DV ADVOCATES' GUIDE TO PARTNERING WITH HEALTH CARE

Models for Collaboration and Remimbursement

California

IN THIS GUIDE

New Health Policy and Partnering with Health Care Providers

Assessing Partnership Capcity and Needs

Partnership Models

Reibursement Models

Delivery System Models

Evaluating Potential Partners

Background:

- Background Memo #1 Affordable Care Act and Expanded Health Insurance
- Background Memo #2 Hardship Exemption for People Who Have Experienced Domestic Violence
- Background Memo #3 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Children Who Have Experienced Trauma: The Basics

Provider Leave-Behind Materials:

- Instructions
- Key Research on Health and Domestic Violence
- What Women Need to Know About The Affordable Care Act
- Current Federal Guidance on the Implementation of ACA Screening and Brief Counseling Recommendations for Domestic Violence and Intimate Partner Violence

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This is a time of tremendous change in how health care is delivered in this country.

Federal health policy, including the Affordable Care Act (ACA) and recent mental health parity legislation, is rapidly transforming the health care sector. For many survivors of domestic violence, affordable coverage is now in reach. Mandated, comprehensive benefit packages include a full range of health services for women, including screening and brief counseling for domestic and interpersonal violence. These changes in health care delivery make the time right for domestic and sexual violence programs to partner with health care providers.

This toolkit is designed to help domestic and sexual violence (DSV) advocates understand the evolving health care landscape and make strategic choices as they decide whether and how to partner with health care providers in order to reach more survivors of DSV in need.

Partnering With Health Care Providers

Health settings provide an early entry point to help victims, as well as an opportunity to deliver prevention messages and anticipatory guidance on healthy relationships. Primary care health providers have ongoing relationships with their patients, and have access to survivors that DSV programs may not be reaching. Research tells us that providers are seen as trusted sources of information and that women who talk to their providers about domestic violence are more likely to seek out support from DSV advocacy programs. For over two decades, health care providers and advocates have worked in partnership to promote routine assessment for domestic violence and effective responses to victims in health care settings. Most professional medical organizations recommend assessing for violence and abuse, including the American Medical Association, the American Colleges of Obstetrics and Gynecology, the American Nurses Association, the American Academy of Pediatrics, and the American College of Emergency Physicians.

However, individual health care providers can only be a partner in helping women and their families if they know how to compassionately and effectively assess for violence and how to provide victims with referrals and support. Providers may need education and consultation on the impact of domestic and sexual violence on health; training to better assess and respond in specific settings; resource materials; training programs; and model policies and procedures that can help develop a framework for moving toward a comprehensive health care response to violence and abuse. The National Health Resource Center on Domestic Violence has these materials available for your programs and for sharing with local health providers or systems.

The key to success is building new leadership and forging new partnerships between health care professionals and advocates for victims of violence who each bring strengths and expertise to the table. It is important to take the time to learn about and understand each other's work.The vision is to integrate practices for addressing violence and abuse into existing programs instead of creating new programs.This integrated approach maximizes existing resources and prevention mesages, and improve the quality of services for patients who have experienced violence and abuse.

It is important to acknowledge that the prevention terminology and tools developed by health care professionals may not be a perfect fit for domestic violence advocates. The practice of medical and behavioral health care has its roots in science and medicine, and consequently places considerable emphasis on empirical evidence and structure. Medical providers and domestic violence advocates may have different philosophies and missions, and often use different terminology that can be confusing, or even conflicting. Nevertheless, both of these fields have strong underpinnings in social equity and a shared goal to end and prevent violence in peoples' lives. Working together can help reach these shared goals, improving the health and safety of survivors and patients.

New Policy Opens the Door for Advocates

Now more than ever, the time is right for advocates to partner with health care providers. Two important policy changes have opened the door to innovative delivery of DSV services:

1. New recommendations from leading researchers on the US Preventive Health Services Task Force now support domestic violence screening[1] and intervention,

2. Health insurance plans are now required to provide coverage of screening and brief counseling for domestic and other interpersonal violence. Most insured women now have access to this benefit and there are no federal policy limits on how the benefit is administered.

It is important to note that this is not a screening requirement; health care providers are not required to screen and offer brief counseling. But if they provide the service, health insurance plans are required to reimburse. This means there is an incentive for providers to offer screening and brief counseling for DSV because it means guaranteed reimbursement.

This is an opportunity for DSV programs to work with and educate providers, and to develop partnerships to provide or supplement the screening and brief counseling services. Providers are looking for ways to more efficiently serve patients overall and many are relying on non-medical support teams to take services outside the four walls of the health care setting. As more providers understand this new screening and brief counseling benefit and begin to screen more patients, DSV programs may see an increase in referrals. In fact, over the course of 2013-2014, DSV organizations reported experiencing an 18.5 percent increase in referrals from health care providers. This is an invaluable opportunity to reach more people in need but because many programs are already at capacity, the need for resources to meet that need is paramount. A formal collaboration with a health care provider may be a source of sustainable funding for services provided by DSV programs.

[1] While most legislation focuses on *screening*, which refers to a strategy used to identify an undiagnosed disease in individuals, FUTURES recommends *assessment* - which includes general conversation about violence and its consequences on health in addition to direct inquiry, brief intervention and support, regardless of the presence of signs or symptoms.

Needs and Ability Assessment

DSV programs provide a wide and diverse range of services that provide value to health care providers—in the short run, in terms of safety and identifying health needs of survivors and thwarting the impact that violence has on children, and in the long term for improved health outcomes of survivors and their families.

Services traditionally provided by DSV programs that may provide value to health care providers include:

- Training, education, and technical assistance
- Accepting "Warm referrals"—being immediately available if a patient discloses abuse
- Offering confidential counseling, case management, and advocacy services
- Following up with patients who disclose abuse
- Emergency services, such as shelter &/or crisis counseling
- Coordinating other services, such as housing and legal services

Many programs also provide health-related services including:

- Helping identify appropriate assessment tools used in the health care setting
- Providing a regular supply of safety cards or other resources to the health care setting
- In-Sourcing/Co-locating an DSV advocate in a provider's office
- Staffing a home visitor, promotora, or community-health worker
- Providing in-person assistance to enroll in health insurance
- Providing brief counseling for DSV as part of the ACA screening and brief counseling requirement

It may be helpful for DSV programs to conduct an assessment of internal resources, services and staffing in order to decide what services would be appropriate to offer a potential health care partner:

- What is your program's goal in this partnership?
- What services are appropriate for a health care setting?
- What services can be provided without additional funding or credentialing?
- What services could be provided if there was additional, sustainable funding?

Considerations:

Consider the institutional and structural requirement of partnering with the health care system. To get reimbursed (i.e., get paid for specific services from a health plan or provider), there may be licensing and contracting obligations required by the State and/or the health insurance companies.

