Health Plan Performance Improvement Project (PIP)

Louisiana Healthcare Connections (LHCC)

PIP Title:
Improve Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation

PIP Implementation Period:
January 1, 2020-December 31, 2020

Submission Dates:

	Proposal/Baseline	Interim/Final
Version 1	2/3/2020	
Version 2	3/11/2020	12/31/2020

MCO Contact Information

1. Principal MCO Contact Person

[PERSON RESPONSIBLE FOR COMPLETING THIS REPORT AND WHO CAN BE CONTACTED FOR QUESTIONS]

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3. External Collaborators (if applicable):

Attestation

Plan Name: Louisiana Healthcare Connections
Title of Project: Improve Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation

The undersigned approve this PIP and assure involvement in the PIP throughout the course of the project.

Medical Director Signature: _____
First and last name: Stewart Gordon, MD
Date: 12/10/2020

CEO Signature: _____
First and last name: James Schlottman, CEO
Date: 12/10/2020

Quality Director Signature: _____
First and last name: Yolanda Wilson, VP Quality
Date: 12/10/2020

IS Director signature (if applicable): _____
First and last name:
Date:

Updates to the PIP

For Interim and Final Reports Only: Report all changes in methodology and/or data collection from initial proposal submission in the table below.
[EXAMPLES INCLUDE: ADDED NEW INTERVENTIONS, ADDED A NEW SURVEY, CHANGE IN INDICATOR DEFINITION OR DATA COLLECTION, DEVIATED FROM HEDIS® SPECIFICATIONS, REDUCED SAMPLE SIZE(S)]

Table 1: Updates to PIP

Change	Date of change	Area of change	Brief Description of change
Change 1	3/10/2020 (Quarter 1)	☐ Project Topic ☒ Methodology ☐ Barrier Analysis / Intervention ☒ Other	Revised data calculations per LDH/IPRO guidance; updated baselines provided. Clarification on data integrity process.
Change 2	7/31/2020 (Quarter 3)	☐ Project Topic ☒ Methodology ☒ Barrier Analysis / Intervention ☐ Other	Incorporated updated OPH data into analysis as new lists were released; intervention modifications to expand outreach, disseminate updated resource materials received, and mitigate identified barriers (i.e. transition to virtual provider outreach).
Change 3	10/31/2020 (Quarter 4)	☐ Project Topic ☒ Methodology ☒ Barrier Analysis / Intervention ☐ Other	Incorporated updated OPH data into analysis as new lists were released; expanded member outreach modalities; intervention modifications to expand outreach and mitigate identified barriers; retired ITM 2b as directed by LDH/IPRO.
Change 4		☐ Project Topic ☐ Methodology ☐ Barrier Analysis / Intervention ☐ Other	

Abstract

For Final Report submission only. Do not exceed 1 page.

Provide a high-level summary of the PIP, including the project topic and rationale (include baseline and benchmark data), objectives, description of the methodology and interventions, results and major conclusions of the project, and next steps.

Project Topic/Rationale/Objectives

Topic:

Improved Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation

Rationale:

The Hepatitis C virus (HCV) is the most common blood-borne disease and the leading cause for liver transplant in the United States (LDH, 2019). HCV prevalence in Louisiana is estimated at 1.6% to 1.8%, with higher rates among urban residents, men and women aged 45-54 years, with highest rates among males in all age groups and among African American males aged 45-54 years (LA OPH, 2015). As of summer 2019, Healthy Louisiana enrollees have access to safe and effective treatment for hepatitis C. Many asymptomatic people are unaware that they are chronically infected with HCV; therefore, screening for HCV in accordance with evidence-based recommendations is indicated for Healthy Louisiana enrollees who are at risk for HCV infection.

Objectives:

Improve the Healthy Louisiana HCV screening rate and initiation of HCV pharmaceutical treatment rate by ten percentage points by implementing a robust set of interventions to address the following key intervention objectives:

- **Member Intervention Objective**: outreach and educate eligible members, and facilitate referrals to schedule appointments with (i) PCPs for screening and (ii) HCV providers (priority; per OPH database) or PCPs (per member preference) for treatment, with tailored interventions targeted to each of the following high risk subpopulations;
- **Provider Intervention Objective**: educate providers on evidence-based recommendations and availability of HCV specialty providers (USPSTF, 2013; AASLD/IDSA, 2018), and coordinate referrals for screening and treatment.

Methodology

Eligible population:

Louisiana residents ages 18 years of age and older who are enrolled in the Louisiana Medicaid program.

Description of Annual Performance Indicators:

Annual Performance Indicators collected through administrative claims data measured the percentage of members receiving screening for HCV based on several categories, including age and risk factor cohorts.

Treatment related performance indicators included the percentage of members for whom treatment for HCV was initiated based on several additional categories including members with a confirmed or probably diagnosis of Chronic Viral Hepatitis C per OPH listings provided, current or past drug use, and HIV subcategories.

Sampling Method:

No sampling is being used; the entire eligible population is being targeted by PIP interventions.

Baseline and Re-measurement Periods:

Baseline period: 1/1/2019 to 12/31/2019, Final Measurement Period 1/1/2020 to 12/10/2020.

Data Collection Procedures:

Data was collected through administrative claims data using the Centene-level corporate Quality Spectrum Insight (QSI-XL) database. Data was also utilized from Centene's Enterprise Data Warehouse and additional programs such as Microstrategy, TruCare, and Sharepoint. Additional data for ITMs was collected through our internal Data Analytics team, Case Management, and Pharmacy reporting. Although some data elements were collected monthly for consistency in process and work flows, PIP data was aggregated and reported on a quarterly basis. Supplemental data from OPH resources provided by LDH have also been utilized for indicators as instructed. Those who collected the data include Data Analysts, Quality Improvement team members, and Case Management and/or Pharmacy staff who tracked and trended their department's data.

Interventions

Member Barriers Identified:

Identified Member barriers to screening and treatment initiatives for HCV include the following: the significant volume of members in universal screening population (> 408,000); difficulty contacting members and/or limited response to outreach communication efforts; member responsiveness to outreach efforts declined as pandemic continued and was compounded with additional outreach initiatives related to hurricane activity during August/September; member reluctance to seek care or attend appointments (attributed to impact of COVID-19, concerns for risk of exposure); decreased access to care limited volume of pharmaceutical treatment initiations; limited member engagement in case management services for HCV population; ambiguity of member treatment history due to variation between OPH information and member/provider reported status; and potential for erroneous disclosure and members unaware of HCV diagnosis.

Interventions to address member barriers:

Several interventions were developed to address the identified member barriers, including the following:

- Member outreach campaigns with targeted communications including telephonic and direct mail outreach, with expansion to automated dialing technologies to broaden scope of member contact efforts for the larger group of age cohort members;
- CM outreach from original pilot subgroup targeting members actively enrolled in CM;
- CM expanded outreach to increase HCV members from the OPH list enrolled in case management and receiving treatment for HCV;
- Stratification of member list based on internal risk tools for prioritization of outreach to members at highest risk;
- Monitoring list of OPH members not receiving treatment monthly;
- Expanded assessment tool for deeper inquiry into member treatment history.

Provider Barriers Identified:

Provider barriers to improving HCV screening and pharmaceutical treatment were identified, including provider knowledge deficit and inconsistent awareness of HCV resources and information to guide clinical practice. Additional barriers were noted as interventions were initiated, particularly surrounding concerns for provider abrasion due to overlapping efforts as multiple MCOs were outreaching providers to share educational offerings, evidence based clinical resources, and member information. With pandemic and hurricane impacts on provider operations and patient needs being prioritized, providers' ability to schedule and/or attend offered education

opportunities was limited. Competing priorities with the ongoing COVID-19 pandemic were also noted as barriers to engaging providers. Continuing practice operations and continuity of care for members were understandable priorities as providers were navigating both pandemic impacts as well as hurricane recovery for affected regions during August/September.

