CalAIM initiative.[33] CalAIM seeks to foster innovations and processes that will enable Medi-Cal to modernize, improve quality outcomes, reduce health disparities, use value-based payment models, simplify the way in which enrollees navigate the Medi-Cal system, and transform Medi-Cal into a health delivery system that supports whole person care and the social drivers of health.[34] CalAIM presents many opportunities for Medi-Cal to adopt evidence-based, whole-person strategies to address the needs of IPV survivors, prevent IPV, and interrupt the intergenerational cycle of violence.

Mathematica's environmental scan of state Medicaid agencies' efforts to prevent IPV and provide support services to IPV survivors included a targeted literature review and interviews with state Medicaid agencies, IPV service organizations, advocates, community-based organizations, and Medicaid managed care plans. (See Appendix A detailed methods.) This issue brief summarizes our findings and highlights key practices for addressing and preventing IPV that Medi-Cal should consider as it implements CalAIM.

Key research questions:

- How do state Medicaid agencies assess and address IPV in their enrollee populations?
- What programs or policies have state Medicaid agencies adopted to address and prevent IPV?
- What authorities did state Medicaid agencies use to implement their IPV-related programs or policies?
- What challenges did state Medicaid agencies face, and how did they overcome those challenges?
- For Medicaid agencies with existing IPV prevention programs, how are they augmenting their efforts to improve response and better meet survivor needs?

II. State Medicaid efforts to address IPV

While all state Medicaid programs must cover certain services, states can go beyond the standard Medicaid benefit package and cover non-traditional value-added services, like IPV screening and prevention. For example, states that have existing managed care programs through authorities like 1932(a), 1915(b), or 1115 can use their managed care contracts to set requirements for providers regarding IPV screening and services. Those requirements can include screening methods and screening frequency and referral network composition and referral methods. Managed care plan contract alterations do not, however, necessarily mean that additional federal Medicaid dollars will flow into a state. Therefore, state Medicaid agencies and managed care plans must also negotiate how to fund new contract requirements related to IPV.[35]

States that wish to exceed the coverage and payment limitations in their existing authorities can use Section 1115 demonstrations to set more innovating requirements on both managed care plans and FFS providers covered by these authorities. Applying for a Section 1115 demonstration is, however, a more involved process than altering managed care contracts. The process requires state Medicaid agencies to develop a comprehensive plan that includes detail on how it will address particular health issues, like IPV, and this plan must be approved by CMS. The plan typically defines state Medicaid agency activities for several years, specifies a third-party evaluation approach, and shows how the plan will maintain budget neutrality. If approved, the state Medicaid agency may have to work with health plans to revise contract requirements, enlist support from community organizations, and coordinate with state government agencies to achieve desired outcomes. The demonstrations can also come with additional federal Medicaid funding.[36]

Our research identified eight states implementing policies to address and prevent IPV by using contracts with managed care plans and/or through Section 1115 demonstrations. All eight states use managed care contracts to, at a minimum, require health plans to screen Medicaid enrollees for IPV. Those states are Arizona, Kansas, Massachusetts, New Mexico, North Carolina, Rhode Island, Virginia, and Wisconsin. Two of those states, North Carolina and Rhode Island, use authority under their Section 1115 Medicaid demonstrations and managed care plan contracts to address the needs of IPV survivors.

III. States that use managed care contract requirements to prevent and address the needs of IPV survivors among Medicaid enrollees

Although most states' Medicaid programs include language in their managed care contracts requiring managed care plans to address at least one social determinant of health (SDOH), only the eight states mentioned above include requirements explicitly addressing IPV screening and referral services for Medicaid enrollees.[37]

The eight states demonstrate a range of IPV-related requirements that state Medicaid agencies can include in managed care plan contracts. However, vigorous monitoring and enforcement mechanisms are essential for successful and effective managed care plan contract requirements, particularly IPV screening and support requirements.[38] Wisconsin, for example, contracts with an external quality review organization to ensure Medicaid enrollees are screened for IPV and referred to services.[39]

In addition to monitoring and enforcement, several other considerations are important when evaluating and crafting managed care contract language:

- How will Medicaid managed care enrollees' IPV-related needs be identified?
- How will Medicaid managed care enrollees be referred to providers?
- Is the managed care provider network sufficient to meet enrollees' IPV-related health and support needs?
- Are managed care providers sufficiently trained to appropriately provide enrollees' health and support?
- Will health care providers, case managers, or managed care plan representative follow-up with Medicaid managed care enrollees in a confidential manner and ensure their evolving needs are met?

These high-level questions may not capture all nuances of Medicaid managed care enrollees' care journey. However, they are a starting point for assessing comprehensiveness of IPV-related MCO contract language and service provision. Table 1 presents summaries of MCO contract language from the eight states. Table B.1 in Appendix B includes actual text from MCO contracts.

