

breaking the cycle of intimate partner violence

Recommendations for Medi-Cal managed care to prevent and address intimate partner violence



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executive summary

Intimate partner violence (IPV) is a widespread, multigenerational threat to individual and community health that requires systemic intervention by public and private entities. As the insurer of one-third of California's residents, Medi-Cal is well positioned to address and prevent IPV, particularly among people with low-income and those that are most vulnerable to the negative effects of IPV.

Several recent and upcoming policy developments in California present opportunities to systemically address and prevent IPV, including Medi-Cal's expanded access to behavioral health services, care delivery reforms put forth in the California Advancing and Innovating Medi-Cal (CalAIM) proposal—including population health management and enhanced care management programs—and the forthcoming re-procurement of Medi-Cal managed care plans (MCPs).

This brief discusses the recent policy developments in California that Medi-Cal can leverage to address the needs of IPV survivors and recommends specific policies that would allow California's Department of Health Care Services (DHCS) to connect IPV survivors and individuals at risk with the education and essential health care and social support services they need to heal and to prevent IPV in future generations. Together with MCPs, DHCS should pursue these four recommendations through the strategies summarized in Table 1:

1. Promote universal IPV education, assessment and response
2. Address health and social support needs of IPV survivors and those at risk
3. Expand access to comprehensive behavioral health services for survivors and those at risk
4. Support privacy and confidentiality needs of survivors and those at risk

table 1. summary of recommendations

Strategy
1. Promote universal IPV education, assessment and response • Train health care providers on prevalence of IPV, risk factors, and related health impacts • Promote universal IPV education in health care settings • Combine IPV screening approaches with universal education and apply best practices to assess and discuss IPV using a trauma-informed approach • Promote development of care plans that are trauma-informed
2. Address social support needs of IPV survivors and those at risk • Cover nonmedical IPV services that are trauma-informed for survivors and those at risk for IPV • Provide enhanced care management that is trauma-informed to IPV survivors and those at risk • Cover prevention education and services that are trauma-informed that CHWs and <i>promotores</i> provide to IPV survivors • Cover home visiting services that address IPV • Build partnerships with community-based organizations to holistically serve survivors' needs • Support state-level interagency collaboration to address and prevent IPV
3. Expand access to comprehensive behavioral health services for survivors and those at risk • Include exposure to IPV as a risk factor that qualifies children to access specialty mental health services • Enhance the definition of dyadic behavioral health visits • Encourage use of evidence-based family therapy and dyadic services
4. Support privacy and confidentiality needs of survivors and those at risk • Adopt and educate health care providers about protocols to protect the privacy and confidentiality needs of survivors • Protect the safety and privacy of survivors in payment strategies developed for IPV

overview

Intimate partner violence (IPV) is a widespread, multigenerational issue that causes profound negative health effects. Systemic intervention by public and private entities can curtail this public health problem and improve the health and well-being of Californians.

California's Department of Health Care Services (DHCS) and Medi-Cal managed care plans (MCPs) have the opportunity to adopt policies and practices that address IPV and, in doing so, improve the health and well-being of Medi-Cal enrollees and their families. In addition to providing the services necessary to help survivors of IPV heal, DHCS and MCPs can prevent IPV by addressing the social determinants of health that place people at risk for experiencing IPV, such as economic and housing instability, and interrupt the intergenerational cycle of IPV.

To help Medi-Cal reduce and prevent IPV, this brief describes the prevalence and health effects of IPV with a specific focus on California; discusses recent policy developments that Medi-Cal can leverage to systemically decrease IPV; and provides specific policy recommendations and strategies for implementing them that, if enacted, will help prevent IPV, support survivors, and expand access to essential health care and social support services for both survivors and those at risk.

IPV is pervasive and negatively impacts public health

Among California residents, 35 percent of women and 31 percent of men report experiencing violence from an intimate partner at some point in their lifetimes.¹ Although IPV occurs across racial, ethnic, and socioeconomic groups, low-income populations experience greater barriers to leaving violent relationships and might be more vulnerable to the poor health outcomes related to IPV.^{2,3,4,5}

Experiencing IPV is linked to profound, long-term negative effects on the survivor's physical, reproductive, and behavioral health, and overall well-being. For example, more than one in four female IPV survivors require medical care for injuries.⁶ In addition to acute injuries, women and men who experience IPV are more likely to experience asthma, chronic pain, irritable bowel syndrome, headaches, poor sleep, and activity limitations. Women are more likely to experience reproductive health problems, such as sexually transmitted infections, unintended pregnancies, pregnancy complications, and genitourinary problems as a result of IPV.⁷ Moreover, behavioral health condi-

tions such as depression, anxiety, post-traumatic stress disorder, suicidal ideation, and substance misuse are significantly more common among IPV survivors than the general population.⁸ A study conducted among California residents, for example, found that adult IPV survivors were three times more likely to report experiencing serious psychological distress than adults who were not exposed. Of the California IPV survivors studied, 33 percent reported needing help for mental, emotional, or substance misuse problems.⁹

Beyond physical and behavioral health conditions, IPV survivors are more likely to experience significant environmental and social disruptions. For example, experiencing IPV is a contributor to homelessness for women; about half of all homeless women reported IPV as the immediate cause of their homelessness.^{10,11} IPV survivors are also at high risk for experiencing food insecurity, unemployment, and lack of transportation.^{12,13} In addition, compared with non-survivors, IPV survivors tend to have fewer deep social connections, such as friends and family members who can provide child care, financial assistance, safe places to stay, and emotional support in difficult times.¹⁴ These social needs further increase the risk of acute and chronic health conditions.

The experience of IPV is not limited to adults; many children and adolescents have witnessed or survived IPV. For example, one study revealed that about one in five children in the United States witnessed the assault of a parent before age 18.¹⁵ Witnessing IPV is associated with adverse behavioral health outcomes in children, including symptoms of post-traumatic stress disorder and difficulty regulating emotions.¹⁶ In addition, strong evidence links experiencing or witnessing IPV in childhood to increased likelihood of perpetrating or experiencing IPV later in life, creating a negative multigenerational cycle.^{17,18}

The health and social sequelae associated with IPV are complex and bidirectional. While experiencing IPV worsens health outcomes and increases social needs, harmful health and social conditions themselves increase the risk of perpetrating and experiencing IPV.¹⁹ People who live in environments with limited social, educational, and economic opportunities and with community and domestic instability are at increased risk for experiencing IPV. To prevent the risk of experiencing violence, underlying root causes, such as economic inequality and social disadvantage, must be addressed.

