Washington State Health Care Authority

January 27, 2023 | 9:00-11:00am

Apple Health Medicaid Advisory Committee (AHMAC)

(formerly the Title XIX Advisory Committee)

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Committee Members:					
☐	**CHAIR:** Marsalli, Bob (WACH) ***Health Association Rep (cat. 2)***	☐	Ewart, Hugh (SEA Children's) ***Health Association Rep (cat. 2)***	☐	Safford, Caitlin (Amerigroup) ***Health Association Rep (cat. 2)***
☐	**EXEC SPONSOR:** Fotinos, Charissa ***Medicaid Director -*** Excused	☐	Herrin, Bradley (Pediatrician, Swedish) ***Board certified physician (cat. 2)-*** Excused	☐	Sawyckyj, Kristina (Consumer Advocate) ***Consumer Advocate (cat. 1))***
☐	Burke, Monica (DOH) ***DOH representative (cat. 3)***	☐	Johnson, Laura (UnitedHealthcare) ***Health Association Rep (cat. 2)***	☐	Shepard, Jeb (WSMA) ***Health Association Rep (cat. 2)***
☐	Busz, Andrew (WSHA) ***Health Association Rep (cat. 2)***	☐	Linares, Adriana (Physician, Peacehealth SW) ***Board certified physician (cat. 2)***	☐	Turner, Maren (DSHS) ***DSHS representative (cat. 3)***
☐	Christian, Ann (WA Council for BH) ***Health Association Rep (cat. 2)*** Excused	☐	Lovell, Emily (WSDA) ***Health Association Rep (cat. 2)***	☐	Vacant
☐	Elias, Hawa (CHPW) ***Health Association Rep (cat. 2)***	☐	Madigan, Richelle (Patient Advocate) ***Medicaid Advocate (cat. 1)***	☐	Vacant

Stakeholders, Guests & HCA Staff:					
☐	Bergman, DorothyAnne (HCA, notes)	☐	McGill, Jason (HCA)	☐	Dobbins, Amy (HCA)
☐	Klein, Evan (HCA)	☐	Rafton, Sarah (DOHi)	☐	Blose, Jessica (HCA)
☐	Kramer, Karin (HCA)	☐	Wilson, Trinity (HCA)	☐	

#	Agenda Items	Time	Lead	Notes/Handouts
1.	**Roll call**	9:00 am *(5 min)*	Jason McGill	Welcome Hawa Elias who is replacing Jessica Emsley, and DorothyAnne Bergman who is replacing Kodi Campbell, Maren Turner who is replacing Barbara Hannemann
2.	**Approval of October 28 Minutes**	9:05 am *(5 min)*	Jason McGill	
• The quorum was not met to vote and approve the October 28, 2022, Meeting Minutes on January 27, 2023. October 28, 2022, and January 27, 2023, Meeting Minutes will be an agenda item on April 28, 2023, to vote and approve.				
3.	**Continuous Coverage Requirement ends 03/31/2023**	9:10 am (20 min)	Amy Dobbins & Trinity WIlson	
• This legislation as it relates to Public Health Emergency (PHE) really decouples The Families First Coronavirus Response Act (FFCRA)				

- Maintenance of eligibility requirement under the FFCRA decouples that requirement from the PHE and that is effective in April of this year.
- Previously, we had really been tracking the PHE timeline to signal when we needed to start processing verifications that could result in either transition of coverage to another program or transition loss of Apple Health Care coverage and hopefully to another affordable care option.
- This legislation does not end the PHE so the Department of Health and Human Services (HHS) at the federal level still must do that.
- It was just renewed for another 90 days, through April 11, 2023.
- We are waiting for guidance from the Centers for Medicare & Medicaid Services (CMS) so we do not have all of the details about what this legislation needs.
- There are some other things that are tied to this Consolidated Appropriations Act, that impact Medicaid and their multiple effective dates for each of those things.
- It extends chip coverage for an additional two years for fiscal year 2029 which is excellent and requires all states to provide 12 months of continuous eligibility for kids effective January 2024, which is significant. We do this in Washington already, so this is great for the rest of the country and territories.
- It makes the state plan postpartum option permanent. This is something that we put into effect over the last summer here, and previously it was a temporary authority for five years and this legislation makes it permanent.
- Also, effective January 25, Medicaid and CHIP must provide specific services to youth 30 days pre-and post-release from an institutional setting.
- A little more about this decoupling. It decouples the continuous eligibility requirement and the enhanced FMAP or federal matching rate which is currently at 6.2% since the implementation of this continuous eligibility requirement. So, states are getting an additional 6.2%. What it instead does is end that requirement March 30 and re-determination may begin April 1, 2023.
- There are some additional requirements to phase out the match, specific redetermination acquirements under the Social Security Act and some of the waiver flexibility that states have leveraged, they must maintain those.
- Between April and June 2024, there are certain required reports states must submit and all the data will be made publicly available. And finally, for these conditions, states could face penalties and corrective actions if they fail to meet those requirements.
- Some of the policy flex abilities that we want to maintain, and we submitted the waiver for this continuous eligibility for kids 0 to 6, and we are expecting we will get this approved.
- Policy flexibilities do not expire until the PHE expires, so we are working with our partners at DHHS to explore which of those policies looks abilities we want to retain.
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4.	**Medicaid Legislative and Programs Updates**	9:30 am (30 min)	Jason McGill	

