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FOR HIV, VIRAL HEPATITIS, STD, AND TB PREVENTION

# New Medicaid Opportunities to Combat Hepatitis C in Correctional Facilities

## Guidance from Subject Matter Experts

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# Agenda

- Hepatitis C in U.S. Carceral Settings
- Overview of 1115 Reentry Waivers
- State Leadership in 1115 Reentry Waivers
- Supporting States with Waiver Applications
- Considerations for Pre-Release Coverage and Implementation
- Q&A

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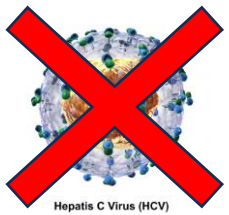
# Hepatitis C in U.S. Carceral Settings

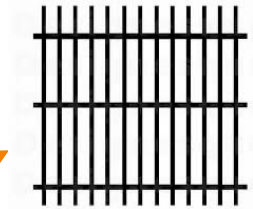
# Hepatitis C Prevalence in Jails and Prisons Is Disproportionately High

- Prisons are federal, state, or private facilities that hold people convicted of a crime serving longer sentences
- Jails are usually local facilities that hold people pre-trial, pre-sentencing, or for minor offenses
- Hepatitis C prevalence in the criminal legal system is ~10-20x surrounding communities
- Interrelationship between high-risk behaviors, drug-related crimes, and incarceration

# Carceral-community Cascade Is Essential for HCV Elimination




Prison
470K admissions



**85% have an active substance use disorder or were incarcerated for a crime involving drugs or drug use.**

nida.nih.gov//drugfacts

Jail
7 million admissions

Community
~6.5 million return

**Nearly one-third of Americans with HCV spend at least part of the year in a carceral facility**

Varan et al. Public Health Rep. 2014

Re-arrest
~1/4 within 1 year

**Recent incarceration - 62% increase in HCV acquisition risk**

Stone et al. Lancet ID. 2018

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*The Journal of Infectious Diseases*

SUPPLEMENT ARTICLE

# Estimates of Hepatitis C Seroprevalence and Viremia in State Prison Populations in the United States

**Anne C. Spaulding,[1] Shanika S. Kennedy,[1] Jeffery Osei,[1] Ebrima Sidibeh,[1] Isabella V. Batina,[1] Jagpreet Chhatwal,[2] Matthew J. Akiyama,[3,4] and Lara B. Strick[5]**

[1]Department of Epidemiology, Rollins School of Public Health, Emory University, Atlanta, Georgia; [2]Massachusetts General Hospital Institute for Technology Assessment, Harvard Medical School, Boston; [3]Department of Medicine, Albert Einstein College of Medicine; [4]Department of Medicine, Montefiore Medical Center, New York, New York; and [5]Department of Medicine, University of Washington, Seattle

***Background.*** Prior studies demonstrate that eliminating hepatitis C virus (HCV) in the United States (US) heavily depends on treating incarcerated persons. Knowing the scope of the carceral HCV epidemic by state will help guide national elimination efforts.

***Methods.*** Between 2019 and 2023, all state prison systems received surveys requesting data on hepatitis C antibody and viremic prevalence. We supplemented survey information with publicly available HCV data to corroborate responses and fill in data gaps.

***Results.*** Weighting HCV prevalence by state prison population size, we estimate that 15.2% of the US prison population is HCV seropositive and 8.7% is viremic; 54.9% of seropositive persons have detectable RNA. Applying prevalence estimates to the total prison population at year-end 2021, 91 090 persons with HCV infection resided in a state prison.

***Conclusions.*** With updated and more complete HCV data from all 50 states, HCV prevalence in state prisons is nearly 9-fold higher than the US general population. The heterogeneity in HCV prevalence by state prison system may reflect variable exposure before arrest and/or differences in treatment availability during incarceration. Elimination of HCV in the country depends on addressing the carceral epidemic, and one of the first steps is understanding the size of the problem.

Spaulding et al. J Infect Dis. 2023.

# Litigation Has Increased Hepatitis C Treatment in Prisons, but Access Remains Limited

## DEATH SENTENCE

There is a simple, outright cure for hepatitis C. But state prisons across the country are failing to save hundreds of people who die each year from the virus and related complications.

A STAT investigation has found that more than 1,000 incarcerated people died from hepatitis C-related complications in the six years after a curative drug hit the market. The death rate in 2019 was double that of the broader U.S. population.

Death Sentence, STAT News: https://www.statnews.com/death-sentence/

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# Jails and Prisons Face Unique Challenges To Expanding HCV Prevention, Testing and Treatment

- High cost of treatment
- Limited healthcare services (e.g., phlebotomy)
- Loss of Medicaid coverage
- Short length of stay in jails
- Lack of harm reduction services

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*Open Forum Infectious Diseases*

MAJOR ARTICLE

# Outcomes of Hepatitis C Virus Treatment in the New York City Jail Population: Successes and Challenges Facing Scale up of Care

**Justin Chan,[1] Jessie Schwartz,[2] Fatos Kaba,[1] Angelica Bocour,[2] Matthew J. Akiyama,[1,3] Laura Hobstetter,[1] Zachary Rosner,[1] Ann Winters,[2] Patricia Yang,[1] and Ross MacDonald[1]**

[1]Correctional Health Services, NYC Health + Hospitals, New York, New York, USA, [2]Bureau of Communicable Disease, New York City Department of Health and Mental Hygiene, Queens, New York, USA, [3]Department of Medicine, Albert Einstein College of Medicine, Bronx, New York, USA

**Table 2. Outcomes: SVR12 and Recurrent Viremia Rates**

| | Total | Had Lab Collected to Assess SVR | Achieved SVR[a] | Had HCV Viral Load Checked After Achieving SVR | Recurrent Viremia[a] |
|---|---|---|---|---|---|
| Treatment group | N (Column%) | N (Row%) | N (Row%) | N (Row%) | N (Row%) |
| Overall | 269 (100) | 195 (72) | 172 (88) | 114 (66) | 18 (16) |
| Jail-initiated treatment | 181 (67) | 119 (66) | 107 (90) | 65 (61) | 9 (14) |
| Community-initiated treatment | 88 (33) | 76 (86) | 65 (86) | 49 (75) | 9 (18) |

Recurrent viremia = 10.6 cases per 100 person-years

# HCV Treatment in Jail Offsets Community Declines

Figure 1a. Direct-acting antiviral HCV medication prescriptions for people covered by Medicaid in New York City, 2014-2020

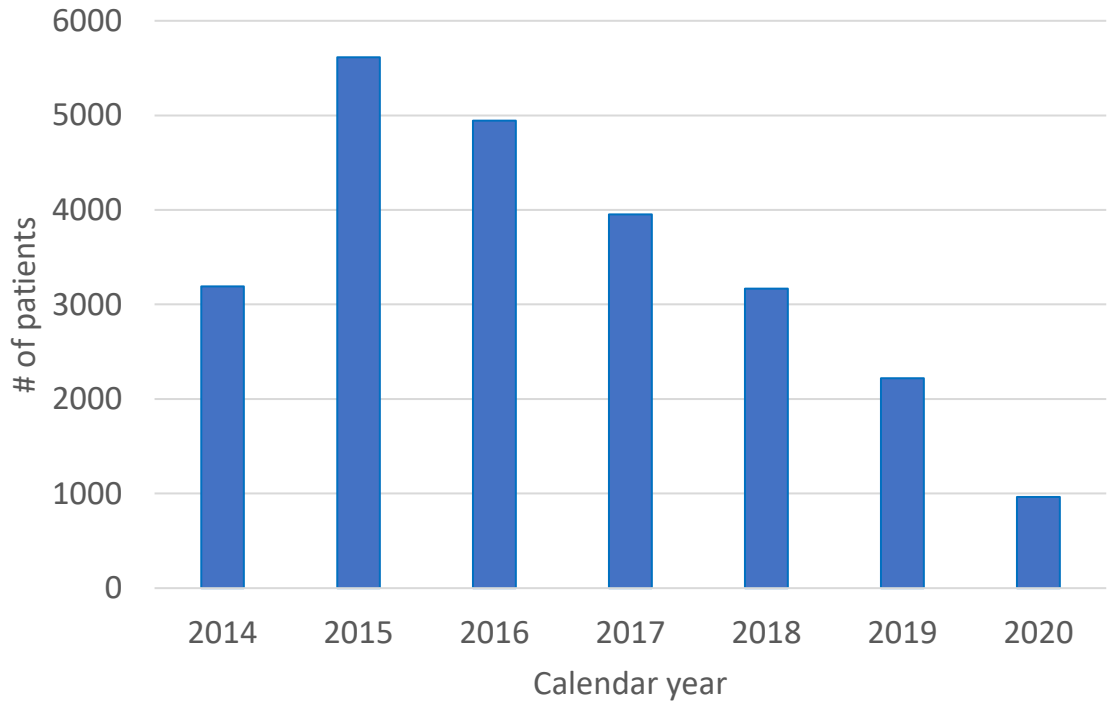
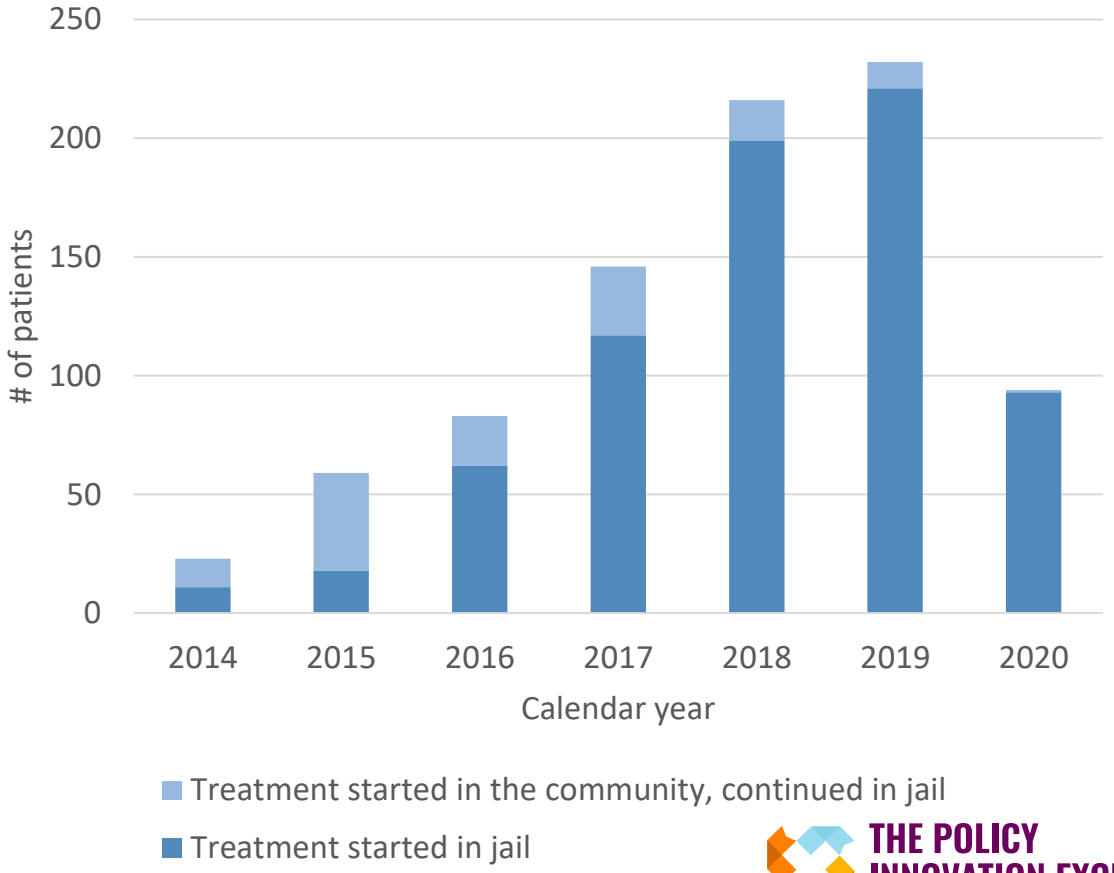