Medi-Cal has a role in addressing IPV

As the insurer of one-third of the state's residents, Medi-Cal is well positioned to address and prevent IPV in California, particularly among the low-income populations it serves that are the most vulnerable to IPV and its consequences. Therefore, Medi-Cal should adopt evidence-based strategies that can address the needs of survivors, prevent IPV, and interrupt the intergenerational cycle.

Over the past several years, Medi-Cal, MCPs, and IPV prevention partners have increasingly focused on improving quality of care and outcomes for vulnerable populations, including those with high behavioral health needs and those who experience social risk factors and health disparities.²⁰ Survivors of IPV should also be a high priority group for those efforts. By providing more effective health care and social support services to IPV survivors and those at risk, Medi-Cal and MCPs have an opportunity to improve health outcomes, bolster quality of life, prevent and interrupt the intergenerational cycle of IPV, and address other unmet social needs.

opportunities exist to systemically address IPV now

Several recent and upcoming policy developments in California provide opportunities for DHCS and Medi-Cal to systemically address and prevent IPV. Those policy developments include:

•The CalAIM proposal

CalAIM is a delivery system, program, and payment reform initiative that aims to improve quality of life for all Californians and implement targeted approaches to improve outcomes among people enrolled in Medi-Cal with complex needs, such as those experiencing homelessness, those with behavioral health conditions, and those with frequent emergency department visits or hospital stays. Changes to Medi-Cal proposed in CalAIM were enacted through California Assembly Bill (AB) 133 in July 2021. DHCS and MCPs should leverage CalAIM's focus on improving care for beneficiaries with complex needs and act to specifically address the needs of IPV survivors.

• The 2021–2022 California Governor's Budget

California's 2021–2022 Governor's Budget, enacted June 28, 2021, includes several investments in health and human services that are important to Medi-Cal beneficiaries experiencing IPV.^{21,22} Such investments, many of which were enacted through AB 133 or otherwise incorporated into Medi-Cal, include funding for the Children and Youth Behavioral Health Initiative that will add Medi-Cal dyadic therapy among other services; funding for a Domestic and Sexual Violence Prevention Grant Program through the California Governor's Office of Emergency Services to expand prevention efforts at local IPV providers (for example, domestic violence centers and rape crisis centers); and funding to expand prevention services and supports for children, youth, and families at risk of involvement with foster care.²³ Notably, the 2021–2022 Governor's Budget contains important funding to add community health workers (CHWs) as a class of providers that can provide benefits and services to Medi-Cal beneficiaries. CHWs provide community-based and culturally relevant care to people, such as IPV survivors, who might have difficulty accessing or navigating the health care system.

- Release of the draft Medi-Cal managed care re-procurement request for proposals (RFP). In the June 2021 draft RFP for managed care procurement, DHCS outlined its goals of increasing quality and access to care along with addressing social determinants of health. These goals are directly relevant to improving services for IPV survivors and their families. The draft RFP also discusses referring Medi-Cal enrollees to CHWs and promotores as part of effective care management.²⁴
- Coverage changes to behavioral health services. The draft procurement RFP includes text that revises the medical necessity criteria for behavioral health to provide specialty mental health services to beneficiaries without a diagnosis. This provision eliminates a potential barrier to care and helps improve timely access to mental health care for survivors and those at risk. Also, in June 2020, DHCS created guidelines for MCPs to cover family therapy for beneficiaries with certain risks, including those experiencing domestic violence.²⁵

centering survivors' needs: policy considerations

It is critical that Medi-Cal develop effective and meaningful interventions that provide targeted health care and social support services for IPV survivors and their families in a considerate, respectful, and safe manner.

Life course perspective. The delivery of Medi-Cal services should be rooted in a life course perspective on IPV prevention. A life course perspective considers the ecological contexts, experiences, outcomes, and individual factors across the lifespan that influence the likelihood of a person engaging in abuse toward intimate partners or children.²⁶ Using a life course perspective will allow policies, programs, and health professionals to intervene at critical periods and, in doing so, address situational, structural, cultural, and developmental factors—such as lack of healthy relationship skills, negative family and peer group values, substance misuse, joblessness and poverty, racism, and harmful gender norms—that are the root causes of IPV.^{27,28,29,30} Sound interventions will require building partnerships across health care and social service providers to address the diverse challenges facing people affected by IPV.³¹

Survivor-centered, whole-person approach. Interventions informed by a life course approach to IPV prevention must also promote survivor-centered approaches that prioritize survivors' rights and preferences, provide whole-person care, and facilitate access to a range of clinical and non-clinical services essential to meeting survivors' health and social needs. Exhibit 1 presents a list of these essential IPV services.

Trauma-informed, survivor-centered care. Survivor-centered approaches must be delivered through partnerships between health care and social service providers who are knowledgeable about IPV and trained in providing trauma-informed care, which is a strengths-based approach to healing that recognizes the pervasiveness of trauma and the profound influence of trauma on health and well-being. Through trauma informed care, providers aim to create environments that promote healing and that avoid re-traumatization.^{33,34} IPV service programs should continue to include trauma-informed service providers who assist with safety planning and provide connections to community supports such as housing and employment services. Providers with lived experience in communities are a particularly important component of providing compassionate and comprehensive care to those experiencing or at risk for IPV. Above all, trauma-informed and survivor-centered approaches must promote the dignity and autonomy of survivors by respecting their choices and providing a comprehensive array of services and supports that promote independence and well-being, including physical and behavioral health care, economic support, employment support, child care, and family support.³⁵ These services, in addition to dyadic therapy and family therapy services, help promote resilience in survivors and families.^{36,37}

exhibit 1.

essential services to support survivors of IPV and promote prevention³²

- **universal education, assessment and response:** Universal education, assessment and response for all patients in health care settings regarding IPV, reproductive coercion, and adverse childhood experiences.
- **plan of care that is trauma informed:** Development of a health care plan for those who disclose IPV that takes partner interference into consideration and that offers referrals to relevant services.
- **comprehensive health care that is trauma informed:** Access to medical care to treat and manage survivors' physical health conditions, which could include physical injuries from IPV, sexually transmitted infections, reproductive and prenatal complications, and chronic conditions. Offer access to a full range reproductive health care services.
- **behavioral health care that is trauma informed:** Use of a trauma-informed approach to promote healing and to address depression, anxiety, post-traumatic stress disorder, substance use, and other behavioral health conditions. Evidence-based approaches include cognitive behavioral therapy and cognitive trauma therapy for IPV survivors.
- **tailored services for survivors:** Connection to survivor-centered services such as advocacy program hotlines, crisis intervention and counseling, and shelters.
- **care coordination:** Navigation services to help survivors access community resources and maintain employment, such as child care, transportation assistance, and food.
- **housing support:** Emergency shelters and transitional housing to support survivors leaving unsafe relationships. Housing navigation services and flexible funds that can be used for security deposits, rent, transportation, and other needs to support long-term housing stability.
- **economic support, including child care and nutrition support:** Services to promote financial security among survivors, such as income supplements, cash transfers, employment assistance, nutrition assistance including the Supplemental Nutrition Assistance Program, child care subsidies, and tax credits.
- **legal advocacy services and access to civil legal protections:** Legal support to help survivors navigate the criminal and civil legal systems and promote safety through protective orders, supervised visitation programs, and removal of lethal weapons from people who use violence.
- **evidence-based family support interventions:** Interventions that provide support and education for families, such as early childhood home visiting programs and prenatal support interventions.