Interventions to address provider barriers:

Interventions developed to address the identified provider barriers include:

- Online distribution of collateral including screening and treatment algorithms (website, blogs, social media);
- Resources for providers posted to LHCC online portal for direct access;
- Expanding on-demand options for convenient scheduling is also being explored to meet provider needs;
- LDH provider guidance/resource collaterals including treatment algorithms incorporated into provider visit agendas for distribution/presentation during virtual visits and mail distribution when indicated; and
- Initiation of a collaborative effort with LDH and other MCOs to align resources directed to providers.

Results

Annual rates are pending year-end aggregation and review; all available performance indicator data through 12/10/2020 may be found beginning on page 21. HCV screening rates improved over prior year baseline, however anticipated increases in treatment rates were less notable. YTD rates for the various cohorts are as follows:

- Screening rates: universal cohort group 11.96%; birth cohort group (>18 yrs) 14.36%; non-birth cohort (ever screened) 26.23%; non-birth cohort (annually screened) 8.42%
- Treatment rates: all members on OPH list with treatment initiated 11.47%; OPH subgroup with current or past drug use 12.18%; OPH subgroup diagnosed with HIV 14.14%.

Conclusions and Next Steps

Ongoing analysis of HCV interventions and outcomes has provided valuable insight into member and provider centric challenges and opportunities for continued improvement. Significant impacts from the COVID-19 pandemic and multiple hurricane events in Louisiana were recognized as disruptive to both member and provider facing initiatives as well as impacting provider operations and member access patterns. PIP activities were suspended for several months as COVID-19 emerged, with activities resuming in July. Although education and outreach initiatives resumed in Quarter 3 with alternative approaches to navigate the pandemic barriers, established targets for the HCV performance indicators were not met. Interventions continue and rates through 12/10/2020 indicate positive trending in all but 1 measure (PI 2B – annual screening for risk factor cohort) as alternative approaches to outreach and resourcing have been implemented. While final rates are pending, 3 of 7 measures are showing improvement over prior year baseline. Overall screening indicators are showing more improvement than treatment indicators.

Provider education and member outreach initiatives were adversely impacted during 2020 and remain a continued focus as we move into 2021. Provider education and access to HCV resources remains a priority, as well as continued member outreach to facilitate linkage to treatment and follow up support and resources. Increasing member knowledge of HCV screening and testing recommendations, along with preferred treatment options is an ongoing effort with promotion through direct communications, online media platforms, and community partners.

Continued efforts and innovation are needed to increase member engagement with care management services in order to provide support and assistance to resources for treatment of HCV. Opportunities include exploring new outreach methods to better impact a population that historically has been difficult to contact, including assessment of member communication preferences to better inform next steps.

Opportunity was also noted for collaboration across MCO's and LDH to streamline provider communications and linkage to resources in an effort to minimize duplicative outreach and overlapping initiatives to avoid provider abrasion. Initial discussions across MCO quality partners in the 4th quarter have been productive and several proposed improvement opportunities were being explored pending 2021 project details to inform next steps.

Project Topic

To be completed upon Proposal submission. Do not exceed 2 pages.

Describe Project Topic and Rationale for Topic Selection

- Describe how PIP Topic addresses your member needs and why it is important to your members:
- Describe high-volume or high-risk conditions addressed:
- Describe current research support for topic (e.g., clinical guidelines/standards):
- Explain why there is opportunity for MCO improvement in this area (must include baseline and if available, statewide average/benchmarks):

Louisiana Healthcare Connections (LHCC) is committed to the mission of improving the health of our community one member at a time. Prevalent infectious disease trends throughout the state and the nation are particularly relevant to our membership and ultimately impact the health and wellbeing of our members. As LDH has emphasized, the hepatitis C virus (HCV) is the most common blood-borne disease and the leading cause for liver transplant in the United States, with Louisiana prevalence estimated at 1.6% to 1.8%. Of particular relevance to our member population, the increased prevalence of HCV among baby boomers (born between 1945-1965), urban residents, and African American males aged 45-54 years underscores the importance of focused intervention for the benefit of our members (LDH, 2019). In addition to demographic risk stratification, there is a general knowledge deficit in the general public; infected individuals may be asymptomatic and unaware of both the inherent health risks they face, as well as the risk of transmission to others. These realities support the need for improved screening for HCV in accordance with evidence-based recommendations for those members who are identified as at risk for HCV infection.

With enrollment of over 400,000 members and many who may be impacted by this risk, LHCC is pleased to partner with LDH and other participants in this performance improvement project to Improve Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation.

Immediate efforts towards initiating this PIP include data aggregation and analysis to determine scope of current membership affected and/or at risk, as well as a review of best practices and recommendations from leading healthcare advisory groups including the Louisiana Hepatitis C Elimination Plan. A review of the current membership as of January 25th, 2020 was conducted and preliminary analysis along with OPH data was initiated to determine the current risk stratification volumes within the Plan membership. Preliminary review indicates significant opportunity is evident, consistent with the established risk per birth cohort alone, with over 83,000 members during 2019 baseline year born between 1945-1965; of these members, only 14% appear to have screening for HCV – supporting the need for increased routine screening activity. The additional benefit of pharmaceutical treatment options and authorization initiatives further support the ability to impact outcomes for those with positive diagnosis. Review of best practices and recommendations from leading healthcare advisory groups including the Louisiana Hepatitis C Elimination Plan have been initiated to enable thoughtful and deliberate focus on optimal strategies to increase compliance with the two core initiatives and ultimately improvement of health outcomes for the at risk populations.

Aims, Objectives and Goals

Aim

Improve the Healthy Louisiana HCV screening rate and initiation of HCV pharmaceutical treatment rate by ten percentage points by implementing a robust set of interventions to address the following key intervention objectives:

1. **Member Intervention Objective**: Outreach and educate eligible members, and facilitate referrals to/schedule appointments with (I) PCPs for screening and (II) HCV providers (priority; per OPH database) or PCPs (per member preference) for treatment, with tailored interventions targeted to each of the following high risk subpopulations (which are not mutually exclusive, as enrollees may have multiple high risk characteristics)::
    a. Beneficiaries born between the years 1945 and 1965
    b. Current or past injection drug use
    c. Persons ever on long term hemodialysis
    d. Persons who were ever incarcerated
    e. Persons with HIV infection

2. **Provider Intervention Objective**: Educate providers on evidence-based recommendations and availability of HCV specialty providers (USPSTF, 2013; AASLD/IDSA, 2018), and coordinate referrals for screening and treatment.

Table 2: Goals

Indicators	Baseline Rate[1] Measurement Period: 1/1/19-12/31/19	Target Rate[2]	Rationale for Target Rate[3]
Performance Indicator #1a (Universal Screening): *The percentage of Healthy Louisiana enrollees ages 18-79 years {denominator} who were ever screened for HCV {numerator}.*	**N:** 41,207 **D:** 399,868 **R:** 10.31%	**R:** 20.31%	Project aim recommendation – improve 10% pts from baseline
Performance Indicator #1b (Birth Cohort Screening): *The percentage of Healthy Louisiana enrollees for whom HCV screening is indicated by birth year between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.*	**N:** 9,405 **D:** 69,110 **R:** 13.61%	**R:** 23.61%	Project aim recommendation – improve 10% pts from baseline
Performance Indicator #2a (Non-Birth Cohort/Risk Factor Screening- ever screened): *The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.*	**N:** 6,298 **D:** 27,193 **R:** 23.16%	**R:** 33.16%	Project aim recommendation – improve 10% pts from baseline
Performance Indicator #2b (Non-Birth Cohort/Risk Factor Annual Screening): *The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born*	**N:** 2399 **D:** 27,193 **R:** 8.82%	**R:** 18.82%	Project aim recommendation – improve 10% pts from baseline

Indicators	Baseline Rate[1] Measurement Period: 1/1/19-12/31/19	Target Rate[2]	Rationale for Target Rate[3]
between 1945 and 1965 {denominator} and who were screened during the measurement year for HCV {numerator}.			
Performance Indicator #3a (HCV Treatment Initiation-Overall): *The percentage of all adults (ages 18 and older) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.*	**N:** 622 **D:** 5189 **R:** 11.99%	**R:** 21.99%	Project aim recommendation – improve 10% pts from baseline
Performance Indicator #3b (HCV Treatment Initiation-Drug Users): *The percentage of the subset of adults with current or past drug use and a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.*	**N:** 241 **D:** 1967 **R:** 12.25%	**R:** 22.25%	Project aim recommendation – improve 10% pts from baseline
Performance Indicator #3c (HCV Treatment Initiation-Persons with HIV): *The percentage of the subset of adults ever diagnosed with HIV and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.*	**N:** 37 **D:** 258 **R:** 14.34%	**R:** 24.34%	Project aim recommendation – improve 10% pts from baseline

[1] Baseline rate: the MCO-specific rate that reflects the year prior to when PIP interventions are initiated.
[2] Upon subsequent evaluation of performance indicator rates, consideration should be given to improving the target rate, if it has been met or exceeded at that time.
[3] Indicate the source of the final goal (e.g., NCQA Quality Compass) and/or the method used to establish the target rate (e.g., 95% confidence interval).