Figure 1b. New York City jail-based direct-acting antiviral HCV treatment by calendar year, 2014-2020




Chan, Akiyama et al. AJPM Focus. 2024.

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# Conclusions

Scaling testing and treatment in jails and prisons is necessary to achieve HCV elimination

Innovative pricing and payer strategies, including Medicaid 1115 waivers, lower the barrier to offer treatment

HCV elimination is possible with strong leadership at the local, state, and national levels

**Thank you!**

**matthew.akiyama@einsteinmed.edu**

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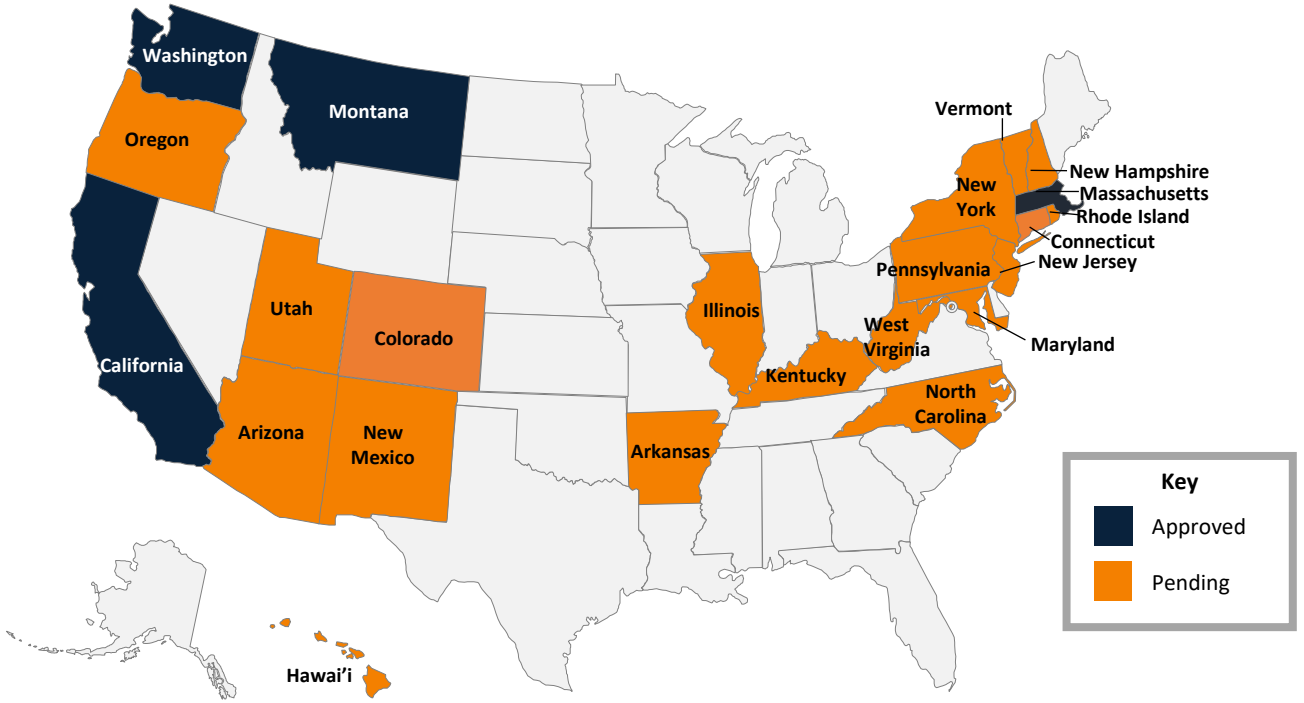
# Overview of 1115 Reentry Waivers

# Reentry Demonstration Submissions *(Updated April 2024)*

**23 states have submitted Reentry Demonstration requests. To date, California, Massachusetts, Montana, and Washington have received approvals.**

- **Together, CMS' Guidance and the approved STCs in CA, WA, and MT provide parameters and areas of flexibility for states seeking to submit Reentry Initiative Demonstration requests.**
- CMS has communicated to states with pending Demonstrations that in order to ensure a timely approval, states should seek to **align** with approved Demonstrations to the maximum extent possible (an approach similar to other recent CMS waivers).
- States will have **flexibility** with how they operationalize their program during the implementation phase of the Demonstration.

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# Eligible Populations

**States may propose a broadly defined Demonstration population that includes otherwise eligible, soon-to-be former incarcerated individuals.**

- States have the **flexibility** to define their populations of focus (e.g., adults and youth in prisons, jails and youth correctional facilities) for pre-release services and to establish eligibility criteria (e.g., individuals with SUD and/or SMI).
- If states establish an **eligibility criteria**, they will need to set up a screening process within the correctional facility and should be mindful of establishing identification criteria for individuals who may have conditions that are currently undiagnosed.

- States may also consider making all **Medicaid-enrolled individuals** in participating carceral facilities eligible for pre-release services.

- States also need to **define which Medicaid eligibility groups will be covered** (e.g., expansion adults, pregnant individuals, children and youth, the aged, and/or the disabled) and **whether Children's Health Insurance Program (CHIP) populations will be included**.

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# Eligible Facilities

**CMS gives states flexibility to provide coverage of pre-release services in state or local correctional facilities (e.g., state prisons, jails, and/or youth correctional facilities).**

- States may seek to provide services in **all eligible correctional facilities statewide or they can choose to only provide services in a subset** of correctional facilities.
- States may also develop a **phased approach** to implementing reentry services across correctional facilities throughout the duration of the Demonstration.
- Participating states will conduct a **readiness assessment** of carceral settings before implementing the demonstration in those locations.

**Example**:

If a state elects to implement pre-release services in its county jails and there are 25 jails in the state, a state could choose to implement the Demonstration in only 12 of the 25 jails.

# Scope of Covered Services-Mandatory Benefits

## CMS requires states to provide a minimum benefit package of three covered services under the Demonstration:

| Covered Benefit | Description |
|---|---|
| Case Management to Assess and Address Physical and Behavioral Health Needs, and Health-Related Social Needs (HRSN) | ▪ Pre-release case management is a required reentry service to assess and address physical and behavioral health needs and HRSNs.<br>▪ Care managers are expected to conduct a comprehensive needs assessment; develop a care plan; ensure a warm handoff to post-release care manager (if different); conduct referral activities for post-release such as scheduling appointments and connect individuals to services upon reentry into the community; and provide on-going monitoring and follow-up activities to ensure the care plan is implemented. |
| Medication Assisted Treatment (MAT) | ▪ MAT is a required minimum service for all types of SUD as clinically appropriate, with accompanying counseling. CMS defines MAT as medication in combination with counseling/behavioral therapies, as appropriate and individually determined, and should be available for all types of SUD (e.g., both opioid and alcohol use disorders), as clinically appropriate.<br>▪ Coverage of MAT under a state plan includes all U.S. Food and Drug Administration–approved medications for opioid use disorder, including buprenorphine, methadone, and naltrexone, and acamprosate and naltrexone for alcohol use disorder. |
| 30-day Supply of All Prescription Medications At Point of Release | ▪ Provision of clinically-appropriate medication(s) upon release may be as either a pre-release demonstration service or as a post-release Medicaid service furnished outside the scope of the demonstration. |

**Note:** CMS will likely not approve a proposal to cover the full scope of state plan services.

# Scope of Covered Services-Optional Benefits

**In addition to the minimum set of services, states have flexibility to cover other important physical and behavioral health services that support reentry into the community, such as:**

- Family planning services;
- **Screening for common health conditions within the incarcerated population,** such as blood pressure, diabetes, **hepatitis C,** and HIV;
- Rehabilitative or preventive services, including those provided by community health workers;
- **Treatment for hepatitis C;** and
- Provision of durable medical equipment and/or supplies.