leverage policies to support survivors and prevent IPV: recommendations

These four policy recommendations provide a framework for DHCS, MCPs, and health care providers to address the needs of survivors and those at risk and begin to prevent IPV:

1. Promote universal IPV education, assessment, and response
2. Address social support needs of IPV survivors and those at risk
3. Expand access to comprehensive behavioral health services for survivors and those at risk
4. Support privacy and confidentiality needs of survivors and those at risk

The tables that follow describe specific strategies that support these recommendations. For each strategy, we list the target audience, provide the rationale, and review the current Medi-Cal context.

recommendation 1: promote universal IPV education, assessment and response

Target audience: DHCS, MCPs, health care providers	
Strategy	Train health care providers on prevalence of IPV, risk factors, health impacts, and appropriate response to IPV disclosure
Description of strategy and proposed DHCS or MCP approaches	DHCS and MCPs, in partnership with community advocacy organizations, can hold trainings for providers on IPV prevalence, IPV impact on health, and risk factors for IPV, such as low income, economic instability, and lack of social support. DHCS should incorporate IPV training into the required network provider training that all MCPs must conduct at the beginning of the managed care contract.
Rationale	Many providers lack the knowledge and training to effectively identify and follow-up on IPV disclosures or might feel uncomfortable doing so. ^{38,39} Helping providers understand the pervasive nature of IPV and its relationship with other social needs will lay the groundwork for uptake of universal education, assessment, and response.
Current Medi-Cal context	Requirements proposed under CalAIM and enacted under AB 133 for MCPs to develop population health management programs that include identifying patients' risks and needs (CalAIM, p. 25).

Strategy	Promote universal IPV education in health care settings
Description of strategy and proposed DHCS or MCP approaches	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. DHCS and MCPs can promote Futures Without Violence's model for universal education known as CUES (Confidentiality, Universal Education and Empowerment, Support).⁴⁰ DHCS and MCPs should promote the distribution of resources such as safety cards for reproductive health, which are screening tools used to ask and educate patients about reproductive and sexual coercion. These resources help ensure IPV survivors and those at risk can receive help even if they do not disclose IPV. An example safety card and sample scripts for incorporating safety cards into discussions with patients are available in the Futures Without Violence guidance for clinicians, "Addressing Intimate Partner Violence Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic, Reproductive Health Care Settings."⁴¹
Rationale	Providing education to all patients ensures they can recognize safety risks when they arise and have access to resources when they need them. This approach helps survivors regardless of whether they disclose IPV (which is important because many survivors choose not to disclose this information), creates prevention opportunities for those at risk for IPV, and can help interrupt the cycle of violence by offering patients strategies to support peer-to-peer education. The Domestic Violence and Health Care Partnerships described in exhibit 2 provide examples of universal education that DHCS and MCPs can follow. An on-line toolkit for integrating IPV into health care, created by Futures Without Violence with funding from the Department of Health and Human Services, provides additional examples of universal IPV education.⁴² Studies of the CUES intervention in primary care settings and school health centers have shown that patients who received the intervention were more likely than those who did not to disclose IPV, to have more knowledge of resources and harm-reduction strategies, to use and share those resources with others, and to end relationships because they felt unhealthy or unsafe.^{43,44} Studies of safety cards have shown that among women who reported IPV at their initial assessment and received the safety card intervention, there was a 71 percent reduction in the likelihood of pregnancy pressure and coercion at follow-up, 12 to 24 weeks later.⁴⁵
Current Medi-Cal context	Requirements proposed under CalAIM and enacted under AB 133 for MCPs to develop population health management programs that include identifying patients' risks and needs (CalAIM, p. 25).

Strategy	Combine IPV screening approaches with universal education and apply best practices to assess and discuss IPV using a trauma-informed approach.
Description of strategy and proposed DHCS or MCP approaches	DHCS should recommend adoption of a standardized, validated IPV screening tool that is incorporated into the individual risk assessment tool put forth in the CalAIM proposal and draft MCP re-procurement RFP. The U.S. Preventive Services Task Force determined that a number of screening tools—such as the HARK (Humiliation, Afraid, Rape, Kick) tool, which includes many forms of IPV—accurately detect IPV.⁴⁶ Best practices for conducting IPV assessment with universal education include the following: • Discussing IPV with patients in private without anyone else present • Avoiding stigmatizing words, such as abuse or battered • Using culturally relevant language • Making patients aware of the limits of confidentiality before screening or providing universal education • Informing patients how information might be documented on paperwork, including explanations of benefits • Working in partnership with local domestic violence providers so that after disclosure of abuse, providers can conduct safety assessments to determine whether patients are in immediate danger, to offer safety planning, and to refer patients to appropriate services
Rationale	Disclosure rates among patients screened for IPV in health care settings are much lower than the known prevalence of IPV from research studies. For example: Although 1 in 4 women and 1 in 9 men are estimated to be survivors of IPV in the general population, disclosure rates in clinical settings range from 1 percent to 14 percent with screening, typically hovering around 7 percent.^{47,48,49,50,51} Among known survivors, only 21 percent of women and 5.6 percent of men report disclosing IPV to a health care professional.⁵² Health care providers might not be aware of the discrepancy between IPV prevalence and IPV disclosure. This factor might lead to false reassurance after negative screenings and missed opportunities to provide patients with needed resources. Therefore, systematically screening and offering universal education on IPV with all patients in health care settings increases opportunities to promote prevention for those at risk and to support survivors regardless of disclosure. ARISE (Aspire to Realized Improved Safety and Equity)—an IPV program developed by the San Francisco Health Network and the University of California, San Francisco—combined a screening tool with universal education and increased the overall number of patients with positive IPV disclosure within the health network from 157 in 2016 to 1,652 in 2019.⁵³
Current Medi-Cal context	Requirements proposed under CalAIM and enacted under AB 133 for MCPs to develop population health management programs that include identifying patients' risks and needs (CalAIM, p. 25).