Methodology

To be completed upon Proposal submission.

Performance Indicators

Table 3: Performance Indicators

Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
Performance Indicator #1a (Universal Screening)	*Performance Indicator #1a (Universal Screening): The percentage of Healthy Louisiana enrollees ages 18-79 years {denominator} who were ever screened for HCV {numerator}.*	Administrative/ Claims/ Encounter data	All Healthy Louisiana enrollees ages 18-79 years	Healthy Louisiana adults with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	Number of Healthy Louisiana enrollees who were ever screened for HCV: CPT code 86803 OR CPT code 86804 OR CPT code 87520 OR CPT code 87521 OR CPT code 87522 OR HCPCS code G0472	Number of members in the eligible population less number of excluded members
Performance Indicator #1b (Birth Cohort Screening).	*The percentage of Healthy Louisiana enrollees for whom HCV screening is indicated by birth year between 1945 and 1965 {denominator} and who were screened for HCV {numerator}.*	Administrative/ Claims/ Encounter data	Healthy Louisiana enrollees born between 1945 and 1965	Healthy Louisiana adults with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	Number of Healthy Louisiana enrollees who were ever screened for HCV: CPT code 86803 OR CPT code 86804 OR CPT code 87520 OR CPT code 87521 OR CPT code 87522 OR HCPCS code G0472	Number of members in the eligible population less number of excluded members

Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
Performance Indicator #2a (Non-Birth Cohort/Risk Factor Screening-ever screened)	*The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.*	Administrative/ Claims/ Encounter data	Healthy Louisiana adults aged 18 and older who were NOT born between 1945 and 1965, and who meet one or more of the following criteria: a. Current or past injection drug use (ICD-9 or ICD-10 codes in Table A); OR b. Persons ever on long term hemodialysis (ICD-9 or ICD-10 codes in Table B); OR c. Persons who were ever incarcerated (ICD-9 or ICD-10 codes in Table C); OR d. Persons ever diagnosed with HIV infection (ICD-9 or ICD-10 codes in Table d)	Healthy Louisiana adults with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	Number of Healthy Louisiana enrollees who were ever screened for HCV: CPT code 86803 OR CPT code 86804 OR CPT code 87520 OR CPT code 87521 OR CPT code 87522 OR HCPCS code G0472	Number of members in the eligible population less number of excluded members

Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
Performance Indicator #2b (Non-Birth Cohort/Risk Factor Annual Screening)	*The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were screened during the measurement year for HCV {numerator}.*	Administrative/ Claims/ Encounter data	Healthy Louisiana adults aged 18 and older who were NOT born between 1945 and 1965, and who meet one or more of the following criteria: a. Current or past injection drug use (ICD-9 or ICD-10 codes in Table A); OR b. Persons ever on long term hemodialysis (ICD-9 or ICD-10 codes in Table B); OR c. Persons who were ever incarcerated (ICD-9 or ICD-10 codes in Table C); OR d. Persons ever diagnosed with HIV infection (ICD-9 or ICD-10 codes in Table d)	Healthy Louisiana adults with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	Number of Healthy Louisiana enrollees who were screened during the measurement year for HCV: CPT code 86803 OR CPT code 86804 OR CPT code 87520 OR CPT code 87521 OR CPT code 87522 OR HCPCS code G0472	Number of members in the eligible population less number of excluded members

Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
Performance Indicator #3a (HCV Treatment Initiation-Overall)	*The percentage of all adults (ages 18 and older) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.*	Administrative/ Claims/ Encounter data	Healthy Louisiana adults with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	None	Number of adults with a pharmaceutical claim for sofosbuvir/velpatisvir (the authorized generic (AG) of Epclusa ®) or other LDH-approved Hepatitis C Virus Direct Acting Antiviral Agent {DAA}	Number of members in the eligible population for Performance Indicator #3a
Performance Indicator #3b (HCV Treatment Initiation-Drug Users)	*The percentage of the subset of adults with current or past drug use and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.*	Administrative/ Claims/ Encounter data	Healthy Louisiana adults with current or past drug use (ICD-9 or ICD-10 codes in Appendix A) AND with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	None	Number of adults with a pharmaceutical claim for sofosbuvir/velpatisvir (the authorized generic (AG) of Epclusa ®) or other LDH-approved Hepatitis C Virus Direct Acting Antiviral Agent {DAA}	Number of members in the eligible population for Performance Indicator #3b

Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
Performance Indicator #3c (HCV Treatment Initiation- Persons with HIV)	*The percentage of the subset of adults ever diagnosed with HIV and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.*	Administrative/ Claims/ Encounter data	Healthy Louisiana adults ever diagnosed with HIV (ICD-9 or ICD-10 codes in Appendix D) AND with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	None	Number of adults with a pharmaceutical claim for sofosbuvir/velpatisvir (the authorized generic (AG) of Epclusa ®) or other LDH-approved Hepatitis C Virus Direct Acting Antiviral Agent {DAA}	Number of members in the eligible population for Performance Indicator #3c

Data Collection and Analysis Procedures

Is the entire eligible population being targeted by PIP interventions? If not, why?
The entire eligible population is being targeted by PIP interventions

Sampling Procedures
If sampling was employed (for targeting interventions, medical record review, or survey distribution, for instance), the sampling methodology should consider the required sample size, specify the true (or estimated) frequency of the event, the confidence level to be used, and the margin of error that will be acceptable.

- **Describe sampling methodology:** No sampling is being used in this PIP.

Data Collection
Describe who will collect the performance indicator and intervention tracking measure data (using staff titles and qualifications), when they will perform collection, and data collection tools used (abstraction tools, software, surveys, etc.). If a survey is used, indicate survey method (phone, mail, face-to-face), the number of surveys distributed and completed, and the follow-up attempts to increase response rate.

- **Describe data collection:**
  Data will be collected through administrative claims data using the Centene-level corporate Quality Spectrum Insight (QSI-XL) database. Data may also be utilized from Centene's Enterprise Data Warehouse and additional programs such as Microstrategy, TruCare, and Sharepoint. Additional data for ITMs will be collected through our internal Data Analytics team, Case Management, and Pharmacy reporting. Although some data elements will be collected monthly for consistency in process and work flows, PIP data will be aggregated and reported on a quarterly basis. Supplemental data from OPH resources provided by LDH have also been utilized for indicators as instructed. Those who collect the data include Data Analysts, Quality Improvement team members, and Case Management and/or Pharmacy staff who track and trend their department's data.

Validity and Reliability
Describe efforts used to ensure performance indicator and intervention tracking measure data validity and reliability. For medical record abstraction, describe abstractor training, inter-rater reliability (IRR) testing, quality monitoring, and edits in the data entry tool. For surveys, indicate if the survey instrument has been validated. For administrative data, describe validation that has occurred, methods to address missing data and audits that have been conducted.

- **Describe validity and reliability:**
  For data reliability, the screening rates, % of diagnosed members per month and treatment initiation rates obtained from QSI-XL (Inovalon) is compared to number of claims in our data warehouse for the same time period, hence a correlation ratio is derived to check data consistency. Data validation is conducted using various methods, including consultation with Medical director, case management team and quality team. Additional validation methods include enrollment checks to ensure timely screening of susceptible HCV population and treatment continuity of diagnosed population. In addition to above methods, statistical methods (experimental design) are used to compare number of HCV related claims received, unique number of Medicaid members.
  Note: Initial proposal baseline data was revised and resubmitted 3/11/2020; data integrity check was performed and an erroneous encounter code had been included during initial data collection, skewing the initial baseline rates reported. This was corrected to include only the specified CPT and HCPCS codes provided by LDH and updated data validated by Data Analyst.