Weigh privacy and confidentiality concerns. Some formal reimbursement structures will require the reporting of patient information for billing purposes; and some providers are responsible for maintaining patient records in electronic health records. Domestic violence programs are required to provide confidential services and federal funds they may receive prohibit sharing personally identifying information about victims without informed, written, reasonably time-limited consent. The release of information (specific and time-limited) must be for services requested by the survivor and they must be fully informed of all possible consequences of disclosure, as well as alternative ways to obtain the service they are requesting. Additionally, there are some federal and state privacy laws that have been enacted to protect patient privacy. At the federal level, the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations provide a federal floor of protections. HIPAA requires providers to inform patients of health information use and disclosure practices in writing and whenever a specific report has been made. In the case of mandatory reporting laws, this provision does not change the actual reporting from a provider to the appropriate authority, but requires that providers consider the circumstances of the victim. Reporting information that is outside the parameters of what is required by the law could be a violation of HIPAA.

Programs that have partnered with health systems have addressed these issues in a variety of ways. They have offered non-identified feedback loops on services provided or have obtained permission to release information from the survivor. In California, both health care providers and domestic violence advocates express concern over mandatory reporting requirements, and how those requirements can impact the safety and autonomy of patients who disclose DSV to their health care provider. California-based health care providers are required to make a report to law enforcement if they provide medical services to a patient whom they suspect is currently suffering from a physical injury due to a firearm or assaultive or abusive conduct (Cal. Penal code §§ 11160-11163.2). It is absolutely critical for the health care provider to discuss limits of confidentiality prior to conducting universal education or assessments for domestic or sexual violence. Not disclosing these limits can harm the relationship between the patient and provider and can dis-empower a victim, remove their choice of what gets reported to authorities and when, and may put patients at risk for retaliation.

However, fear of mandatory reporting should not prevent providers from talking with patients about DSV. Futures Without Violence has several resources to help advocates and providers navigate confidentiality and mandatory reporting concerns, including information on disclosing limits of confidentiality before asking about DSV, providing universal education on healthy relationships, how experiencing violence can affect your health and DSV services information regardless of whether a patient discloses experiencing DSV, and trauma-informed mandatory reporting that includes the support of DSV advocates in instances where a report is required.

While California has recently adopted strong privacy and confidentiality laws for health care information, they apply primarily to what information gets sent home in an explanation of benefits form and less about services provided to the survivor. Though federal laws also seek to provide privacy for health data, it is important to weigh what this means for survivors and for the mission of your program and what you can and can not share as feedback to health partners without breaking your confidentiality principles.

Understand what licensing requirements will be required of your staff. Additional state licensing may be required to provide medical or behavioral health services. It depends on what services you want to provide, and how you will be reimbursed for those services.

If the DSV program continues to operate within the scope of its services—and does not provide reimbursable medical services or behavioral health services—it should not be necessary to obtain additional licensing with the state. In other words, if your program will keep providing the same basic services you are now and in the same manner, no changes should be necessary – but you may have more limited options for reimbursement from providers .

If working with or for a health care provider, the DSV advocate would not necessarily have to develop a formal relationship with insurers or Medicaid—the provider could do the billing. This could mean that your DSV advocates could offer brief counseling under the supervision of the provider and be reimbursed for it—but not need to become a licensed Medicaid provider. In this scenario it is the health provider's role to identify the supervisor and supervision strategy and pay the advocate directly. (Please see "Formal Referral Partnership" chart below).

Alternatively, to provide other medical and behavioral health services—or to bill Medi-Cal directly—requires state licensing under the scope of California state law. In addition, a licensed provider must be credentialed and contracted by the managed care plan. This means that in order to be reimbursed through Medi-Cal, the person who is doing the DSV assessment needs to be either a) under the supervision of health care provider or b) a licensed provider, such as LCSW's, MFT's, psychologists, RN's etc.

California's Domestic Violence & Mandatory Reporting Law Requirements for Health Care Practitioners
http://www.futureswithoutviolence.org/userfiles/file/HealthCare/mandatory_calif.pdf

Health Cares About IPV: Confidentiality Procedures
http://www.healthcaresaboutipv.org/getting-started/confidentiality-procedures/

A full list of who can be a licensed Medi-Cal provider can be found here:
http://www.dca.ca.gov/publications/healthcare_providers.shtml#professionals

The application packet to become a Medi-Cal provider can be found here:
http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackages AlphabeticalbyProviderType.aspx

Partnership Models

Partnership with health care providers can be structured in many different ways. There are advantages and challenges with all approaches, but each can represent a significant impact in reaching patients who are experiencing DSV. It is important to evaluate your program's mission, capacity, and expertise to determine which models make sense—but remember they all provide significant value.

There are many discrete types or bundles of services that a DSV program can offer a health care practice. These can include the following:

- Periodic training to specific providers or groups of providers on assessing for domestic violence and how to do a successful intervention;
- Ongoing technical assistance and education to providers or medical practices—and working with them to offer warm hand offs when a patient discloses abuse or wants more information;
- Work in partnership with a provider or practice to deliver specific services (e.g., universal education and direct assessment for all patients and brief counseling or other preventive services to all patients who disclose abuse);
- Work with a group practice to integrate a DSV advocate into the practice; or
- Directly deliver specific medical or behavioral health services to patients;
- Lead support groups on site at the health center (allowing the provider to bill for preventive services offered to a group);
- Provide access to new patients through referrals to clinic or by hosting on-site clinic hours (i.e. mobile health vans, home visitation programs on-site, health education services, coordination with a local pharmacy for medication);
- Assist enrollment in health insurance and Medicaid by using clinic based enrollers or navigators to help fill out applications etc.

It is also possible to develop an innovative partnership that builds the costs of DSV services into a provider's delivery model or becomes self-sustaining funding for the provider and DSV program. Listed below are snapshots of different arrangements for modeling formal partnerships with providers. It is important to note that these are not mutually exclusive, and it may be possible and desirable to pursue more than one at a time.

Reimbursement Models

The following models provide general structures for reimbursement-based models. This includes potential payments from insurance companies, as well as from providers.

Basic Referral Plan

Providers may be more likely to provide universal education on healthy relationships and direct assessment for DV if they have a trusted resource to whom they can refer a patient who discloses abuse. Providers could be educated on how to provide universal education, assessment, harm reduction and warm referrals—and then offer a warm hand-off to DSV programs to patients who disclose abuse or request assistance; DSV advocates would provide their typical services to the patient. There may or may not be a feedback loop back to the provider. Together that constitutes a brief intervention – or covered benefit.

Core competencies

- Develop a relationship with the provider so that they know who you are and what services you provide.
- Establish a referral protocol so that provider knows how to contact you and under what circumstances, including immediate safety planning for the patient and transportation information.
- Ensure availability to the provider and maintain the relationship
- Provide training and technical assistance to the providers' office and staff about DSV program services as needed.

Potential benefits

- Reaching more survivors in need
- Opportunity to educate health care providers about services available
- Ensures that survivors are able to access DSV-informed care
- No additional licensure required of advocates to provide services.

Likely Partners

- Individual providers
- Large or small group practices
- Federally qualified health centers (FQHCs)
- Hospitals

Potential Revenue

- Limited opportunities for revenue from referring provider unless program specific grants are awarded
- Increased referrals to your program could result in revenue

Challenges to Consider

- Requires provider education
- Ability to meet potentially increased need
- Uneven referral patterns from providers

Formal Referral Partnership

Develop a formal relationship with a provider for specific health services, such as providing education and training for health center staff , and “brief counseling” to patients. This model assumes a continuous feedback loop between the DSV program and the provider over the care of the patient, of some sort, and that the DSV program is operating in contract with the provider for a specific scope of services. These arrangements may vary, but there is likely to be information shared between provider, advocate, and the insurance company (for billing purposes). Some arrangements may include a provider supervision requirement, and it will be important to understand what this means and what survivor information must be shared.