Strategy	Promote development of care plans that are trauma-informed
Description of strategy and proposed DHCS or MCP approaches	DHCS should encourage the development of health care plans for those who disclose IPV that take partner interference (that is, when someone controls access to health care) into consideration and that offer referrals to relevant services. MCPs should partner with IPV advocacy organizations to train providers on ways IPV can impact health of survivors and encourage the development of care plans that are trauma-informed. For example, if a patient discloses IPV, providers can brainstorm with the patient about ways to stay connected to health care even when partner interference is a concern. Strategies could include choosing a safe mode of communication (for example, text, health portal message, or phone) or discussing contraceptive options that are less vulnerable to tampering (for example, an intrauterine device). Care plans and referrals can be documented in a private section of the medical record.
Rationale	IPV survivors and those at risk might have complications, health risks, and safety concerns that providers should consider when developing patient care plans, particularly about reproductive and sexual health. Examples include the following:⁵⁴ • Women who disclosed IPV by their husbands were 2.4 times more likely to experience interference with contraception than women who did not have a history of IPV. • Among women seen at family planning clinics, 1 in 4 women who had experienced IPV reported being pressured by their partners to become pregnant. Understanding these and similar concerns enables providers and patients to develop care plans that are most likely to improve health.
Current Medi-Cal context	Requirements proposed under CalAIM and enacted under AB 133 for MCPs to develop wpopulation health management programs that include identifying patients' risks and needs (CalAIM, p. 25).

exhibit 2.

example of building connections between health care providers and community-based organizations: the Domestic Violence and Health Care Partnerships

The **Domestic Violence and Health Care Partnerships**, a collaboration between Blue Shield of California Foundation and Futures Without Violence, serves as a model for building the capacity of health care providers and relationships with community organizations. This project partnered health care safety net providers with IPV service organizations. IPV service professionals trained health care providers to offer universal education, assessment, and health promotion strategies to patients, and health care providers referred patients who disclosed safety needs to their partner IPV organizations. The program showed an increase in the number of health care providers who discussed IPV with their patients. Health care and IPV service providers reported greater confidence in referring clients to one another. The project evaluation determined that communication protocols and referral processes between health care providers and IPV organizations were critical to building collaboration and integration across settings. Specific communication procedures included formal agreements regarding the referral processes and written protocols for health care providers regarding assessment and response to IPV.

recommendation 2: address social support needs of IPV survivors and those at risk

Target audience: DHCS, MCPs	
Strategy	Cover nonmedical IPV services that are trauma-informed for survivors and those at risk for IPV
Proposed DHCS approach - DHCS should encourage MCPs to cover the wide range of services that address the needs of IPV survivors and those at risk and encourage MCPs to provide these as in-lieu-of or value-added services, especially transportation support, job placement services, child-care subsidies, financial services, legal services, home visiting, and parenting programs. - DHCS can use Medicaid managed care contract language to encourage, incentivize, and require MCPs to cover services. For example, the Medicaid agency in Florida requires MCPs to develop procedures to identify community support services, make referrals to those services, document referrals, and follow up on receipt of services.⁵⁵ - DHCS should clarify and publicize that Medi-Cal can reimburse for nonmedical IPV services in community-based settings and provide MCPs and health care providers with a list of examples of covered community-based settings and provider types. - DHCS should consult with IPV service providers and MCPs to develop guidance regarding appropriate payment methods for in-lieu-of and value-added services. For example, as described in exhibit 3, DHCS and experts might consider adapting the model of the North Carolina's Healthy Opportunities Pilots—which include per-member-per-month payment and per-occurrence payments depending on the specific service types. Discussions with providers and MCPs should include adapting payment methods to protect patient confidentiality. - DHCS should consider statewide conversations with MCPs, IPV providers, and advocacy organizations (such as Futures Without Violence and California Partnership to End Domestic Violence) to explore strategies to prepare providers, many of whom are unfamiliar with the complexities of Medicaid billing, to become Medi-Cal providers and to design payment and billing systems that minimize burden for community-based organizations (CBOs).	
Proposed MCP approach - MCPs should identify common social service needs of their members at risk of IPV by (1) including aggregated IPV data in their analysis of social determinants of health (SDOH) and health-related social needs and (2) holding focus groups with survivors, IPV advocacy organizations, and CBOs to identify social needs. Special consideration must be made to protect the privacy of IPV survivors during this process (see recommendation 4). - MCPs should hold focus groups with survivors, IPV advocacy organizations, and CBOs to identify community resources that can meet identified social needs. - MCPs should partner with IPV service providers and other CBOs to form a network of providers that address IPV service needs. MCPs should consider whether to intentionally incorporate IPV into a comprehensive SDOH strategy to meet the needs of all members or to tailor an SDOH approach to populations experiencing or at risk of IPV. Exhibit 4 provides an example of a partnership, between CareSource of Ohio and a CBO network, that provides services to all members with SDOH needs. - MCPs should build on or adapt processes from other SDOH programs to connect members who screen positive for IPV to services. Exhibit 4 provides an example of a partnership, between Kaiser Permanent Colorado and Hunger Free Colorado, that connects members with food and nutrition services. MCPs could develop similar protocols for members who screen positive for IPV to connect them with behavioral health services, social services, and community IPV advocacy organizations. MCPs should work with IPV advocacy organizations and providers to protect patient security and confidentiality when developing these processes. - MCPs should draw from other population health management programs that include contracts with nonmedical providers to test appropriate payment methods for in-lieu-of and value-added services. Payment methods should incorporate protections for patient confidentiality. - MCPs should consider how best to structure payments to cover service delivery costs and reward IPV service providers for achieving health and social service outcomes. Layering value-based purchasing (VBP) payment approaches—such as pay for performance, shared savings/risk, pay for success, and capitated payments—on top of FFS payments could be considered.⁵² Adapting payment models over time might be useful when working with CBOs, many of which might not be able to take on financial risk at first. Exhibit 4 provides an example of a partnership, between PacificSource Columbia Gorge Coordinated Care Organization (CCO) and the Bridges to Health Pathways Hub, that adapted a payment model over time. - MCPs should define outcomes for IPV services (for example, obtaining the needed value-added service) to track whether IPV survivors are receiving needed services and to support potential VBP payment models, such as pay for performance. - MCPs should collect and analyze aggregated, de-identified data on service use and outcomes for IPV services to support program improvement. - MCPs should educate contracted health care providers on the community resources available to members.	
Rationale	Survivors and those at risk have a wide range of social support needs. See exhibit 1 for a comprehensive list.
Current Medi-Cal context	Requirements proposed under CalAIM and enacted under AB 133 for MCPs to develop population health management programs through which plans will partner with contracted health care providers and community-based partners to identify and address health-related social needs (CalAIM, p. 25).