Data Analysis
*Explain the data analysis procedures and, if statistical testing is conducted, specify the procedures used (note that hypothesis testing should only be used to test significant differences between **independent** samples; for instance, differences between health outcomes among sub-populations within the baseline period is appropriate).Describe the methods that will be used to analyze data, whether measurements will be compared to prior results or similar studies, and if results will be compared among regions, provider sites, or other subsets or benchmarks. Indicate when data analysis will be performed (monthly, quarterly, etc.).*
Describe how plan will interpret improvement relative to goal.

Describe how the plan will monitor intervention tracking measures (ITMs) for ongoing quality improvement (e.g., stagnating or worsening quarterly ITM trends will trigger barrier/root cause analysis, with findings used to inform modifications to interventions).

- **Describe data analysis procedures:**
  Data is compared to previous year's data as available; denominators and numerators will be checked for inclusion of all eligible populations and any identified discrepancies are investigated. Data is compared to all sources and histories available in an effort to produce the most valid data possible.
- **Describe how plan will interpret improvement relative to goal:**
  Improvement will be monitored via internal benchmarking against established baseline thresholds. Preliminary analysis (as described above) indicated variation in HCV diagnosed population by age and region, providing a baseline upon which ongoing performance may be compared to benchmark progress towards higher engagement, screening and/or treatment for at-risk and HCV diagnosed enrollees.
- **Describe how plan will monitor ITMs for ongoing QI:**
  ITM's will be monitored at minimum monthly to evaluate positive improvement, plateaus, or identify adverse trends for prompt investigation, analysis and/or action to modify interventions if indicated. Bi-weekly and monthly monitoring of enrollees who are HCV diagnosed will be conducted using Business Intelligent tools to support initiatives promoting increased awareness, screening, and treatment for HCV.

(Tentative) PIP Timeline

Report the baseline, interim and final measurement data collections periods below.
Baseline Measurement Period:
Start date: 1/1/2019
End date: 12/31/2019

Submission of Proposal/Baseline Report Due: 2/3/2020

Interim/Final Measurement Period:
Start date: 1/1/2020
End date: 12/31/2020

PIP Interventions (New or Enhanced) Initiated: 2/1/2020

Submission of 1st Quarterly Status Report for Intervention Period from 1/1/20-3/31/20 Due: 4/30/2020
Submission of 2nd Quarterly Status Report for Intervention Period from 4/1/20-6/30/20 Due: 7/31/2020
Submission of 3rd Quarterly Status Report for Intervention Period from 7/1/20-9/30/20 Due: 10/31/2020

Submission of Draft Final Report Due: 12/10/2020
Submission of Final Report Due: 12/31/2020

Barrier Analysis, Interventions, and Monitoring

Table 4: Alignment of Barriers, Interventions and Tracking Measures

Barrier 1: New Healthy Louisiana HCV treatment benefit may be unknown to enrollee. **Method of barrier identification: IPRO HCV PIP guidance document.**		**2020**			
		Q1	**Q2**	**Q3**	**Q4** *(Partial)*
Intervention #1a to address barrier: Enhanced Case Management Outreach for HCV Treatment Initiation **Planned Start Date:** 3/1/2020 **Actual Start Date**: 3/1/2020	**Intervention #1a tracking measure :** **N:** # members with appointment scheduled by MCO Case Manager / Care Coordinator for HCV treatment assessment/initiation **D**: # members with confirmed or probable HCV per OPH listing not receiving treatment **Initial outreach began with a smaller subset of population to test on smaller scale – both measures provided for Q1.*	*Denom / Initial subset group - N: 43 D: 121 R: 35.5% Denom / Total on OPH list N: 43 D: 5,223 R: 0.82%	*PIP suspended*	N: 12 D: 3,645 R: 0.33%	N: 6 D: 4,579 R: 0.13%
Barrier 2: Asymptomatic enrollees may not know they are infected with HCV. **Method of barrier identification: IPRO HCV PIP guidance document.**		**2020**			
		Q1	**Q2**	**Q3**	**Q4** *(Partial)*
Intervention #2a to address barrier: CM Outreach: Enhanced Case Management Outreach for HCV Screening **Planned Start Date:** 3/1/2020 **Actual Start Date**: 7/1/2020	**Intervention #2a tracking measure:** **N:** # members with appointment scheduled by MCO Case Manager / Care Coordinator for HCV screening **D:** # members at risk for HCV per MCO claims/encounter data	**Screening outreach set to begin 3/1 but was delayed; COVID restrictions mid-March.*	*PIP suspended*	N: 243 D: 31,950 R: 0.76%	N: 256 D: 32,455 R: 0.79%
Retired **Intervention #2b to address barrier:** Provider Outreach: Provide PCP's with customized list of members for whom HCV screening is indicated by birth year between 1945 and 1965. **Planned Start Date:** 3/1/2020 **Actual Start Date**: 3/1/2020	**Intervention#2b tracking measure:** **N:** # members in birth cohort receiving HCV screening **D:** # members with HCV screening indicated per birth year cohort	N: 8,601 D: 66,387 R: 12.96%	N: 9,405 D: 69,110 R: 13.61%	N: 10,574 D: 74,338 R: 14.22%	N: 10,803 D: 75,232 R: 14.36%

Barrier 3: Providers may not be aware that Epclusa does not require prior authorization. **Method of barrier identification: Plan assessment of provider network.**		**2020**			
		Q1	**Q2**	**Q3**	**Q4** *(Partial)*
Intervention #3a to address barrier: Provider education regarding SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) prescription. **Planned Start Date:** 3/1/2020 **Actual Start Date**: 3/1/2020	**Intervention #3a tracking measure:** **N:** # members who were dispensed SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) **D:** # members with any DAA dispensed	N: 778 D: 790 R: 98.48%	N: 510 D: 526 R: 96.96% *PIP suspended*	N: 527 D: 539 R: 97.77%	N: 179 D: 183 R: 97.81%
Intervention #3b to address barrier: Provider Outreach: Provide PCP education to include prior authorization is not required for Epclusa generic and applicable billing guidelines for HCV DAA agents and Medicaid reimbursement. **Planned Start Date:** 3/1/2020 **Actual Start Date**: 9/1/2020	**Intervention #3b tracking measure:** **N:** # of providers outreached by Provider Network and provided education/resource materials for generic Epclusa availability without PA, billing/ reimbursement guidelines **D:** # of providers targeted for outreach	**Outreach set to begin 3/1 but was delayed; COVID restrictions mid-March.*	*PIP suspended*	N: 95 D: 636 R: 14.94%	N: 126 D: 636 R: 19.81%
Barrier 4: Members must voluntarily agree to Case Management to benefit from available plan support/resources. **Method of barrier identification: Plan assessment of internal case management barriers**		**2020**			
		Q1	**Q2**	**Q3**	**Q4** *(Partial)*
Intervention #4 to address barrier: CM Outreach: Increase members enrolled in CM through targeted CM outreach and strategic care coordination for identified members with HCV. **Planned Start Date:** 3/1/2020 **Actual Start Date**: 7/1/2020	**Intervention #4 tracking measure:** **N:** # of HCV members targeted that agreed to CM services **D:** # of HCV members targeted for CM outreach	**Outreach set to begin 3/1 but was delayed; COVID restrictions mid-March.*	*PIP suspended*	N: 3 D: 286 R: 1.05%	N: 0 D: 2,210 R: 0.00%

Barrier 5: Member compliance with course of pharmaceutical treatment (length of treatment, adverse symptoms/side effects, lack of support) **Method of barrier identification: Plan assessment of internal case management and pharmacy observed barriers**		**2020**			
		Q1	**Q2**	**Q3**	**Q4** *(Partial)*
Intervention #5a to address barrier: Enhanced case management/ongoing outreach to support members through course of therapy. **Planned Start Date:** 7/1/2020 **Actual Start Date**: 7/1/2020	**Intervention #5a tracking measure:** **N:** # of members receiving treatment outreached by CM/provided ongoing support/services **D:** # members with SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) dispensed	*Outreach set to begin 3/1 but was delayed; COVID restrictions mid-March.	*PIP suspended*	N: 72 D: 527 R: 13.66%	N: 29 D: 179 R: 16.20%
Intervention #5b to address barrier: Treatment completion: Member compliance with course of treatment as prescribed. **Planned Start Date:** 3/1/2020 **Actual Start Date**: 3/1/2020	**Intervention #5b tracking measure :** **N:** # Members completing prescribed medication therapy **D:** # Members prescribed treatment	N: 82 D: 201 R: 40.80%	N: 202 D: 294 R: 68.71%	N: 298 D: 412 R: 72.33%	N: 431 D: 592 R: 72.80%

Results

To be completed upon Baseline, Interim and Final Report submissions. The results section should present project findings related to performance indicators. ***Do not*** interpret the results in this section.