- This is a critical effort. Probably the most critical effort since Apple Health expansion in 2014.
- This will have a significant and serious impact on the people we serve. This is a great opportunity.
- Congress has extended our QHP, subsidies for health benefit exchange products. So, if people need that instead of Medicaid. If they have an over income that no longer qualifies. That is available.
- Managed care plans give them direct referral services.
- We know how difficult it is to sign up for healthcare. As much as we have made it so much easier through the exchange, and automation, and honestly Washington state has really hit an effort across the nation in that regard. It is still difficult. So, this will be a challenge for call center staff. And really, all of you.
- You are all ambassadors for the people we serve across the state. So, give them information early so they don't lose coverage.
- If they are over, look to navigators and NCOs to find more coverage if they need them. Of note, people who aged out of Medicaid during the pandemic. They still may be in Medicaid even though they probably should be signed up for Medicare. They may not have signed up for Medicare. That may be a population that we need to help.
- CMS will have a special Medicare enrollment.
- With the 988-system bill, we are also looking at House Bill 1134, that is the 988 system. This is continuing to focus on enhancing our crisis system. A response to its responses is very beneficial to anyone experiencing a behavior health crisis within our state.
- Having the ability to provide a rapid in person behavioral health response to those in need is greatly.
- We know that the development of a conference of training curriculum that can be offered to a variety of responders will lead to a more effective response system, the increase in liability protections would also benefit to those providing calls, HCA is working closely on this bill with a sponsor and has suggested amendments and provided testimony.
- Senate Bill 5555 and House Bill 1583, this is the certified peer specialist Bill 1583 is in partnership with the children youth behavioral workgroup. This is the third year since the version of this bill has been introduced. The policy is to support

increased access of peer services, but we also know this strategy may increase licensing fees for this profession. So, watching that angle of the bill as well because we know this is a historically low paid profession. A lot of stakeholder engagement on this and HCA is working closely with stakeholders and bill sponsors and sibling agencies.

- **Grant updates and workforce updates-** We continue to work to build out workforce plans that support behavioral health workforce. We have the start your path at work campaign, they both start with "start", start your work campaign is in the second phase and we are seeing a great intake of numbers and impact across that campaign across platforms. It is on Tik-Tok and Reddit and Amazon.
- There's been a great increase of people clicking on those ads, interested in that campaign and there is a toolkit coming from that campaign so a lot of good work happening for the behavioral health workforce team on that.
- More opportunities for peers with 37 certified peer training courses coming in June and more opportunities in the workforce space continuing overall.
- We know the 100 million from last session, about 95% of that is out in the community. We have a survey and the outcomes report due next December.
- We are excited to have that report finalized and hear about the impact of that 100 million on workforce stabilization and recruitment.
- We have House Bill 1504 from 2021, with the teaching clinic pilots and those are coming back and reporting great outcomes.
- All sites that have received that funding have said that it's extremely hopeful and we have had some very interesting snapshot remarks from them in our funding reports coming out.
- More information on that will be published on our fact sheets on our website.
- **Behavioral health grants updates** - We have nine federal block grants right now which cover mental health, substance use treatment and recovery programs, and it includes many enhancement grants. Including our most recent which is the bipartisan safer communities act work plan we submitted that workplan last fall and was approved in December, we will use that 1.3 million advancement that we received from SHAMSA to expand CAPS.
- The Suspension will help identify youth earlier in the diagnosis of psychotic illness, supporting engagement and Courtney to specially care and reduces the duration of untreated psychosis. And can prevent inpatient hospitalizations.
- A couple of bills following 1357, prior authorization reforms, looking at that in considerable detail in terms of the requirements there, laudable but logistics matter. And cost matters.
- Looking and seeing what we can support and as always, we will have fiscal notes and bill analyses to complete on these sometimes-challenging bills to get right and to assess the impact so that when we will have impacts.
- For example, it requires a one-to-two-day prior authorization review, really something that we want to do, but it also requires a certain professional level of reviewer and in Medicaid it may be challenging to hit the dual markers.
- We have a managed peer procurement bill 5540, that may be something that we can resolve without the bill moving forward, had some good sponsorship conversations with the sponsors on that, very consistent with our planning procurement, really wanting to engage, certainly providers you have my commitment to come back to this committee when we know more.
- We are in the early stages there and we must prioritize our work right now particularly regarding unwinding. The reprocurement at this stage is something of slightly less priority for us right now.
- We are going to just pause some of that more intensive work, again we were early stages in the first place, and next few months, probably next six months really focus on the unwinding work and then take up reprocurement again so we will come back to this committee.
- We would love to do some in-depth feedback with you, and that was our commitment as well with the legislature.
- 1515, behavioral health network, managed-care network, and procurement bill. Working with sponsors on the house side and really taking the next steps to words productive, efficient integration model.
- We have had some challenges over the last few years particularly with COVID and now the workforce. Not the ideal situation and environment to have transformed the system.
- This bill has some very positive next steps, looking to work with the sponsor on that to improve and transform some of our work in the next stages. We have language access that we are also following.
- We are working with a sponsor on how we engage the certified training for interpreters and how best we can accomplish that.
- A few others on my list, 5422, regarding behavioral health in schools.
- 1188 is child welfare, a bill related to children and youth with intellectual development disabilities. Some challenges in that bill, I understand DHS developmental disability administration is working with that one now.
- Reentry, of course. A continuing, important topic. 5134 reentry bill is something we are watching and positive development with DOC reentry. On that note, CMS approved California's reentry waiver yesterday. Our waiver request is very similar.
- For the first time ever, a segment of reentry and related transitional services will be paid through Medicaid, prior to people being released from the setting, from jail or DOC.
- To date, we have not really been able to pay for any service through Medicaid prior to release. That is a major transformation. The congressional legislation that was passed late last year, the unwinding, it also covered juveniles in that setting. So that is the first step there as well, prior to the swivel approval for juveniles in rehabilitative settings.