Target audience: DHCS	
Strategy	Promote housing stability among Medi-Cal enrollees experiencing, surviving, or at risk for IPV
Description of strategy and proposed DHCS approach	DHCS should provide MCPs with guidance for how to provide and tailor housing services as in-lieu-of or value-added services to support survivors and those at risk. Guidance from DHCS should describe the critical components of housing assistance for IPV survivors, such as the need for trauma-informed and survivor-driven services with flexible financial assistance to enable survivors to meet their housing needs. Exhibit 5 highlights the Domestic Violence Housing First programs in California and Washington State as examples of survivor-driven housing assistance programs to which MCPs can connect survivors
Rationale	IPV survivors have a particular need for housing supports because housing instability can place people at risk for experiencing IPV and experiencing IPV can cause housing instability. For example: • In California, women who have experienced IPV are four times more likely to report housing insecurity than those who have not.⁵⁶ • In 2020, the U.S. Department of Housing and Urban Development's Continuums of Care in California reported 1,960 victims of IPV were in emergency shelters, 819 were in transitional housing, and 7,996 were unsheltered.⁵⁷
Current Medi-Cal context	The CalAIM proposal, as enacted through AB 133, authorizes managed care plans to provide in-lieu-of services, or nonmedical services, as alternatives to more costly standard Medicaid benefits. Examples of in-lieu-of services specified in CalAIM include housing transition and navigation services, housing deposits, and housing tenancy and sustaining services (CalAIM, p. 9–10).

Target audience: DHCS, MCPs	
Strategy	Provide enhanced care management that is trauma-informed to IPV survivors and those at risk
Description of strategy and proposed DHCS or MCP approaches	As part of the enhanced care management program proposed through CalAIM, DHCS should specifically include survivors and those at risk for IPV as a category of enrollees in need of enhanced services and ensure that MCPs tailor these services to the needs of survivors, those at risk, and their families. MCPs should coordinate social support services (as in-lieu-of or value-added services) and health services for survivors and coordinate with nonmedical providers such as behavioral health providers and IPV service providers. IPV service providers can be professional or peer staff at organizations that serve, navigate, or advocate for survivors, such as domestic violence shelters and community service organizations. MCPs should consider using their Medicaid capitation payments to provide care management services themselves or pay other entities, such as CBOs to deliver these services. As one example, PacificSource Columbia Gorge CCO uses the global payment it receives from Oregon Medicaid to finance care coordination provided by contracted agencies.⁵²
Rationale	Survivors and those at risk have a wide range of needs that span physical health, behavioral health, and community-based social services sectors. Care management services help link survivors to services that address each of their needs and coordinate care across providers. These efforts increase care quality and efficiency and reduce risk.
Current Medi-Cal context	Requirements proposed under CalAIM and enacted under AB 133 for MCPs to provide enhanced care management for specific high-need populations, including people experiencing homelessness, high utilizers, and people with a serious mental illness, serious emotional disturbance, or substance use disorder (CalAIM, p. 9).

Strategy	Cover prevention education and services that are trauma-informed that CHWs and promotores provide to IPV survivors
Description of strategy and proposed DHCS or MCP approaches	DHCS should provide guidance to MCPs on how to best contract with CHWs and <i>promotores</i>. The California Health Care Foundation has released a four-part resource package to provide guidance for MCPs to integrate CHWs and <i>promotores</i> into their care management strategy. This resource package discusses the role of CHWs and <i>promotores</i>, training, data collection, outcome measurement, and strategies for financing and sustaining CHW and <i>promotores</i> services. DHCS can use this resource to provide guidance on best practices for contracting with CHWs (see exhibit 6 for detailed considerations). DHCS can apply examples from other state Medicaid agencies. For example, New Mexico incorporates the cost of CHWs into the administrative portion of its MCP capitation payment and requires MCPs to directly hire or contract with CHWs. CHWs or their contracting organizations receive a capitated fee per member or are reimbursed directly for services.⁵² DHCS can work with IPV service providers to ensure contracted CHWs and <i>promotores</i> receive training in trauma-informed care and confidentiality measures as well as develop a process that enables CHWs and <i>promotores</i> to follow up to ensure survivors and those at risk receive the supports they need while protecting privacy and safety. MCPs should build on or adapt processes from other population health management programs that use CHWs to develop payment models and protocols for providing this service for IPV survivors. See the section above on covering nonmedical IPV services for additional MCP strategies on service needs assessments, payments, partnerships with CBOs, data collection, and monitoring that also apply to covering services by CHWs and <i>promotores</i>.
Rationale	CHWs and <i>promotores</i> are typically trusted community members or people with a particularly strong understanding of the communities they serve. As such, CHWs and <i>promotores</i> are well positioned to build trust with survivors, identify health and social needs, and help survivors navigate services.^{58,59} Many Medi-Cal MCPs, particularly those participating in the Health Homes Program and the Whole Person Care Pilots, effectively employ or contract with CHWs and <i>promotores</i> to provide outreach, navigation, and peer support services to beneficiaries with complex needs.
Current Medi-Cal context	Requirements proposed under CalAIM and enacted under AB 133 for MCPs to develop population health management programs through which plans will partner with contracted health care providers and community-based partners to identify and address health-related social needs (CalAIM, p. 25). The Governor's Budget includes \$16.3 million to add CHWs to the class of health workers who can provide benefits and services to Medi-Cal beneficiaries effective January 1, 2022, with an increase to \$201 million by 2026–2027 (p. 70).⁶⁰ This presents an opportunity for DHCS to ensure that more survivors and people at risk have access to CHW and <i>promotores</i> services.