**States that seek approval of pre-release services beyond the minimum benefit package will need to provide justification in their Demonstration applications for how such services promote the objectives of the Demonstration and support a smooth reentry into the community.**

**Note**: States that do not provide all covered outpatient drugs during the pre-release period may not seek federal or supplemental state-specific rebates under section 1927 for any of the pre-release drugs covered under the demonstration.

# California and Washington: Scope of Covered Services

**California and Washington, in addition to covering the minimum set of services, will provide several additional services.**

**Pre-Release Services**

- Care management services.
- ★ Physical and behavioral health clinical consultation services provided through telehealth or in-person, as needed, to diagnose health conditions, provide treatment, as appropriate, and support pre-release case managers' development of a post-release treatment plan and discharge planning.
- ★ Laboratory and radiology services.
- ★ Medications and medication administration during the pre-release period.
- MAT for all FDA-approved medications, including coverage for counseling.
- ★ Services provided by community health workers with lived experience.

**Post-Release Services**

Qualifying members will also receive upon release, consistent with approved state plan coverage authority and policy:

- **Covered outpatient prescribed medications, over-the-counter drugs** (a minimum 30-day supply as clinically appropriate), and
- **Durable medical equipment (DME).** ★

★ **Additional Services**

Source: CMS, California 1115 Waiver Approval Letter.

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# Pre-Release Timeframe

**States have the flexibility to provide coverage of pre-release services for up to 90 days before the incarcerated individual's expected date of release.**

## 30 Days Prior to Re-Entry

States will evaluate in the Demonstration application hypotheses related to improving care transitions for soon to be released individuals.

## Between 30 and 90 Days Prior to Re-Entry

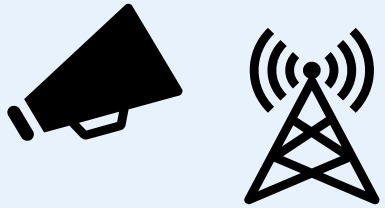
States must include in their Demonstration application one or more additional hypotheses related to the longer duration of services, to be approved at the Secretary's discretion.

# Capacity Building Funds

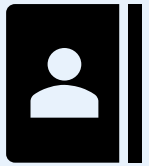
**CMS will consider state requests for time-limited financing for certain new expenditures that support implementation of the Reentry 1115 Demonstration. States that did not include a request for capacity building funds in their initial application may do so without submitting an amendment. Capacity building funds can be directed to correctional facilities, providers, and other implementation partners.**

**Allowable capacity building activities include, but are not limited to:**

Development of new business and operational practices related to health information technology (IT) systems.



Outreach, education, and stakeholder convening to advance collaboration across the Medicaid agency, correctional facilities, providers, managed care plans, and community-based organizations, among others.



Hiring and training of staff to assist with implementing the initiative.

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# State Leadership in 1115 Reentry Waivers:
## California

# California CalAIM 1115 Demonstration: Justice-Involved Initiative

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

April 2024

# California Actively Works With Implementation Partners

**Over the past 24 months, DHCS has actively met with its Justice-Involved Advisory Group and one-on-one with implementation partners, to inform the 1115 Demonstration and provide input into development of operational policies.**

**Justice-Involved Advisory Group members include:**

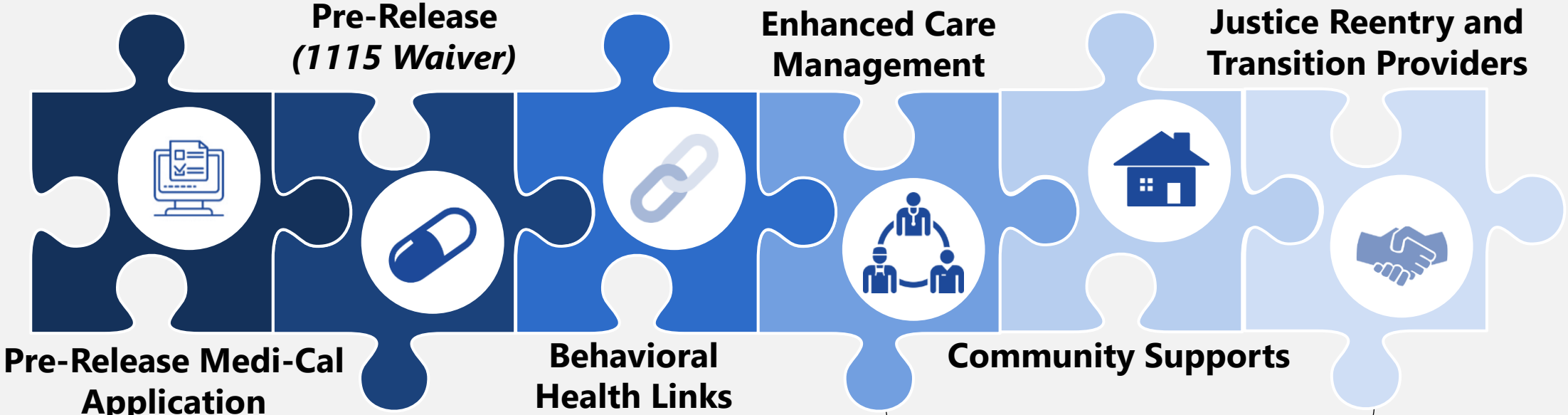
- CDCR/California Correctional Health Care Services (CCHCS) which delivers health care services in State prisons
- County Jails, including correctional officers and correctional health staff
- Chief Probation Officers of California (CPOC)/County Youth Correctional Facilities
- Board of State and Community Corrections (BSCC)
- County Welfare Directors Association (CWDA)
- County Social Service Departments (SSDs)
- County Behavioral Health Department (including working group of county behavioral health directors)
- Council on Criminal Justice and Behavioral Health (CCJBH)
- Office of Youth and Community Restoration (OYCR)
- Reentry Providers (including TCN, STOP, Healthright360, WestCare, and Amity Foundation)
- Medicaid managed care plans
- Individuals with lived experience
- Community based organizations

**Listen to this Medicaid Leadership Exchange podcast episode to hear more about the importance of collaboration with implementing partners**

# The CalAIM Justice-Involved Initiative is Comprised of Pre-Release and Reentry Components

**CalAIM justice-involved initiative support justice-involved individuals by providing key services pre-release, enrolling them in Medi-Cal coverage, and connecting them with behavioral health, social services, and other providers that can support their reentry.**

***Initiatives Include:***



# Justice-Involved Initiative Timeline

**January 1, 2023**

- Pre-Release Medi-Cal Application Mandate: **requires all counties to** facilitate enrollment in Medi-Cal for individuals who are incarcerated

**January 1, 2024**

- Enhanced Care Management for the Population of Focus for Adults and Youth who are transitioning from incarceration

**October 1, 2024-September 30, 2026**

- 2-Year Period for Correctional Facilities to Go Live with 90-Day Pre-Release Services
- Correctional Facilities will have a six-month readiness assessment review and approval process prior to the go-live date.

# Eligibility Criteria for Pre-Release Services

**Medi-Cal-eligible individuals who meet the pre-release access screening criteria may receive targeted Medi-Cal pre-release services in the 90-day period prior to release from correctional facilities. DHCS developed detailed definitions for qualifying criteria, based on extensive stakeholder feedback (See Appendix).**

**Criteria for Pre-Release Medi-Cal Services**

*Incarcerated individuals must meet the following criteria to receive in-reach services:*

- ✓ Be part of a **Medicaid or CHIP Eligibility Group**, and
- ✓ Meet **one** of the following health care need criteria:
  - Mental Illness
  - Substance Use Disorder (SUD)
  - Chronic Condition/Significant Clinical Condition
  - Intellectual or Developmental Disability (I/DD)
  - Traumatic Brain Injury
  - HIV/AIDS
  - Pregnant or Postpartum

***Note:*** *All Medi-Cal/CHIP eligible youth incarcerated at a youth correctional facility are eligible to receive pre-release services and do not need to demonstrate a health care need.*

**Medi-Cal Eligible:**

- Adults
- Parents
- Youth under 19
- Pregnant or postpartum
- Aged
- Blind
- Disabled
- Current children and youth in foster care
- Former foster care youth up to age 26

**CHIP Eligible:**

- Youth under 19
- Pregnant or postpartum

# Covered Pre-Release Services

- Reentry case management services;
- Physical and behavioral health clinical consultation services provided through telehealth or in-person, as needed, to diagnose health conditions, provide treatment, as appropriate, and support pre-release case managers' development of a post-release treatment plan and discharge planning;
- Laboratory and radiology services;
- Medications and medication administration;
- Medication assisted treatment/medications for addiction treatment (MAT), for all Food and Drug Administration-approved medications, including coverage for counseling; and
- Services provided by community health workers with lived experience.

In addition to the pre-release services specified above, qualifying individuals will also receive **covered outpatient prescribed medications and over-the-counter drugs** (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid State Plan) and **durable medical equipment (DME)** upon release, consistent with approved state plan coverage authority and policy.

