
HMA

HEALTH MANAGEMENT ASSOCIATES
HMA COMMUNITY STRATEGIES

*Reimbursement for Domestic Violence Advocacy
Services Provided to Members of Oregon's
Coordinated Care Organizations*

PREPARED FOR
THE OREGON COALITION AGAINST DOMESTIC AND SEXUAL VIOLENCE

Executive Summary

The Oregon Coalition Against Domestic and Sexual Violence (OCADSV) contracted with Health Management Associates Community Strategies (HMACS) to identify options for ensuring sustainable Medicaid funding for domestic violence advocacy in Oregon. HMACS examined state reimbursement models, talked with domestic violence and health care reimbursement experts and stakeholders, and partnered with OCADSV to identify opportunities for reimbursing domestic violence advocacy in Oregon.

Methodology

HMACS conducted a literature review and investigated research, demonstration programs and advocacy information. The team also conducted interviews with stakeholders and experts, including current and past Oregon Health Authority (OHA) leadership, domestic violence advocates, and HMA colleagues with extensive OHA and Medicaid experience.

Findings

Effects of Interpersonal Violence on Health Care. Researchers have identified utilization and cost differences between individuals who have experienced IPV and those who have not. Screening and counseling are primary prevention services and thus Essential Health Benefits in the Affordable Care Act.

Models outside Oregon. Other states are not actively exploring ways to reimburse domestic violence advocacy services for Medicaid recipients. Some states have good models for reimbursing Community Health Workers, as described in the Appendix at the end of the report.

Oregon Model. Oregon allows Coordinated Care Organizations (CCOs) to pay for “flexible services,” non-medical services that support health outcomes and cost containment. This includes reimbursement of services by Traditional Health Workers (a category established in 2013). The barriers to such funding include the categorization of flexible services as administrative costs and the need for clarity on how to code such activities. In addition, the lack of quantitative evidence about efficacy and concerns about confidentiality and patient safety discourage systematic reimbursement for domestic violence advocacy.

Opportunities

Oregon’s proposed Section 1115 Waiver proposes allowing flexible services to be credited in rates development. Use of social determinant of health diagnosis codes could help track service use without compromising survivor privacy or safety. The OHA Transformation Center could provide help to CCOs seeking to bridge understanding between the State, CCOs and providers regarding what and how to bill.

Findings

HMACS recommends the following next steps for OCADSV:

1. Serve as a facilitator between payers and providers on the issue of Medicaid reimbursement in order to bridge the gap between what OHA, providers and CCO think is reimbursable.
2. Work with health plans to be prepared for action upon approval of Oregon’s Section 1115 waiver renewal, to prepare health plans to increase billing for flexible services.
3. Utilize an existing payment arrangement to support data collection and analysis.

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Project Overview

The Oregon Coalition Against Domestic and Sexual Violence (OCADSV) contracted with Health Management Associates Community Strategies (HMACS) to conduct research and analysis on reimbursement for domestic violence advocacy in Medicaid, and to recommend ways to ensure sustainable Medicaid funding for domestic violence advocacy in Oregon.¹ During the course of the project, HMACS examined other states to investigate similar models for reimbursement, spoke with stakeholders and experts in domestic violence and healthcare reimbursement in Oregon and nationally, and worked with OCADSV staff to assess the current landscape and potential opportunities for the reimbursement of domestic violence advocacy in Oregon.

While the Oregon Health Authority (OHA) rules allow Coordinated Care Organizations (CCOs) to reimburse for domestic violence advocacy, CCOs see barriers to using capitation dollars to pay for these services. HMACS researched this disconnect and identified both systemic and organizational barriers and interest in overcoming these barriers.

This report provides high-level findings from the research and recommendations for next steps that OCADSV can take to help trained domestic violence advocates in Oregon receive reimbursement for their services. These recommendations are:

4. **Serve as a facilitator between payers and providers.** As a subject matter expert in domestic and sexual violence issues and as an organization with deep connections in the state, OCADSV should continue to play a facilitator role on the issue of Medicaid reimbursement. By working with the various stakeholders, OSCADV can help reduce differences between what OHA sees as a reimbursable service, what providers believe is billable, and what CCOs think is reimbursable.
5. **Work with health plans to be prepared for action upon approval of Oregon's Section 1115 waiver renewal.** OCADSV can leverage the momentum it has been building prior to the CMS' approval of the waiver to prepare health plans for the proposed improved conditions for billing for flexible services.
6. **Leverage opportunities for data collection and analysis.** Utilize an existing payment arrangement to collect data on a pilot basis. Details of the data to be collected, process for collection, secure data sharing and analysis should be worked out in collaboration between OCADSV and the funding CCO.