Strategy	Cover home visiting services that address IPV
Description of strategy and proposed DHCS or MCP approaches	Medi-Cal should fully cover home visitation services to make visitation uniformly available in all California counties and to make the programs more accessible and affordable to people at high risk for IPV. DHCS could consider using Medicaid financing strategies that other states have used for home visiting programs (for example, asthma, maternal and child health) to cover IPV home visiting services. For example, states such as Michigan and Oregon cover targeted case management within maternal and child home visiting programs through state plan amendments. Other states, such as Minnesota and New York, have incorporated home visiting for maternal and child health into Medicaid managed care. Additional states, such as Illinois and North Carolina, have used Medicaid waivers to develop home visiting programs to provide specific services to identified populations (for example, perinatal substance use).⁶¹ Moreover, DHCS should fully integrate IPV assessment and trainings into all its home visitation programs. Home visitation personnel should be well versed about the impacts of IPV, be able to recognize the signs of IPV, provide safe interventions in homes in which IPV is taking place, offer trauma-informed parenting strategies and connect IPV survivors with community-based IPV services. MCPs should build on or adapt processes from other population health management programs in other states that include home visiting services (for example, asthma, maternal and child health) to develop payment models and protocols for providing home visiting services for IPV survivors. See the section above on covering nonmedical IPV services for additional MCP strategies on service needs assessments, payments, partnerships with CBOs, data collection, and monitoring that also apply to home visiting services.
Rationale	Home visitation programs are designed to prevent child abuse, neglect, and IPV; help ameliorate the negative physical and mental health impacts of IPV; and help connect families to community-based supports such as IPV services. As a two-generation approach, home visiting programs can disrupt the intergenerational cycle of violence by equipping parents and children with tools that promote positive parenting and child development.⁶² California's home visitation programs are currently funded by a patchwork of federal, state, and local dollars.⁶³ As a result, visitation programs are available in some, but not all, of California's counties and only reach about 10 percent of those who could benefit from regular home visits.⁶⁴
Current Medi-Cal context	Requirements proposed under CalAIM and enacted under AB 133 for MCPs to develop population health management programs through which plans will partner with contracted health care providers and community-based partners to identify and address health-related social needs (CalAIM, p. 25).

Target audience: MCPs	
Strategy	Build partnerships with community-based organizations to holistically serve survivors' needs
Description of strategy and proposed MCPs approach	MCPs should engage with IPV advocacy organizations and IPV service providers to develop specific guidance on how health care providers can build relationships with community-based organizations that serve survivors and those at risk. As MCPs engage with advocacy organizations and IPV service providers, they can also consider examples of building partnerships from California and other states: • Exhibit 2 includes an example of relationship building between California providers and community-based organizations through the Domestic Violence and Health Care Partnerships project. • The Oregon Health Care Coordinated Care Organizations, discussed in exhibit 7, and the Accountable Health Communities (AHC) Model, discussed in exhibit 8, represent other models of building connections between Medicaid managed care and community-based organizations. • MCPs should develop strong referral and contractual relationships with community resources such as IPV advocacy organizations. For example, Kaiser Permanente Northern California, as part of its approach to improving response to IPV, developed partnerships with IPV advocacy organizations for crisis response and legal services.⁶⁵ • MCPs should consider supporting training sessions with providers and IPV advocacy organizations to increase the comfort level of provider staff in making referrals to community organizations and vice versa.
Rationale	Survivors and those at risk have a wide range of needs across physical health, behavioral health, and community-based social services settings. Cross-sector partnerships will improve communication, strengthen referrals, help make whole-person care more seamless, and better meet the health and social needs of survivors and other Medi-Cal enrollees.
Current Medi-Cal context	Requirements proposed under CalAIM and enacted under AB 133 for MCPs to develop population health management programs through which plans will partner with contracted health care providers and community-based partners to identify and address health-related social needs (CalAIM, p. 25).

Target audience: DHCS	
Strategy	Support state-level interagency collaboration to address and prevent IPV
Description of strategy and proposed DHCS approach	DHCS should develop and support work groups to connect the multiple state agencies that address the needs of survivors and those at risk. DHCS can build upon prior interagency efforts, such as the California Leadership Group on Domestic Violence and Child Well-being and the State Interagency Team on Children and Families work group on domestic violence.
Rationale	Many agencies within the state provide services that address the needs of survivors and those at risk. With a few exceptions, however, these agencies often operate in silos, which leads to fragmented service delivery systems and limited coordination.
Current Medi-Cal context	Requirements proposed under CalAIM and enacted under AB 133 for MCPs to develop population health management programs through which plans will partner with contracted health care providers and community-based partners to identify and address health-related social needs (CalAIM, p. 25).

exhibit 3.

Medicaid coverage of IPV advocacy services: North Carolina's Healthy Opportunities Pilots^{66,67,68}

North Carolina is pursuing direct Medicaid reimbursement for interpersonal violence advocacy services under its Health Opportunities Pilots. These pilots are part of the state's Medicaid Section 1115 demonstration and its transition to Medicaid managed care. Within these pilots, a local lead entity will facilitate relationships between local human services organizations, including organizations providing services that address interpersonal violence. The state managed care plans will pay the local lead entities, which in turn will pay local human services organizations for covered services. Payment rates will depend on the fee schedule generated by the state and approved by the Centers for Medicare & Medicaid Services. Two services, IPV case management services for survivors and violence intervention services for people who use violence, will be paid for on a per-member-per-month basis, whereas parenting support programs, evidence-based home visiting services, and dyadic therapy will be reimbursed on a fee-for-service basis. North Carolina learned that community-based organizations do not have the experience or software necessary for Medicaid billing. The state is providing technical assistance and considering creative workaround options.

North Carolina Healthy Opportunities Pilot fee schedule ⁶⁹		
Service name	Unit of service	Rate or cap
IPV case management services	Per member per month	\$209.37
Violence intervention services	Per member per month	\$152.44
Evidence-based parenting curriculum	One class	\$21.50
Home visiting services	One home visit	\$63.43
Dyadic therapy	Per occurrence	\$68.18

Note: This pilot program was put on hold because of the COVID-19 public health emergency. As of June 2021, the North Carolina Department of Health and Human Services has selected three organizations to serve as Healthy Opportunity Lead Pilot Entities with plans to begin service delivery in spring 2022.

exhibit 4.