Core competencies

- Develop a specific scope of health services that the DSV program will provide to referred patients
- Establish a referral protocol so that provider knows how to contact you and under what circumstances, including immediate safety planning for the patient
- Develop a protocol for a feedback loop to provider
- Consider co-locating a DSV advocate at the provider’s office
- Establish a supervision plan

Potential benefits

- Providers may be more likely to conduct universal education and assessment, harm reduction and warm referral
- More survivors would receive brief counseling services from trained DSV staff
- No additional licensure required of advocates to provide services.

Likely Partners

- Large or small group practices
- Federally qualified health centers (FQHCs)
- Hospitals
- Public Health Clinics

Potential Revenue

- The DSV provider could bill the provider directly on a fee for services basis.
- If the partnership involved the DSV advocate providing a service for which the provider gets reimbursed—such as screening and brief counseling—the DSV advocate should be able to share in that reimbursement.
- It is also possible for the provider to establish a flat fee or monthly retainer for the DSV advocate to provide these services.

Challenges to Consider

- Requires provider education
- Ability to meet potentially increased need
- Uneven referral patterns from providers

Become a Provider

DSV pRograms can become a licensed provider and directly bill for the services they provide to patients. They would bill insurers (including Medi-Cal) a negotiated fee for each service provided. These services (e.g. preventive health services) would have to be covered by the plan, and be medically necessary medical or behavioral health services under the scope of CA law. Reimbursement may also be available for case management and home visitation services.

Core competencies

- Requires negotiating contract or fee schedules with providers and/or insurers.
- This would require several steps including: 1) Be a licensed provider who can practice independently; 2) enroll as a Medi-Cal provider; 3) be credentialed by the managed care plan; 4) be contracted by the managed care plan.

Potential benefits

- Providers are more likely to provide universal education, assessment and harm reduction and warm referrals
- More survivors receive services from domestic and sexual violence programs
- Sustainable revenue for the DSV programs to provide these services

Likely Partners

- Medi-Cal
- Health Insurance plans

Potential Revenue

- Revenue is based on actual services provided

Challenges to Consider

- Need to develop a good understanding of the actual costs of providing services
- Lengthy and complicated process
- Requires negotiating rates with plans
- Requires billing for services and consent of client to share information about services in order to bill

Per-Member Per-Month (PMPM)

DSV advocates would be paid a flat fee by a health insurance plan or by another provider for each beneficiary in their caseload (i.e. for every person referred to them by the health provider). It is typically a nominal fee provided for coordinating the care of these beneficiaries, often on top of fee-for-service payments. It can also be a flat fee for providing a bundle of services (such as all the services that a DSV program would provide).

This model is particularly suited for home visitation or community health worker services.

Core competencies

- Develop a formal, contractual relationship with the provider or health plan and agree on a set of services that will be provided to each patient. For every patient that is referred to the DSV program, the provider will pay a set fee
- Alternatively, receive a small coordinating fee on top of fee-for-service payments, for providing coordinating services

Potential benefits

- Providers are more likely to provide universal education, assessment and harm reduction and warm referrals
- More survivors receive services from domestic and sexual violence programs
- More likely to have a sustainable revenue for the DSV programs to provide these services

Likely Partners

- Large group practices
- FQHCs
- Hospitals
- Public health programs

Potential Revenue

- Revenue is based on actual services provided

Challenges to Consider

- As the fee is fixed, it is important to ensure that reimbursement is at least equal to the actual costs of providing the services
- Confidentiality of patient records could be a challenge unless non identifiable report on services provider could be offered.

Pay-for-Performance

In this model, DSV advocates would provide a specific bundle of service that would be tied to specific quality measures. This could be done in partnership with an individual provider and their reporting measure, or tied to a health plan reporting measure. For example, a plan could try to ensure that maternal depression screening takes place at all postnatal screenings, or that a DSV assessment takes place at every home visit. If the services are provided at the agreed rate (e.g., 80% of women receive DSV education), the DSV advocate would receive a bonus payment on top of their regular rates.

Core competencies

- Identify specific quality metrics that would improve the health outcomes of survivors
- Identify specific evidence-based interventions
- Set an achievable goal

Potential benefits

- Providers are more likely to provide universal education, assessment and harm reduction and warm referrals
- More survivors receive services from domestic and sexual violence programs
- Potential sustainable revenue for DSV programs who are able to meet their quality thresholds

Likely Partners

- Health plans
- Providers

Challenges to Consider

- In order to receive, the bonus payment, it is important that the goal is achievable and that the DSV program has the appropriate level of sustained resources.

Delivery System Models

Listed below are different health care partnership arrangements. While these may include formal reimbursement structures, these models focus the ways health care services delivered, and by whom and may help advocates think about who to form new partnerships with.

Federally Qualified Health Centers (FQHC)

Federally qualified health centers (FQHCs) are community-based health centers and clinics that provide a wide range of comprehensive primary care and case management services to patients on a sliding fee scale. Services provided can vary from center to center but many offer mental and behavioral health services in addition to medical and dental services. FQHCs have experience integrating a wide range of services into their model.

Core competencies

- FQHCs frequently rely on community health workers and other providers to take services beyond the four walls of the clinic
- Strong ability to partner with community-based programs and advocates

Potential benefits

- FQHCs have broad latitude in the categories of provider and mental health providers that they work with (and bill for)
- Serve all patients without regard to ability to pay, insurance status, immigration status

Challenges to Consider

- Federal financing requirements impose certain restrictions on how services are provided in an FQHC. For example, FQHCs may only bill for one visit per day (so a mental health visit and a physical health visit cannot be done on the same day for the same patient in California).

Primary Care Medical Homes

Primary Care Medical Homes (PCMHs), or Patient-Centered Medical Homes, are physician-led primary care arrangements that offer team-based care. The medical team organizes the care across the "medical home neighborhood" and then leverages nonmedical supports and services when appropriate and necessary. Nonmedical supports can include community health workers, home visitation, and other supports and services that take care to the patient and outside the primary care provider's clinic walls.[1]

Who can be a PCMH?

- Any primary care provider, including FQHCs, can be PCMHs.
- The primary care provider will coordinate the care of all providers the patient receives services from, as well as work with non-medical supports.

How do they get paid?

- Insurers provide a PMPM fee to the primary care provider for coordinating all care. The primary care provider may use that fund to hire additional staff or care coordinators to provide additional supports and services.

Opportunities for DSV Advocates

- By partnering with PCMHs, DSV advocates can play a critical role in providing supports to survivors as a part of the care team.

[1] Learn more about Primary Care Medical Homes, or Patient-Centered Medical Homes, here: https://pcmh.ahrq.gov/page/defining-pcmh

Community Health Workers

Community Health Workers (CHW) are non-licensed professionals who provide health education, chronic disease management and community prevention activities to the communities they serve and work with providers to enhance team-based care.

Who can be a CHW?