Table 5: Results

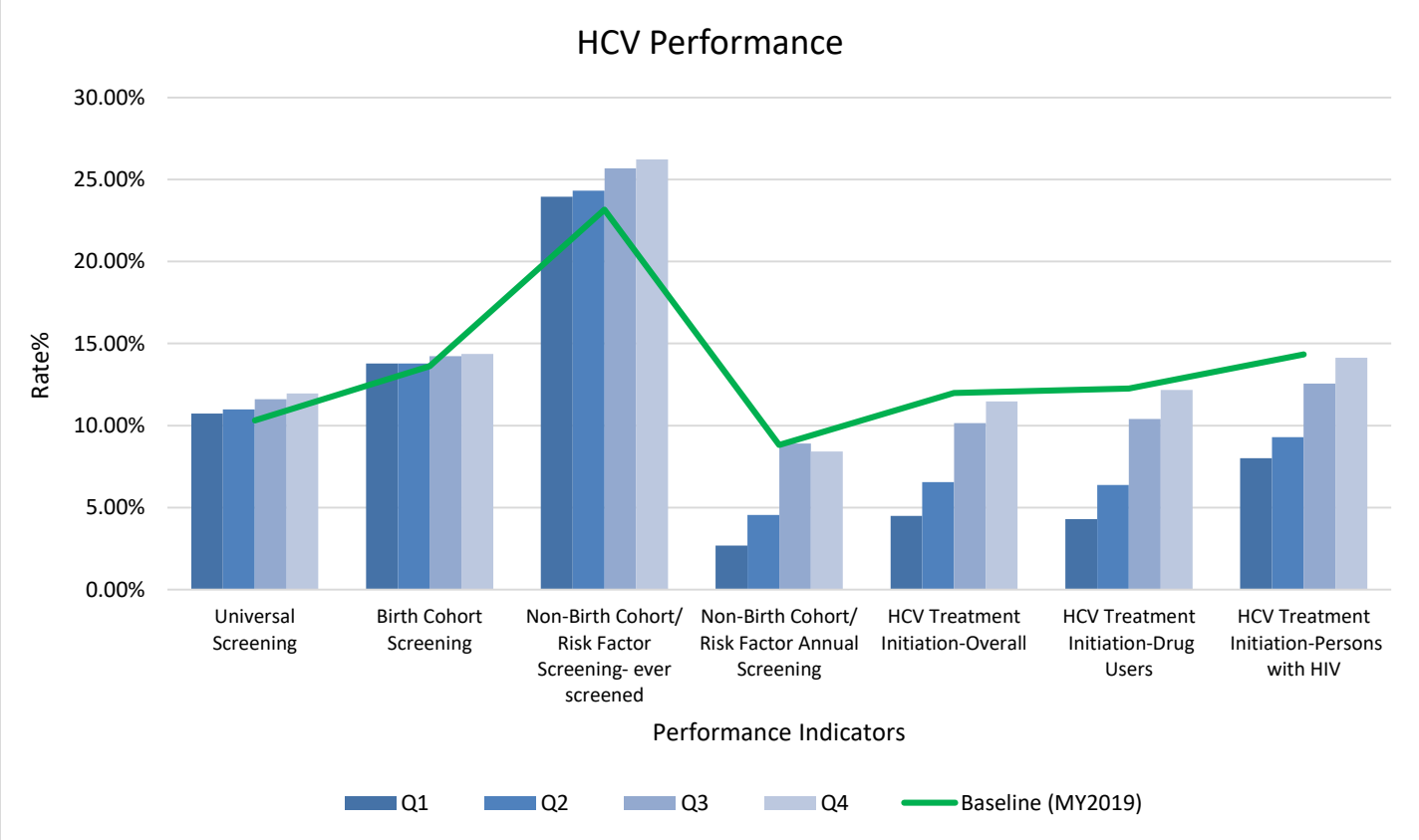
Indicator	Baseline Period Measure period: 1/1/19-6/30/19 **prior to LA HCV treatment benefit*	Updated Baseline Measure period: 1/1/19-12/31/19	Final Period Measure period: 1/1/20-12/10/20	Target Rate[1]
Performance Indicator #1a (Universal Screening): *The percentage of Healthy Louisiana enrollees ages 18-79 years {denominator} who were ever screened for HCV {numerator}.*	N: 36,503 D: 385,873 R: 9.46%	N: 41,207 D: 399,868 R: 10.31%	N: 51,556 D: 430,990 R: 11.96%	Rate: 20.31%
Performance Indicator #1b (Birth Cohort Screening): *The percentage of Healthy Louisiana enrollees for whom HCV screening is indicated by birth year between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.*	N: 8,601 D: 66,387 R: 12.96%	N: 9,405 D: 69,110 R: 13.61%	N: 10,803 D: 75,232 R: 14.36%	Rate: 23.61%
Performance Indicator #2a (Non-Birth Cohort/Risk Factor Screening-ever screened): *The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk*	N: 5,265 D: 24,231 R: 21.73%	N: 6,298 D: 27,193 R: 23.16%	N: 8,512 D: 32,455 R: 26.23%	Rate: 33.16%

Indicator	Baseline Period Measure period: 1/1/19-6/30/19 **prior to LA HCV treatment benefit*	Updated Baseline Measure period: 1/1/19-12/31/19	Final Period Measure period: 1/1/20-12/10/20	Target Rate[1]
factors other than being born between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.				
Performance Indicator #2b (Non-Birth Cohort/Risk Factor Screening-Annual Screening): *The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were screened during the measurement year for HCV {numerator}.*	N: 1216 D: 24,231 R: 5.02%	N: 2399 D: 27,193 R: 8.82%	N: 2,733 D: 32,455 R: 8.42%	Rate: 18.82%
Performance Indicator #3a (HCV Treatment Initiation-Overall): *The percentage of all adults (ages 18 and older) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.*	N: 20 D: 4982 R: 0.40%	N: 622 D: 5189 R: 11.99%	N: 592 D: 5,161 R: 11.47%	Rate: 21.99%

Indicator	Baseline Period Measure period: 1/1/19-6/30/19 **prior to LA HCV treatment benefit*	Updated Baseline Measure period: 1/1/19-12/31/19	Final Period Measure period: 1/1/20-12/10/20	Target Rate[1]
Performance Indicator #3b (HCV Treatment Initiation-Drug Users): *The percentage of the subset of adults with current or past drug use and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.*	N: 6 D: 1331 R: 0.45%	N: 241 D: 1967 R: 12.25%	N: 354 D: 2,907 R: 12.18%	Rate: 22.25%
Performance Indicator #3c (HCV Treatment Initiation-Persons with HIV): *The percentage of the subset of adults ever diagnosed with HIV and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.*	N: 2 D: 246 R: 0.81%	N: 37 D: 258 R: 14.34%	N: 41 D: 290 R: 14.14%	Rate: 24.34%

[1] Upon subsequent evaluation of quarterly rates, consideration should be given to improving the target rate, if it has been met or exceeded at that time.

The graph below is a visual representation of HCV performance indicators compared to the MY2019 baseline.



Discussion

To be completed upon Interim/Final Report submission. The discussion section is for explanation and interpretation of the results.