Examples of partnerships between managed care plans and community-based organizations to offer nonmedical services for social determinants of health^{70,71}

MCPs can work with CBOs to achieve the following objectives:

- Build a network for nonmedical services. CareSource, a Medicaid managed care organization in Ohio, partnered with CBO network Healthify to provide a range of social services to CareSource members throughout the state.
- Develop a process for connecting members to needed services. Kaiser Permanente Colorado partnered with Hunger Free Colorado, a statewide nonprofit organization aiming to end hunger in the state, to connect members with food and nutrition services. Clinicians obtained immediate consent to share patient information with Hunger Free Colorado after a member screened positive for food insecurity. The nonprofit contacted the patient directly within 48 hours of referral.
- Develop payment models. PacificSource Columbia Gorge Coordinated Care Organization adapted payment models for services provided by the Bridges to Health Pathways Hub, including community service referrals and care coordination to residents in Oregon. The CCO initially paid Bridges to Health with a grant to cover program costs, but both partners agreed that they would move toward a VBP payment approach when the grant ended.

exhibit. 5

examples of addressing housing instability for IPV survivors: the Domestic Violence Housing First Programs

The Domestic Violence Housing First Programs implemented in Washington State and California are evidence-based models that increase access to permanent and affordable housing as a foundational step for empowering survivors to leave violent environments and rebuild their lives. The Washington State program, first funded by the Bill & Melinda Gates Foundation in 2010, included 13 agencies serving more than 500 survivors across the state.⁷² The California pilot, funded by the California Office of Emergency Services, was implemented in 33 nonprofit agencies across the state by 2017 to support survivors in need of housing and supportive services. As part of the Washington and California initiatives, participants received flexible funds for rental assistance, move-in costs, transportation, and debt assistance, along with mobile advocacy and community engagement services. An evaluation of 925 California survivors who received flexible funds found that most participants (58 percent) used their funds to prevent homelessness.⁷³ Currently, California has more than 65 sites that have received grants for Domestic Violence Housing First, and California's Domestic Violence Housing First Program served more than 10,000 new people in fiscal year 2019–2020.⁷⁴ The evaluations of the California and Washington models emphasized the importance of flexible funding to meet each survivor's needs. In one example from Washington, an advocate noted how paying for a survivor's shoes led to the survivor obtaining housing services. Another survivor noted that the forms of assistance that were most helpful for her were obtaining transportation to doctor's appointments, help with divorce documents, and money for food.

exhibit. 6

Considerations for contracting with CHWs and promotores⁷⁵

The California Health Care Foundation has put together materials to help managed care plans define contract terms for partnering with organizations that employ CHW or promotores. These materials list several important considerations for managed care plans to discuss with contracted organizations, including the following:

- Defining the services that CHWs will provide and the populations they will serve
- Defining the expectation of training and supervising CHWs
- Selecting measures and goals and determining the data required to evaluate CHWs
- Determining a payment methodology and amount. These methods could include the following:
 - Flat rates per referral
 - Per-member-per-month payments
 - Risk-adjusted flat rates
 - Value-based payments based on outcomes or savings
- Determining responsibility for invoicing and payments
- Determining a communication strategy between the plan and the contacted organization, including for referrals and secure data sharing

exhibit. 7

example of building connections between managed care plans and community-based organizations: Oregon health care coordinated care organizations⁷⁶

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

exhibit. 8

Bridging health care and community social services: the Accountable Health Communities Model⁷⁷

The Centers for Medicare & Medicaid Services' Accountable Health Communities (AHC) Model systematically identifies health-related social needs (HRSN) of Medicare and Medicaid beneficiaries, including IPV, at clinical sites, and addresses identified needs by offering referrals to community services and providing navigation to those who are eligible. The Guide to Using the AHC Screening Tool provides tips for managing privacy and safety needs for survivors and those at risk (page 21) that DHCS and MCPs can reference, including a recommendation for universal education. The AHC Model also builds partnerships among health care systems, community service providers, and state Medicaid agencies that work to align community services to ensure capacity to meet beneficiaries' needs, including for referrals and secure data sharing.

recommendation 3: expand access to comprehensive behavioral health services for survivors and those at risk

Target audience: DHCS, MCPs

Strategy	Include exposure to IPV as a risk factor that qualifies children to access specialty mental health services
Description of strategy and proposed DHCS or MCP approaches	DHCS should explicitly include exposure to IPV as identified in screenings for adverse childhood experiences (ACEs) as a risk factor that qualifies children to receive specialty mental health services.⁷⁸ DHCS-approved trauma-screening tools should include specific questions regarding exposure to IPV. The Pediatric Adverse Childhood Experiences and Related Life Events Screener (PEARLS), the screening tool that Medi-Cal providers currently use as part of the ACEs Aware Initiative, includes a screening question related to children's exposure to violence. DHCS should promote MCPs' use of universal education combined with PEARLS as an approved trauma-screening tool.
Rationale	Enabling children and youth who need specialty mental health services to receive them based on IPV exposure is an important mechanism for intervening at critical junctures in their development and disrupting the intergenerational cycle of IPV. The proposed clarification to the Early and Periodic Screening, Diagnostic and Treatment protections criteria will allow children to access specialty mental health services based on experience of trauma, such as IPV, and can help ensure children receive care that can prevent future mental health conditions. Screening children specifically for exposure to IPV is critical because of the increased risk of emotional and behavioral problems as well as emotional, physical, and sexual abuse among children who experience or witness IPV.⁷⁹ Many survivors with mental health symptoms, or those at risk for developing such conditions, have not engaged with a mental health provider or received a mental health diagnosis. Barriers might include perceived stigma, lack of affordable or linguistically appropriate services, or coercive behavior from a perpetrator who prohibits access to services. Allowing reimbursement for treatment without diagnosis can help survivors who are in immediate need of care and potentially prevent development or progression of chronic mental health conditions. Expanding access to specialty mental health services for adults and children at risk for IPV can help families heal and play a role in breaking the intergenerational cycle of violence.
Current Medi-Cal context	The CalAIM proposal revises behavioral health medical necessity criteria to provide specialty mental health services to beneficiaries before a diagnosis has been made (CalAIM, p. 84). It also expands access to specialty mental health services for children, adolescents, and young adults based on the experience of trauma and risk of developing future mental health conditions as evidenced by scoring in the high-risk range on a DHCS-approved trauma screening tool, involvement in the child welfare system, or experience of homelessness (CalAIM, p. 84).

Strategy	Enhance the definition of dyadic behavioral health visits
Description of strategy and proposed DHCS or MCP approaches	Dyadic care refers to models of care that integrate physical and behavioral health screening and services for children, youth, and their families and promote positive parenting approaches. Dyadic models typically embed child development specialists within pediatric primary care teams to promote screening, offer interventions, and provide referrals to behavioral health and social support services. DHCS should incorporate the needs of survivors as it works to define the dyadic services benefit and update the language as shown in exhibit 9 below. DHSC should clarify that parents of children enrolled in Medi-Cal are eligible to receive dyadic services even if the parents are not enrolled in Medi-Cal.
Rationale	There is evidence that dyadic models of care improve access to preventive care, coordination of care, parenting skills, and resilience in children and families. There is also evidence of improved maternal mental health and children's social-emotional health and safety.^{80, 81, 82, 83} Local providers in California already use several evidence-based models of family therapy and dyadic care, such as HealthySteps, DULCE, Parent-Child Interaction Treatment, and Child Parent Psychotherapy.
Current Medi-Cal context	California Assembly Bill 133, signed into law by Governor Newsom on July 27, 2021, makes dyadic therapy services a Medi-Cal-covered benefit starting no sooner than July 1, 2022.