# Policy and Operational Guide

**On October 20, 2023, DHCS released the updated Policy and Operational Guide for Planning and Implementing the CalAIM Justice Involved Initiative.**

- This guidance lays out to implementing stakeholders—correctional facilities, County Behavioral Health Agencies, providers, community-based organizations, and Medi-Cal managed care plans, among others—the policy, design and operational processes that will serve as the foundation for implementing this important initiative.
- DHCS will update the Policy and Operational Guide on an as needed basis as implementing partners begin to advance the process of standing up the JI Initiative and as CMS continues to refine its sub-regulatory guidance for states that receive 1115 demonstration approval.

# Short-Term Model

| Pre-Release Activity | Week 1 of JI Aid Code | | | | | | | Week 2 of JI Aid Code | Week 3 of JI Aid Code | Week 4 of JI Aid Code |
|---|---|---|---|---|---|---|---|---|---|---|
| | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 | Day 8-14 | Day 15-21 | Day 22-28 |
| Aid Code is Turned on via Provider Portal | X | | | | | | | | | |
| Initiate Medications & Medication Administration | X | | | | | | | | | |
| Initiate MAT, as needed | X | | | | | | | | | |
| Care Manager Contact/Assignment | | X | | | | | | | | |
| Care Management – Health Risk Assessment | | | | | X | | | X *(day 8 for in-reach)* | | |
| Care Management – Reentry Plan | | | | | | | | X *(day 14)* | | |
| Schedule Physical and Behavioral Health Clinical Consultation | | | | | | | | | X *(day 21)* | |
| Laboratory and Radiology Services, as needed | | | | | | | | | X *(day 21)* | |
| CHW Services, as available | | | | | | | | | X *(day 21)* | |
| Case Management – Warm Handoff | Warm handoff between pre- and post-release care manager can occur at any point prior to release, but must occur at least 14 days prior to release date, if known. If individual is released prior to health risk assessment from embedded provider (day 7), then they must leave with information on ECM referrals. | | | | | | | | | |
| Behavioral Health Link – Professional to professional handoff | County BH must be contacted within two business days of identifying a BH need. If an individual is incarcerated for 14 days, meaning the health risk assessment is completed, and a BH need is identified; CF and County BH must facilitate BH Link. A professional-to-professional clinical handoff must occur prior to release or within two business days after release | | | | | | | | | |
| Medication Upon Release | | X | *Must be provided to individuals incarcerated for 48 hours* | | | | | | | |
| DME Upon Release | | | | | | | | ***X (day 14)*** *Must be provided to individuals incarcerated for 14 days* | | |

**Note:** This model is for those who are already enrolled in Medicaid and begins once the aid code is activated; for those who are not yet enrolled, this timeline starts the day the aid code is activated. DHCS expects county correctional facilities to begin pre-release services as soon as possible to ensure those with short-term stays receive the maximum extent of pre-release services. If an individual is still incarcerated after 28 days, and it is likely they will remain incarcerated for more than 60 days, correctional facilities can request to pause the JI aid code when they notify the SSD of their incarceration to suspend their Medi-Cal coverage. Once a release date is known, correctional facilities should update this information through the Screening Portal.

# Care Management in the Pre-Release Period

**To maximize continuity of care management and access to services in the pre- and post-release period, care management may be provided via an in-reach model or embedded model that includes a warm handoff between pre- and post-release providers.**

## Care Management Models:

- **In-Reach Model:** Some correctional facilities will rely on community-based care management providers to deliver pre-release care management services to individuals in correctional facilities (in person or via telehealth). This community-based provider will become the ECM provider after release and enrollment into managed care.
- **Embedded Model:** Some correctional facilities will use care managers that they directly employ or contract with to deliver pre-release care management services to individuals in correctional facilities (in person).
  - *Note: If an embedded care management model is used, correctional facilities will be required to implement a warm handoff between the pre-release care manager and post-release ECM provider (in person or via telehealth).*

## Warm Handoff Requirements:

Minimum requirements for the warm handoff between the pre-release care manager and post-release ECM provider include:

- **Share reentry care plan** with the post-release ECM provider and MCP.
- **Schedule and conduct a pre-release care management meeting** (in-person or via telehealth) with the individual present and pre- and post-release care managers (if different) to:
  - Establish a trusted relationship.
  - Develop and review care plan with individual.
  - Identify outstanding service needs.

*Eligibility criteria for the JI ECM POF are the same as pre-release service eligibility criteria, so everyone who is eligible to receive pre-release services is also eligible to receive post-release ECM.*

# Behavioral Health Links

**To promote continuity of treatment for individuals who receive behavioral health services while incarcerated, DHCS will require correctional facilities to facilitate referrals/links to post-release behavioral health providers and share information with the individual's health plan.**

- Correctional facilities, county behavioral health agencies, and MCPs are required to implement:
  - Linkages to behavioral health providers to achieve behavioral health care initiation or continuity through professional-to-professional clinical handoffs as set forth in California Penal Code section 4011.11(h)(5) and consistent with the CalAIM Behavioral Health Links initiative *(see page 51 of the CalAIM Proposal and AB 133)*.
  - Processes for facilitated referrals and linkages to continued behavioral health treatment in the community for individuals who receive behavioral health services while incarcerated.

- Behavioral health links will be facilitated by county behavioral health agencies, pre-release care managers/providers, and correctional facilities.

- Behavioral health links include referrals and professional-to-professional clinical handoffs for Justice-Involved individuals to county behavioral health plans, including MHPs, DMC, and DMC-ODS.



**Source:** CA Penal Code 4011.11(h)(5)

# Questions?

# CalAIMJusticeAdvisoryGroup@dhcs.ca.gov

DHCS

# State Leadership in 1115 Reentry Waivers:
## Washington

# 1115 Medicaid Waivers: *The Next Generation for Correctional Health Care*

Jason T. McGill, JD
Assistant Director
Health Care Authority
Medicaid Programs

Washington State Health Care Authority

# Overview of 1115 Demonstration Requests and Approvals: *Medicaid Transformation Project (MTP) 2.0*

## Aims

- Ensure equitable access to whole person care, empowering people to achieve their optimal health and wellbeing in the setting of their choice.
- Build healthier, equitable communities, with communities.
- Pay for integrated health and equitable, value-based care.

## Goals

- Expand coverage and access to care, ensuring people can get the care they need.
- Advance whole-person primary, preventive, and home- and community-based care.
- Accelerate care delivery and payment innovation focused on health-related social needs.

## Programs

- Justice-involved reentry initiative (new)
- Continuous Apple Health enrollment (new)
- Post-partum coverage expansion (new)
- SUD and MH IMD Services (continuing)
- MAC and TSOA (continuing)
- LTSS innovations and efficiencies (new)
- Clinical integration advancements (pended)
- Services to address health-related social needs (new)
- Foundational Community Supports (continuing)
- Health equity investments (pended)

# MTP 2.0

The Medicaid Transformation Project (MTP) is Washington State's Section 1115 Medicaid demonstration waiver. MTP allows our state to create and continue to develop projects, activities, and services that improve Washington's health care system.

All MTP programs support Apple Health (Medicaid) enrollees.

In June 2023, the federal government approved MTP to continue for an additional five years. We call the MTP renewal "MTP 2.0," which will help widen our reach to provide more programs, services, and supports to our most vulnerable populations.



IMD stands for "institution for mental diseases." IMDs are hospitals, nursing facilities, or other institutions of more than 16 beds that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, which includes SUD.

We acknowledge the term "mental disease" may be harmful or stigmatizing. We use it in this context only to reflect the legal terminology used in statute.

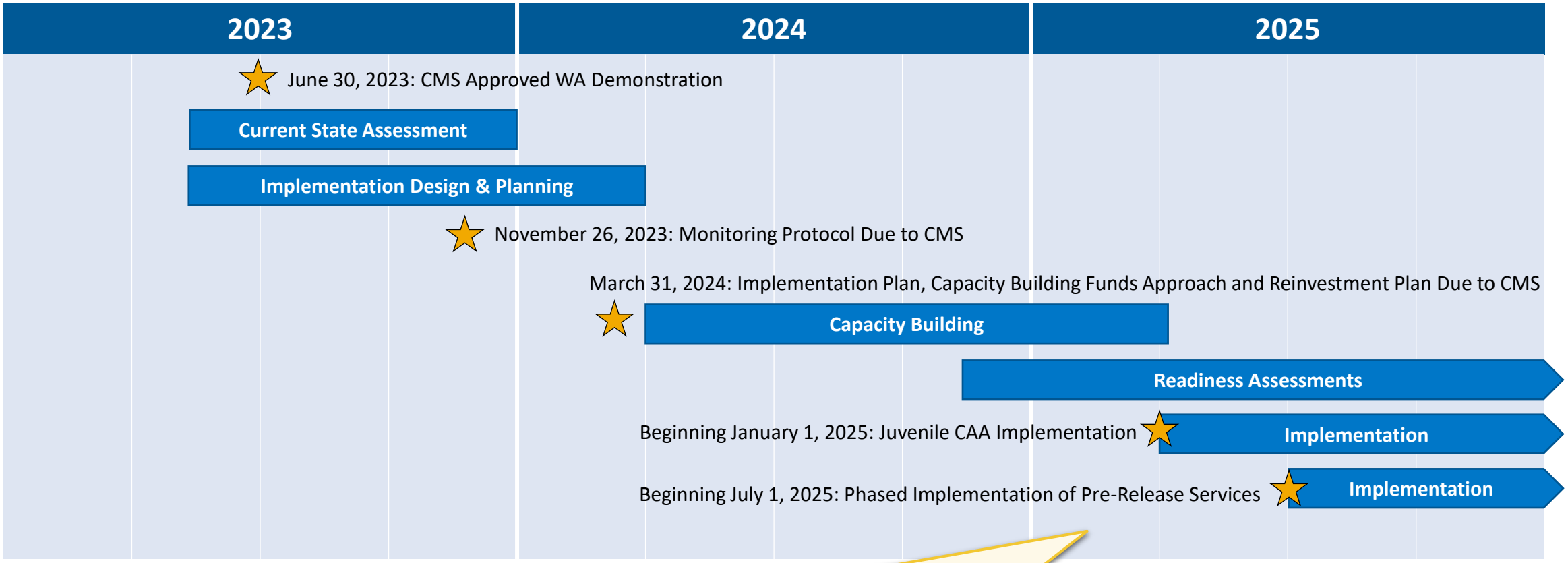
# Health-Related Social Need (HRSN) Services