	• Where Medicaid, again, has not been paid. Now they will pay for these transitional services. And that looks to include some pharmaceutical, medical management. Particularly related to substance use disorder. Some mental health treatment. •			
5.	**Committee housekeeping items:** • We have 2 vacancies and have not received nominations since our October 2022 meeting. Should we implement an online application process which has been done in the past? (see chart below for membership distribution & information)	10:00 am *(10 min)*	Jason McGill	
	• Quorum was not met, and this discussion will be brought up in an upcoming meeting.			
6.	**Suboxone struggles statewide and increased uptakes in SNFs**	10:10 am *(30 min)*	Jessica Blose	
	• Medication accessibility in different settings. Specifically, topics around difficult discharge populations. Where there have been reports that individuals entering skilled facilities were not able to get access because they needed to initiate on paper the medication to treat their opiate disorder or continue treatment. • They use the skilled nursing facility setting to be a case example. But really a lot of what we are going to be talking about his access issues in several settings as well. • The State Opioid Treatment Authority Office has been hearing, for years, unfortunately, issues of patients who are in hospital settings and maybe have something like endocarditis, related to their IV drug use. Maybe they are there because they have something chemically unrelated to their drug use. Maybe it was an accident, maybe it was a stroke. For whatever reason, that individual also has ever occurring opiate use disorder diagnosis. Often, they will be on medication to treat this disorder. That can be methadone or other products. It can be naltrexone. For methadone, what we have been hearing from the district population in hospitals is that an element that is difficult for these patients is they fall into two buckets. Maybe they have been put on the is in a hospital setting directly related to ongoing substance use. They are just started on the medication and now will be discharged to an acute care setting. Now they need to continue. Or, the other bucket of patients, maybe it's someone who has been on methadone for 10 years. They are stable with their opiate use disorder because they are taking these wonderful medications. But now, they need to be discharged. • We also still have a significantly large number of skilled nursing facilities and nursing home settings who cannot accept individuals, so we have been doing things at the state level to figure out why this is going on. • We partnered with a couple of providers like WACHA, and we polled their members last year to ask why it is so difficult to accept patients? We had so many responses with everything from there is just really a lack of knowledge around what is and is not allowable, there are so many federal regulations around methadone and historically those medications have been siloed from the rest of mainstream medicine, maybe I cannot prescribe these medications, we are not legally allowed to hold them on-site, there is a lot of need for myth busting, there's also just concerns around care coordination, these patients like any behavioral health patient often times need these pharmacological interventions and if it is something that cannot be provided on-site by the provider, it is going to require peer coordination. • These settings will often say "we don't feel like we are being resourced appropriately to do this additional care coordination" we are just not sure how to do this care coordination, who the partners need to be" so there's really a need for education. • There is also stigma, lots of questions and concerns about who these patients are, and really a misunderstanding of that piece. Providers often times equate these patients as if you take one of these medications you are equivalent to someone who is actively using an illicit substance. And really these populations say that if we accept a patient into a nursing home setting of any kind we are worried that they are going to be disruptive on the mill you, that they will be bringing contraband into the unit, but the reality is patient's on these medications are not experiencing withdrawal symptoms and cravings as long as they are on the medication and it is actually a protective factor for these settings if they accept patients who are taking these medications because the patient is less likely to be experiencing behaviors that might be associated with substance use and have historically been inaccurately classified as drug seeking behaviors, but the reality is these behaviors are probably because of an individual not having adequate dosing to a medically necessary medication. • Overall, we have a lot of work to do around stigma reduction. Historically, some of the stigma has been because we have not had the regulatory abilities to allow for those care coordination to be happening for those patient populations because historically the federal rules made it hard to care coordinate for these patients.			