¹ Domestic violence advocates provide information, assistance finding and accessing resources, and support to survivors of domestic and intimate partner violence.

Primary Project Questions

OCADSV identified a number of questions that fell into the following categories:

- Understanding how to best work with Oregon’s current CCO model to get reimbursed for domestic violence advocacy services ;
- Examining Oregon’s current rules/regulations that support or prevent the reimbursement of such services; and
- Investigating whether other models exist for such reimbursement in other states.

OCADSV also expressed interest in recommendations for what an alternative payment model (APM) would look like, and what the organization could do to help its partner organizations contract to provide services under an APM.

Methodology

This project was conducted in partnership with the client, OCADSV. Sarah Keefe, Health Systems Program Coordinator at OCADSV was a collaborator and key informant who provided information on the OSCADV past and current work and future plans. Leveraging her knowledge and past work helped us pursue our research and analysis more efficiently. Sarah connected HMA to numerous resources, including key informants and written resources.

Building on the resources that Sarah shared, HMA conducted a literature review focused on:

- Domestic violence reimbursement models in a medical setting, including:
 - Billing and coding;
 - Private payer initiatives; and
 - Team-based care.
- Oregon’s current reimbursement model, including:
 - An in-depth examination of Oregon’s CCO model;
 - Oregon’s current and proposed Section 1115 waiver; and
 - Oregon’s current definition of traditional health workers (THWs).

The HMA team also explored domestic violence organization reports, websites, and other public documents including research papers, pilot findings, policy papers, webinars and information on specific initiatives. HMA also conducted interviews to obtain additional information. This includes current and past OHA leadership and HMA colleagues with experience with OHA and Medicaid in the state.

Brief Review of Findings from Literature

Effects of Interpersonal Violence (IPV) on Health Care

The Centers for Disease Control and Prevention (CDC) has identified interpersonal violence as a “serious, preventable public health problem that affects millions of Americans.”² IPV comprises different types of

² <http://www.cdc.gov/violenceprevention/intimatepartnerviolence/definitions.html>

violence, including sexual violence, which is defined as a “sexual act committed against someone without that person’s freely given consent.”³ The CDC emphasizes the need for a standard case definition for IPV and sexual violence because it allows for higher quality surveillance of data regarding IPV/sexual violence, which in turn allows for comparisons between geographic areas around the country or within a region, as well as for comparisons over time (e.g. measuring improvements or deteriorations). As such, comparisons can help inform preventive methods and/or interventions, which could be replicated to improve health in other areas.

Interpersonal violence, also referred to as domestic violence, has tremendously high costs not only to the mental and physical health of those directly affected by it, but also to the health care system. It was estimated that in 2011, sexual violence cost the state of Utah an estimated \$4.9 billion, of which medical and mental health care cost an estimated \$163 million.⁴ In comparison, only an estimated \$569,000 was spent on efforts to prevent sexual violence in the state. The literature also shows that women who experience IPV incur 1.4 to 4 times higher health care costs than women who do not. Fishman et al. (2010)⁵ found that even after the initial health care experience for IPV, health care costs for these women were sustained for three years following the end of exposure to IPV. After four years, costs were similar to women who had not experienced IPV. The authors also found that managing patients who experience IPV may be “more similar to a chronic health condition, in which the diagnostic and treatment phase must be followed by long-term management...” and that their research may point to cost savings and an economic benefit gained from interventions that are designed to “reduce the prevalence of IPV or to mitigate its impact once it has occurred.”⁶

From the payer perspective, the federal government has also begun to recognize the need for those affected by IPV to have greater ties to the healthcare system. On July 27, 2015, the Centers for Medicare and Medicaid Services (CMS) published guidance allowing a special enrollment period for victims of domestic abuse and spousal abandonment. This means that survivors⁷ of recent abuse or abandonment can enroll in health insurance through either their state’s health insurance exchange, or through the federal exchange, even outside of the annual open enrollment period. They can also be exempt from the penalty for not having insurance coverage during the year.⁸ These individuals also may be eligible for advance premium tax credits and cost-sharing reductions depending on their updated income and

³ <http://www.cdc.gov/violenceprevention/sexualviolence/definitions.html>

⁴ “Costs of Sexual Violence in Utah,” Logan Cowan, MPH. 2015. The report is a partner publication of the Utah Department of Health Violence and Injury Prevention Program & the Utah Coalition Against Sexual Assault.