Strategy	Encourage use of family therapy and dyadic services
Description of strategy and proposed DHCS or MCP approaches	DHCS and MCPs should conduct outreach to health care providers about the new family therapy and dyadic benefits and promote their use. Specific activities that DHCS and MCPs can undertake include: • Training providers on evidence-based family therapy and dyadic services • Encouraging providers to render these services • Making patients aware of the new covered services • Common strategies that state Medicaid agencies and MCPs use to promote new Medicaid benefits to providers and enrollees include the following: - Posting information on providers' websites and including it in providers' newsletters - Hosting provider trainings on the new benefit and related billing codes - Offering providers continuing medical education credits for participating in trainings⁸⁴
Rationale	See above for benefits of dyadic services on resilience in family and children, and children's socio-emotional health and safety. Research also shows that family therapy and dyadic services are connected with violence prevention. For example, children who receive psychotherapy after experiences of childhood physical abuse may be less likely to use violence in adulthood.⁸⁵
Current Medi-Cal context	In 2020, DHCS released new family therapy benefit guidelines for Medi-Cal MCPs specifying that family therapy is reimbursable for treatment of mental health conditions in children and adults and for prevention of mental health conditions in children with certain risk factors, including exposure to domestic violence or other traumatic events or having a parent who has a history of IPV. California Assembly Bill 133, signed into law by Governor Newsom on July 27, 2021, makes dyadic therapy services a Medi-Cal covered benefit starting no sooner than July 1, 2022.

exhibit. 9

proposed updates to the definition of dyadic behavioral health visits

Recommend the following language additions: Dyadic behavioral health visits are provided for the child and caregiver or parent at medical visits, providing screening for behavioral health problems, interpersonal violence in the home, tobacco and substance misuse and social determinants of health such as food insecurity and housing instability, and referrals for appropriate follow-up care, including immediate safety planning and other IPV services, behavioral health care, and appropriate social services.

recommendation 4: support privacy and confidentiality needs of survivors and those at risk

Target audience: DHCS, MCPs

Strategy	Adopt and educate health care providers about protocols to protect the privacy and confidentiality needs of survivors
Description of strategy and proposed DHCS or MCP approaches	MCPs should support survivors' use of and trust in the health care system by partnering with IPV advocacy organizations to train providers on several key protections, including the following: • Robust and informed patient consent about any reporting requirements and sharing of health care data • Patient control over how their data are shared and with whom • Transparency over who has access to their data and when data are shared • Enforceable penalties for violations of privacy MCPs must consider how information is shared on explanation-of-benefit (EOB) forms and other plan documents, so that information about the receipt of sensitive services is not included and potentially accessible to those who use violence. Documents should not include identifying information about disclosures of IPV. Patients should have input on what is included in the medical record documentation. In addition, any data collection, evaluation, or reimbursement for services to IPV survivors for IPV should be considered sensitive, with special protections in place. Protections could include creating clear consent protocols with survivors and using de-identified information in the aggregate or unique identifying numbers that do not disclose identity but still allow data collection and evaluation of the impact of services on health outcomes. Futures Without Violence has established privacy principles for the use of survivor health care information that MCPs can use as a model (see exhibit 10).
Rationale	Disclosure of and receipt of services for IPV, medical, behavioral health, or social needs might present safety issues for survivors. For example, survivors could be at risk for experiencing harm from a partner following a disclosure or confidential service. Therefore, there is a need for special considerations regarding payment of IPV services, related documentation of services, and reporting requirements. Partnerships with IPV advocacy organizations would enhance MCPs' understanding of these considerations. AB 1184, which California Governor Newsom signed into law on September 22, 2021, revises the Confidentiality of Medical Information Act to protect the privacy rights of people who receive "sensitive services," such as those related to IPV, sexual and reproductive health, and sexually transmitted infections. The law specifies that health plans meet the following obligations: They cannot require protected individuals to obtain the policyholder's, primary subscriber's, or other enrollee's authorization to receive services or submit a claim for these services if they have the right to consent to care. They must direct communications regarding a protected individual's receipt of sensitive services (for example, bills, EOBs, requests for information regarding claims) to them via their preferred communication method. They must not disclose medical information related to sensitive health care services to the policyholder, primary subscriber, or other enrollee without written authorization.⁸⁶

Target audience: DHCS	
Strategy	Protect the safety and privacy of survivors in payment strategies developed for IPV
Description of strategy and proposed DHCS or MCP approaches	MCP should implement tools and strategies to protect privacy and confidentiality. To develop their plans, MCPs can seek recommendations from IPV service providers (for example, community IPV advocacy organizations that provide counseling, safety planning, and ongoing support), health centers, and CBOs for innovative strategies that Medi-Cal can employ to pay for IPV services without compromising beneficiaries' safety. For example, payment models, such as monthly flat fees that cover services for an assumed number of survivors, rather than payment tied to billing based on services rendered to individual beneficiaries, would help protect the privacy and safety of survivors.
Rationale	See above.
Current Medi-Cal context	Requirements proposed under CalAIM and enacted under AB 133 for MCPs to develop population health management programs through which plans will partner with contracted health care providers and community-based partners to identify and address health-related social needs (CalAIM, p. 25).

exhibit. 10

Futures Without Violence's privacy principles for protecting victims of IPV⁸⁷

- Patients should receive an explanation of how health information is used, shared, and disclosed, including specific notification of the limits of confidentiality.
- Patients should be made aware of their rights to access, correct, amend, and supplement their own health information.
- Personal and sensitive health information should be de-identified whenever possible.
- Providers must understand and respect patients' preferences for mode of communication (for example, by phone or email). These should be built into electronic health records as mandatory fields.
 - Privacy safeguards and consents should follow the data if they are shared with other providers.
 - Providers should have broad discretion to withhold information when disclosure could harm the patient.
 - There should be strong and enforceable penalties for violations of privacy and consent in clinical settings and across electronic health information exchanges.

endnotes

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- 23 Dyadic care refers to models that integrate physical and behavioral health screening and services for children and youth and their families and promote positive parenting approaches. Dyadic models typically embed child development specialists within pediatric primary care teams to promote screening, offer interventions, and provide referrals to behavioral health and social support services. See "Analysis of New Medi-Cal Family Therapy Guidance and Dyadic Integrated Care Models Currently Implemented in California," Manatt and Center for the Study of Social Policy, Available at CA Dyadic Care Crosswalk 09 27 2020 (first5center.org). Accessed August 13, 2021.
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