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TO: Family Violence Prevention and Services Act (FVPSA) State/Territory Administrators, Tribes, State/Territory Domestic Violence Coalitions, and FVPSA Subrecipients (e.g., Domestic Violence Service Providers)

SUBJECT: Medical Advocacy and Health Care Services Payment or Reimbursement for FVPSA Grant Recipients and Subrecipients

PURPOSE: The purpose of this information memorandum (IM) is to provide guidance to Family Violence Prevention and Services Act (FVPSA) grant recipients and subrecipients (e.g., domestic violence service providers) regarding their ability to receive payment(s) from health programs or other third-party payers, including reimbursement through Medicaid and health insurance plans, for the provision of domestic violence related health care services and medical advocacy that is not otherwise funded through FVPSA.

LEGAL REFERENCES: Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010), § 1001, 42 U.S.C. § 300gg-13 (amending § 2713 of the Public Health Services Act); the Family Violence Prevention and Services Act (FVPSA), 42 U.S.C. § 10401 *et seq*.; the FVPSA Regulations, 45 CFR § 1370; the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, 45 CFR § 75.

INFORMATION

As the health care sector continues to move toward paying for expanded services that address social determinants of health (SDOH), including intimate partner violence (IPV) and domestic violence (DV), it is critical for FVPSA grant recipients and subrecipients to know how to be reimbursed for providing health care services and medical advocacy that is not otherwise funded through FVPSA and to have guidance on receipt of such payments.

While the FVPSA statute allows for reimbursement to subgrantees for medical advocacy[1], it does not allow for reimbursement for health care services (42 U.S.C. § 10408(b)(1)(G)(iii)).[2] **Given the FVPSA statute prohibition on reimbursement for any health care services, this Information Memorandum (IM) confirms that all FVPSA subrecipients may bill and receive payment(s) from health programs or other third-party payers, including Medicaid and health insurance plans for both health care services and medical advocacy but may not use FVPSA funding for reimbursement.**

In terms of reimbursement for health care services, this IM refers only to payment(s) from health insurance plans, Medicaid, health programs, or other third-party payers to FVPSA subrecipients for services provided to survivors of domestic violence or IPV).[3] Direct payment to the FVPSA subrecipient from the survivor receiving services is prohibited by the FVPSA statute (42 U.S.C. §10406(c)(3)).

I. Background

As reported by the Centers for Disease Control and Prevention (CDC), about 1 in 4 women and nearly 1 in 10 men have experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime and reported some form of IPV-related impact.[i] Experiencing these types of physical and mental traumas can have lifelong, health related consequences for survivors, including chronic pain, traumatic brain injury, digestive problems, reproductive and maternal health concerns, and the potential loss of access to health care providers. Domestic violence is a significant public health issue that is preventable.

Healthcare settings, working in bi-directional partnership with domestic violence service providers, represent important sites for domestic violence screening, education, safety planning, referral, and/or treatment.

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[1] See ACF-ACYF-FVPSA-IM- 22-03 for guidance regarding the provision of domestic violence related medical advocacy.

[2] While the FVPSA statute allows for reimbursement to FVPSA grant recipients for medical advocacy, it does not allow for reimbursement for health care services (42 U.S.C. § 10408(b)(1)(G)(iii)). Specifically, the FVPSA statute states the following: 42 U.S.C. § 10408(b)(1)(G)(iii) medical advocacy, including provision of referrals for appropriate health care services (including mental health, alcohol, and drug abuse treatment), but which shall not include reimbursement for any health care services.

[3] The term "survivor" will be used throughout the document except in those places where statute, regulations or other official guidance uses the term "victim." In either instance, the reference is to the person experiencing domestic violence.

II. Discussion and Analysis

FVPSA subrecipients may bill Medicaid, health programs, and other third-party payers for the health care services they deliver. Similar to how subrecipients currently track multiple, separate and distinct sources of funding and income; the provision of medical advocacy or health care services must be documented as a specialized service and tracked and charged through a separate source.

A FVPSA grant recipient or subrecipient who receives the FVPSA funding *can* bill Medicaid for services not funded in whole or in part by the FVPSA funds.

If a subrecipient would like to bill Medicaid for non-FVPSA funded services, the subrecipient must consider the Code of Federal Regulations (CFR) Uniform Administrative requirements, cost principles and audit requirements at 45 CFR § 75.405(a)(2). Under 45 CFR § 75.405(a)(2), a subrecipient must provide a reasonable methodology when costs will be paid by the federal award and when costs will be paid by other means; i.e., the subrecipient will need to document how it will determine when FVPSA funds or Medicaid (or another payer) pays for a service. Additionally, the subrecipient must commit to whichever method is presented (45 CFR § 75.403(d)). Subrecipients must be mindful to properly document separate billing streams to ensure that they are not charging the same costs to Medicaid (or another third-party payer) and the FVPSA funds.