- Authorizes payment to support a menu of new services:
  - Nutrition supports
  - Recuperative care and short-term post hospitalization housing
  - Housing transition navigation services
  - Rent/temporary housing for up to six months
  - Stabilization centers
  - Day habilitation programs
  - Caregiver respite services
  - Environmental accessibility and remediation adaptions
  - Case management: Community Hubs and Native Hub to pay for community-based workforce
  - Community transition services: Personal care and homemaker services, and transportation services

# Foundational Community Supports

- Foundational Community Supports
  - Supportive housing and supported employment services for Apple Health beneficiaries who have a qualifying social risk factor and a needs-based factor
  - Enhancements under MTP 2.0
    - Expanded supportive housing eligibility from 18 and older to 16 and older (now consistent with employment)
    - Transition costs/housing deposits
    - Rent/temporary housing for up to six months

# *Preliminary* Implementation Timeline




- Early adopter facilities that demonstrate readiness may implement pre-release services as early as July 1, 2025.
- Facilities that require more time to demonstrate readiness will go-live in several cohorts after the initial go-live date with the timing for specific cohorts to be defined by HCA.

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# Facilities at a Glance

**DOC facilities typically have longer sentences and more predictable release dates. Individuals in jails and YCFs have shorter stays and less predictable release dates, which will require tailored implementation.**

**County Jails in Washington**

1. Adams County Jail (Ritzville)
2. Asotin County Jail (Clarkston)
3. Benton County Jail (Kennewick)
4. Clallam County Jail (Port Angeles)
5. Chelan County Regional Jail (Wenatchee)
6. Clark County Jail (Vancouver)
7. Columbia County Jail (Dayton)
8. Cowlitz County Jail (Longview)
9. Ferry County Jail (Republic)
10. Franklin County Jail (Pasco)
11. Garfield County Jail (Pomeroy)
12. Grant County Jail (Ephrata)
13. Grays Harbor County Jail (Montesano)
14. Island County Jail (Coupeville)
15. Jefferson County Jail (Port Hadlock)
16. King County Jail (Seattle Downtown)
17. King County Jail (Kent) – Maleng Regional Justice Center
18. Kitsap County Jail (Port Orchard)
19. Kittitas County Jail (Ellensburg)
20. Klickitat County Jail (Goldendale)
21. Lewis County Jail (Chehalis)
22. Lincoln County Jail (Davenport)
23. Mason County Jail (Shelton)
24. Okanogan County Jail (Okanogan)
25. Pacific County Jail (South Bend)
26. Pend Oreille County Jail (Newport)
27. Pierce County Jail (Tacoma)
28. San Juan County Jail (Friday Harbor)
29. Skagit County Jail (Mt. Vernon)
30. Skamania County Jail (Stevenson)
31. Snohomish County Jail (Everett)
32. Spokane County Jail (Spokane)
33. Stevens County Jail (Colville)
34. Thurston County Jail (Tumwater)
35. Wahkiakum County Jail (Cathlamet)
36. Whatcom County Jail (Bellingham)
37. Walla Walla County Jail (Walla Walla)
38. Whitman County Jail (Colfax)
39. Yakima County Jail (Yakima)

**City Jails in Washington**

1. Aberdeen
2. Enumclaw
3. Forks
4. Hoquiam
5. Issaquah
6. Kent
7. Kirkland
8. Lynnwood
9. Marysville
10. Oak Harbor
11. Olympia
12. Puyallup
13. Des Moines – SCORE (Regional City Jail)
14. Sunnyside
15. Yakima

**Tribal Jails in Washington**

1. Chehalis Tribal Jail (Oakville)
2. Colville Tribal Jail (Nespelem)
3. Makah Tribal Jail (Neah Bay)
4. Nisqually Tribal Jail (Yelm)
5. Puyallup Tribal Jail (Tacoma)
6. Yakama Tribal Jail (Toppenish)

### Correctional Settings at Glance

*(data are directional since not all facilities reported population and release data)*

| | # of Facilities | Average Daily Population | Average Length of Stay | Average Monthly Releases |
|---|---|---|---|---|
| **Adults** | | | | |
| DOC State Prisons[1] | 11 | 12,854 | 31 months** | 452 |
| County Jails[2] | 58 | 246 | 23 days | *TBD* |
| City Jails[2] | 13 | 30 | 7 days | *TBD* |
| **Youth** | | | | |
| DCYF Juvenile Rehabilitation | 2 | 80 and 170 | 12 months | 10-15 |
| City/County Juvenile Detention[3] | 20* | 12 | 7 days | *TBD* |

*Excludes two out of state facilities that are not in scope for the Initiative.
**12% of the DOC population stays in prison for less than 3 months

**Note on Tribal Populations**

Fact finding and data collection for tribal populations and jails are in progress to assess:

- Design considerations for supporting reentry for tribal members in non-tribal carceral settings; and,
- Considerations for including tribal jails as an authorized facility under the Demonstration

[1]Based on September 2023 DOC Agency Fact Card. Available at: https://doc.wa.gov/docs/publications/reports/100-RE005.pdf
[2]Based on 2022 WASPC data. Available at: https://www.waspc.org/assets/2022%20Jail%20Statistics%20Website.xlsx
[3]Based on August 2023 data provided by HCA.



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# Eligible Population and Scope of Services

**Eligible Population:** All Medicaid-eligible individuals within 90 days of release from a state prison, jail, or youth correctional facility (pretrial or post-conviction).

| Approved Scope of Services |
| --- |
| ***Mandatory:*** |
| Case management/care coordination |
| Medication-assisted Treatment (MAT) pre-release |
| For post-release: 30-day supply of medications and durable medical equipment |
| **Secondary:** |
| Medications during the pre-release period, **including HepC** |
| Lab and radiology |
| Services by community health workers |
| Physical and behavioral clinical consultations (as needed) |

Coverage for these benefits will allow care coordination staff to:

- Assess health care needs.
- Develop re-entry care plans.
- Work with facility staff to ensure the provision of medications for opioid use disorder (OUD) and alcohol use disorder (AUD) treatment.
- Facilitate referrals and transportation to treatment following re-entry.
- Arrange for medications/durable medical equipment (DME) upon release.
- Connect individuals to supports to address health-related social needs.

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# Juvenile: Consolidated Appropriations Act, 2023

- Consolidated Appropriations Act, 2023, requires states to provide justice-involved youth eligible for Medicaid or CHIP with services in the 30-days prior to and following their release from detention.
- Scheduled to implement January 1, 2025
- Requires states to provide certain required screenings, referrals, and case management services for Medicaid and CHIP-eligible juvenile youth in public institutions.
  - 30 days prior to release, or within one week or soon as practicable after release
    - Behavioral health screenings
    - Diagnostic services
  - 30 days prior to release and for at least 30 days following release targeted
    - Case management services
    - Referrals to appropriate care

# A special emphasis for treatment for Opioid Use Disorder And HepC

Washington State Health Care Authority


**Providing Medication to Treat Opioid Use Disorder in Washington State Jails**

July 3, 2018

Lucinda Grande, MD
Clinical Instructor, Department of Family Medicine,
University of Washington School of Medicine
Partner, Pioneer Family Practice, Lacey, Washington

Marc Stern, MD, MPH
Affiliate Assistant Professor, Department of Health Services,
University of Washington School of Public Health

Prepared for the Division of Behavioral Health and Recovery
Washington State Department of Social and Health Services
Contract 1731-18409

"We estimate that of the approximately 47,751 residents of Washington who are regular illicit users of opioids (heroin and prescription pain medications), 26,727 (56%) will exit the gates of a Washington prison or jail this year, including 25,510 (53%) exiting a jail (see Appendix). ***Thus we believe that individuals in our state's jails are not just part of the opioid tableau – they are the epicenter."***
-Lucinda Grande, MD and Marc Stern MD, MPH, July 3, 2018