CHW are a broad category of the health care workforce who provide community-level outreach and care coordination to vulnerable populations in the community. Anyone can be a CHW and it does not currently require specific licensing. Training requirements vary based on the provider and the community. For information on training competencies , visit: http://www.institutephi.org/our-work-in-action/community-health-worker-initiatives/chw-training-programs/ or http://www.ccsf.edu/en/educational-programs/school-and-departments/school-of-health-and-physical-education/health-education-and-community-health-studies0/CommunityHealthWorkerCertificate.html

Who CHWs Serve?

CHWs serve patients with multiple chronic conditions, vulnerable patients, hard-to-reach populations. It varies by community and by provider.

How do they get paid?

CHWs can be paid through a variety of mechanisms. Health plans may hire CHWs directly. But more likely, CHWs work with public health departments or with FQHCs to enhance their outreach beyond the walls of the medical clinic. They can be salaried jobs, or on a fee-for-service basis.

Opportunities for DSV Advocates

DSV advocates may become CHWs and provide a wide range of services to survivors. To make this happen, DSV programs will need to demonstrate how violence and trauma are a significant and widespread public health crisis, and that addressing the causes of violence will improve health outcomes.

DSV program may also play a role in educating the CHW workforce to ensure that they are able to spot DSV—and know how to respond.

Likely Partners

- FQHCs
- Public Health Departments

Evaluating Potential Partners

Many different types of providers, including health plans, would benefit from a partnership with DSV programs. There is no one model for partnering—and each type of provider has different advantages. The larger groups and health plans have more available resources and ability to participate in innovative health care delivery. While small group practices have fewer disposable resources, they may be more nimble and interested in increasing their ability to serve patients.

What type of partner is your best fit?

Managed Care Companies

- Local public health plans and commercial managed care companies contract with a wide range of individual providers. They develop a system of in-network providers and encourage (or require) their enrollees to access services through these in-network providers.
- In Medi-Cal and Covered California, health plans are not required to offer contracts to any willing provider. In Covered California, they are required to contract with a certain number of essential community providers such as federally qualified health centers and Ryan White clinics.
- Plans are required to have enough providers in-network to make care accessible in a reasonable amount of time.
- Individual providers or provider groups negotiate contracts with the plans and then receive reimbursement for provide a service or bundle of services.
- There are no limits to the types of providers that a plan may contract with and DV advocates could contract directly with the health plan to receive reimbursement.

Hospitals

- Hospitals contract with a wide range of community-based providers and social services support to help with transitions of care and reduce readmissions.
- Increasingly, they are hiring community health workers and public health workers to address social determinants of health in their communities and to reduce health care disparities.

Federally Qualified Health Clinics and Rural Health Clinics

- Federally qualified health centers hire based on a staff model. They also offer a range of community health education and outreach services and increasingly are expanding promotoras staffing and using a public health model.

Large Medical Groups/ Independent Practice Associations

- These are large medical practices with many providers and potentially many different specialties.
- Because of the size of their practice, medical groups may be able to in-source a DV advocate

Small Group Practices

- Individual or small group practices, such as a pediatrician's office or an OB-GYN may need the most TA, and have the least bandwidth.

Demonstrating your value

If you decide you want to partner with a health care program, you will need to make a compelling case to providers about the benefits of partnering with your organization. Like you, providers have many competing demands on their time already, and they need to understand that the services you are offering will save them time and improve the health outcomes of their patients.

As more women get insured, more will have covered screening and brief counseling for domestic and interpersonal violence, but providers may not know how to screen or what to do if someone discloses. DSV programs provide an invaluable solution for providers, adding bandwidth and expertise to help provide effective interventions to a chronic problem facing their patient population.

Develop materials and talking points that demonstrate the value of the services your program provides and what you can offer the provider. For the purposes of demonstrating your value, assume that providers have a low understanding of the services offered by DSV programs. Your goal is to establish that routine assessment and intervention with violence and abuse can provide primary, secondary and tertiary interventions and prevent further injury and mortality—this is the provider's key goal, too. What's more, you need to demonstrate that these goals are attainable by working in partnership.

The attached worksheets can help you develop talking points and resources to demonstrate your value. Use these when working with providers to establish a relationship, to make your business case, to demonstrate potential return on investment, and to cement the partnerships.

Approaching Providers

With talking points, marketing materials and research in hand, it is time to approach the provider. At this stage, a packet of materials should be prepared and researched—and it is time for a meeting.

Every meeting will be different. In some instances, you may meet with the health care provider directly or you may meet with the office manager. Remember that the goal of each meeting is the same: educate the provider about the program and lay the groundwork for the partnership.

A few key things to consider:

- Building relationships takes time. Don't expect the first meeting to result in a signed contract.
- Start from the beginning—how does DSV impact your community?
- Be concise—remember that these are busy professionals just like you.
- Leave behind good materials.
- Try to leave the meeting with an action step (e.g., let's meet again next week; let's set a date to train your staff on DSV).

APPENDICIES:

Background Memos

- BACKGROUND MEMO #1 Affordable Care Act and Expanded Health Insurance
- BACKGROUND MEMO #2 Hardship Exemption for People Who Have Experienced Domestic Violence
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BACKGROUND MEMO #1

Affordable Care Act and Expanded Health Insurance

The Affordable Care Act (ACA) makes coverage available and more affordable for millions of people. In addition, it guarantees that plans will cover a comprehensive set of benefits. For women who have been un- or under-insured, the ACA puts health insurance within reach. Women who have a pre-existing condition cannot be turned away from coverage – this includes prohibiting insurance discrimination against victims of domestic violence. Plans cannot put lifetime limits on coverage, or cancel coverage after an enrollee gets sick. Young adults can now remain on their parents' insurance until they are 26 years old. For women who have stayed in unhealthy relationships for fear of losing their health insurance, the ACA offers options to access affordable health care not tied to their partner. In other words, affordable and comprehensive coverage is within reach for all women.

It is important to note that all individuals and families are now required to have health insurance, or else pay a penalty on their taxes. Domestic and sexual violence (D/SV) advocates can play an important role in helping enroll survivors in health insurance, and there is special relief available for survivors.

If someone has experienced domestic violence, it is possible to get a waiver (known as a hardship exemption) from the insurance requirement. If granted a hardship exemption, a survivor will not be subject to the tax penalty for being uninsured. While this is an important temporary exception, it is very important to note that the survivor will also not have health insurance coverage – which is critical to a move toward wellness and healing.

The ACA prohibits insurance companies from using domestic violence as an excuse or a "pre-existing condition" to deny coverage. Before the ACA, seven states allowed insurers to deny health insurance to DV survivors and only 22 states had adequate protections against this practice.

Health Insurance Options

Survivors who don't have access to health insurance through their job may be eligible for free or reduced cost coverage through the state of California. There are two primary sources of public coverage: Medi-Cal and Covered California.

Medi-Cal (Medicaid)
Medi-Cal provides medical insurance coverage and a comprehensive benefit package that includes certain acute, preventive, and long term care. Enrollment in Medi-Cal is open year-round. California had recently expanded Medi-Cal to everyone. Eligibility limits in California are adults under 65 with income less than 138% of the federal poverty line(FPL), children under 19 with income less than 266% FPL, and pregnant women with income less than 213% FPL.