Federal financial reporting requirements do not change under this clarification. The non-Federal entity that holds the obligation with the federal government will have to report program income and may have other implications under the Office of Grants Management. It is important that subrecipients understand the implications of program income per 45 CFR § 75.307(e)(1):

> (e) *Use of program income.* If the HHS awarding agency does not specify in its regulations or the terms and conditions of the Federal award, or give prior approval for how program income is to be used, paragraph (e)(1) of this section must apply.
>
> (1) *Deduction.* Ordinarily program income must be deducted from total allowable costs to determine the net allowable costs. Program income must be used for current costs unless the HHS awarding agency authorizes otherwise. Program income that the non-Federal entity did not anticipate at the time of the Federal award must be used to reduce the Federal award and non-Federal entity contributions rather than to increase the funds committed to the project.

Subrecipients are not required to charge Medicaid, or other payers, for provision of medical advocacy or health care services and may choose to discontinue doing so at any time.

III. Survivor Consent, Confidentiality, and Privacy

It is vital that FVPSA grant recipients and subrecipients understand that implementing a process to bill Medicaid, health programs, or other third-party payers for provision of medical advocacy and health care services must be structured and operationalized in a way that supports survivor-

informed, time-limited consent, and does not violate individual privacy or confidentiality (42 U.S.C. § 10406(c)(5) and 45 CFR § 1370.4). In order to ensure the safety of adult, youth, and child victims of family violence, domestic violence, or dating violence, and their dependents, FVPSA grant recipients or subrecipients shall protect the confidentiality and privacy of victims and their dependents (45 CFR § 1370.4(a)):

> (1) [FVPSA grant recipients or subrecipients ***shall not***] disclose any personally identifying information (as defined in 45 CFR § 1370.2) collected in connection with services requested (including services utilized or denied) through grantees' and subgrantees' programs.
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> > Personally identifying information (PII), or Personal Information is, *individually identifying information for or about an individual including information likely to disclose the location of a victim regardless of whether it is encoded, encrypted, hashed or otherwise protected* (45 CFR § 1370.2). For example, PII may include a person's full name, home address, date of birth, driver's license number, email address, and patient identification number, among other forms of identification or combination of information that when linked together would identify a person.
>
> (2) [FVPSA grant recipients or subrecipients ***shall not***] reveal any personally identifying information without informed, written, reasonably time-limited consent by the person about whom information is sought, whether for this program or any other Federal, Tribal or State grant program, including but not limited to: whether to comply with Federal, Tribal, or State reporting, evaluation, or data collection requirements; or
>
> (3) [FVPSA grant recipients or subrecipients ***shall not***] require an adult, youth, or child victim of family violence, domestic violence, and dating violence to provide consent to release his or her personally identifying information as a condition of eligibility for the services provided by the grantee or subgrantee.

Additionally, best practice for provision of domestic violence services and supports would necessitate that advocates, as well as healthcare providers,[ii] conduct safety planning with survivors before they can agree to have their insurance billed. It is difficult to know with certainty what documents and information an insurance provider may send out to their customers, or what other contact (i.e., phone, email) they may have with the primary insurance holder. It will be important to discuss the possibility that the abuser may obtain information about the services received from the domestic violence program via the insurance provider and to develop a plan for survivor safety if a dangerous situation were to unfold.

Within the context of providing medical advocacy or health care services, the following questions arise:

- **For FVPSA funded domestic violence service providers who offer screening and brief counseling for IPV/DV <u>and</u> who receive federal funds as subrecipients through the FVPSA, are these programs allowed to seek reimbursement from Medicaid, or other payers, for provision of the screening and brief counseling benefit?** The FVPSA statute at 42 U.S.C. § 10406(c)(3) uses the language: "No fees may be levied for assistance or

services provided with funds appropriated to carry out this chapter," which means FVPSA prohibits service providers (i.e., subrecipients) from charging fees to individuals for DV shelter and supportive service. However, nothing prohibits service providers from charging other entities (e.g., Medicaid) for those services. Further, medical advocacy is included as an allowable use of funds under supportive services in the FVPSA statute at 42 U.S.C. § 10408(b)(1)(G)(iii): "medical advocacy, including provision of referrals for appropriate health care services (including mental health, alcohol, and drug abuse treatment), but which shall not include reimbursement for any health care services."