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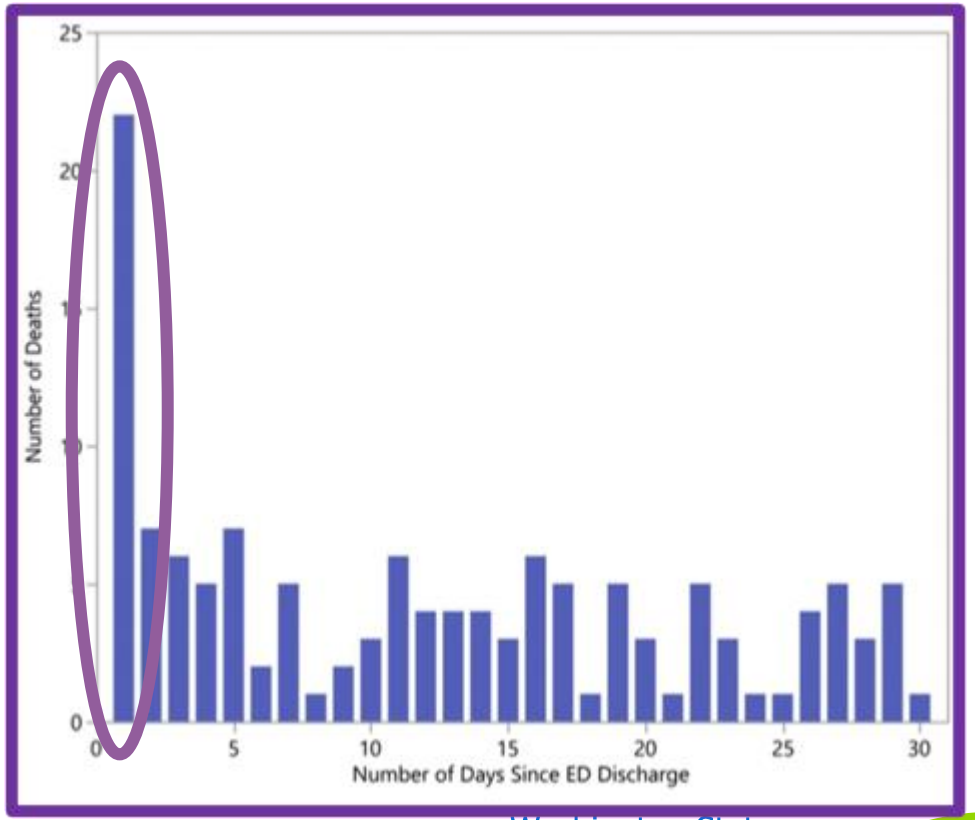
# Medications for Opioid Use Disorder (MOUD)

- One year mortality of patients after ED treatment for Nonfatal Opioid Overdose is 5.5%!
- Medications for Opioid Use Disorder (MOUD) including Methadone and Buprenorphine **decrease mortality by 50%**
- Failure to treat opioid use disorder during incarceration has serious consequences, including an extremely high risk of overdose death after release [from] incarceration. *–Grande and Stern*

TOXICOLOGY/BRIEF RESEARCH REPORT

One-Year Mortality of Patients After Emergency Department Treatment for Nonfatal Opioid Overdose

Scott G. Weiner, MD, MPH*; Olesya Baker, PhD; Dana Bernson, MPH; Jeremiah D. Schuur, MD, MHS



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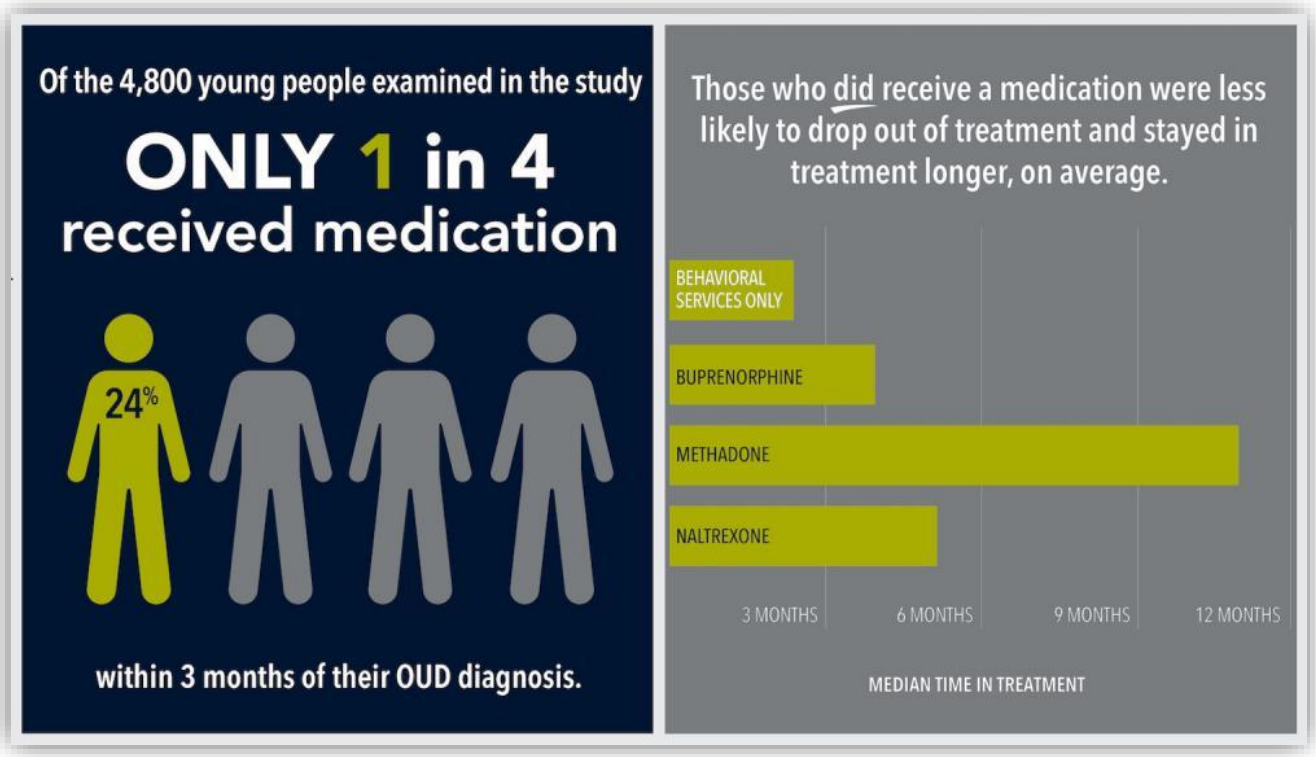
# Why are things so different with fentanyl?

- Extremely potent and addictive (50 to 100 times more potent than heroin or morphine)
- Short half-life; need to use larger amounts more frequently.
- Withdrawal symptoms and cravings tend to be much worse.
- Individuals using fentanyl to develop moderate to severe opioid use disorder much faster than ever before.
- Inexpensive and extremely accessible on the illicit drug market
- Fentanyl is lethal: A single pill can cause an overdose and death

# Youth considerations

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# Harm reduction and Naloxone

- Harm reduction is an evidence-based approach that incorporates community-driven public health strategies to empower people who use drugs with the choice to live health, self-directed, and purpose-filled lives.


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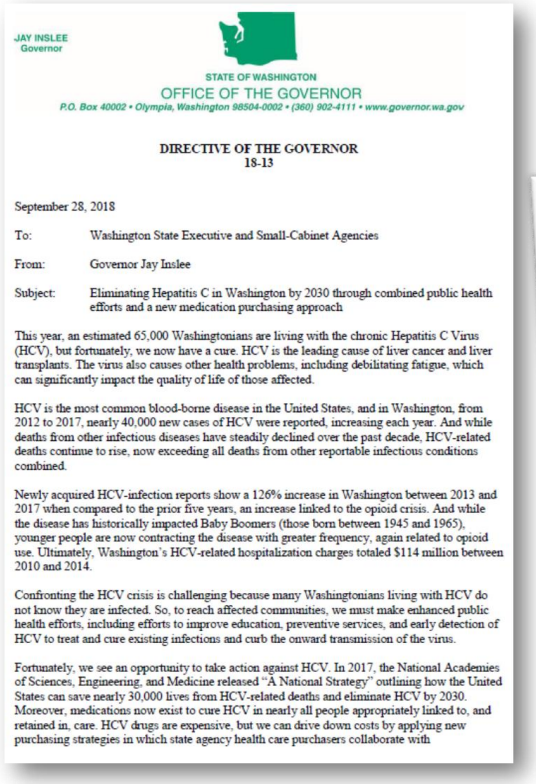
# Eliminate Hepatitis C in Washington by 2030



JAY INSLEE
Governor

STATE OF WASHINGTON
OFFICE OF THE GOVERNOR
P.O. Box 40002 • Olympia, Washington 98504-0002 • (360) 902-4111 • www.governor.wa.gov

**DIRECTIVE OF THE GOVERNOR**
**18-13**

September 28, 2018

To: Washington State Executive and Small-Cabinet Agencies

From: Governor Jay Inslee

Subject: Eliminating Hepatitis C in Washington by 2030 through combined public health efforts and a new medication purchasing approach

This year, an estimated 65,000 Washingtonians are living with the chronic Hepatitis C Virus (HCV), but fortunately, we now have a cure. HCV is the leading cause of liver cancer and liver transplants. The virus also causes other health problems, including debilitating fatigue, which can significantly impact the quality of life of those affected.

HCV is the most common blood-borne disease in the United States, and in Washington, from 2012 to 2017, nearly 40,000 new cases of HCV were reported, increasing each year. And while deaths from other infectious diseases have steadily declined over the past decade, HCV-related deaths continue to rise, now exceeding all deaths from other reportable infectious conditions combined.

Newly acquired HCV-infection reports show a 126% increase in Washington between 2013 and 2017 when compared to the prior five years, an increase linked to the opioid crisis. And while the disease has historically impacted Baby Boomers (those born between 1945 and 1965), younger people are now contracting the disease with greater frequency, again related to opioid use. Ultimately, Washington's HCV-related hospitalization charges totaled $114 million between 2010 and 2014.

Confronting the HCV crisis is challenging because many Washingtonians living with HCV do not know they are infected. So, to reach affected communities, we must make enhanced public health efforts, including efforts to improve education, preventive services, and early detection of HCV to treat and cure existing infections and curb the onward transmission of the virus.