These newly eligible people will be guaranteed Medicaid coverage; and the coverage will include all of the federally required benefits. This means that all of the newly eligible women will have access to screening and counseling for domestic and interpersonal violence, which is explicitly included under the preventive health services for women as part of the Essential Health Benefits.

Medi-Cal is a Medicaid program, which is a jointly financed federal/state partnership. The federal government sets minimum standards for eligibility as well as the services that must be covered. States have considerable latitude to shape their program to fit its unique populations and needs. California's program is designed and implemented by the state specifically for California.
Covered California

The ACA established state insurance marketplaces, which provide a place for individuals to purchase standardized, regulated health insurance plans. In California, the Marketplace is called Covered California.

Open Enrollment

During Open Enrollment, anyone is able to shop for health insurance coverage for themselves and their family through their state's Health Insurance Marketplace. People who are already covered by a Marketplace plan will also be able to renew or change their plan.

Survivors of DV do not need to wait for Open Enrollment to enroll in coverage. They can apply any time.

Most people who purchase coverage through Covered California will be offered a significant discount on the cost of buying health insurance. This financial help is available on a sliding scale to individuals and families who qualify. The amount of the discount varies based on a number of factors (e.g., income; family size; offer of other coverage). People apply for financial help after answering questions as part of the Marketplace application, and there are special rules for some victims of domestic violence that can help them receive more.

If you are married and your spouse can buy family insurance through your job, you as an individual are not eligible to get financial help to purchase insurance on the Marketplace. This is true even if the family coverage is prohibitively expensive or if the spouse refuses to cover the victim.

If you are legally married but have separated from an abusive spouse, you may be eligible for financial help. Almost everyone can buy insurance through Covered California. Undocumented immigrants may not purchase coverage through Covered California, but lawfully present immigrants (including those subject to the 5-year ban) may buy insurance there.

Helping to Enroll

Domestic violence advocates play an important role in ecouraging and helping survivors enroll in health insurance. Explain why health insurance is important and that it can help pay for needed services. All health plans covered in the Marketplace must cover a package of core preventive health services. This includes primary and emergency care, as well as behavioral and mental health services, substance use services and screening and brief counseling for DV/IPV.

California has a network of free in-person "assisters" who are trained to help people through the application process. There are special rules to help some victims of domestic violence during the application process; these assisters will understand how to help navigate the enrollment process. Consumers can get help comparing their coverage options and can learn the types of financial assistance available. They can also get help applying for the hardship waiver for domestic violence. To get help in English or Spanish, contact **www.coveredca.com** or call 1-800-300-1506. For help in a language other than English, language specific help is available and listed on **http://www.coveredca.com/contact/**. Local, confidential in-person help may also be available.

What do DV victims in particular need to know about buying a plan?

Most people who purchase coverage in Covered California will be offered a significant discount on the cost of buying health insurance. This financial help is available on a sliding scale to individuals and families who qualify. The amount of the discount varies based on a number of factors (e.g., income; family size; offer of other coverage). People apply for financial help after answering questions as part of the Marketplace application, and there are special rules for some victims of domestic violence to get as much help as they can.

Survivors of domestic violence may apply for health insurance through Covered California at ANY TIME. They do not need to wait for Open Enrollment. They qualify for a Special Enrollment Period (SEP) because they are survivors of domestic violence.

Covered California: A qualifying life event

[If] "You and your dependents, if any, are victims of domestic abuse or spousal abandonment (please select "Other qualifying life event" in the drop-down menu and "Single" or "Head of Household" in the "Personal Data-Tax Information" section of the application)."

To enroll, these consumers should call the Covered CA Call Center and share that they were a "survivor of DV". It is important to use the phrase "survivor of DV" as it will help the Call Center initiate the appropriate process. The Call Center representative will be able to grant a SEP. The SEP allows consumers 60 days to pick a plan and get enrolled. Some survivors of domestic violence may qualify for significant financial help for the purchase of health insurance. The application will ask for information about income in order to determine what type of financial help will be available.

The application requires all members of the family to report their income in order get a complete picture of the household's income; when a couple is married, both people are required to report their income. But survivors of domestic violence and abandoned spouses who are legally married but who do not live with their spouse and will file taxes separately are not required to count the spouse's income towards their household income. This means that these individuals are able to qualify for financial help based on their own salary—making needed health insurance much more affordable to these victims.

In order to do this, survivors of domestic violence who meet the criteria must mark "not married" on their healthcare.gov application. This is the only way that the online application is able to process the applications. After they have completed the application, consumers will be able to see what financial help they are eligible for based only on their income.

No documentation is needed to prove domestic violence. But married survivors who get the special DV relief will need to "attest" on the next year's tax return that the victim is unable to file taxes jointly due to domestic abuse. This means that anyone who receives financial help based on this "DV exception" will have to certify on their tax form that he or she fits the criteria—though no documentation is required.

BACKGROUND MEMO #2

Hardship Exemption for People Who Have Experienced Domestic Violence

All individuals and families are now required to have health insurance. Individuals who do not have the minimum essential coverage during the year—in other words, if they are uninsured or have non-qualifying coverage—have to pay a penalty on their taxes.

It is possible to get a waiver from the insurance requirement. One category of hardship that qualifies for an exemption is "domestic violence." Both women and men, as well as their dependents, are eligible to apply for the exemption. A hardship application for domestic violence must be filed within three years after the month(s) during which the hardship occurred.

Survivors who are granted a hardship exemption will not be subject to the tax penalty. But it is very important to note that she will also not have health insurance coverage. Many people will benefit from substantial help paying premiums or will be qualified for Medicaid coverage in some states; they should pursue qualifying coverage through their state's Marketplace in order to get coverage as soon as they are able.

To apply for a hardship exemption, the individual will apply through the federal government. Covered CA does not run the exemption process—this is done through **www.healthcare.gov** and filed with the IRS. Covered CA explains this on their website at: **http://www.coveredca.com/individuals-and-families/getting-covered/tax-penalty-details-and-exemptions/**

More information about the domestic violence hardship exemption, including the application, can be found at: **https://www.healthcare.gov/exemptions-tool/#/results/2015/details/domestic-violence.**

The application requests a Social Security number for the applicant and other basic information about the applicant's tax status (because this is waiving the tax penalty, information about if and how the applicant will file taxes is important). The application includes a menu of hardship circumstances and needed supporting documentation. In the case of "domestic violence," no further documentation is needed.

There is assistance available for women who need help understanding or applying for health insurance. Women can get help comparing their coverage options and can learn the types of financial assistance available that can make comprehensive coverage for themselves and their children affordable. They can also get help applying for the hardship waiver for domestic violence. To get help in English or Spanish, contact www.healthcare.gov or call 1-800-318-2596. For help in a language other than English, call 1-800-318-2596 and tell the customer service representative the language you need and free help will be provided. Local, confidential in-person help may also be available. Go to https://localhealth.healthcare.gov and type in the zipcode to see what type of in-person assistance is in your area.

BACKGROUND #3

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Children Who Have Experienced Trauma: The Basics

Medicaid, known in California as Medi-Cal, is an important source of reimbursement for physical and behavioral health services for children who have experienced trauma. Under this program, children are entitled to a comprehensive benefits package that is specifically designed to meet children's physical and mental health needs.

