2022 NATIONAL

HIV & HEPATITIS

TECHNICAL ASSISTANCE MEETING

Integration of HCV Services within SUD and OTP Settings in Washington State

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2022 NATIONAL HIV & HEPATITIS TECHNICAL ASSISTANCE MEETING

Agenda

- Hep C Free WA Initiative – HCV Elimination in WA State
- Integration of infectious disease services within Behavioral Health settings
- Collaboration and Partnership between state agencies to address challenges
- Ongoing efforts to integrate HCV screening and treatment efforts into OTP and SUD settings
- Ongoing challenges

Governor Inslee issued directive on September 28, 2018 to eliminate Hepatitis C in Washington by 2030

JAY INSLEE
Governor

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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 [illegible], 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"

https://www.governor.wa.gov/sites/default/files/18-13%20-%20Hepatitis%20C%20Elimination.pdf

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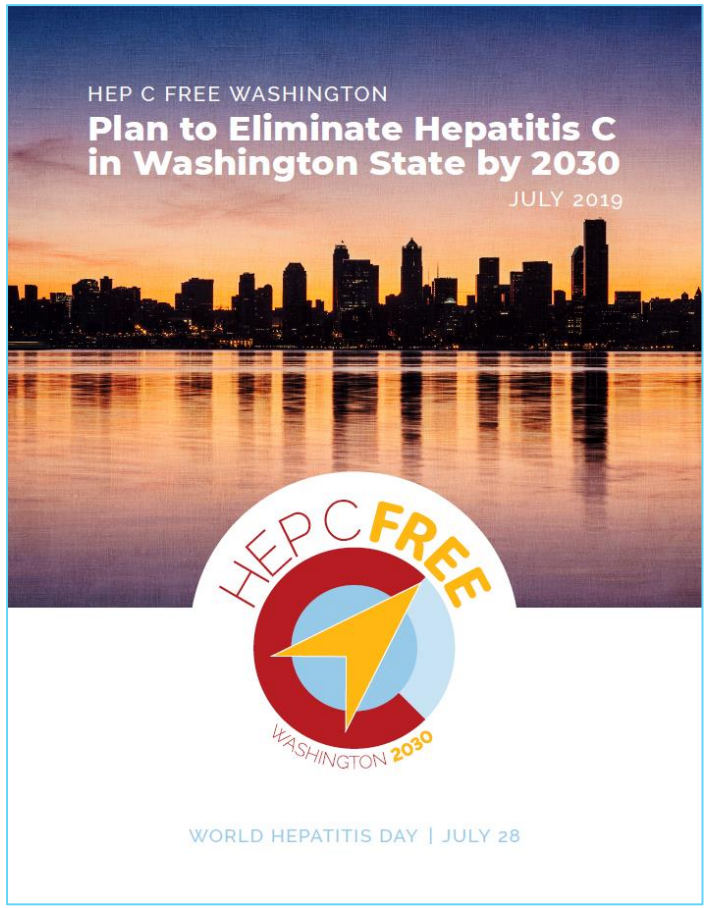
Hep C Free Washington's Plan



- Elimination plan released in July 2019
- Plan comprised of 15 goals and 90 recommendations
- Goal 6: Improve access to and use of preventive and health care services in non-clinical settings through expansion and co-location of services.

Expand the provision of clinical services, including HCV and other infectious disease screening and diagnostic testing (e.g., HIV testing, HBV testing, testing for sexually transmitted infections), linkage to care services, HCV treatment, vaccination (e.g., against HAV and HBV), wound care, overdose education and naloxone distribution in high-impact settings (settings that serve a high proportion of clientele who inject drugs, such as syringe service programs, **substance use disorder treatment facilities, opioid treatment programs**, organizations serving people experiencing homelessness).

https://www.doh.wa.gov/Portals/1/Documents/Pubs/150nonDOH-HepCFreeWA-PlanJuly2019.pdf