⁵ Paul A. Fishman et al., “Changes in Health Care Costs over Time Following the Cessation of Intimate Partner Violence,” *Journal of General Internal Medicine* 25.9 (2010): 920-5.

⁶ Ibid: 924.

⁷ HMAACS chose “survivor” as the term to use through the report, in part because someone who is either in the middle of being abused, or has been abused in the past are both survivors of the abuse. The word survivor also helps convey the strength and resilience of those seeking medical care and engaging with authorities or advocates about the abuse.

⁸ Futures Without Violence, “The Affordable Care Act: an FAQ Guide for Domestic Violence Advocates and Survivors,” 2014. <https://www.futureswithoutviolence.org/wp-content/uploads/FVPSA-FAQs1.pdf>
Exemptions Screening Tool. <https://www.healthcare.gov/exemptions-tool/#/>

family size.⁹ Furthermore, screening and counseling for domestic violence is considered a primary prevention service and thus covered as an essential health benefit under the Affordable Care Act (ACA). Essential health benefits are categories of services that are reimbursable to the provider and do not require member cost-sharing. Domestic violence can also no longer count as a pre-existing condition, meaning that insurance companies cannot deny coverage to a woman who has a history of domestic violence. Prior to the passage of the ACA, seven states permitted payers to deny coverage on this basis.¹⁰

Models Outside of Oregon

We found that other states are not actively exploring ways to reimburse domestic violence advocates for services through Medicaid or other reimbursement mechanisms. Correspondence with subject matter experts in other states outside of Oregon, including state agency staff and nonprofit staff, further indicated that little progress has been made on reimbursement for domestic violence advocacy and related services in a healthcare setting. In Colorado, some programs use licensed therapists to provide therapeutic interventions for survivors, and seek reimbursement for these services. However, this is happening only in certain care settings in limited areas of the state. In Iowa, some progress has been made in increasing the number of providers trained on screening and counseling related to domestic violence, but not on reimbursing domestic violence advocates who work in health settings. According to the Kaiser Family Foundation, a survey of state Medicaid agencies across the country found that as of January 2013, 22 state Medicaid programs reimburse providers for screening and counseling for “interpersonal and domestic violence,” but do not indicate who is permitted to reimburse for these services, and the assumption is that it is a traditional provider (e.g. MD, PA, NP). Of note, in these 22 states, 5 state Medicaid programs indicated that there was cost-sharing involved with these services, meaning that the patient is responsible for covering some of the cost of the visit.¹¹

Model in Oregon

Traditional Health Workers

Oregon offers flexibility in the reimbursement mechanisms for historically unregulated healthcare providers in the state’s coordinated care organization (CCO) structure for the Oregon Medicaid program. Each of Oregon’s 16 CCOs has a single budget to pay for physical, behavioral and dental health services, and has control of how funds are spent. The CCO can pay for services that are not strictly medical if they can be expected to support health outcomes and overall cost containment. This allows the CCO to

⁹ Centers for Medicare & Medicaid Services, “Updated Guidance on Victims of Domestic Abuse and Spousal Abandonment,” July 27, 2015. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Updated-Guidance-on-Victims-of-Domestic-Abuse-and-Spousal-Abandonment_7.pdf

¹⁰ Futures Without Violence, “How the Affordable Care Act (ACA) Affects Victims of Domestic, Sexual, and Dating Violence,” June 2012. <https://www.futureswithoutviolence.org/userfiles/file/HealthCare/ACA%20and%20DV%20final.pdf>

¹¹ Alexandra Gates, Usha Ranji, and Laura Snyder, “Coverage of Preventive Services for Adults in Medicaid,” The Henry J. Kaiser Family Foundation, November 2014, <http://kff.org/report-section/coverage-of-preventive-services-for-adults-in-medicaid-survey-findings/>

advance innovative models of care, including supporting programs that focus on prevention and the Triple Aim of better health, better care, and lower healthcare costs for their patient population.¹²

In addition, legislation passed in 2013 established the Traditional Health Worker Commission within the Oregon Health Authority Office of Equity and Inclusion.¹³ The Commission regulates the five types of traditional health workers (THWs) in Oregon that can be reimbursed by CCOs for their services:

- Community Health Workers (CHW)
- Peer Support Specialists (PSS)
- Peer Wellness Specialists (PWS)
- Personal Health Navigators (PHN)
- Birth Doulas

Oregon's CCOs are authorized to reimburse for members' use of services provided by THWs. In Oregon, THWs go through a certification process, which requires successful completion of approved training, completion of a background check and continuing education to maintain certification. Curricula for the approved trainings for those seeking certification as a CHW, PWS, PHN, and PSS include requiring coursework on topics such as:

- Knowledge of community resources
- Legal responsibilities
- Crisis identification and problem-solving
- Social determinants of health
- Trauma-informed care¹⁴

A minimum of 80 contact hours is required for an individual attending a training to become certified as a THW in Oregon. THWs can enroll as Medicaid providers by completing Form 3113¹⁵, and attaching a copy of their certification. Form 3113 is also titled the "Non-Payable Provider Enrollment Form," and indicates that the form should be used to "enroll providers with Oregon Medicaid for reasons other than direct reimbursement." While THWs can be reimbursed by CCOs, they cannot get paid by OHA directly through fee-for-service. In contrast, Form 3114,¹⁶ which physicians complete to enroll in OHA, is for health care professionals who can seek direct fee-for-service reimbursement from the Medicaid program.

¹² Oregon Health Policy Board, "Coordinated Care," <http://www.oregon.gov/oha/OHPB/pages/health-reform/ccos.aspx>

¹³ House Bill 3407. 2013 Legislative Session. <https://www.oregon.gov/oha/oei/Documents/HB%203407.pdf>

¹⁴ A full list of all the topics required to be address in a training curriculum can be found in in pages 24-27 of the Oregon Health Policy Board's report "The Role of Non-Traditional Health Workers in Oregon's Health Care System" (January 2012) <http://www.oregon.gov/oha/healthplan/Policies/180rb011514.pdf>.

¹⁵ Oregon Department of Human Services, "Form 3113." https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/oe3113.pdf

¹⁶ https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/oe3114.pdf

Flexible Services

When CCOs were being developed as organizations that manage their members' health care (physical, behavioral health and dental) under a single budget that grows at a fixed rate, OHA also established the concept of flexible services. Giving each CCO a budget and associated outcome and quality requirements meant giving the CCO flexibility to administer funds in ways not previously allowed in the state's Medicaid program. Flexible services are non-medical services that result in better health for the patient at a lower cost than could be provided otherwise. While flexible services may not generate a claim, they can be reimbursed within the CCO's global budget.

Former Governor Kitzhaber often used the example of purchasing an air conditioner for an individual with congestive heart failure. A \$200 air conditioner that could help the patient stay out of the hospital in the hot summer months could result in thousands of dollars of savings, in addition to improving the individual's health and quality of life. Services by traditional health workers can also be paid under the flexible services umbrella. OHA requires that there be a health-related reason for using a non-medical service or good, and the provider must identify the service/good as something intended to help manage a health-related condition. There needs to be a health-related reason for this "non-medical" purchase and services must contribute to effective management of a health condition.

Barriers

Administrative Costs

Although CCOs in Oregon can legally provide their members with services from THWs, few CCOs utilize many THWs. An operations staffer at one CCO pointed to the limitation inherent in the rule that flexible services be considered administrative costs rather than medical costs. As administrative expenses, spending on flexible services are not used to build the next year's capitation. In addition, if the CCO replaces too many medical services with ones considered administrative costs, this could put the CCO at risk of spending more than the allowed percentage of its funds on administrative costs.¹⁷ This barrier may inform why CCOs have been reticent to institute reimbursement models for THWs, domestic violence advocates or other non-clinical service providers, even if such models can reduce costs for health care.

Billing/Coding

Another barrier to CCO reimbursement of flexible services is the gap in understanding regarding what is reimbursable and how flexible services should be coded. OHA (including the Office of Equity and Inclusion) has indicated that domestic violence advocacy is reimbursable under flexible services and CCOs have what they need to make this happen. Medicaid CCOs expressed concern that they lack the diagnosis or treatment codes needed for documentation and reimbursement. There is a need for education on numerous levels for providers and payers (e.g. CCOs) so that all relevant parties can be in alignment with each other and with OHA.

The following diagnosis and treatment codes relate to screening for domestic violence:

¹⁷ CMS rules finalized in April 2016 require 85% of Medicaid capitation must go to medical care and activities that improve quality. The other 15% can fund employee salaries, marketing, profits and other administrative tasks.