Table 1. Summary of managed care plan contract language related to IPV

State	Summary of managed care plan contract language	Authority for managed care	Managed care program reviewed
Arizona[40]	Arizona's contract language regarding assessing Medicaid enrollees' health needs does not specifically mention IPV. However, depending on the screening tool and approach used by managed care plans and their health care providers, Medicaid enrollees might be assessed for IPV. Arizona does, however, specifically require MCOs to provide care coordination services for survivors of sex trafficking and provide them with trauma-informed resources.[41]	1115(a)	Arizona Health Care Cost Containment System

State	Summary of managed care plan contract language	Authority for managed care	Managed care program reviewed
Kansas[42]	Kansas's MCO contract language requires managed care plans to assess Medicaid enrollees' health needs at least every other year.[43] The state requires managed care plans to use a standard health screening that includes a question capturing physical, emotional, and verbal forms of IPV. Kansas also requires plans to provide physical and behavioral health coordination and to refer patients to community resources and non-Medicaid supports as needed.[44]	1115(a)	KanCare
Massachusetts[45]	Massachusetts's MCO contract language requires plans to assess enrollees' social needs, including needs related to experiencing violence. The state's contract language also requires plans to provide enrollees assistance in accessing services to meet their needs. Of note, the state emphasizes that these services are not limited to medically necessary services and can include nonmedical support services.[46] Support services can include: • providing referrals to social services agencies • coordinating transportation services • providing enrollees information regarding community providers counseling • facilitating transition to other levels, settings, and frequencies of care and providers.	1115(a)	Accountable Care Partnership Plans & MassHealth Managed Care
New Mexico[47]	New Mexico's contract language requires that MCOs screen pregnant mothers for IPV. In addition, the state's contract language requires MCOs to provide individuals and families with health education services focused on IPV.[48]	1115(a)	Centennial Care
North Carolina[49]	North Carolina's contract language requires that its managed care plans, called prepaid health plans, use risk scoring and stratification to identify members who are part of priority populations and explicitly includes members experiencing or witnessing domestic violence as a priority population.	1115(a)	Community Care of North Carolina
Rhode Island[50]	Rhode Island's contract language specifies that each managed care plan create a network of specialty providers that is sufficient to meet the health care needs of the women and men who have experienced IPV. These requirements only apply to Rhode Island's managed care population, which constitutes approximately 30 percent of the state's Medicaid enrollees. The remaining 70 percent of enrollees are part of the Health System Transformation Project demonstration's FFS coverage. Provider requirements related to the FFS population (described in section V.B of this report) are outlined in the demonstration and the AE certifications.	1115(a)	RIte Care, Rhody Health Partners and Medicaid Expansion

State	Summary of managed care plan contract language	Authority for managed care	Managed care program reviewed
Virginia[51]	Virginia's contract language focuses on minor children experiencing domestic and sexual violence and/or neglect. The contract language requires that each MCO create a network to examine and treat survivors of child domestic and sexual violence and neglect.	1915(b)	Medallion 4.0
Wisconsin[52]	**Screening for violence or abuse:** Wisconsin's MCO contract requires that managed care providers assess vulnerability and risk factors for abuse and neglect among Medicaid enrollees. Depending on the care setting, the assessment is completed by a social services coordinator or a licensed registered nurse. **Care management and referrals:** MCOs are required to identify and authorize services and supports that will help ensure an IPV survivor's health, safety, and well-being. MCOs and are required to ensure their provider networks have adequate providers with experience and expertise working with victims of abuse, including domestic violence. **Monitoring:** MCOs are required to report incidents that include IPV. For example, they are required to report when a member has suffered or caused an injury or accident related to physical or sexual abuse, or neglect. **Enforcement:** The Wisconsin Department of Health Services (DHS) contracts with an external quality review organization to monitor MCOs' assessment of IPV risk annually and to ensure that identified IPV risk is addressed. DHS conducts follow-up with MCOs that need additional coaching. MCOs also conduct internal monitoring related to IPV assessment and referrals.	1932(a)	BadgerCare Plus

IV. States that use Medicaid 1115 demonstrations to prevent and address IPV among Medicaid enrollees

Two states use 1115 demonstrations to identify and address IPV: North Carolina and Rhode Island. Below we describe each briefly. (Appendices C and D provide additional information about each state's approach, respectively.)

A. North Carolina: Healthy Opportunities Pilots

Background

North Carolina used Section 1115 demonstration authority to implement its Healthy Opportunities Pilots. The pilots are designed to enhance direct medical care with social services, including IPV supports. Eligibility for the Healthy Opportunities pilots is limited to Medicaid enrollees who live in one of the three pilot regions and who participate in a Medicaid managed care plan. Medicaid enrollees must also have at least one physical or behavioral risk factor and one social risk factor to qualify.[53,54,55,56]

Program structure

Community-based organizations (CBOs) play an important role in the demonstration because they offer a variety of nonmedical, wraparound services that support the four targeted needs: (1) housing, (2) food, (3) transportation, and (4) IPV.[57,58] The Healthy Opportunities pilots refer to IPV as "interpersonal violence and toxic stress." For consistency and clarity in this report, we will use "IPV."

Screening and referral for services and referral for health-related social needs

Medicaid enrollees in the pilot program are screened at least once a year for physical health, behavioral health, and social health needs by a managed care plan representative using a SDOH tool. Medicaid enrollees who screen for IPV are referred to needed social support services, like housing assistance, IPV case management, and legal services. Referrals are made using a closed-loop referral platform.[59]

Payment models and billing

North Carolina's Medicaid agency pays MCOs on a per-member-per-month or capitated basis. MCOs use the funds to pay CBOs on a FFS basis. CBOs can submit claims, such for violence intervention services, using an easy point and click billing platform developed by the state Medicaid agency. The state developed the billing platform because CBOs often lack the infrastructure and staffing necessary to develop and implement their own billing programs.[60]

Covered services

North Carolina's pilot covers a set of 29 nonmedical support services categorized into one of four priority domains: (1) food, (2) housing, (3) transportation, and (4) IPV. IPV services include: IPV case management services, violence intervention services, evidence-based parenting education, home visiting services, and dyadic therapy. Medicaid enrollees experiencing IPV may also avail themselves of other billable support services, such as: housing move-in assistance, healthy food boxes, and reimbursement for health-related public transportation.[61,62]

Challenges

Although IPV-related nonmedical services are a core component of North Carolina's Healthy Opportunity Pilots, they are not yet fully implemented. Only the home visiting services and evidence-based parenting curriculum are fully implemented as of August 2022. Rolling out IPV-related services proved challenging due to several factors—most notably, the challenge of ensuring that billing and referral systems maintain IPV-survivor confidentiality in a manner consistent with the Violence Against Women Act of 1994. The legislation prohibits, for example, disclosure of survivors' personally identifying information even when it is collected in connection with health services.