42 U.S.C. § 10408(b)(1)(G)(iii) does not bar the organization (i.e., subrecipient) from receiving funds for the provision of health care services; however, it does prohibit reimbursement for those services when they are provided using the FVPSA grant funds. FVPSA subrecipients that receive health care services payments are required to have an established policy, a process for documenting such payments for auditing purposes and in accordance with best financial practices, the ability to make such supportive services available to any program participant in need of the same or similar assistance, and the expense must be reasonable and appropriate (45 CFR 75.302).

- **How can a FVPSA funded domestic violence service provider make a referral for health services for a survivor?** FVPSA funded domestic violence service providers can take several steps to make a safe and supportive referral to health services on behalf of survivors. With the written consent of survivors, domestic violence service providers can develop a formal relationship with a provider for specific health services, such as providing education and training for health center staff, and "brief counseling" to patients. This model assumes a continuous feedback loop between the domestic violence program and the provider over the care of the patient, of some sort, and that the domestic violence program is operating through a contract with the provider for a specific scope of services. These arrangements may vary, but there is likely to be information shared between provider, advocate, and the insurance company (for billing purposes). Some arrangements may include a provider supervision requirement, and it will be important to understand what this means and what survivor information must be shared. Providers should keep in mind, however, the confidentiality requirements discussed above and the need for a written, informed, time-limited release should victim information be shared.

  FVPSA funded domestic violence service providers may use the Health Resources and Services Administration (HRSA), a federal agency, to find a health center database to identify local providers at HRSA-funded Community Health Center (CHC), http://findahealthcenter.hrsa.gov/tool.

- **How can a health care provider make a referral to a FVPSA funded domestic violence service provider?** An evidence-based intervention, called CUES, is a three step approach referral to domestic violence and sexual assault advocacy services from a health care provider, in which the provider is able to offer patient access to an onsite domestic violence and sexual assault advocate; offer use of the clinic's phone to call a local resource; offer

the name and phone number so they can reach out independently, or complete a warm referral with a brochure or safety card from a local domestic violence and sexual assault agency, if it is safe for the patient to take home. Ideally, the provider has an established relationship with the domestic violence and sexual assault advocacy program and is familiar with the staff and services available, thus increasing the likelihood of the patient following through with the connection, https://ipvhealthpartners.org/wp-content/uploads/2021/01/CUES-graphic-1.12.21.pdf.

Will direct payments to survivors be an option? Has the statutory prohibition on direct payments to survivors been lifted or waived? – No, FVPSA Section 308(d) (1) prohibits direct payments to survivors of domestic violence and/or their dependents, and states, *no funds provided under this title may be used as direct payment to any victim of family violence, domestic violence, or dating violence, or to any dependent of such victim.* The FVPSA Program does not have the legal authority to waive the direct payment prohibition outlined in Section 308(d)(1) to allow FVPSA funding to be used to make direct payments to survivors. Please note that FVPSA grant recipients and subrecipients may make third party payments to a vendor or business on behalf of a DV survivor. Grant recipients or subrecipients that make such types of payments are required to have an established policy, a process for documenting such payments for auditing purposes and in accordance with best financial practices, the ability to make such supportive services available to any program participant in need of the same or similar assistance, and the expense must be reasonable and appropriate, (45 CFR 75.302). Examples of third-party payments may include rental subsidies; hotel motel vouchers; travel vouchers for relocation; transportation; and childcare.

IV. Conclusion

Through the implementation of the FVPSA grant funds and American Rescue Plan (ARP) supplemental funding, states, territories, tribes, coalitions, domestic violence service providers, rape crisis centers and sexual assault service providers, and culturally specific organizations have access to over $1 billion in funding to provide shelter and supportive services, including medical advocacy, health advocacy, and health care services for millions of survivors and their children, http://www.acf.hhs.gov/fysb/programs/family-violence-prevention-services/fvpsa-arp-grants-portal/arp-grants-program.

FVPSA subrecipients (e.g., domestic violence service providers) can receive reimbursement for medical advocacy with FVPSA grant funds and receive payment from other sources for health care services that are not funded by the FVPSA grants. FVPSA subrecipients can receive payment(s) for health care services from health programs or other third-party payers, including reimbursement through Medicaid or health insurance plans for provision of medical advocacy, such as health advocacy and/or health services, if not otherwise funded by FVPSA.