Diagnosis Codes (ICD-10)	Description
T74.01xA - T74.02xS	Neglect or abandonment, confirmed
T74.11xA - T74.12xS	Physical abuse, confirmed
T74.21xA - T74.22xS	Sexual abuse, confirmed
T74.31xA - T74.32xS	Psychological abuse, confirmed
T74.91xA - T74.92xS	Unspecified maltreatment, confirmed
T76.01xA - T76.02xS	Neglect or abandonment, suspected
T76.11xA - T76.12xS	Physical abuse, suspected
T76.21xA - T76.22xS	Sexual abuse, suspected
T76.31xA - T76.32xS	Psychological abuse, suspected
T76.91xA - T76.92xS	Unspecified maltreatment, suspected
Treatment Codes (CPT)	Description
V82.89	Special Screening for Other Conditions
99381-99397	Preventive Medicine services; includes an age- and gender-appropriate history and examination; includes counseling, anticipatory guidance, and risk factor reduction interventions, usually separate from disease-related diagnoses

Evidence-Based Services

Across the country, private payers recommend that providers conduct screening for domestic violence, and reimburse for it, but do not specifically call out or recommend domestic violence advocacy as an important or intrinsic resource for providers or practices. One barrier to payers including domestic violence advocacy is the lack of quantitative data, particularly with regards to return on investment or cost-effectiveness, that “proves” the case to payers on why recommending such a model is worthwhile. While experiencing domestic violence is associated with higher health care utilization and costs, there is little research on the impact of providing referrals and advocacy to individuals identified as survivors. Human subjects concerns complicate such research.

Confidentiality / Patient Safety

One reason there is little data on the return on investment or cost-effectiveness of domestic violence advocacy work or similar care interventions is that safety is of the utmost concern when working with domestic violence survivors. A provider and/or an advocate does not want to put the patient further at risk, which may mean that no documentation of domestic violence concerns or treatment occurs, for fear that such information could accidentally be communicated (e.g. through an online patient portal or Explanation of Benefits (EOB) to which the abuser has access). This (appropriate) focus on the patient over reporting can undermine data completeness that would allow reliable assessment of return on investment or cost-effectiveness.

Domestic violence advocates may also be limited by confidentiality guidelines, which could hinder reimbursement, particularly if it is based on a patient getting a referral/other treatment from another provider. For example, if a higher reimbursement is made after a patient completes treatment at another facility, but the domestic violence advocate cannot attest to whether that patient completed

the treatment (due to confidentiality guidelines), that higher reimbursement will be unable to be processed.

Opportunities

Despite the barriers identified above, there are opportunities to continue to pursue reimbursement for services provided by domestic violence advocates. This section details two of these opportunities.

Section 1115 Waiver

Section 1115 of the Social Security Act allows the federal Department of Health and Human Services to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. A state may apply for a Section 1115 waiver to test a policy approach, and in the process increase flexibility to provide services to their state's Medicaid population. Oregon's current Section 1115 waiver authorizes CCOs as they currently operate, and allows CCOs to use capitation to pay for flexible services. As described above, flexible services are considered administrative costs. Oregon's current waiver ends on December 31, 2016, and the proposed waiver renewal includes language that would allow flexible services to be considered medical for the purposes of rates development.¹⁸ While this does not affect the medical-loss ratio issue, it would allow CCOs to get "credit" in their out-year rates for flexible services provided in 2016 and beyond.

The proposed waiver also outlines ways in which THWs would be able to be reimbursed for their services, such as a doula being able to "work with Medicaid-enrolled practitioners to serve OHP members on a fee-for-service basis. Doulas are required to have an agreement with the practitioner, which allows for reimbursement of doula services as a practice expense."¹⁹ Under the waiver amendment, Oregon also proposes to seek a waiver of federal authority that requires the doula to be supervised by an existing "licensed medical provider to provide services within licensed practitioner's scope of practice," stating that "Oregon will ensure that our rules and regulations require doulas and THWs to coordinate and share information with recognized Patient Centered Primary Care Homes and CCOs, which are foundational partners in health system transformation."²⁰

Further, the waiver amendment notes the increasing importance of THWs in serving Oregon's Medicaid population, indicating that the state has key focal areas that include "pursuing strategies to integrate THWs into the CCOs; advancing community engagement opportunities; and developing and implementing ongoing revisions to the THW scope in the context of health system transformation." This focus will require "CCO engagement to define the role and use of THWs in community settings and to increase the percentage of CCOs and their providers that employ them, to the extent needed within a community."²¹ Such a focus from the state indicates the high level of need and momentum for the CCOs

¹⁸ Oregon's Section 1115 waiver is currently under negotiation and is expected to go into effect in January 2017.

¹⁹ Oregon Medicaid and Children's Health Insurance Program, "APPLICATION FOR AMENDMENT AND RENEWAL, Oregon Health Plan 1115 Demonstration Project," <https://www.oregon.gov/oha/OHPB/Documents/Oregon%27s%20Draft%20Waiver%20Application.pdf>: 37.