IPV service providers in North Carolina raised concerns about maintaining Medicaid enrollee confidentiality when billing and making referrals. Addressing these concerns is a priority for North Carolina's Medicaid agency, as confidentiality concerns may prevent CBOs from participating in the pilot. Healthy Opportunity Pilots leadership's primary strategy to address confidentiality issues is to work with key stakeholders who have expertise in IPV survivor policy and safety. For example, pilot leadership is collaborating with the North Carolina Coalition Against Domestic Violence and their legal counsel to identify and implement necessary billing and referral platform modifications before IPV services launch. Healthy Opportunity leadership also noted, however, that managed care plans must at a minimum be able to identify covered Medicaid enrollees, assess their physical and behavioral health and HRSN, and authorize appropriate services for the pilot program to be effective and bill appropriately.[63,64]

Looking forward

In the future, the Healthy Opportunity Pilots will include the following activities:

- Technology and privacy—North Carolina's statewide closed-loop referral system needs additional security and privacy enhancements to protect IPV survivors' safety.[65]
- Contract amendments with CBOs—North Carolina will modify CBOs contracts to ensure Medicaid enrollee data is secure, shared appropriately, and Medicaid enrollee contact preferences are respected.[66]
- Training for care managers—North Carolina will provide care managers with additional trauma-specific trainings so they can improve their communication skills and effectively help IPV survivors.[67]

B. Rhode Island: Health System Transformation Project Social Determinants of Health Investment Strategy

Background

Rhode Island used Medicaid 1115 demonstration authority to implement its Health System Transformation Project (HSTP), a social determinants of health investment strategy that focuses, in part, on IPV.[68]

Program structure

The HSTP Medicaid demonstration divides Rhode Island into seven regions, with one Accountable Entity (AE) in each region. AEs are health care provider-led organizations, such as federally qualified health centers (FQHCs), large primary care networks, or hospitals. The AEs provide direct medical care to

Medicaid enrollees in their region. They also contract with local CBOs to provide nonmedical support services, such as housing navigation, food access, transportation, and IPV assistance, to Medicaid enrollees.[69,70] Together, the AEs and CBOs function effectively as accountable care organizations.[71]

Screening and referral for health-related social needs

Medicaid enrollees' physical health HRSNs are assessed annually using screening tools developed by each AE. For example, the screening tool created by the AE Prospect Health Services RI, Inc. includes questions about food security, financial strain, employment, and several other domains (see table IV A of the appendix for the complete Prospect Health screening tool). The screening tools vary by AE, however each tool must be approved by the state Medicaid agency and contain an IPV component. If the assessment process reveals that enrollees are experiencing IPV, they are referred to medical care and social support services, such as a domestic violence resource centers, using a close-loop referral platform called Unite Us.[72] Each AE must maintain contracts with domestic violence resource centers for referral.[73]

Rhode Island's Medicaid agency does not provide direct training to AEs on how to best screen Medicaid enrollees for IPV. However, some AEs are augmenting their IPV screening and referral efforts by partnering with the Rhode Island Coalition Against Domestic Violence. The coalition is training care managers on best practices for interacting with Medicaid enrollees experiencing IPV, identifying IPV risk factors, duty to report requirements, and safely sharing enrollee information with care teams and CBO personnel.[74]

Payment models and billing

Rhode Island Medicaid pays Accountable Entities on a fee-for-service basis and incentivizes HRSN screening with a shared savings program based on performance.[75,76]

Challenges

To foster patient-provider trust, AEs are working to ensure that Medicaid enrollees consistently interact with the same care managers and primary care providers. Patient–provider trust is essential for honest responses to SDOH assessments, particularly the IPV components of the tool.[77,78]

Looking forward

Rhode Island identified three areas for further work as the demonstration progresses:

- Evaluation—The collaboration between AEs and CBOs is relatively new to Rhode Island, with most partnerships beginning in 2016. As with all Section 1115 demonstrations, third-party evaluation is required. Third-party evaluation will not only enable the state to evaluate the demonstration comprehensively, but it will also allow Rhode Island to look at IPV-specific components with a focus on effectiveness and potential improvements.[79]
- Sustainability—Rhode Island is committed to continuing the work of the demonstration and its IPV components. To that end, Rhode Island Medicaid personnel are exploring options to make the AE program sustainable.[80]
- Shared savings—The Rhode Island Medicaid team found that AEs are unfamiliar with shared savings, and sometimes struggle to use shared savings to produce positive health outcomes among

high-risk populations, such as IPV survivors. Consequently, the Rhode Island Medicaid team plans to coach AEs about how to access an optimize shared savings to better serve high-risk populations.[81]

V. Future considerations and recommendations

Program authorities and monitoring: Two states featured in this report, North Carolina and Rhode Island, use 1115 Medicaid demonstrations to create comprehensive programs that test methods to address a range of SDOH, including IPV. Other states include IPV-related requirements in their managed care contracts. For example, Wisconsin includes language specific to screening, network adequacy, an IPV response program in its managed care plan contracts. To monitor and hold plans accountable for IPV requirements, Wisconsin contracts with an external quality review organization (EQRO) to annually assess MCOs' IPV screening efforts. The state also conducts follow-up based on an EQRO assessment and provides additional coaching as needed. North Carolina and Rhode Island, however, work with third-party evaluators to assess IPV program fidelity and effectiveness.