Fortunately, we see an opportunity to take action against HCV. In 2017, the National Academies of Sciences, Engineering, and Medicine released "A National Strategy" outlining how the United States can save nearly 30,000 lives from HCV-related deaths and eliminate HCV by 2030. Moreover, medications now exist to cure HCV in nearly all people appropriately linked to, and retained in, care. HCV drugs are expensive, but we can drive down costs by applying new purchasing strategies in which state agency health care purchasers collaborate with


*Photos from Seattle Times, September 28, "Inslee: Erase hepatitis C in Washington by 2030"*

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# HCA, DOC and Public Health Partnership

- Health Care Authority
  - Develop innovative procurement strategy to reduce costs of drugs for all state covered lives and finance public health efforts
- Department of Health
  - With multisector stakeholder group, develop comprehensive strategy to eliminate public health threat of HCV in Washington
- Department of Corrections and local jails
  - Enhance screening and treatment under 1115 demonstration (DOC % of incoming population screened for HCV: 83%)

Washington State Health Care Authority

# Hepatitis C in Washington State

- Estimated 59,100 (32,500-71,500) people living with HCV in WA at beginning of 2018 (Source: Center for Disease Analysis Foundation, 2019)
- In 2017:
  - 543 deaths attributed to HCV
- In 2018:
  - 479 deaths attributed to HCV
  - Highest number of acute HCV cases in over twenty years
- Risk/exposure data for chronic cases is sparse (~80% missing), but when present, injection drug use is often reported

| Newly Reported HCV cases | | | |
|---|---|---|---|
| Year | Acute | Chronic | Total |
| 2012 | 54 | 4,865 | 4,919 |
| 2013 | 63 | 4,438 | 4,501 |
| 2014 | 83 | 5,995 | 6,078 |
| 2015 | 63 | 7,085 | 7,148 |
| 2016 | 95 | 8,118 | 8,213 |
| 2017 | 73 | 8,839 | 8,912 |
| 2018 | 118 | 8,085 | 8,203 |

Source: WA DOH Hepatitis Surveillance Records

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eliminate Hepatitis C by 2030. #EndHepC

...see more

Repost

Washington State Health Care Authority
6,481 followers
5d •

Are you living with Hepatitis C? Getting cured can take as little as 8 wee
doctor about setting up a treatment plan. Learn more at hca.wa.gov/hep-c


# HepC Free WA

# QUESTIONS?

**Jason T. McGill,**
jason.mcgill@hca.wa.gov

# Supporting States with Waiver Applications

# Toolkit on Opportunities to Strengthen Access to Hepatitis C Treatment Through Section 1115 Demonstrations

**As a companion to the Civil Rights Litigation Clearinghouse's recent publication, Policies for Expanding Hepatitis C Testing and Treatment in United States Prisons and Jails, the Clearinghouse released an issue brief to support states in completing Section 1115 Justice-Involved Reentry Initiative Demonstration applications.**

## Issue Brief

- ✓ Outlines required sections within a state's Section 1115 Demonstration application
- ✓ Identifies where and how a state can be explicit about its intent to address the health care needs of individuals with hepatitis C, as part of its Reentry Initiative.
- ✓ Builds on the Clearinghouse's publication of policies for improving hepatitis C testing and treatment in prisons and jails

**Source**: "Opportunity to Strengthen Access to Hepatitis C Treatment Through Section 1115 Justice-Involved Reentry Initiative Demonstrations." Civil Rights Litigation Clearinghouse, November 2023. https://clearinghouse.net/resource/4006/.

THE POLICY INNOVATION EXCHANGE
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# Required Components and Hepatitis C-Specific Considerations for Section 1115 Demonstration

**Three key areas—Sections I, II, and IV—are places where states can explicitly outline its intent to address the health care needs of individuals with hepatitis C.**

## Required Section 1115 Demonstration Sections

- ✓ **Section I – Program Description**
- ✓ **Section II – Demonstration Eligibility**
- Section III – Demonstration Benefits and Cost Sharing Requirements
- ✓ **Section IV – Delivery System and Payment Rates for Services**
- Section V – Implementation of Demonstration
- Section VI – Demonstration Financing and Budget Neutrality
- Section VII –List of Proposed Waivers and Expenditure Authorities
- Section VII – Public Notice
- Section IX— Demonstration Administration

**Source**: "Opportunity to Strengthen Access to Hepatitis C Treatment Through Section 1115 Justice-Involved Reentry Initiative Demonstrations." Civil Rights Litigation Clearinghouse, November 2023. https://clearinghouse.net/resource/4006/.

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# Section I – Program Description

**States are required to summarize the proposed program, explain how it will further the objectives of the Medicaid program, and offer a rationale for the initiative.**

| | Example Content |
|---|---|
| Objectives and Rationale | • Describes a state's objectives and rationale for implementing the initiative (e.g., disproportionate health care needs of justice-involved and disproportionate rates of individuals with hepatitis C, including related risk of transmission during and following incarceration) |
| Covered Services | • Notes the type of covered services being provided to members during the pre-release period (e.g., medication during the pre-release period, including direct-acting antiviral treatment for hepatitis C, and clinical consultation including evaluation and management of hepatitis C) |
| Eligible Individuals | • Explains the Medicaid and CHIP-eligible justice involved individuals identified as eligible to access the benefit |
| Eligible Correctional Facilities | • Outlines facilities eligible for the initiative that will provide pre-release services to members (i.e., state and/or local prisons, jails, and/or youth correctional facilities) |
| Pre-Release Time Period | • Indicates if a state is seeking to provide coverage up to 90 days of coverage, which will be critical for individuals with hepatitis C. |

**Source**: "Opportunity to Strengthen Access to Hepatitis C Treatment Through Section 1115 Justice-Involved Reentry Initiative Demonstrations." Civil Rights Litigation Clearinghouse, November 2023. https://clearinghouse.net/resource/4006/.

# Section I – Program Description, Continued

**States must lay out the hypotheses being evaluated to address the healthcare needs of justice-involved individuals and the approach for testing the hypotheses.**

## Expected Goals To be Tested

- Increase coverage and continuity of coverage
- Improve access to services
- Improve coordination and communication
- Increase investments in healthcare and related services
- Improve connections between carceral settings and community
- Reduce all-cause deaths in the near-term post-release
- Reduce emergency department visits and inpatient hospitalizations

## Additional Hepatitis C-Specific Objectives to Test

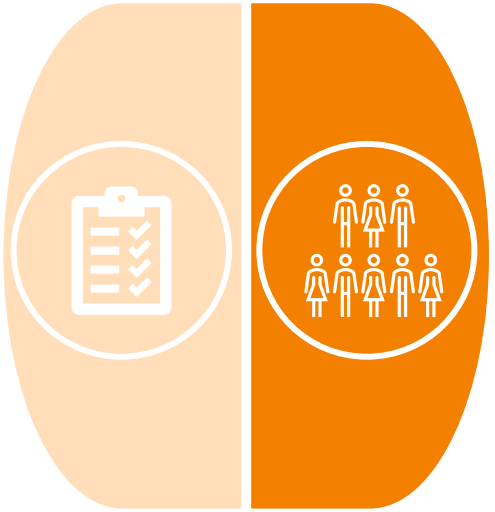
- Improve rates of initiation and engagement in hepatitis C care
- Promote data-sharing with community health providers to facilitate continuity of care
- Strengthen clinical education and training for providers related to screening, diagnosis, and treatment of hepatitis C
- Reduce hepatitis C transmission rates
- Expand access to hepatitis C testing, particularly direct acting treatment
- Increase accountability and oversight over testing and treatment programs

**Source**: "Opportunity to Strengthen Access to Hepatitis C Treatment Through Section 1115 Justice-Involved Reentry Initiative Demonstrations." Civil Rights Litigation Clearinghouse, November 2023. https://clearinghouse.net/resource/4006/.

# Section II – Demonstration Eligibility

**States must include a chart outlining the populations whose eligibility would be impacted by the Demonstration.**

A state must provide information, including each eligibility group's income eligibility level, on the Medicaid and CHIP eligibility groups participating in the Demonstration.



States should include groups that are most likely to have hepatitis C, such as Medicaid expansion adults, parents, aged and disabled populations

**Source**: "Opportunity to Strengthen Access to Hepatitis C Treatment Through Section 1115 Justice-Involved Reentry Initiative Demonstrations." Civil Rights Litigation Clearinghouse, November 2023. https://clearinghouse.net/resource/4006/.

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# Section IV – Delivery System and Payment Rates for Services

**States are required to include information on the means by which benefits will be provided, including whether services will be delivered via fee-for-service, managed care, or multiple delivery systems.**

**States should:**

Note if the services will be delivered via fee-for-service, managed care, or a combination.

Explain what entities will provide treatment for hepatitis C, such as a correctional facility and/or community-based pharmacies.

Indicate that all correctional facility pharmacies must be enrolled in Medicaid to bill and claim Medicaid for medications provided during the pre-release period.

**Source**: "Opportunity to Strengthen Access to Hepatitis C Treatment Through Section 1115 Justice-Involved Reentry Initiative Demonstrations." Civil Rights Litigation Clearinghouse, November 2023. https://clearinghouse.net/resource/4006/.

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# Considerations for Pre-Release Coverage and Implementation

# Driving Home How Waiver Applications Can Be Used to Combat Hepatitis C

**States have discretion to promote hepatitis C testing and treatment by including the following elements in their waiver applications:**

Keep an eye out for public comment opportunities in your state!