Integration of Infectious Disease Services in SUD/OTP Settings

- *2020 HHS Affinity Group – supporting state-generated solutions to eliminating HCV*
  - Exploring opportunities to co-locate HCV screening and treatment with treatment for substance use disorder.
  - In partnership with WA Health Care Authority and University of WA – developed a survey for OTP program administrators and Medical directors for all 28 OTPs in WA State.
  - Survey findings (barriers to OTP and HCV integration):
    - Adequate staffing
    - Laboratory capacity
    - Client related barriers
    - Sufficient space to deliver clinical care
    - **Program reimbursement for HCV clinical services**

Integration of Infectious Disease Services in SUD/OTP Settings

- Surveyed OTP Program Administrators
  - Most frequent response to Apple Health reimbursement levels for HCV clinical services were "not offered" or "do not know"
  - Reimbursement amounts for clinical services are "unknown" (31.3%)
  - Reimbursement rates are "least satisfactorily" (12.5%)
- Discussions with OTP sites through monthly calls indicated –
  - Reimbursement rates are low for those who do offer services
  - Billing for physical services vs. behavioral services is a challenge

Table 3 Apple Health Reimbursement Levels for Hepatitis C Clinical and Behavioral Services Reported by Program Administrators (n = 16 administrators representing 16 programs)

	Level of Apple Health Reimbursement for the Service				Not Offering the Service or Not Sure	
HCV Clinical Service	None n (%)	Very Poor or Poor n (%)	Satisfactory or Good n (%)	Excellent n (%)	Do Not Know n (%)	Not offered n (%)
Hepatitis A Immunization	1 (6.3)	0 (0.0)	1 (6.3)	0 (0.0)	3 (18.8)	11 (68.8)
Hepatitis B Immunization	1 (6.3)	0 (0.0)	1 (6.3)	0 (0.0)	3 (18.8)	11 (68.8)
Hepatitis C Rapid Screen	1 (6.3)	0 (0.0)	0 (0.0)	0 (0.0)	5 (31.3)	10 (62.5)
Hepatitis C RNA Test	1 (6.3)	0 (0.0)	0 (0.0)	0 (0.0)	5 (31.3)	10 (62.5)
Provider Visit for Hepatitis C Care	1 (6.3)	0 (0.0)	2 (12.5)	0 (0.0)	4 (25.0)	9 (56.3)
Hepatitis C Medication	1 (6.3)	0 (0.0)	0 (0.0)	0 (0.0)	3 (18.8)	12 (75.0)
Directly Observed Medication Therapy	2 (12.5)	1(6.3)	0 (0.0)	1(6.3)	4 (25.0)	8 (50.0)
Hepatitis C Education	1 (6.3)	0 (0.0)	4 (25.0)	0 (0.0)	4 (25.0)	7 (43.8)
Care Management	4 (25.0)	0 (0.0)	3 (18.8)	1 (6.3)	3 (18.8)	5 (31.3)
Peer Support	2 (12.5)	0 (0.0)	2 (12.5)	1 (6.3)	4 (25.0)	7 (43.8)

Integration of Infectious Disease Services in SUD/OTP Settings

Surveyed Substance Use Disorder Professionals (SUDP)

- 340 survey respondents in the analytic sample

Areas with **lowest** provider Awareness

- DAAs have few to no side effects (mean=2.94)
- DAA is covered under Medicaid (mean=3.16)