Medi-Cal and Medi-Cal managed care plans can improve screening and promote universal education, an approach which entails training health care providers on the prevalence of IPV and encouraging them to discuss IPV with every patient, even those who do not disclose. Currently, requirements for IPV screening or universal education in Medi-Cal are not clearly stated in Medi-Cal managed care contracts. For example, no IPV screening requirements were identified in a review of Medi-Cal managed care boilerplate contracts from fiscal year 2017-2018.[82] In August of 2022, Medi-Cal released a notice of award for new managed care plan contracts. The new contracts are currently publicly unavailable, so whether they contain IPV requirements remains unclear.[83]

- **Recommendation**: Medi-Cal should consider leveraging the CalAIM transformation process to support IPV survivors by requiring IPV screening and referral as part of the CalAIM population health management program, and pairing those requirements with robust monitoring, enforcement, and evaluation.
- **Recommendation**: In addition to screening, universal education is an evidence-based approach in which providers speak with all patients about elements of healthy versus unhealthy relationships and the health effects of violence. Through universal education programs, providers also connect patients with resources such as crisis hotlines. Medi-Cal and managed care plans can promote Futures Without Violence's model for universal education known as CUES (Confidentiality, Universal Education and Empowerment, Support). Futures Without Violence developed Confidentiality, Universal Education and Empowerment, Support (CUES) an evidence-based intervention to prevent, identify, and respond to domestic violence in health care settings.[84] Research on universal education shows that it may improve patient knowledge of resources and support survivors in improving their safety and reducing harm.[85]

HRSN screening and trust*:* Wisconsin, North Carolina, and Rhode Island screen Medicaid enrollees at least annually for HRSN and IPV. In North Carolina, Medicaid enrollees are screened using the Pilot Eligibility and Service Authorization (PESA) screener, a tool developed by North Carolina's Medicaid agency. Rhode Island, however, allows each of its AEs to develop and use their own HRSN screeners. The HRSN screeners in both states contain mandatory IPV components, but different care team members conduct the HRSN and IPV assessments depending on the state. Rhode Island Medicaid personnel noted that, regardless of who is responsible for conducting HRSN and IPV assessments, provider–patient trust

is essential for garnering honest answers from Medicaid enrollees—and honest answers are the basis for appropriate referral.

- **Recommendation**: As part of the CalAIM transformation, the California Department of Health Care Services expects each managed care plan to gather and use a wide variety of data, such as Medicaid enrollee assessments and screenings.[86] Medi-Cal should therefore review existing screening tools to determine which tool to apply to its IPV screening efforts. Beyond the HRSN tools developed by North Carolina and Rhode Island, several screeners with IPV components exist. The Social Interventions Research and Evaluations Network at the University of San Francisco California created a comprehensive list of HRSN screeners and identified those with IPV questions.[87] Several other screening tools accurately detect IPV: HARK (Humiliation, Afraid, Rape, Kick) tool; HITS (Hurt, Insult, Threaten, Scream); E-HITS (Extended—Hurt, Insult, Threaten, Scream); PVS (Partner Violence Screen); and WAST (Woman Abuse Screening Tool). Additionally, the HRSN screener PRAPARE (developed by the National Association of Community Health Centers)[88] is widely used in community health centers, and the Accountable Health Communities Health-Related Social Needs Screening Tool (developed by the Centers for Medicare & Medicaid Services)[89] also contains an IPV component.[90]
- **Recommendation**: Medi-Cal can encourage health plans and health care providers to establish provider-patient trust by consistently using the same care team member when interacting with IPV survivors. Moreover, Medi-Cal may consider training health providers on the health consequences of abuse, IPV prevention education for enrollees, maintaining enrollee confidentiality, and effective social interventions for IPV.

Referral networks and platform privacy: North Carolina and Rhode Island established robust referral networks with CBOs that work in housing, transportation, food security, and IPV services. Both states also developed closed-loop platforms so that CBOs and health care providers can make seamless referrals to one another. However, both North Carolina and Rhode Island noted that maintaining survivor privacy is a concern when using their referral platform, so the states are working with local domestic violence advocacy organizations to make platform reforms.

Recommendation: As part of CalAIM, managed care plans will need to connect members to community support services through closed-loop referral processes. These processes can allow healthcare providers and CBOs of all sizes and capacities to connect patients experiencing or at risk for IPV with needed non-medical, social support services. However, because IPV survivors have unique privacy needs, Medi-Cal and managed care plans will need to ensure the platforms prioritize survivor privacy and confidentiality, and should engage with CBOs in developing appropriate protections. A California Health Care Foundation report discusses more detailed recommendations for developing closed-loop referral platforms and processes.[91]

Covered services and supports: Both North Carolina and Rhode Island developed a fee schedule of covered IPV services and supports that was informed by a public comment period where IPV survivors, experts, Medicaid enrollees, and concerned community members voiced their opinions.

- **Recommendation**: Medi-Cal should consult IPV survivors, experts, Medicaid enrollees, community members, and advocates if it develops its own suite of covered IPV services and supports.

Payment models and billing: North Carolina's and Rhode Island's payment models are different in that North Carolina makes capitated payments to network leads and Rhode Island makes FFS payments and

shared savings to AEs. However, both states pay CBOs participating in their respective programs on an FFS basis. Both states also developed billing platforms for CBO use, as many CBOs lack the infrastructure and staffing to develop their own billing programs—potentially hindering their participation and a robust referral network.