In addition to mandatory 30-day supply of medications upon release:

**Eligible Populations**:
All Medicaid-enrolled Individuals

**Eligible Facilities**:
Jails AND prisons

**Pre-Release Covered Services**:
Hepatitis C testing and treatment & community health workers

**Pre-Release Time Period**:
Full 90 days

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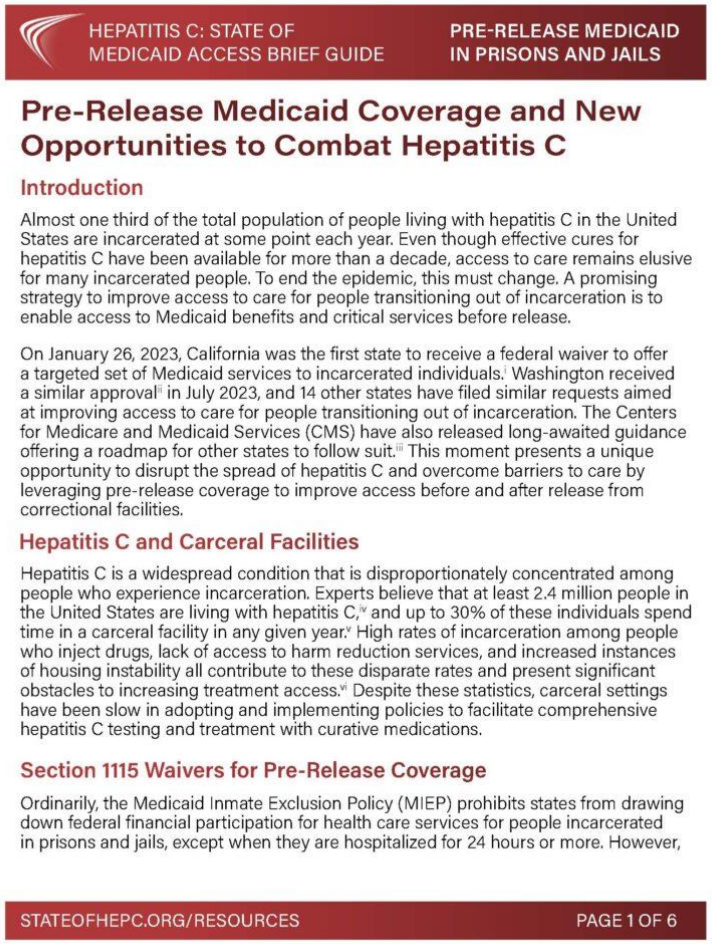
# Considerations for Pre-Release Coverage and Implementation

- Community engagement
- Data sharing & privacy
- Culturally responsive, evidence-based services
- Accessible and timely care



HEPATITIS C: STATE OF MEDICAID ACCESS BRIEF GUIDE | PRE-RELEASE MEDICAID IN PRISONS AND JAILS

## Pre-Release Medicaid Coverage and New Opportunities to Combat Hepatitis C

### Introduction

Almost one third of the total population of people living with hepatitis C in the United States are incarcerated at some point each year. Even though effective cures for hepatitis C have been available for more than a decade, access to care remains elusive for many incarcerated people. To end the epidemic, this must change. A promising strategy to improve access to care for people transitioning out of incarceration is to enable access to Medicaid benefits and critical services before release.

On January 26, 2023, California was the first state to receive a federal waiver to offer a targeted set of Medicaid services to incarcerated individuals.[i] Washington received a similar approval[ii] in July 2023, and 14 other states have filed similar requests aimed at improving access to care for people transitioning out of incarceration. The Centers for Medicare and Medicaid Services (CMS) have also released long-awaited guidance offering a roadmap for other states to follow suit.[iii] This moment presents a unique opportunity to disrupt the spread of hepatitis C and overcome barriers to care by leveraging pre-release coverage to improve access before and after release from correctional facilities.

### Hepatitis C and Carceral Facilities

Hepatitis C is a widespread condition that is disproportionately concentrated among people who experience incarceration. Experts believe that at least 2.4 million people in the United States are living with hepatitis C,[iv] and up to 30% of these individuals spend time in a carceral facility in any given year.[v] High rates of incarceration among people who inject drugs, lack of access to harm reduction services, and increased instances of housing instability all contribute to these disparate rates and present significant obstacles to increasing treatment access.[vi] Despite these statistics, carceral settings have been slow in adopting and implementing policies to facilitate comprehensive hepatitis C testing and treatment with curative medications.

### Section 1115 Waivers for Pre-Release Coverage

Ordinarily, the Medicaid Inmate Exclusion Policy (MIEP) prohibits states from drawing down federal financial participation for health care services for people incarcerated in prisons and jails, except when they are hospitalized for 24 hours or more. However,

STATEOFHEPC.ORG/RESOURCES | PAGE 1 OF 6

https://stateofhepc.org/resources/

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# Engage communities in the design and implementation of waiver

People with lived experience

Reentry organizations (e.g., housing & employment services)

Clinical providers

Carceral system stakeholders

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# Enhance data sharing with public health entities and community-based organizations

Data sharing allows for enhanced coordination between stakeholders, reduces barriers to care for people reentering the community, and plays a key role in response, control, and surveillance of infectious diseases

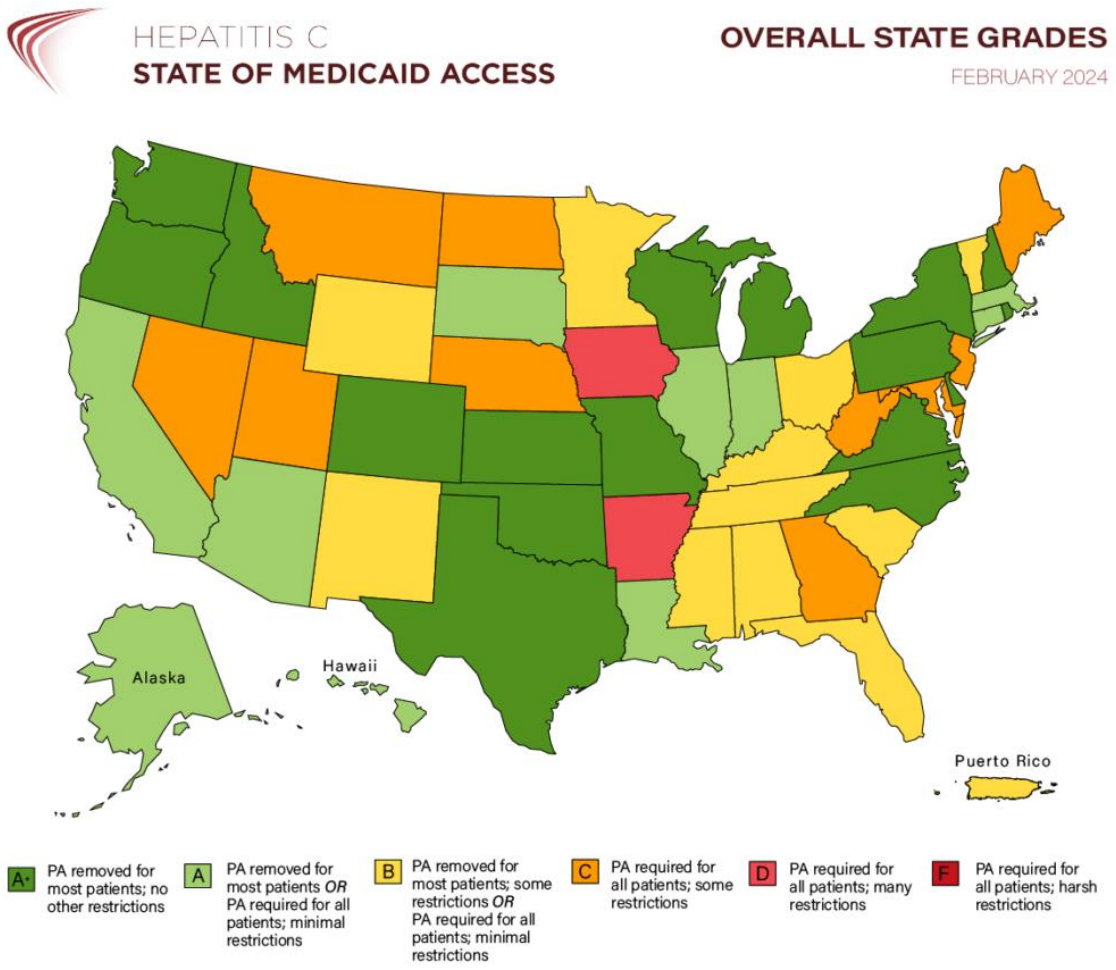
Ensure the privacy and confidentiality of people seeking healthcare services and provide protections for sensitive health data

Measure and monitor the impact of new policies, including adverse changes in access to care following the implementation of pre-release coverage

# Invest in pre- and post-release services that are culturally responsive and evidence-based

- Prioritize partnerships with community-based, non-profit organizations
- Invest in evidence-based strategies such as harm reduction and community health workers
- Ensure that healthcare and reentry providers understand how stigma, bias, and trauma impact care

# Ensure that Medicaid policies allow timely access to treatment




Center for Health Law and Policy Innovation & National Viral Hepatitis Roundtable, Hepatitis C: State of Medicaid Access (2024), www.stateofhepc.org.

- Support completion of treatment course pre-release whenever possible
- Remove prior authorization requirements
  - Of states who have submitted waiver applications, 9 states require prior authorization for initial treatment: AR, KY, MD, MT, NJ, NM, UT, VT, WV*
- Ensure that access to care is consistent across fee-for-service and managed care policies
- Allow medication to be filled by non-specialty pharmacies and dispense the full course of treatment
- Eliminate co-pays during pre-release

* Of states who have submitted waiver applications, 14 states have removed PA for initial treatment: AZ, CA, CO, CT, HI, IL, NC, NH, NY, MA, OR, PA, RI, WA

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# Q&A