Provider **Attitudes**

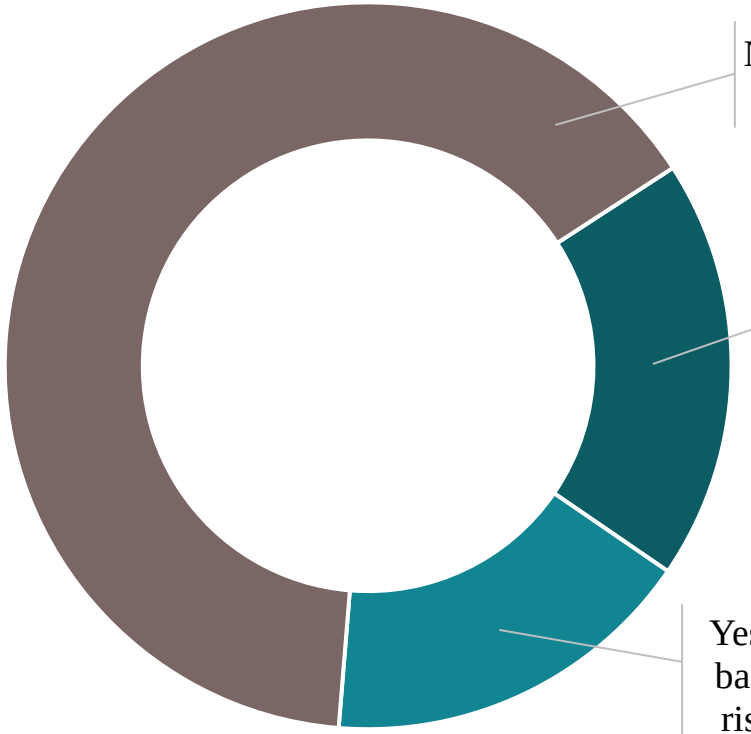
- Lowest: I have sufficient time to talk with my clients about HCV/HIV (3.72)

Practices

- Over 60% of providers indicated their place of work **did not** have a policy for HIV testing or HCV testing

Analysis completed by JSI Research & Training Institute, Inc. as part of the Ryan White HIV/AIDS Program SPNS project, Strengthening Systems of Care for People with HIV and Opioid Use Disorder

PRACTICES: **IS THERE A HCV TESTING POLICY AT YOUR WORK SITE?** (N=251)



Excludes missing (n=30) and unknown (n=59) responses

Integration of Infectious Disease Services in SUD/OTP Settings Collaboration to Address Challenges

- Key partnerships between behavioral health agencies, Medicaid, and Office of Infectious Disease (WA DOH)
  - Behavioral Health Agencies
    - Majority of programs (OTP/SUD) programs indicated a strong desire to integrate HCV screening and treatment services.
    - Policy change to the WAC/RCW to mandate HCV services would not be feasible due to funding.
    - Reimbursement rates for the delivery of physical services was too low for programs to sustain services and/or lack of understanding how to bill for physical services.
    - Care coordination was highlighted as a major need among programs.
    - Identifying providers to treat and manage care for clients is a barrier for programs who do not have a clinician on-site.

Integration of Infectious Disease Services in SUD/OTP Settings Ongoing Efforts

Partnership between HCA/SOTA/DOH staff setting up meaningful planning on this topic

- ***A legislative ask for funding (HCA and DOH)***
  - *530 legislative ask in Governor's Opioid Legislation from 2019*
  - *Lead to legislative/Governor's report in 2021 "Complex Treatment Needs of Individuals with OTP" for standardizing services in OTP settings, above and beyond requirements in state and federal law.*
  - *Recommendations in report around infectious disease*
- ***Proposed rates and proposed Medicaid budget changes (HCA)***
  - *Enhancing OTP to Medicare Rates*
  - *HCA attempt at a decision package in 2022 Legislative session*
  - *Outcome- not successful, but we are going to keep going*
- ***Strategies within Medicaid's normal authority/book of business (HCA and DOH)***
  - *Clarifying with MCO that OTP should be able to do infectious disease work fee-for-service*
  - *Working on a billing guide for Viral Hep work for OTP*
- ***Proposed changes in OTP standards and development of a COE- Phase 2 (HCA)***
  - *Planning for the future*
  - *Alternative payment model*
  - *Helping OTP to become patient centered medical home*

Challenges and Observations

- Partnership between Behavioral Health, Medicaid, and DOH is essential. Specifically, working with HCA's Treatment Authority.
- OTP/SUD "buy-in" for integrating HCV screening/treatment services among programs was leveraged by HCV elimination efforts.
- Understanding state agency roles vs. Governors and Legislature's role
- Integrating physical services within behavioral health agencies is complex – it involves; staff training, clinic flow development, established referral system, billing infrastructure, etc..
- Appropriate sustainable funding is critical for programs to integrate HCV services. Public Health funding is not enough.

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