- **Recommendation**: In August 2022, the California Department of Health Care Services released guidance stating that managed care plans are expected to support CBOs in their billing of rendered services. The guidance also stated that managed care plans and CBOs should utilize billing systems that respect confidentiality.[92] Medi-Cal may consider emulating some components of North Carolina and Rhode Island's billing program to augment its own efforts.

Federal Medicaid policy provides authority to states to respond to the needs of survivors of IPV. The eight states highlighted in this report illustrate the range of IPV-related activities that are currently covered in state Medicaid programs. Medi-Cal should consider adopting these approaches and other initiatives to support survivors' needs.

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Appendices

Appendix A. Methods

We collected information to inform this brief via (1) a literature review and (2) interviews with staff from state departments of health, Medicaid agencies, managed care plans, and community organizations.

Targeted literature review

We reviewed published and gray literature as well as state Medicaid documents. To identify relevant literature, we conducted several searches in early June of 2022 to early July of 2022. We first searched the databases PubMed and EBSCO with search terms such as intimate partner violence, domestic violence, and Medicaid. Next, we used Google to search for grey literature concerning IPV and Medicaid, targeting websites with relevant content by limiting results to the .gov, .org, and .edu domains. We also used Harvard's Think Tank Search to identify results from institutions that produce public policy research and analysis, and we scanned news articles using the research database Nexis. Finally, we reviewed select Medicaid State Plan Amendments, Section 1115 demonstrations, and managed care plan contracts posted on state-maintained websites. Those documents were selected from states that our published and grey literature review suggested may be addressing IPV through Medicaid.

Interviews with states

Identifying states. We targeted states for interview based on the results of our literature review and suggestions from staff at Futures Without Violence and O'Rourke Strategies. We included states that appeared to be addressing IPV and other social determinants of health (SDOH), such as housing and food security, meaning the states were included in reports categorizing state efforts to address IPV and other SODH through 1115 waivers[93] and/or managed care contracts.[94] The states included Arizona, Delaware, Illinois, Kansas, Maryland, Massachusetts, Minnesota, Nebraska, New Jersey, New Mexico, New York, North Carolina, Rhode Island, Virginia, Washington, and Wisconsin.

Recruiting states for interviews. We began by emailing state Medicaid agency staff with information about our research objectives and requests for interview. If we did not hear from Medicaid agency staff, we sent a follow-up email approximately three days after the first email, requesting an interview. If state Medicaid agency staff did not respond to either email, we contacted them by phone.

Developing the interview protocol. We developed a semi-structured interview protocol in collaboration with in-house experts and external partners. The interview protocol included a brief introduction to our study, interview goals, and a set of questions that we adapted based on individuals' responses, such as: "can you provide a general overview of the program and how it addresses or prevents IPV,", "What authorities did you use to implement the program?", and "How services are paid for?"

Conducting interviews. A Mathematica researcher and notetaker conducted all interviews by telephone from mid-May through late July 2022. With permission from interview participants, we recorded the interviews using the WebEx videoconferencing service. Although we contacted all 15 states listed above, not all were responsive or available for interviews during our target time period. We completed interviews with six states: Maryland, New Jersey, New York, North Carolina, Oregon, and Rhode Island.

Analyzing interview data. An analyst reviewed each recording and accompanying written notes from each interview and summarized key findings.

Appendix B. Managed care plan contract language by state

Futures Without Violence found that, although state managed care practices related to IPV vary, they generally fall into three categories of requirements: (1) screening for IPV, (2) building provider networks, and (3) connecting to CBOs.[95] This table presents MCO contract language organized by those three categories.

Table B.1. Managed care contract language by state

State	Managed care plan contract language
Arizona[96]	**Conducting IPV screening:** "The Contractor shall make a best effort to conduct an initial screening of each member's needs as outlined in AMPM Policy 920 [42 CFR 438.208(b)(2)(iv)(3)]. The Contractor shall share with the State or other contracted entities serving the member, the results of any identification and assessment of the member's needs to prevent duplication of services and activities [42 CFR 438.208(b)(4)]." AMPM Policy 920 specifies Quality Management/Performance Improvement (QM/PI) Program administrative requirements and requires managed care plans to submit QM/PI program plans containing the MCO's activities to "identify member needs and coordinate care, follow-up activities to ensure appropriate and medically necessary treatment is received in a timely manner, and participation in community and/or Quality initiatives"[97] **Build provider networks:** "The Contractor is responsible for providing outreach to members identified by the Arizona Child Abuse Hotline assessed as survivors of sex trafficking once notification is received from the Hotline. The Contractor or its contracted provider shall outreach to the member's guardian to provide trauma-informed resources, including the description of how to access behavioral health assessment services and subsequent treatment if medically necessary. The Contractor shall ensure the results of the outreach are communicated back to the Arizona Child Abuse Hotline within 30 days of the referral, including the date of contact with the member's guardian, and a description of services referred or delivered." **Connection to community-based organizations (CBOs):** "The Contractor shall have procedures to coordinate the services provided for members between services provided by the Contractor and services received from other AHCCCS Contractors, from FFS Medicaid, or from the community and social support providers."
Kansas[98]	**Conducting IPV screening:** "The CONTRACTOR shall employ, as a Health Screen, the document known as "Attachment F" in the original bid event and use the scoring included in that tool. Health Screen must be completed via telephone or in person at least every other year."[99] "Attachment F includes the following question: "Because difficult relationships can cause health problems, we are asking all of our patients the following question: Does a partner, or anyone at home, hurt, hit, or threaten you?" **Connection to CBOs:** "Attachment L in the state's documents notes that managed care plans are responsible for: physical health coordination, behavioral health coordination, transportation coordination, completion of health screen, health risk assessment and needs assessments, development, implementation, monitoring and approval of plan of service, member contacts and home visits, linkage and referral to community resources and non-Medicaid supports, health and safety monitoring, support for education, employment and housing includes making referrals, advocacy and follow up."