Discussion of Results

Interpret the performance indicator rates for each measurement period, *i.e., describe whether rates improved or declined between baseline and interim, between interim and final and between baseline and final measurement periods.*

Analysis of screening and treatment indicator performance demonstrated improved screening for HCV, while initiation of pharmaceutical treatment was below prior year baseline despite expanded coverage for antiviral therapy and targeted interventions to engage and support members. Though some improvements were noted over baseline, none of the performance indicators met the established 10 percentage point improvement target established. Interruption in PIP activities due to COVID-19 pandemic is attributed to the plan's limited impacts in these initiatives. A synopsis of performance indicator outcomes is provided below:

Screening indicators (universal, birth, and risk factor/ever screened) increased from the MY2019 baseline, with the risk factor/even screened subgroup showing the most notable increase. The risk factor/annual screening subgroup did not improve as initially projected.

Screening indicators demonstrating the percentage of Healthy Louisiana enrollees for whom HCV screening is indicated and who were ever screened for HCV - outcomes across the following subgroups:

- Indicator #1a Universal Screening for enrollees 18-79 years increased 1.65 percentage points over baseline; YTD screening increased 1.24 percentage points from Q1.
- Indicator #1b Birth Cohort screening for enrollees born between 1945 and 1965 increased 0.75 percentage points over baseline; YTD screening increased 0.58 percentage points from Q1.
- Indicator #2a Non-Birth Cohort/Risk Factor Screening for enrollees 18 and older with one or more risk factors other than age cohort (ever screened) increased 3.07 percentage points over baseline; YTD screening increased 2.28 percentage points from Q1.
- Indicator #2b Non-Birth Cohort/Risk Factor Screening for enrollees 18 and older for one or more risk factors other than being born between 1945 and 1965 (annual screening) decreased 0.40 percentage points from baseline; YTD screening increased 5.73 percentage points from Q1.

Treatment indicators for all subgroups (overall, past/current drug use, HIV) have increased consistently from Quarter 1 through the end of the year, but have not exceeded baseline MY2019 rates. Treatment for the subgroup of members with past or current drug use had the most notable increase.

Treatment indicators demonstrating the percentage of LHCC enrolled adults (ages 18 - 79) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing for whom pharmaceutical treatment for HCV was initiated - outcomes across the following subgroups:

- Indicator #3a HCV Treatment Initiation-Overall rates (adults 18 -79) were 0.52 percentage points below baseline; YTD initiation increased 6.99 percentage points from Q1.
- Indicator #3b HCV Treatment Initiation-Drug Users: subset of adults with current or past drug use was 0.07 percentage points below baseline; YTD initiation increased 7.89 percentage points from Q1.
- Indicator #3c HCV Treatment Initiation-Persons with HIV: subset of adults ever diagnosed with HIV was 0.20 percentage points below baseline; YTD initiation increased 6.14 percentage points from Q1.

Explain and interpret the results by reviewing the degree to which objectives and goals were achieved. *Use your ITM data to support your interpretations.*

LHCC engaged a multidisciplinary team to support this HCV initiative and collaborate on impactful interventions to improve HCV screening and treatment. In particular, Case Management and Provider Network teams have worked diligently to improve outcomes through member and provider outreach and education, expanding access to information and resources, and modifying interventions and processes as needed. LHCC continues to explore barriers in member contact and engagement as well as provider education and awareness needs, with ongoing collaboration across disciplines to explore alternate mitigation strategies and improvement opportunities.

LHCC care management teams have made diligent efforts to outreach all members in the HCV population in order to provide education regarding HCV screening recommendations, plan benefits, and HCV treatments available; additionally, CM outreach efforts included offering support and resources, including assistance to schedule to appointment to follow-up on previous positive results and/or prior treatment when indicated. Direct mail campaigns were initiated to supplement telephonic outreach. The number of members not receiving treatment trended downward each month through September of MY2020.

Analysis of case management outreach results indicated members previously enrolled in case management services were significantly more engaged with outreach activities, while members on the OPH list not previously enrolled in case management were more difficult to contact and less responsive to efforts to engage them for follow-up and treatment. The data demonstrated that inability to contact members was a common and progressive barrier throughout 2020, initially impacted with the onset of COVID-19 and compounded with hurricane activity affecting several regions. Additionally, since member outreach resumed in July, results indicated more than 35 percent of members contacted reported prior HCV treatment initiation or completion, with an additional 10 percent preferring to schedule follow-up treatment independently, declining health plan assistance. The data further indicates that case management teams were able to successfully engage and support approximately 16 percent of members as they completed the treatment process. These supplemental findings were informative when considering the limited progress in outreach and support efforts as noted in the limited CM appointment scheduling rates.

Provider facing interventions were similarly impacted by COVID-19 and hurricane activities during 2020, with notable impact on outcomes. PIP activities were suspended in March as the pandemic was emerging in Louisiana, while provider operations and priorities were adapting to the evolving crisis and population impacts. Stay at home orders, restrictions on some health access activities such as elective procedures, and concerns for exposure risks influenced member activity patterns in general, with related impact on HCV efforts surrounding screening and treatment appointment scheduling and so on. As PIP's resumed in Q3, Provider outreach modalities were adapted to navigate the COVID limitations and exposure concerns while still promoting HCV initiatives, resources, and provider education needs. As interventions resumed in Q3, ITM data indicated live virtual Provider trainings for HCV screening, testing and treatment guidelines by Provider Consultants has been provided to nearly 15 percent of the provider network in Q3; these efforts continue through Q4 with 35 percent of provider groups receiving HCV information and resources at the time of submission.

Prescriber activity for generic Epclusa has been relatively consistent during MY2020 with 96-98 percent of members receiving the approved generic Epclusa over other available antiviral treatments. Monthly monitoring and review of authorization data for direct acting antiviral utilization reflected notable declines in the volume of Epclusa/all DAA prescriptions with the onset of COVID-19 in Q2, with pharmacy claims averaging 261 per month in Q1 and subsequent decline to an average of 172 monthly prescriptions in Q3 and 181 claims through October. Despite the decline in overall prescriptions, the rate of Epclusa utilization over other non-preferred DAA's remained favorable and indicative of provider adherence to the recommended treatment options for Medicaid members. Additionally, case management outreach and education regarding treatment improved treatment outcomes; member completion of the treatment regimen increased steadily from 40.8 percent to 72.8 percent since Q1.

What factors were associated with success or failure? *For example, in response to stagnating or declining ITM rates, describe any findings from the barrier analysis triggered by lack of intervention progress, and how those findings were used to inform modifications to interventions.*

While significant challenges impacted the Case Management and Provider Network teams' provision of education and resources in the first half of 2020, these member and provider interventions resumed in Q3 with favorable impact noted. In particular, initiatives related to the utilization and completion of therapy with the preferred approved generic Epclusa, namely 3A, 5A and 5B, showed improvement as provider outreach efforts continued. ITM 3A, utilization of the preferred approved generic Epclusa, fell to 96.96 percent during Q2, but increased to 97.81 percent YTD. Similarly, ITM 5A related to outreach and support of members through the course of therapy increased from 13.66 percent 16.20 percent; and ITM 5B measuring completion of the course of therapy increased 32.0 percentage points YTD.

Several factors were identified as contributing to the limited progress with performance indicators and intervention outcomes. Significant member populations reflected in ITMs 1A and 2A for screening and treatment required a strategy for prioritizing outreach due to scope/volume. Expanding routine outreach efforts to incorporate automated systems for broader contact opportunity was recognized as positively impacting screening outreach initiatives with notable increase in contacts to the larger group of age cohort members for routine screening.

Beyond the scope of this HCV initiative, impacts from the onset of COVID-19 overall included member reluctance to schedule and/or attend appointments due to fear of exposure; similar concerns were raised with member utilization of transportation services. In an effort to address or overcoming these barriers, CM offered to assist members with making appointments (3-way calls with member, CM and MD office), promoted the option for telehealth visits (if member preferred), and explained the benefits of treating/eradicating HCV. COVID-19 also resulted in a decline in overall RX claims, including decline in DAA claims (including AG Epclusa) from the onset of COVID that has shown minimal improvement through the remainder of the measurement period.