²⁰ Ibid: 37.

²¹ Ibid: 38.

to take up innovative models using non-traditional healthcare workers, of which domestic violence advocates could play an integral role.

In its comments to OHA on the proposed waiver, OCADSV highlighted the need to include domestic and sexual violence as a core social determinant of health, and asked that CCOs be encouraged to address this issue through partnerships with community based organizations. OCDSAV also sent out a request to its partners and stakeholders that they let OHA know about their support for the Section 1115 waiver and echo these sentiments regarding domestic violence and flexible services.

Social Determinant of Health Diagnosis Codes

Utilizing a social determinant of health billing code would allow CCOs and other organizations to address systems-level and provider-level concerns. This code could be used to identify that a health-impacting issue was raised without requiring the specific issue to be identified. CCOs could use existing ICD-10 codes, categories Z00 – Z99 for this purpose. These diagnostic categories are used to identify a diagnostic circumstance other than disease, injury or external cause (Categories A00 – Y89). This includes a circumstance or problem that impacts the patient’s health status, including but not limited to homelessness, violence or economic stability. Increasing use of these codes, which can be specific to the needs of CCOs but also not specific enough to raise concerns that information being included on an EOB or health record could be accidentally disclosed to an abuser, could help domestic violence advocates get reimbursed by the CCO for their work. Such codes, especially when paired with a social determinants billing code, would support a financial arrangement between CCO and advocacy organization in which the advocate is paid a monthly rate rather than reimbursed on a fee-for-service basis. A social determinants code would allow the CCO to identify how many advocacy services are offered and to account for the cost of services in its rates development without tagging the recipient’s medical record with a domestic violence marker.

Nationally, there is momentum building around the need to address domestic violence as a social determinant of health. CMS has established an Accountable Health Communities model that “addresses a critical gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of beneficiaries’ impacts total health care costs, improves health, and quality of care.”²² Interpersonal violence is one of the core areas that CMS is seeking to identify and address, and the program sites will test the impact of an ACH intervention on total health care costs and utilization, as well as health and quality of care for Medicare and Medicaid beneficiaries.

Transformation Center

The Oregon Health Authority Transformation Center provides assistance to CCOs and helps them overcome barriers working with OHA. Transformation Center “Innovator Agents” are assigned to work with particular CCOs, so that they get to know and build trust with local staff. As one of the roadblocks

²² Centers for Medicare and Medicaid Services, “Accountable Health Communities Model,” <https://innovation.cms.gov/initiatives/AHCM>

identified by CCOs is the lack of OHA approved diagnosis or billing codes, Innovator Agents may have a role in helping bridge the knowledge gap between CCOs and OHA.

Recommendations

In support of OCADSV's efforts to address domestic violence as a public health issue and overcome the barriers to Medicaid reimbursement for domestic violence advocacy, HMA CS has identified three areas it recommends that OCADSV pursue or continue to take action; these are described below

Continue to Build Relationships with CCOs

By continuing to develop relationships with a number of CCOs, OCADSV can become the "go-to" resource for these CCOs regarding domestic violence, understanding its impact on member health, and how to overcome barriers to covering domestic violence-related services under capitation. Understanding the perceived barriers will allow OCADSV to help CCOs overcome those barriers.

To build on relationships the Coalition has started to develop with staff at individual CCOs, OCADSV could convene meetings like "lunch-and-learns" or webinars to provide information on the benefits to members and the CCO for addressing domestic violence in the healthcare setting. Other ways to help the CCOs prepare for reimbursement could include resources and educational programming; topics may include: domestic violence screening protocols, the role of domestic violence advocates and where they fit into a clinic workflow, and how these services should be coded.²³

This work will build strong personal relationships that increase trust between the CCOs and the domestic violence advocates whom OCADSV represents, and provide technical assistance to CCOs to make needed changes required to support sustainable domestic violence advocacy services.

Serve as Educator for Providers and Payers Ahead of Next 1115 Waiver

In addition to providing support to CCOs regarding domestic violence services more generally, OCADSV can serve as a subject matter expert while the CCOs prepare for reimbursing for non-medical benefits through the state's next Section 1115 waiver, once it is approved. OCADSV can work to make it as easy as possible for the CCOs to begin this reimbursement, by assisting in answering questions such as:

- What kind of assistance can OCDSAV provide to the CCOs to help get them ready to reimburse for these flexible services under the new rules?
- What issues will the CCOs need to think through or prepare for?