	• There's a lot of feedback that we have been getting at Health Care Authority and we have partnered with DSHS and RCS and some of these provider associations for post-acute care settings and we are going to make 2023 all about information for our post-acute care setting partners to try to help raise awareness around what is possible for stigma reduction. • We just had a meeting with all these partners and at least 70 participants from 30 to 40 organizations who created a whole PowerPoint presentation. We presented for two hours and talked about what MOUD is, why these medications are incredibly important to combat the opioid crisis, confronting myths around these medications, breaking down some of the stigma on patients, and again why this is so important to help keep people alive and have patients have good outcomes in these post-acute care settings. Because what we are seeing is individuals either not being able to gain access to post-acute care settings that really need it and some individuals being asked to make a choice of going or stop taking your medicine and then they end up becoming destabilized with their opioid use disorder and oftentimes they may relapse or leave the post-acute care setting because they are in a state of withdrawal and leading to relapse. • We also made sure that we presented to these partners discrimination. Sometimes stigmas are just a nicer term for calling something what it is, and it is discrimination. Throughout this year, we will continue to do this and are educated. State and federal law for disability does protect any individual who takes medication to prevent this disorder and refusing or limiting a person from accessing treatment in a setting could be in violation of those state and federal laws which are the ADA, and W LAD, and similarly on requiring an individual an opportunity to change their medication of the condition of them continuing can also be seen as discriminatory. • We shared with the partners several news articles from other states where the federal government and other states have begun to take actions against facilities but this could really be any acute care setting. • And then making sure that we say that we at Medicaid have already released information this past year and put out documentation stating that Medicaid funded health services need to be provided for care that is nondiscriminatory against individuals, CMS at the federal level has been updating guidance and to treat folks with substance use disorders including those on MOUD, to speak candidly our own Attorney General's Office has been asking around the state considering taking negative action against healthcare providers who might be discriminating against patients on MOUD. • We really wanted to appoint this group of providers in helping them to understand that they have the potential for risk and liability now and that they were willing to update their policy and procedures and create pathways for continuity of care for these patients. • Settings would still need to have procedures around how they will be implementing and tracking these laws. If they will have their nursing staff readministered the patient's administration or watch them and observe the self-implemented medication. • There is even more flexibility in how this can become a methadone clinic and take it to a third-party location. Either an OTP can go through care coordination and agreement, they can physically transport the handoff up to 28 days of medication. • Legally approved custody agreement, if they live or fill it out, it can say John Doe in this healthcare setting, and they accepted these many doses for patient on the state. Everyone will sign off and then there can be a record of the transfer of medication. But then the long-term care settings act for that medication, it can be worked out to a methadone clinic. • And the third party, at what cadence should that delivery system happen? Should it happen daily? Weekly? Bimonthly? Once a month? There is a lot of flexibility. In a post-acute care setting or really any other staff could go to OTP and actually pick up the medication through this agreement. • Then they can bring it back to the facility and hold it for the patient there. Then they will administer it. This can happen at any cadence that the two providers work out. Then, you know, lots of information. We are aware that these are major changes and it's going to take a while. So, we are going to be continuing to meet with our partners about how to continue to communicate throughout the year. I have already signed up to present at several conferences. • We offer free one-on-one technical assistance to any party. And then with this case example that I've been talking about today, while it has been hyper focused on post-acute care settings, we really see, again, access issues in all settings. Anyplace that the patient may be staying overnight. • Whether that is residential treatment, substance use, withdrawal management settings, mental health inpatient, correctional health, recovery housing, anywhere. These types of regulatory allowances can likely be used to help ensure that these patients can both gain admission to the settings and continue their medicines. •			
7.	**Wrap-up** • Next meeting: April 28, 2023 • Agenda items for next meeting	10:40 am *(20 min)*	Jason McGill	

As per our bylaws, here is the current make up of the advisory committee:

	Category 1	Category 2	Category 3

Category Descriptions	Members of consumer groups, including Medicaid recipients and advocates.	Board-certified physicians and other representatives of the health professions and associations who are familiar with the medical needs of low-income population groups and with the resources available and required for their care.	The Secretary of the Department of Social and Health Services (DSHS) and the Secretary of the Department of Health (DOH) or designee.
Current # per category	2	11	2