State	Managed care plan contract language
Massachusetts[100]	**Conducting IPV screening:** "As further directed by EOHHS, evaluate Enrollees' health-related social needs (HSRN), including whether the Enrollee would benefit from receiving community services to address HSRN. Such services shall include but not be limited to: • Housing stabilization and support services; • Housing search and placement; • Utility assistance; • Physical activity and nutrition; and • Support for Enrollees who have experience of violence." **Connection to CBOs:** "Ensure that Enrollees who are identified as having care needs as described in this Section receive assistance in accessing services to meet those needs. Such assistance shall include activities such as but not limited to: Referring the Enrollee to providers, social service agencies, or other community-based organizations that address the Enrollee's needs, including but not limited to Medically Necessary services; **Providing the Enrollee with support to ensure a successful referral, including:** a) Ensuring the Enrollee attends the referred appointment, including activities such as coordinating transportation assistance and following up after missed appointments; b) The Enrollee's PCP communicating and sharing records with the provider being referred to, as appropriate to coordinate care; and c) The Enrollee's PCP directly introducing the Enrollee to the service provider, if co-located, during a medical visit (i.e., a "warm hand-off"). Providing information and navigation to the Enrollee regarding community providers of social services that address the Enrollee's HSRN, as appropriate; Providing the Enrollee with information and providing impartial counseling about available options; Coordinating with service providers and state agencies to improve integration of Enrollees' care; and Facilitating the transition of an Enrollee to a different level of care, setting of care, frequency of care, or provider, to better match care to the Enrollee's indicated needs"
New Mexico[101]	**Conducting IPV screening:** MCOs must "provide appropriate oversight of all contracted services and monitor the program fidelity of HV model delivery based on agreed upon criteria. Activities that may be conducted as part of the visits include but are not limited to: Screening: HV services include best practice guidelines and standards for screening services. These include screenings for pregnant mothers to help identify services or resource supports needed to prevent, assess and treat maternal problems such as high-risk pregnancy, depression, trauma, intimate partner violence and mental health and substance use disorders and may also include home and family relationship assessment" **Health Education** The managed care plan "shall coordinate with the public health offices operated by the New Mexico Department of Health regarding the following services" including "Health Education services for individuals and families with a particular focus on injury prevention, including car seat use, domestic violence, and lifestyle issues, including tobacco use, exercise, nutrition and substance use"

State	Managed care plan contract language
North Carolina[102]	**Conducting IPV screening:** "The PHP shall use risk scoring and stratification to identify Members who are part of priority populations for care management and should receive a Comprehensive Assessment to determine their care management needs. Priority populations include members experiencing or witnessing domestic violence or lack of personal safety"
Rhode Island[103]	**Build provider networks:** "The network must include providers experienced in serving adults and children, low-income populations, subspecialists, or specialty providers experienced in sexual abuse, domestic violence, rape, and dual diagnosis (behavioral health and substance use) in sufficient numbers to meet the needs of the population to be served in a timely manner. The composition of the network shall also recognize the multi-lingual, multicultural nature of the population to be served and include providers in locations where members are concentrated." Connection to CBOs: "Contractor will include all BHDDH-licensed Community Mental Health Centers (CMHCs) in its network. Contractor will include Evidence Based Practice/ABA providers in the network."
Virginia[104]	**Build provider networks:** "8.6.F.a.b Assurance of Expertise for Child Abuse and Neglect and Domestic Violence. The Contractor shall arrange for the provision of examination and treatment services by providers with expertise, capability, and experience in dealing with the medical/psychiatric aspects of caring for victims and perpetrators of child abuse, neglect, and domestic violence. Such expertise and capability shall include the ability to identify possible and potential victims of child abuse, neglect, and domestic violence and demonstrated knowledge of statutory reporting requirements and local community resources for the prevention and treatment of child abuse, neglect, and domestic violence." **Connection to CBOs:** "The Contractor shall include such providers in its network. The Contractor shall utilize human services agencies or appropriate providers in their community." "The Contractor shall notify all persons employed by or under contract to it who are required by law to report suspected child abuse and neglect and ensure they are knowledgeable about the law and about the identification requirements and procedures. The Contractor assures that providers with appropriate expertise and experience in dealing with perpetrators and victims of domestic abuse and incest are utilized in service provision."
Wisconsin[105]	**Conducting IPV screening:** "The comprehensive assessment will include documentation by the interdisciplinary staff of all of the following: An assessment of vulnerability and risk factors for abuse and neglect in the member's personal life or finances including an assessment of the member's potential vulnerability/high risk per Article V.J.1., and an assessment of the member's understanding of abuse, neglect and exploitation." **Build provider networks:** "The MCO shall arrange for the provision of examination and treatment services by providers with expertise and experience in dealing with the medical/psychiatric aspects of caring for victims and perpetrators of elder abuse, abuse of vulnerable adults, and domestic violence. Such expertise shall include the identification of possible and potential victims of elder abuse and domestic violence, statutory reporting requirements, and local community resources for the prevention and treatment of elder abuse and domestic violence." **Connection to CBOs:** "The MCO shall consult with human service agencies on appropriate providers in their community. The MCO shall further assure that providers with appropriate expertise and experience in dealing with perpetrators and victims of domestic abuse and incest are utilized in service provision."