Below is a short description of one of Medi-Cal's most important protections for children: Early and Periodic Screening, Diagnostic and Treatment (EPSDT). This benefit guarantees children periodic screening and assessments as well as the services needed to maintain or improve their health.

Background

Medi-Cal provides health insurance coverage for certain low-income people, including many women, children, seniors, and people with disabilities. It provides a comprehensive benefit package that includes certain acute, preventive, and long term care services. Beginning May 2016, all low income children, regardless of immigration status, will be eligible for full scope Medi-Cal coverage. Watch for information from California Department of Health Care Services about outreach and enrollment procedures and potential grant opportunities.

Similar to private employer-sponsored coverage, there are defined benefits that beneficiaries are entitled to. Because this is a federal-state partnership, the federal government sets a floor of benefits that must be included. For example, Medi-Cal programs must cover inpatient hospital services. States may decide to offer additional optional benefits, such as physical therapy or prescription drugs. The state makes important decisions on the "amount, duration and scope" of the benefits. In other words, the state decides how much of any service you are entitled to (e.g., how many visits per month) and what that service actually looks like. For the most part, Medicaid will only reimburse for services that are medically necessary and are covered as part of the benefit package.

EPSDT

Children, however, have a special benefit called Early and Periodic Screening, Diagnostic and Treatment—or EPSDT, as it is commonly known. Under this federally mandated benefit, children are able to access all needed habilitative or rehabilitative services that are medically necessary to maintain or restore their optimal health. Children under age 21 are entitled to periodic screenings—and to all of the medically necessary treatment they need to fix or maintain physical health, dental, mental health and specialty services.

EPSDT works by having an initial screening for each child who has a caregiver or professional request one. The initial screening does not have to be done at the regular well-child visit (but it can). Subsequent screenings are provided at a periodic basis at well-child visits. If a parent can't be there in person, neighborhood workers, caseworkers, or health aids will have a follow up meeting with the parent.

Exams are performed by or under the supervision of, a provider who is certified by Medi-Cal to provide EPSDT screenings. In California, most children in Medi-Cal are enrolled into Medi-Cal managed care plans to receive care. Therefore, a provider must contract through the managed care plan to receive reimbursement. Ensuring adequate access to care for Medi-Cal members is the responsibility of managed care plans. The issue of "network adequacy" is receiving increasing scrutiny and monitoring by state regulators. A wide range of clinics, school health centers, and private physicians are included in most managed care plans and participate in EPSDT. Initial screenings may be provided at a variety of settings including school health programs, clinics, children and youth programs, or other licensed practitioners in a variety of settings.

The initial screening includes medical, dental, vision, and hearing; developmental history; physical exams including assessment of nutritional status, immunizations, laboratory tests, health education, lead screenings. Screenings must follow a pre-set periodicity schedule, as well as when needed. Treatment

services to "correct or ameliorate" conditions discovered by the screening services include dental services, prescription drugs, physical therapy, and medical equipment. If, during this screening, any mental or physical health is diagnosed—or the provider determines that further assessment is needed—the child is eligible for additional screenings and all treatment necessary to restore or maintain full health.

In short hand, EPSDT requires states to provide kids the screenings they need—and the treatment they need to maintain optimal health. What is more, The Center for Medicare & Medicaid Services (CMS) recently released a "Dear State Director" letter that reiterates CMS' commitment to EPSDT as an appropriate benefit to identify and treat the complex mental and behavioral health needs of children who have experienced trauma. In practice, however, there are some real challenges to fulfilling the promise of EPSDT. The EPS and D (Early and Periodic Screening and Diagnosis) are routinely provided through Medi-Cal. This is the first and biggest step towards assessing children for trauma—and developing an appropriate plan of care. States are provided lots of tools to help notify families of their rights under EPSDT and states frequently partner with child welfare programs, schools and others to do the outreach, screening and case management.

The "T" for treatment is harder to navigate. Many barriers exist that keep children from actually getting the treatment they need—and are entitled to under EPSDT. The barriers include: low reimbursement rates, complicated billing rules that deter providers who would otherwise be willing to serve these children; and the lack of community based treatment providers (and licensed community providers). With careful coordination and good advocacy, however, it is possible to help children access needed treatment.

Mental health services are included under supplemental specialty mental health services for eligible children under 21 through county Medi-Cal mental health plans. These services are provided by mental health specialists, such as: psychiatrists, psychologists, licensed clinical social workers, and licensed marriage and family therapists and involve conditions not responsive to treatment by a physical health care provider. Services include mental health, rehabilitative, psychiatric inpatient hospital, and psychiatric nursing facility services. EPSDT requires that Medi-Cal programs engage in outreach and notification services for eligible children and families, as well as offer scheduling, transportation, referral, and appointment follow-up assistance. States implement care coordination in many different ways. Some states provide extra funding to primary care providers to hire extra staff; other states have care coordinators outside the provider's office who support the practices. As states develop their internal health information technology capabilities, programs are being developed across different systems with the hopes of improving care coordination.

Many Medicaid agencies across the country have found they need to educate providers and managed care companies about the EPSDT benefit and how children should access the services that are not otherwise covered. Local AAP chapters, for example, provide education to pediatricians and their administrative staff on how to help children navigate EPSDT. States should emphasize EPSDT, and define and clarify EPSDT requirements in their Medicaid managed care contracts.

Questions to Ask

As you consider how to link children with trauma-informed services, it will be important to know a little bit more about how EPSDT actually works in your state.

Remember, every child under 21 who is enrolled in Medi-Cal is entitled to all medically necessary services through the EPSDT benefit but it might take some persistence to figure out how best to get those services covered.

First, you'll want to identify who in your community provides EPSDT screens. Then you'll want to begin to detangle how to navigate the complex system to really get the services they need. It might be good to work with the local AAP chapter; the school system or a trusted provider to understand reliable ways EPSDT works in your state—and to identify partnership opportunities.

What kids are eligible for an EPSDT screening?
The answer to this is "all kids enrolled in Medi-Cal." While that is true, a lot of kids aren't getting the screenings or the treatments. Working with local partners, you may be able to identify gaps of screening that can help figure out where you can target your efforts. For example, adolescents have far lower rates of EPSDT screening than younger children.

Who in my state cares about EPSDT?
Ask around! You'll find partners in the local AAP chapter; a statewide kids' coalition; local education authorities; and individual providers who are doing EPSDT screens. Working together, you can help identify the best practices needed for you to help get kids the trauma-informed services they need.

Who can be licensed to provide an EPSDT screening? Can my organization become a Medi-Cal EPSDT provider?
It is required to be a licensed Medi-Cal provider to be reimbursed for these services but each state sets different qualifications to be an EPSDT provider. Physicians, nurse practitioners and school districts are widely licensed to do EPSDT screenings. Some states include local health departments; community health programs, home visiting programs and family planning clinics. Ask about the requirements for your organization—or individual providers—to become licensed Medicaid providers, eligible for reimbursement. Make sure to ask about doing the initial screening assessments!