FVPSA subrecipients that choose to seek reimbursement from a health program or other third-party payer for medical advocacy services and health services are advised of the following:

- Pursuing this route of funding must ensure that the billing, referral, and service mechanisms do not violate the FVPSA Legislative and Regulatory requirements regarding victim confidentiality and privacy requirements (42 U.S.C. § 10406(c)(5) and 45 CFR § 1370.4);

- Domestic violence service providers may not charge clients (i.e., survivors) for services funded in whole or in part with FVPSA grant funds (42 U.S.C. § 10406(c)(3));

- FVPSA grant recipients and subrecipients must discuss with their FVPSA Federal Program Officer[4] and Administration for Children and Families (ACF) Grants Management Specialist any scenario whereby the subrecipient wants to seek reimbursement for medical advocacy via Medicaid, health programs, and/or other third-party payers;

- Under the guidance of an accountant/fiscal professional, FVPSA grant recipients and subrecipients should clearly separate FVPSA funding from health care reimbursements, including those from Medicaid, health programs, and/or other third-party payers, to avoid inadvertently co-mingling funding streams and to ensure compliance with relevant rules and regulations (45 CFR § 75.405(a)(2)); and

- FVPSA grant recipients and subrecipients must report income received from health care sources as program income with prior approval from the FVPSA Federal Program Officer and the ACF Office of Grants Management Specialist (45 CFR § 75.307).

RESOURCES

Explanation of Benefits and Safeguarding Sensitive Information

This technical assistance document developed by the National Health Resource Center on Domestic Violence discusses the Explanation of Benefit (EOB) documents, explains the concerns about how they handle sensitive information, and explores possible solutions. It builds on important privacy and confidentiality conversations and explores where action and advocacy are needed to ensure that health insurance companies adhere to privacy principles. http://ipvhealthpartners.org/wp-content/uploads/2017/03/FUTURES-EOB-Principles.pdf.

Technical Assistance Resources

National Health Resource Center on Domestic Violence
http://www.futureswithoutviolence.org/health/
The National Health Resource Center on Domestic Violence (HRC), a project of Futures Without Violence, supports health care professionals, domestic violence experts, survivors and policy makers at all levels as they improve health care's response to domestic violence. The HRC offers technical assistance, including online toolkits for health care providers and victim advocates to prepare a clinical practice to address domestic and sexual violence (http://ipvhealth.org/ and http://ipvhealthpartners.org/ for community health centers), a free ebulletin and webinar series, and other resources. The HRC also holds the biennial National Conference on Health and Domestic

[4] FVPSA Federal Project Officer contact list is available online at, http://www.acf.hhs.gov/fysb/fvpsa-regional-contact-list

Violence (http://nchdv.org/)—a scientific meeting at which health, medical, and domestic violence experts and leaders explore the latest health research and programmatic responses to domestic violence.

Webinar
Reimbursement and Payment Strategies for DV/Health Partnerships
http://www.futureswithoutviolence.org/reimbursement-and-payment-strategies-for-dv-advocates-partnering-with-health-webinar/
This webinar will help domestic and sexual violence (DSV) advocates understand the evolving health care landscape and make strategic choices as they decide whether and how to partner with health care providers in order to promote sustainability and collaboration. Additional relevant materials are linked.

National Network to End Domestic Violence
http://nnedv.org/
The National Network to End Domestic Violence (NNEDV) is a social change organization dedicated to creating a social, political, and economic environment in which violence against women no longer exists. NNEDV provides training and assistance to the statewide and territorial coalitions against domestic violence. It also furthers public awareness of domestic violence and changes beliefs that condone intimate partner violence. Find your State/Territorial DV Coalition at: http://nnedv.org/content/state-u-s-territory-coalitions/. NNEDV's Safety Net project focuses on the intersection of technology and domestic and sexual violence and works to address how it impacts the safety, privacy, accessibility, and civil rights of victims.

Online Toolkit
Confidentiality Toolkit
http://www.techsafety.org/confidentiality
This toolkit provides information on the confidentiality and privacy obligations for programs that receive federal grants that serve victims of domestic violence, sexual assault, dating violence, and stalking. The toolkit was created to assist non-profit victim service organizations and programs, co-located partnerships, coordinated community response teams, and innovative partnerships of victim service providers working to address domestic and dating violence, sexual assault, and stalking and to understand and follow the confidentiality obligations mandated by the funding they receive through the Violence Against Women Act (VAWA), Family Violence Prevention and Services Act (FVPSA), Victims of Crime Act (VOCA), and related state and federal privacy laws.