Appendix C. Additional detail about North Carolina's 1115 demonstration

Background

North Carolina's Healthy Opportunities Pilots is a comprehensive Medicaid 1115 demonstration designed to evaluate the use of select evidence-based, nonmedical interventions alongside direct medical care to address complex health issues and SDOH among Medicaid enrollees. The interventions focus on housing, food, transportation, and IPV.[106] The state selected these priority domains because, when combined with access to direct medical care, they constitute the fundamental pillars of a whole-person approach to health.[107] In addition, research suggests that reliable access to food, housing, transportation, and safe environments are associated with improved health outcomes for people with low income.[108]

The Centers for Medicare & Medicaid Services (CMS) authorized North Carolina to spend as much as $650 million in state and federal Medicaid funding over five years on the demonstration. As much as $100 million will be spent on infrastructure and capacity building, and most of the remaining $550 million will be used to pay for the evidence-based nonmedical services.[109] The goal of the demonstration is to facilitate an emphasis on whole-person health care, decrease care costs, increase care quality, and improve overall health outcomes for Medicaid enrollees.[110]

Program structure

The demonstration consists of three pilot regions located in the western, eastern, and southern areas of the state, with 5 to 18 counties in each pilot region. Each region is organized under a network lead, which are care coordination organizations that help the pilot regions operate like accountable care organizations (ACO). The network leads contract with and liaise between health care providers, managed care plans, and local community-based organizations (CBOs) operating in their pilot regions.[111]

For example, a CBO contracted through the Healthy Opportunities pilots to provide housing supports might offer Medicaid enrollees housing navigation services, while a CBO contracted to provide IPV support might offer IPV case management and legal services.[112] The CBOs receive part of their operating costs from their respective network leads, which distribute a portion of the $100 million demonstration infrastructure and capacity building funds in the form of grants. The network leads also provide CBOs with training and technical assistance.[113]

Screening and referral for services and referral for health-related social needs

Upon enrollment in the pilot program, each Medicaid enrollee is assessed for physical health, behavioral health, and social support needs by a plan representative using a HRSN screening tool. The Pilot Eligibility and Service Authorization tool (see table B below), developed by the state's Medicaid program, includes a series of questions related to IPV.[114] Once screened, enrollees are connected to care managers employed by the health plan.

For enrollees who identify HRSNs, the care managers authorize access to nonmedical support services and make nonmedical support service referrals via a closed-loop referral system. A closed-loop referral system is a technology platform designed to make and track referrals between health care providers CBOs. North Carolina's closed-loop referral system, called NCCARE360, was created as part of a public-private partnership which included North Carolina's Department of Health and Human Services, the

Foundation for Health Leadership and Innovation, Unite Us, United Way of North Carolina, and Expound Decision Systems. The referral system is available to managed care plans, healthcare providers, and CBOs participating in the pilots. Once appropriate referrals are made, care managers share HRSN assessment results and referrals with enrollees' primary care providers for continued follow-up during regular office visits. All enrollees are reassessed by a care manager on the anniversary of enrollment.[115,116]

In addition to the initial and annual assessments, the pilot program takes a "no wrong door" approach to identifying enrollees who can benefit from nonmedical support services and connecting enrollees to those services.[117] For example, CBOs offering a food pantry might encounter enrollees who reveal that their food insecurity is caused by homelessness due to IPV. In those situations, the CBO can inform enrollees of the other nonmedical IPV-related support services in their ACO and make referrals to those services via the closed-loop platform. The CBO can also refer enrollees, with their consent, to health plan care managers who will reassess the enrollees' needs using the standardized screening tool and authorize payment for appropriate support services.[118,119]

Payment models and billing

The Healthy Opportunities Pilots are one component of the larger Section 1115 Medicaid demonstration designed to transition North Carolina's Medicaid program from fee-for-service to managed care. As a result, Healthy Opportunities Pilots principally use managed care payment models. The state Medicaid program pays the managed care plans through capitated payments, and the plans in turn pay the local CBO for covered services that they provide on a mostly fee-for-service (FFS) basis. Because the state pays managed care plans on a prospective basis, the plans are in a unique position to pay CBO claims immediately after submission. Most CBOs participating in the pilot have limited operating budgets, so the North Carolina Medicaid agency staff worked with the managed care plans to facilitate quick remittance and to encourage CBO participation in the pilot.[120]

Small community-based CBOs often lack the infrastructure, such as sophisticated software, and experience necessary for Medicaid billing. To address that challenge, the state worked with a vendor to develop, distribute, and implement an "easy point and click" billing system for CBOs. The system enables CBOs to enter basic information: patient names, services rendered, cost, and date of services. This information is then shared with the patients' managed care plan, which converts it to a standard claim for reimbursement.[121]

Table C.1. Pilot Eligibility and Service Authorization (PESA): HRSN screening tool developed by North Carolina's Medicaid Agency[122]

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all your needs, but we will try and help as much as we can.

	Yes	No
Food		
Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
Within the past 12 months, did the food you bought just not last, and you didn't have money to get more?		
Housing/ Utilities		
Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
Are you worried about losing your housing?		
Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
Interpersonal Safety		
Do you feel physically or emotionally unsafe where you currently live?		
Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
Optional: Immediate Need		
Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.		
Would you like help with any of the needs that you have identified?		