How do families learn about EPSDT? What tools are available to me to help inform kids about EPSDT? States are required to inform eligible families about the EPSDT benefit. Schools, public health departments and other community providers can play a role in getting children in the door to have their EPSDT screening. Ask for resources in your community where you can send a child to start the EPSDT process. Ask for materials to refer families to get their screenings.

Who in my state provides care coordination and/or case management for EPSDT?
There are many different models for who can actually provide the care coordination for kids receiving EPSDT. Some states hire case managers; some help manage the process through the health home coordinators; some contract out the care coordination work. This position is vital for helping families navigate the system, provide necessary support services like transportation, and ensure that children get the prior approval they need.

What is the role of managed care in EPSDT?
Most families receive their Medi-Cal coverage through a managed care organization. They are required to provide EPSDT to all kids. Some may have care coordinators on staff. It is important to understand the role of the managed care company in the state. How do they do prior authorization? How do they do care coordination? Have they even heard of EPSDT? States have contracts with each managed care company and those contracts will detail what coverage should look like. Who in the state is working with the managed care companies to implement EPSDT? And what should families do if the managed care company says no to needed services?

The promise of EPSDT to link children who have experience trauma with the services they need is real. The benefit is designed to help children to access all needed habilitative or rehabilitative services that are medically necessary to maintain or restore the child's health. Advocates need to understand how EPSDT works in their state in order to help families navigate the system and access needed services. Detangling Medicaid and EPSDT can take some time but advocates can make headway by asking these questions and by working with allies in the states.

PROVIDER LEAVE-BEHIND MATERIALS

Develop a packet of materials to use while talking to providers about potential partnerships. These materials should be designed to educate the provider about the health impacts of domestic violence and sexual assault, share solutions and strategies for partnering with DV/SA programs, and propose concrete suggestions for working together.

Key elements of this package should include a variety of personalized one-pagers. Examples of some of the key elements are attached but it is important to personalize each document for your program and community.

- One pager of research talking points that shows the relationship between health care and DV, including all citations; template included below
- Patient brochure on new screening and brief counseling: a template brochure for either the DV/SA Program to distribute to survivors and/or to give to a provider as part of their education/TA; template included below
- One page overview of your program including:
    - Overview of the services you provide
    - De-identified data on the demographics of your client population
    - Service region area
- Instruction worksheet on when a provider should call you. Instructions on how to do a warm referral. Other education materials on screening and universal education
- FUTURES Safety Cards and other patient education materials
- One pager on the new domestic violence coverage requirement (brief screening and counseling for DV/IPV) as well as recommendations for performing effective screenings; template included below.
- Information about survivors of DV/IPV and enrollment in health insurance
- Recommendations for partnering

KEY NATIONAL RESEARCH ON HEALTH AND DOMESTIC VIOLENCE

An increasing body of scientific and peer-reviewed literature shows the dramatic impact that domestic and sexual violence has on health outcomes over the life course.

IMPACT OF VIOLENCE ON HEALTH OUTCOMES

- ✓ Domestic and sexual violence is a critical health care problem and one of the most significant social determinants of health for women and girls. The prevalence of this issue is enormous; nearly one-third of women in the United States report being physically or sexually abused by a husband or boyfriend some time in their lives.[1]
- ✓ Women who have experienced domestic violence are 80 percent more likely to have a stroke, 70 percent more likely to have heart disease, 60 percent more likely to have asthma and 70 percent more likely to drink heavily than women who have not experienced intimate partner violence.[2]

HEALTHCARE RESPONSE TO VIOLENCE

- ✓ The United States Preventive Services Task Force gave screening and brief counseling for DV/IPV a B rating as effective preventive services for women of childbearing age.
- ✓ Regular, face-to-face assessment of women by skilled health care providers markedly increases the identification of victims of violence and abuse as well as those who are at risk for verbal, physical, and sexual abuse.[3]
- ✓ When victims or children exposed to violence and abuse are identified early, providers may be able to break the isolation and coordinate with advocates to help patients understand their options, live more safely within the relationship, or safely leave the relationship. Expert opinion suggests that such interventions in adult health settings may lead to reduced morbidity and mortality.[4]
- ✓ Talking with patients about violence and abuse provides a valuable opportunity for providers to learn about their experiences with abuse. Battered women report that one of the most important aspects of their interactions with a physician was being listened to about the abuse.[5]
- ✓ Research shows that provider compliance with violence and abuse protocols increases significantly with administrative support, including adequate staffing and training time and by offering provider tools to assist with assessment. Over time, systems with these supports in place see significant improvements in provider compliance with violence and abuse protocols.
- ✓ In the United States in 1995, the cost of intimate partner rape, physical assault and stalking totaled $5.8 billion each year for direct medical and mental health care services and lost productivity from paid work and household chores.[6] When updated to 2003 dollars, the cost is more than $8.3 billion.[7]

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2. Adverse Health Conditions and Health Risk Behaviors Associated with Intimate Partner Violence, Morbidity and Mortality Weekly Report.February 2008. Centers for Disease Control and Prevention. Available at http://www.cdc.gov/mmwr/PDF/wk/mm5705.pdf
3. McFarlane J, Christoffel K, Bateman L, Miller V, Bullock L. (1991). Assessing for abuse: self-report versus nurse interview. Public Health Nursing. Vol. 8, 242-250. Koziol-McLain, J. Coates, C., and Lowenstein, S. (2001). Predictive validity of a screen for partner violence against women, American Journal of Preventative Medicine, 21 (2), 93-100.
4. Saltzman LE, Salmi, LR, Branche, CM, Bolen, JC. (1997) Public health screening for intimate violence. Violence Against Women. Vol. 3, 319-331.
5. Hamberger LK, Ambuel B, Marbella A, Donze J. (1998). Physician interaction with battered women: the women's perspective. Archives of Family Medicine. Vol. 7, 575-582.
6. Costs of Intimate Partner Violence Against Women in the United States. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. 2003. Available at http://www.cdc.gov/ncipc/pub-res/ipv_cost/IPVBook-Final-Feb18.pdf.
7. Max, W, Rice, DP, Finkelstein, E, Bardwell, R, Leadbetter, S. 2004. The Economic Toll of Intimate Partner Violence Against Women in the United States. Violence and Victims, 19(3) 259-272.

What Women Need to Know About The Affordable Care Act

Women can now get free preventive health care screenings and services through their health insurance because of changes in the Affordable Care Act. These services are designed to help your provider work as a partner with you to improve or maintain your physical and mental health. Your primary care doctors, nurses and OB-GYNS and other providers are now able to ask all their patients about exposure to violence or abuse at home and in relationships. Insurance companies must cover this screening and also covers brief counseling and referrals—at no cost to you.

Futures Without Violence recommends that every patient be asked questions about their relationships, not just you. Not all providers will ask you about abuse, but some will. If you are experiencing violence and want to talk about it, your provider will be ready to help with brief counseling, safety planning and to help connect you to a local domestic violence organization.

What will my provider ask me?

Your insurance plan will cover "screening and brief counseling for domestic violence." It means that your provider may ask you about your relationships, your home life, and your community. They may ask questions like: Do you feel safe at home? Has your partner tried to tamper with your birth control? Are you ever scared of your partner?

What happens if I share my story with my provider?