National Center on Domestic Violence, Trauma and Mental Health
www.nationalcenterdvtraumamh.org
Emphasizing an accessible, culturally responsive, and trauma-informed approach, the National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH) offers training and consultation to domestic violence and sexual assault advocates, programs, and coalitions; healthcare, mental health, and substance use disorder treatment providers; legal and child welfare professionals; and local, state, and federal policymakers.

National Indigenous Women's Resource Center
http://www.niwrc.org/
The National Indigenous Women's Resource Center, Inc. (NIWRC) is a Native nonprofit organization created to serve as the National Indian Resource Center (NIRC) Addressing Domestic Violence and Safety for Indian Women. NIWRC is a national technical assistance provider to Alaska Village programs and Tribal Coalitions across Indian Country. NIWRC offers free trainings, networking, NIWRC Toolkits, resources and culturally relevant responses to intimate partner and gender violence and promotes the leadership of Indigenous programs serving their communities.

Resource for DV Survivors and Advocates

National Domestic Violence Hotline
http://www.thehotline.org/resources/connecting-survivors/
The Survivor Health Connection Project is implemented by the National Domestic Violence Hotline and supported through an interagency collaboration between ACF, Health Resources and Services Administration (HRSA) Office of Women's Health, and the HRSA Bureau of Primary Health Care. Through SHCP, the Hotline trains HRSA-funded Community Health Center (CHC) staff on the warning signs and immediate and chronic health impacts of experiencing domestic violence, and how to refer patients safely and confidentially to resources and support from the Hotline and local shelters and programs, many of whom receive FVPSA funding. In addition to training HRSA CHC staff, the Hotline trained its entire advocate staff on the unique services provided by CHCs and on the *Find a Health Center tool*, http://findahealthcenter.hrsa.gov/tool.The Find a Health Center tool helps advocates and survivors find HRSA-funded health centers in their communities. By equipping Hotline advocates with training and information on the CHC's scope and services, they can support survivor connections to a local health care provider, regardless of their ability to pay. These bi-directional referrals are particularly important for those who contact The Hotline presenting an increased need for medical assistance related to the abuse (e.g., strangulation and traumatic brain injury) or reporting other critical health needs such as being pregnant or postpartum, https://www.thehotline.org/resources/connecting-survivors/.

Reports and Briefs

Integrating Intimate Partner Violence Assessment and Intervention into Healthcare in the United States: A Systems Approach
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4302956/
The Institute of Medicine, United States Preventive Services Task Force (USPSTF), and national healthcare organizations recommend screening and counseling for IPV within the US healthcare setting. The ACA includes screening and brief counseling for IPV as part of required free preventive services for women. This article outlines a systems approach to the implementation of IPV screening and counseling, with a focus on integrated health and advocacy service delivery to support identification and interventions, use of electronic health record (EHR) tools, and cross-sector partnerships.

Intimate Partner Violence (IPV) Screening and Counseling Services in Clinical Settings
http://www.kff.org/womens-health-policy/issue-brief/intimate-partner-violence-ipv-screening-and-counseling-services-in-clinical-settings/
The ACA requires private plans and Medicaid expansion programs to cover preventative screening for IPV. Despite improved coverage for IPV screening, there are several challenges to implementing IPV screenings in health care settings, including ensuring patient privacy, mandatory reporting laws, and time constraints during appointments. The brief gives an overview of IPV in the U.S., discusses the populations most impacted, and insurance coverage of IPV screening, counseling, and referral services. It also provides case studies of providers.

Training

Financial Grants Management and Internal Controls Training Resources
The FVPSA Program partnered with the ACF Office of Grants Management to develop accessible financial grants management trainings for all FVPSA grantees and subgrantees, to provide information on financial regulations, internal controls and grant practices to help effectively manage federal grant awards. All three financial grants management training modules can be found here: http://www.acf.hhs.gov/fysb/programs/family-violence-prevention-services/fvpsa-arp-grants-portal/fvpsa-arp-learning-portalhttps://www.acf.hhs.gov/fysb/programs/family-violence-prevention-services/fvpsa-arp-grants-portal/fvpsa-arp-learning-portal.

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[i] Smith, S. G., Zhang, X., Basile, K.C., Merrick, M.T., Wang, J., Kresnow, M., Chen, J. (2018). The National Intimate Partner and Sexual Violence Survey (NISVS): 2015 Data Brief—Updated Release. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[ii] Morse DS, Lafleur R, Fogarty CT, Mittal M, Cerulli C. "They told me to leave": how health care providers address intimate partner violence. *J Am Board Fam Med*. 2012;25(3):333-342. doi:10.3122/jabfm.2012.03.110193