Appendix D. Additional detail about Rhode Island's 1115 demonstration

Background

Like North Carolina, Rhode Island's Health System Transformation Project (HSTP) social determinants of health investment strategy is a Medicaid 1115 demonstration aimed at enabling stakeholders to address individuals' HRSNs and improve health inequities by pairing direct medial services with nonmedical support services. The demonstration creates seven accountable entities (AEs) in Rhode Island. Each AE partners with local CBOs, and together they work on the state's four priority SDOH domains: (1) housing insecurity, (2) food insecurity, (3) utility assistance, and (4) interpersonal violence.[123]

Program structure

Becoming a regional AE is a rigorous process. Each prospective AE must meet certification standards outlined by the state. The certification standards focus on breadth and characteristics of participating healthcare providers, corporate structure and governance, leadership and management, information technology infrastructure, commitment to population health and system transformation, integrated care management, member engagement and access, and quality management.[124] Moreover, AEs must submit an intervention plan that focuses one of the four defined SDOH domains: (1) housing insecurity, (2) food insecurity, (3) utility assistance, and (4) IPV[125]. As of August 2022, no AEs implement IPV-focused interventions, however all AEs are expected to offer at least some services in all four domains.[126]

After the state certifies and selects the prospective AEs, the AEs can begin contracting with CBOs. The CBOs participating in each of Rhode Island's AE-regions consist of nonprofit housing navigation organizations, food pantries, transportation assistance entities, and domestic violence advocates and service providers. Each AE must partner with a diverse range of CBOs, and the combined CBO network in each region must be able to assist Medicaid enrollees with the four SDOH domains. However, an AE region that is implementing a food insecurity intervention, for example, might have more food panties in its network than an AE focused on housing.[127]

Screening and referral for health-related social needs

Regardless of the AE's intervention, all Medicaid enrollees' health and HRSN are assessed at least once a year. Depending on the AE, a primary care provider, community health worker, or care manager conducts the assessment. Rhode Island does not require AEs to use a particular assessment tool. However, the state must approve all assessment tools, and each tool must include questions related to the following domains: housing insecurity, food insecurity, transportation, utility assistance, and interpersonal violence. If a HRSN screening is conducted during a telephone visit, e-visit, virtual check in, or independent of an in-person visit, providers may use their discretion whether to ask questions related to IPV. The interpersonal violence question must, however, be included for all screenings administered during in-person visits. Medicaid enrollees that indicate that they have HRSNs are referred to an appropriate community organization for assistance.[128]

Rhode Island uses the closed-loop referral platform Unite Us. Unite Us allows primary care providers and care managers to share information regarding their patients' needs, and it enables CBOs to report back to health care providers when patients use support services or refer to other CBOs if additional support is needed. The platform also enables AEs and CBOs to exchange and review aggregate and individual-level

data, facilitating collaborative study of how services are rendered, navigated, and financed within the ACO. Those data and analyses can inform current and future intervention initiatives and activities. Like North Carolina, domestic violence advocates in Rhode Island are concerned about IPV survivor privacy protections related to referral platform use, and the state Medicaid agency is currently working with advocates to make platform improvements.[129]

Payment models and billing

All AEs are paid on a FFS basis, and approximately 70 percent of Rhode Island's Medicaid enrollees participate in an AE. The remaining 30 percent of Rhode Island's Medicaid population are enrolled in managed care plans that do not participate in AEs. However, managed care plans maintain a network of providers to meet the needs of enrollees who have experienced IPV.[130]

In addition to the direct FFS payments that AEs receive from the state, AEs can also access shared savings based on their performance. The shared savings arrangement is based on the percentage of members screened for health and social support needs, and AEs with higher screening rates receive more shared savings. AEs can use the shared savings funds to build connections with CBOs, service networks, and implement strategic population health plans.[131] However, 10 percent of shared savings funds must be reinvested in CBOs with which the AE contracts that provide behavioral health care, substance abuse treatment, or SDOH interventions.[132]

Challenges

Patient–provider trust is essential to providing quality and effective health care, especially IPV services. Once a primary care provider or case manager establishes trust with a Medicaid enrollee, enrollees have open dialogues about IPV and the social support services that they may need. Building that trust, however, takes time and relies on having health providers that are trained on how to address IPV. To that end, some of Rhode Island's AEs are working to ensure that Medicaid enrollees interact with the same primary care providers and care managers consistently, establishing a deep rapport between patients and providers.[133,134]

Table D.1. HRSN Screening Tool Developed by Prospect Health Services RI, Inc.[135]

Category	Question	Yes / No
Food Insecurity	In the past 6 months, did you ever eat less than you felt you should because there wasn't enough money for food?	Y / N
Housing Stability	Are you worried or concerned that in the next few months you may not have stable housing?	Y / N
Housing Conditions	Do any of the following describe a problem(s) with your current housing situation? (Circle all that apply) **Bugs/Rodents Mold Peeling/Chipping Paint Other**	Y / N
Utility Needs	In the past 6 months, has the electric, gas, oil, water, telephone, or internet company threatened to shut off services in your home?	Y / N
Transportation	In the past 6 months, has lack of transportation kept you from medical appointments, meetings, work, or getting things for daily living?	Y / N
Financial Strain	In the past 6 months, did you skip medications or doctors' appointments to save money?	Y / N
Caregiving	Do problems arranging care for a child, disabled adult or elderly person make it difficult for you to work or study?	Y / N
Health Literacy	Do you often have a problem understanding what is told to you about your medical conditions and treatments?	Y / N
Employment	In the past 6 months, has being unemployed or underemployed been a problem for you?	Y / N
Social Isolation and Support	Are you disappointed with the amount of socialization and support that you receive from family, friends and the community?	Y / N
Urgency	Are any of the needs that you identified above urgent? (for example: I don't have food tonight, I don't have a place to sleep tonight)	Y / N
Assistance	If you checked 'YES' to any of the boxes above, would you like to receive information or assistance with any of these needs?	Y / N
Interpersonal Violence	In the past 6 months, has anyone in your life hurt you, made you feel uncomfortable, or made you feel unsafe?	Y / N
IPV Assistance	If you checked 'YES' to the interpersonal violence question, would you like to speak to someone who can assist you with this need?	Y / N

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