It is important to listen to your provider about the limits of confidentiality. Providers want to help you be safe and get the care you need—but there are rules about keeping information secret. Talk with your provider and ask questions. Trusted providers will be prepared to help with safety planning and referrals to domestic violence organizations. Your insurance plan will cover "brief counseling", which means that your provider can provide some help and guidance during that same visit at no extra cost to you.

How much will this service cost me?

Preventive services like this are free. There will be no co-pay for this part of your visit. (There may be a co-pay for other parts of your visit.)

What if I need more help or want more counseling?

Insurance plans are required to cover mental and behavioral health services including counseling. Depending on your health plan, you may need to pay a co-pay for these services but they should be covered with an in-network provider. You can also get services from an out-of-network provider but that might cost more.

Health and Domestic Violence Partnerships

[customize this text for your organization on your organization's letterhead]

Domestic violence and sexual assault impact women across our community and has life-long effects on the health outcomes of survivors. [Insert program name] would like to work with you to develop a unique partnership to provide health care services to these survivors and to enhance your capacity to help your patients.

With a long history of servicing our community, we can provide a wide range of services to your practice. Some ideas include:

- ✓ Provide technical assistance and education to your staff about screening for DV—and what to do if a patient discloses abuse
- ✓ Be available for warm hand offs when a patient discloses abuse or wants more information
- ✓ Provide specific counseling services to your patients
- ✓ Have "office hours" at your practice and provide in-house DV support for your providers and patients
- ✓ Develop innovative partnership for warm referrals and follow up
- ✓ Develop a formal relationship to provide DV-related preventive services, including the new "brief counseling" service that plans are required to cover
- ✓ Materials and other resources for your waiting room

[Include your organization's contact information.]

Current Federal Guidance on the Implementation of ACA Screening and Brief Counseling Recommendations for Domestic Violence and Intimate Partner Violence

Millions of insured women have access to coverage of screening and brief counseling for domestic and interpersonal violence (DV/IPV). By law, this service must be covered with no cost sharing. The specific guidance offered by HHS on the screening and brief counseling for DV/IPV outlines the general requirements of coverage but leaves many details of the exact benefit design to the states and the private insurance companies.

It is important to note that this is not a screening requirement. Providers are not required to screen for DV/IPV—but if they do, the provider is eligible for reimbursement from the patient's health insurance.

Q: Who is eligible to receive screening and brief counseling for DV/IPV?

A: Today, all people insured by new private insurance plans are eligible to receive screening and brief counseling for DV/IPV with no cost sharing (plans that existed before the Affordable Care Act was signed in to law are exempt).

Some Medicaid beneficiaries—those in traditional Medicaid—may not have access to the same benefits. This could include pregnant women, people with disabilities and some other categories of traditional Medicaid populations. States have the ability to amend their state plans to offer these services; and also to offer these populations the ability to enroll in an Alternative Benefit Plan. Advocates will need to monitor state decisions and plan details to make informed decisions about which benefit package is the best fit for these populations.

Q: What exactly does HHS say that screening for DV/IPV is?

A: The federal guidance states "screening may consist of a few, brief, open-ended questions. Screening can be facilitated by the use of brochures, forms, or other assessment tools including chart prompts. One option is the five-question Abuse Assessment Screening tool available here: (http://www.cdc.gov/ncipc/pub-res/images/ipvandsvscreening.pdf, page 22)." Another option is brochure based assessments that have been shown to be effective.http://www.healthcaresaboutipv.org/tools/brochure-based-screening/

Q: What exactly does HHS say that the counseling requirement includes?

A: The federal guidelines say that "counseling provides basic information, including how a patient's health issues may relate to violence and referrals to local domestic violence specialists when patients agree to referrals. Easy-to-use tools such as patient brochures, safety plans, and provider educational tools, as well as training materials, are available through the HHS-funded Domestic Violence Resource Network, including the National Resource Center on Domestic Violence (http://www.acf.hhs.gov/programs/fysb/programs/family-violence-prevention-services/programs/centers)."

Q: Who will decide how the screening and counseling provision will actually work and what is required?

A: All insurers are mandated to offer screening and brief counseling for DV/IPV. The new guidelines provide information for what must be covered and places few limits restricting the full implementation of this important provision. Individual insurers will determine exactly what will be covered and how the benefit will be administered. State Insurance Commissioners and state Medicaid Directors (as well as other key state officials) will play an important role in helping to define the benefit.

According to the guidance, if a specific preventive service recommendation or guideline (such as those issued by the United States Preventive Services Task Force) does not specify the frequency, method, treatment, or setting for the provision of that service, the plan or issuer can use reasonable medical management techniques to determine any coverage limitations. In other words, plans have the ability and responsibility to define the amount, duration, and scope of the service for each preventive service.

Q: How often can a woman receive screening and brief counseling for DV/IPV?

A: At least once a year. The guidelines place no restrictions or limits on the number of visits that can be covered. It does explicitly say that more than one well-woman visit can be covered in order to receive all necessary preventive services if a provider feels it is necessary. It will be up to individual plans to decide if they want to offer more frequent screening specifically for the screening and brief counseling for DV/IPV.

For example, screening may occur during the well woman visit but professional health organizations also recommend assessment during other types of reproductive, mental and adolescent health visits.

Q: Where should the screening take place?

A: There are no limits as to where the screening must take place. The guidance suggests that the well-woman visit include all women's preventive health services. The plans will determine the settings for the provision of the screening.

However, it is a critical safety issue that screenings occur alone with no other family or friends present during the assessment. It is important to note that there is no additional guidance regarding the privacy and confidentiality disclosures necessary to protect these sensitive interactions.

Q: Who can receive reimbursement for providing screening and brief counseling for DV/IPV?

A: The guidelines referenced above do not provide any details on who can receive reimbursement for providing screening and brief counseling. It will be up to individual insurers under the scope of state law to determine who can provide screening. This will apply to all private plans and, begining in 2014, those plans in the health insurance marketplace.

In other words, it is possible for a wide range of providers, including traditional medical providers, mental health counselors, and more, to become eligible for reimbursement for providing screening and counseling. But it will be up to the plans, under the scope of state law, to make those determinations.

No guidance was provided on what codes to use when assessment and counseling occurred. However, some provider groups are exploring using Preventive Medicine Service codes 99381-99397 which include age appropriate counseling/anticipatory guidance/risk factor reduction interventions. There are also separate codes (99401-99412) for counseling provided separately, at a different encounter on a different day, from the preventive medicine examination.

The full federal guideline can be found at: **http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html**

Providers and advocates can also contact the **National Health Resource Center on Domestic Violence** for assistance:

health@futureswithoutviolence.org
www.healthcaresaboutipv.org; www.futureswithoutviolence.org
415.678.5500

health@futureswithoutviolence.org
www.healthcaresaboutipv.org
www.futureswithoutviolence.org
415.678.5500

FUTURES WITHOUT VIOLENCE

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100 Montgomery St, The Presidio San Francisco, CA 94129-1718 TEL. 415.678.5500	1320 19th St NW, #401 Washington, DC 20036-0343 TEL. 202.595.7382	50 Milk Street, 16th Floor Boston, MA 02109 TEL. 617.702.2004