Billing and coding for domestic violence advocacy services is an area where the providers and the CCOs could benefit from greater understanding and clarity. OCADSV could use the pending new rules that identify what services count as medical costs (for the purpose of capitation development) as an opportunity to help CCOs find ways around the perceived difficulties. Much like in the recommendation for building relationships with the CCOs to help them prepare for the approved Section 1115 waiver,

²³ This factsheet or toolkit would need to be created in collaboration with relevant subject matter experts from OCADSV and the CCO. On the CCO side, staff members from the billing, IT, provider education, and other relevant divisions should be included to create and approve these materials.

OCADSV could work to organize webinars, training sessions, or presentations to CCO staff/provider audiences, as well as work with OCADSV's member organizations to build their competence and confidence talking about this topic area.

Leverage Opportunities for Data Collection and Analysis

While the flexibility granted to CCOs presents opportunities that other states do not have, CCOs are still focused on making sound investments in models that both improve the health of their member population and provide a positive return on investment. At present we lack significant evidence-based research findings regarding the outcomes and financial benefits of investing in domestic violence interventions in healthcare settings.

One way to support the business case to a CCO is to partner with a CCO on a pilot data collection and analysis effort. Using an existing or new funding effort, partner with the CCO funder to collect data on health care utilization and costs for members affected by domestic violence. As noted elsewhere, for a variety of reasons, not all providers bill for violence-related services or include such information in member health records. Incomplete data can hamper an analysis that seeks to compare individuals affected by violence with other members of the patient population. However, it is possible to gather and analyze information on the health care utilization and costs of individuals who have received domestic violence advocacy services. Looking at utilization over time would allow a comparison of utilization at the time domestic violence advocacy services are received within a period years after the intervention. While this effort has challenges, including CCO members losing and gaining Medicaid eligibility over time, individuals changing CCO due to a move, and other common life changes, a pre/post-intervention comparison can be easier to administer and evaluate than other study types. To protect patient privacy and security, data analysis should be done at the aggregate level within a health plan.

Recognizing that violence can challenge efforts to assess the long-term utilization impact of an IPV intervention, an alternative to measuring this impact is to assess program quality. Existing research indicates that IPV is associated with an increase in utilization of healthcare services. As a high quality program is more likely to help survivors, an argument can be made for a meaningful correlation even if direct impact cannot be determined. Direct impact may not be able to be determined quickly or ever, given the life changes that make it difficult to track long-term impacts for a small member population. Considerations for the pilot would need to account for how patient safety, privacy, and confidentiality would be prioritized and protected, while still gathering useful data from the work.

Conclusion

As momentum and interest builds towards value-based payment and improved population health across the country, and especially within Oregon, the topic of how to seek reimbursement for domestic violence advocacy services is increasingly tied to understand the impact services can have on health outcomes and longer term costs. Research across the country indicates an increasing understanding of the need to engage with those affected by domestic violence as early on as possible in order to reduce health care utilization (and thereby costs) to levels similar to those not affected by domestic violence. Domestic violence advocacy is a successful model for helping healthcare settings to engage with and

support patients who present with these service needs. Yet as the research for this work shows, there are still real and perceived barriers to achieving these goals of reimbursement for DV advocate services, including the need to align systems and build relationships with organizations that have not historically worked together.

OCADSV can continue to overcome these barriers and work towards attaining reimbursement for DV advocates across Oregon by continuing to build up or create new relationships with CCOs across the state in order to help them prepare for the upcoming changes from the Section 1115 waiver. Instituting a cost analysis pilot study would help provide CCOs with data and outcomes to illustrate the benefits of reimbursing for domestic violence advocacy services. Utilizing OCADSV's skills and relationships could bridge the gap of understanding with regards to billing and coding between OHA, the CCOs and providers.

Appendix: Billing for Community Health Workers

In Oregon, Community Health Workers (CHW) are one of the five groups of Traditional Health Workers that CCOs are allowed to use to provide services in the community for their member populations. CHWs provide health promotion, health education, and related services within their communities, and often have a deep understanding of or shared experiences with the communities they serve. There are parallels between how domestic violence advocates and CHWs function in the health care system. In some states, Community Health Workers are able to bill for their services. This section details relevant information regarding information on the billing and reimbursement process for CHWs in selected states.

Minnesota²⁴

Training/Education Requirements

Providers must have a valid certificate from the Minnesota State Colleges and Universities (MnSCU) demonstrating that the applicant has completed an approved community health worker curriculum.