Ambiguity of member treatment history due to variation between OPH information and member/provider reported status and the potential for erroneous disclosure to members unaware of HCV diagnosis prompted additional validation measures during member encounters to reduce disclosure risks. In addition, opportunity was noted for deeper inquiry with members reporting historical diagnosis but no treatment – or members with treatment years back but potential for re-exposure. Feedback from members reporting prior treatment revealed some perceptions that their condition had been managed or resolved, prompting them to decline CM services/support. This resulted in missed opportunity to provide education related to HCV risk factors including potential for reinfection, and the importance of maintaining physician relationships and annual wellness visits. Revised scripting/queries were developed with some success in mitigating these threats and resulted in additional information that brought value to the assessment of member status, history and needs. Unfortunately the limited response to member outreach attempts did not allow for sufficient interaction to engage in this level of inquiry on a broad level. The enhanced inquiry scripts were incorporated into outreach efforts and will continue as the HCV initiatives continue on. Additional improvements were achieved through dedicating case management and health care coordinators as designated HCV outreach staff to allow closer monitoring of process, fluency of outreach, and consistency in scripting.

Provider awareness of updated screening recommendations by USPSTF, removal of prior authorization requirements for generic Epclusa, and availability of provider toolkits/treatment algorithms were core areas of opportunity for targeted intervention as reflected by ITM 3B. Initial distribution of resource materials and collaterals including screening and treatment algorithms were disseminated online (website, blogs, social media) and posted to the LHCC online portal for direct access. As provider visits transitioned to virtual encounters, review and promotion of these resources were incorporated into live virtual provider visits as well as mail distribution when indicated. The Provider network team continues to deliver these resources, with 35 percent of provider groups receiving the resources in latter half of 2020. With the interruption of PIP activities and continued decline in member access and engagement in care activities during the pandemic, translation of improved provider awareness into measure outcomes has opportunity for further improvement. Continued monitoring of these interventions will allow better evaluation of impact and opportunity for adaptation as needed to achieve goals.

Adverse impacts on measure achievement were largely attributed to the challenges with contacting and engaging members as well as providers, as reflected in intervention outcomes including ITMs 1A, 2A, 4A and 5A, In Q1, CM outreach to schedule treatment appointments began with a smaller study of members on the OPH list who were already enrolled in CM. The response to this initial group was favorable and over 35 percent of these members were assisted to schedule an appointment. In Q3 and Q4, there was a significant decrease in

successful outreach with the expanded target group which broadened the focus to the remainder of members on the OPH list. Rates of appointments scheduled declined to 0.82 percent in members not previously enrolled in case management, further supporting the value of case management engagement and intervention through establishing communications and relationships with members,

There was consideration that the impacts on communications and outreach modalities may contribute to member and provider 'outreach fatigue' secondary to the volume of outreach efforts related to COVID-19, multiple hurricane safety preparedness campaigns, and continuity of care efforts in recent months which is substantiated by the declining rate of appointments scheduled (ITM 1A) from 0.82 percentage points in Q1 to 0.13 percentage points through (partial) Q4. Screening appointments (ITM 2A) during this same time frame remained below 1 percent, with a slight rate increase from 0.76 percentage points to 0.79 percentage points through (partial) Q4. Member and provider safety and wellness remained primary focus in accordance with LDH guidance and automated outreach services and virtual communication methods were employed to facilitate communication with members and providers. Ongoing evaluation of these interventions also revealed potential for provider abrasion, noting that providers may be receiving multiple communications and varied resource materials across all MCO's. An opportunity to align or designate consistent resources and promote unified messaging in alignment with LDH goals was recognized and collaborative discussions with MCO quality, LDH, and IPRO representatives were initiated in October to explore shared barriers and consider potential alignment of efforts to reduce duplication and minimize provider abrasion.

Limitations
As in any population health study, there are study design limitations for a PIP. Address the limitations of your project design, i.e., challenges identified when conducting the PIP (e.g., accuracy of administrative measures that are specified using diagnosis or procedure codes are limited to the extent that providers and coders enter the correct codes; accuracy of hybrid measures specified using chart review findings are limited to the extent that documentation addresses all services provided).

Were there any factors that may pose a threat to the internal validity the findings?
Definition and examples: internal validity means that the data are measuring what they were intended to measure. For instance, if the PIP data source was meant to capture all children 5-11 years of age with an asthma diagnosis, but instead the PIP data source omitted some children due to inaccurate ICD-10 coding, there is an internal validity problem.

No internal validity issues were noted; however, there was a revision in the reporting of select performance measure data from quarterly to cumulative to better reflect progress in rates as discussed with IPRO.
Potential threats to the internal validity of the findings were considered, including case management ITM data accuracy due to variation in staff documentation of member engagement outcomes and the inherent limitations of episodic documentation by case managers.

Were there any threats to the external validity the findings?
Definition and examples: external validity describes the extent that findings can be applied or generalized to the larger/entire member population, e.g., a sample that was not randomly selected from the eligible population or that includes too many/too few members from a certain subpopulation (e.g., under-representation from a certain region).

No external threats were identified; however, potential threats to the external validity of the findings may include provider accuracy in coding/documentation practices and resulting impact on the validity of administrative measure rates.

Describe any data collection challenges.
Definition and examples: data collection challenges include low survey response rates, low medical record retrieval rates, difficulty in retrieving claims data, or difficulty tracking case management interventions.

The primary challenge to data collection was the ability the successfully outreach members in order to assess and collect relevant information to guide interventions. Expanding the outreach efforts was a continual process - engaging the automated dialing system and incorporating multiple outreach methods to increase connection to members.

Member feedback and scheduling barrier information collected during successful outreach was reviewed and analyzed cumulatively to monitor for major themes. A significant number of members outreached for linkage to treatment reported that treatment was previously initiated or completed prior to outreach. In these instances there was not an opportunity for linkage of treatment in order to impact case management interventions. Similarly, a portion of members outreached successfully had declined assistance from case management staff and/or expressed a preference to schedule follow-up appointments independently. Again, in these instances, there was not an opportunity to collect data reflective of case management intervention. Another small number of members successfully contacted were unaware of a positive HCV result in their medical history, and therefore declined intervention thus impacting case management intervention data collection.

Next Steps

This section is completed for the Final Report. *For each intervention, summarize lessons learned, system-level changes made and/or planned, and outline next steps for ongoing improvement beyond the PIP timeframe.*

Table 6: Next Steps

Description of Intervention	Lessons Learned	System-Level Changes Made and/or Planned	Next Steps
CM Outreach: Enhanced Case Management Outreach for HCV Screening	Population size/volume has proven labor intensive to outreach; member response limited in comparison to volume of outreach attempts.	Expanded routine CM outreach to include automated telephonic support for increased contacts. Planned vendor evaluations for potential addition of expanded SMS/texting capabilities.	Continued case management outreach and supplemental outreach methods; exploration of alternative methods to outreach populations and better engage members via preferred communication methods. Exploring addition of HCV screening care gap flags to customer service systems and provider portals.
CM Outreach: Enhanced Case Management Outreach for HCV Treatment Initiation CM Outreach: Increase members enrolled in CM through targeted CM outreach and strategic care coordination for identified members with HCV. CM Outreach: Enhanced case management/ ongoing outreach to support members through course of therapy. Treatment completion: Member compliance with	Members not previously enrolled in CM services are more difficult to outreach successfully. Member response limited in comparison to volume of outreach attempts. Inconsistent availability of information regarding treatment history; 1/3 of members outreached successfully had reported completing treatment previously. COVID-19 impact on appointment adherence as well as prescription compliance.	Expanded routine CM outreach to include automated telephonic support for increased contacts. CM outreach – additional inclusion of information about alternative resources including telehealth, reinforcing COVID prevention strategies including social distancing/social support. Incorporated alert into clinical documentation software for enhanced member recognition for	Continued case management outreach and supplemental outreach methods; exploration of alternative methods to outreach populations and better engage members via preferred communication methods. Continue to promote telehealth options, reinforcing COVID prevention strategies including social distancing/ social support. Exploring addition of HCV care gap flags to