Billing Procedure²⁵

CHW services providing patient education for health promotion and disease management are covered if provided under the supervision of a physician, dentist, advanced practice registered nurse (APRN), certified public health nurse (PHN) or mental health professional. Medical providers participating in Minnesota Health Care Programs (MHCP) must bill for services for the CHW to receive payment.

Providers must bill MHCP electronically:

- Use hospitals, clinics, physicians, APRN's, public health nursing organization's or mental health professional's National Provider Identifier (NPI) as billing provider
- Use the following procedure codes:
 - 98960 Self-management education & training, face-to-face, 1 patient
 - 98961 Self-management education & training, face-to-face, 2–4 patients
 - 98962 Self-management education & training, face-to-face, 5–8 patients
- Bill in 30-minute units: limit 4 units per 24 hours; no more than 24 units per calendar month per recipient
- Bill separate lines for each day service is provided (only one calendar month of service per claim)
- Enter appropriate diagnosis
- Use the CHW non-pay Unique Minnesota Provider Identifier (UMPI) number as rendering provider.

²⁴ Minnesota Department of Human Services, "Community Health Worker (CHW)," http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_140357

²⁵ Ibid.

New Mexico

Training/Education Requirements

Certification²⁶ is voluntary and can be done through the New Mexico Department of Health. CHW applicants must complete a New Mexico Department of Health (DOH) approved training program and demonstrate proficiency in CHW core competencies. A background check is required. CHW certificates are valid for two years. Continuing education units are required for recertification.

Applicants must complete a 100-hour core competency training through the DOH Office of Community Health Workers or complete a DOH-endorsed curriculum available through community colleges, universities, agencies and other community based organizations.

Billing Procedure

Through a Section 1115 Waiver, New Mexico's Medicaid program (Centennial Care) uses its contracts with Medicaid managed care organizations (MCOs) to support the use of CHWs in serving Medicaid enrollees. CHW salaries, training, and service costs are considered administrative costs and are embedded in capitated rates paid to Medicaid MCOs.²⁷

The MCOs' financial arrangements with CHWs include:

- Direct employment with the MCO;
- Contracting with agencies or groups that employ CHWs;
- Contracting directly with independent CHWs, covering their costs as part of a care team (flat fee or PMPM); and
- Fee-for-service²⁸

South Carolina

Training/Education Requirements

All CHWs must pass a competency exam reflective of a 6 week training curriculum in order to become certified as a CHW.

Billing Procedure

CHWs can be supervised through a team approach but the final responsibility for CHW's contributions and outcomes is the responsibility of the designated clinical supervisor. CHWs are a non-enrolled provider, and services must therefore be billed by a Medicaid-enrolled provider to receive payment.

The Medicaid-enrolled physician or nurse practitioner will bill the following codes under their National Provider Identifier for services rendered by a CHW:

²⁶ <http://nmhealth.org/about/phd/hsb/ochw/>

²⁷ <http://www.nashp.org/sites/default/files/NOSOLO-new3.pdf>

²⁸ <https://www.statereforum.org/sites/default/files/precon.1.weinberg.j.pdf>

- **S9445:** Patient education, not otherwise classified, non-physician provider, face to face, individual session, per session
 - \$20.00 per patient for no more than 4 units per day per patient (30 min units=2 hours) with no more than 8 units per month (4 hours)
- **S9446:** Patient education, not otherwise classified, non-physician provider, face to face, group session, per session
 - \$6.00 per patient with a maximum of 5 recipients in a group for no more than 2 units (1 hour) maximum session per day with no more than 8 units (4 hours) per month

Documentation for reimbursement must contain:

- A Physician Order for services signed by a provider with number of units ordered and whether the service was delivered in group or individually

Documentation of date of service, start and end time, group or individual service, number of participants if a group, summary of services or session content, CHW signature and printed name.²⁹

Other Resources for State CHW Models

State Refor(u)m30 maintains an updated chart of CHW models around the country, and notes how the states finance these models. A number of states (Arkansas, California, Colorado, Connecticut, Idaho, Kentucky, Maine, Maryland, Michigan, Minnesota, Oregon) included CHWs in their State Innovation Model (SIM) plans, which may be worthwhile to track to note how they plan to make the financing of these models sustainable after the conclusion of the SIM grants. Other states are pursuing alternative ways to reimburse for CHW services through Medicaid, including through submitting State Plan Amendments (DC, Kentucky, Massachusetts, South Carolina, Washington) to CMS for approval.

²⁹ Ibid: Slide 37-40.

³⁰ "State Community Health Worker Models," Last updated March 2016, <https://www.statereforum.org/state-community-health-worker-models>