Description of Intervention	Lessons Learned	System-Level Changes Made and/or Planned	Next Steps
course of treatment as prescribed.		HCV engagement/ outreach. Planned vendor evaluations for potential addition of expanded SMS/texting capabilities.	customer service systems and provider portals.
Provider Outreach: Provide PCP's with customized list of members for whom HCV screening is indicated by birth year between 1945 and 1965.	Potential for claims lag – delay in member screening status updates. Technological limitations for revision of current provider portal measure build to add HCV to existing logic/reporting system.	Updated HCV collaterals to reflect USPSTF revisions for screening to include members 18-79 years of age. Planned incorporation of HCV screening care gaps into routine provider care gap reporting.	Distribution of custom provider gap list pending confirmation of system capabilities for incorporation of HCV screening into existing provider portal/ automated reporting systems.
Provider Outreach: Provider education regarding SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) prescription. Provider Outreach: Provide PCP education to include prior authorization is not required for Epclusa generic and applicable billing guidelines for HCV DAA agents and Medicaid reimbursement.	Limited provider awareness of ongoing HCV initiatives and treatment algorithms/ available guidance. PCP comfort level with prescribing treatment for HCV – deference to specialty providers. Pandemic and hurricane impacts on Provider ability to schedule and/or attend offered education was limited.	LHCC provider guidance/resource collaterals including provider toolkit, treatment algorithms, updated and posted to online resource library. Transitioned from traditional in person provider office visits to virtual encounters to maintain provider relations and support; incorporated review and promotion of HCV initiative/collaterals.	Continue to promote HCV screening/ treatment initiatives during virtual provider visits. Expanding on-demand vs live virtual options for convenient scheduling is also being explored to meet provider needs. HCV screening indicator added to LDH performance monitoring indicators; add to routine quality reporting for continued focus.

References

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United States Preventive Services Task Force. Screening for Hepatitis C Virus Infection in Adults: U.S. Preventive Services Task Force Recommendation Statement. Ann Intern Med. 2013; 159:349-357.

Table A: **Current or past injection drug use** (any one or more of diagnosis codes or diagnosis code combinations in this table, not restricted to place of service and not restricted to principal or primary diagnosis; note: a limitation of this measure is that ICD-9 and 10 codes do not specify injection vs. other route)

ICD-9 code or code combination	ICD-10 code or code combination	Description
	F11-	Opioid related disorders (Hyphen indicates that all codes within F11 should be included. This applies to all other ICD-10 and ICD-9 codes with hyphens that are listed in this table, as well.)
304.0-		Opioid dependence
304.7-		Opioid combined with other drug dependence
	F14-	Cocaine related disorders
304.2-		Cocaine dependence
	F15-	Other stimulant related disorders
304.4-		Amphetamine and other psychostimulant dependence
V69.8 AND 304.91		(other problems related to life style) AND (unspecified drug dependence continuous)
	Z72.89 AND F19.20	(other problems related to life style) AND (other psychoactive substance abuse, uncomplicated)

Table B. Persons ever on long term hemodialysis (any one or more of diagnosis codes in this table, not restricted to place of service and not restricted to principal or primary diagnosis)

ICD-9 code	ICD-10 code	Description
	Z49-	Encounter for care involving renal dialysis (Hyphen indicates that all codes within Z49 should be included. This applies to all other ICD-10 and ICD-9 codes with hyphens that are listed in this table, as well.)
	Z99.2	Dependence on renal dialysis
V4511		Dependence on renal dialysis
V560 or V561 or V562 or V5631 or V5632 or V568		Encounter for care involving renal dialysis

Table C. Persons who were ever incarcerated (any one or more of diagnosis codes in this table, not restricted to place of service and not restricted to principal or primary diagnosis)

ICD-9 code	ICD-10 code	Description
	Z65.1	Imprisonment and other incarceration
	Z65.2	Problems related to release from prison

Table D. Persons ever diagnosed with HIV infection. (any one or more of diagnosis codes in this table, not restricted to place of service and not restricted to principal or primary diagnosis)

ICD-9 code	ICD-10 code	Description
	B20	Human immunodeficiency virus (HIV) disease
042		Human immunodeficiency virus (HIV) disease
	Z21	Asymptomatic human immunodeficiency virus (HIV) infection status
V08		Asymptomatic human immunodeficiency virus (HIV) infection status

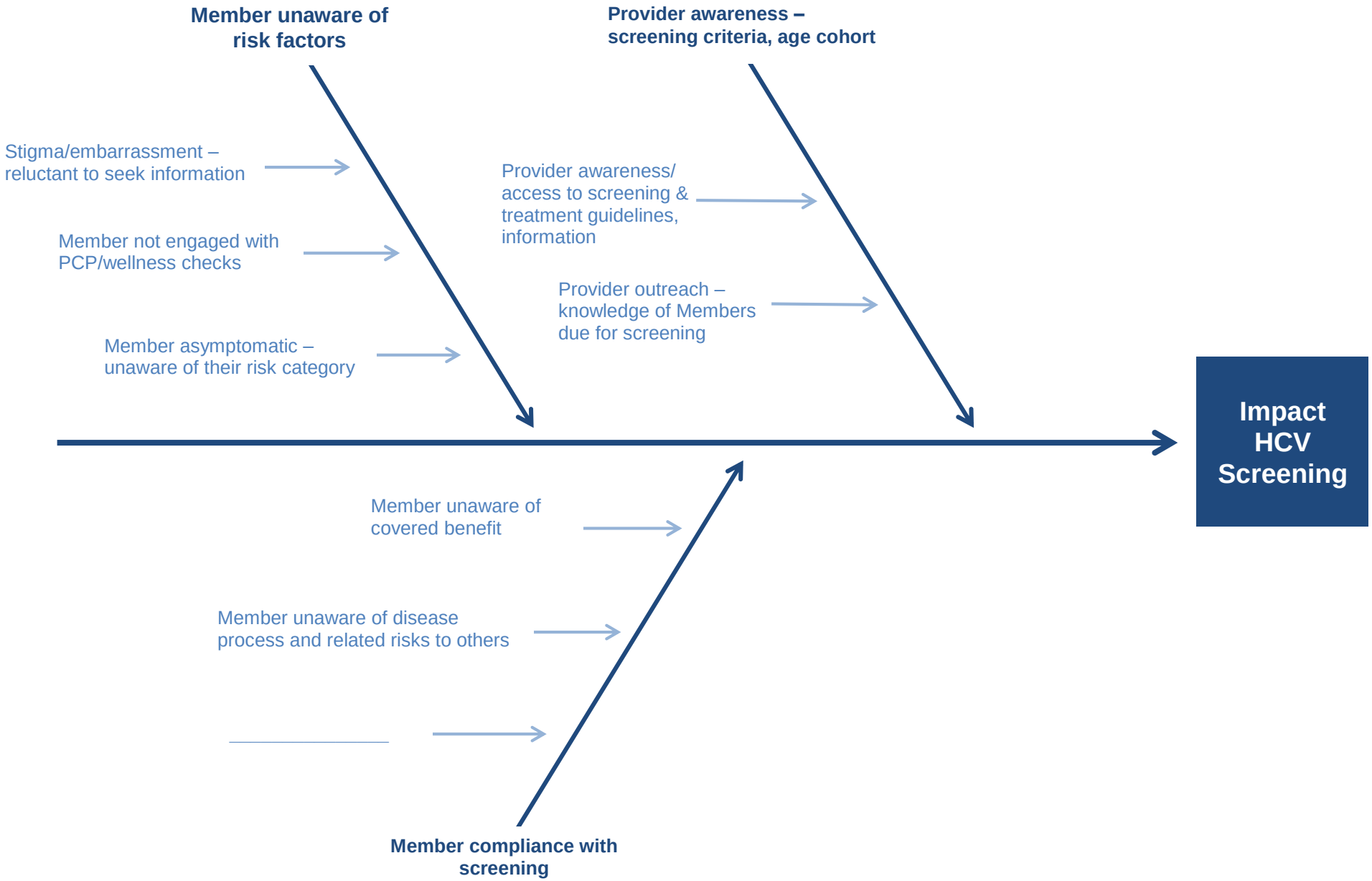
Glossary of PIP Terms

Table 7: PIP Terms

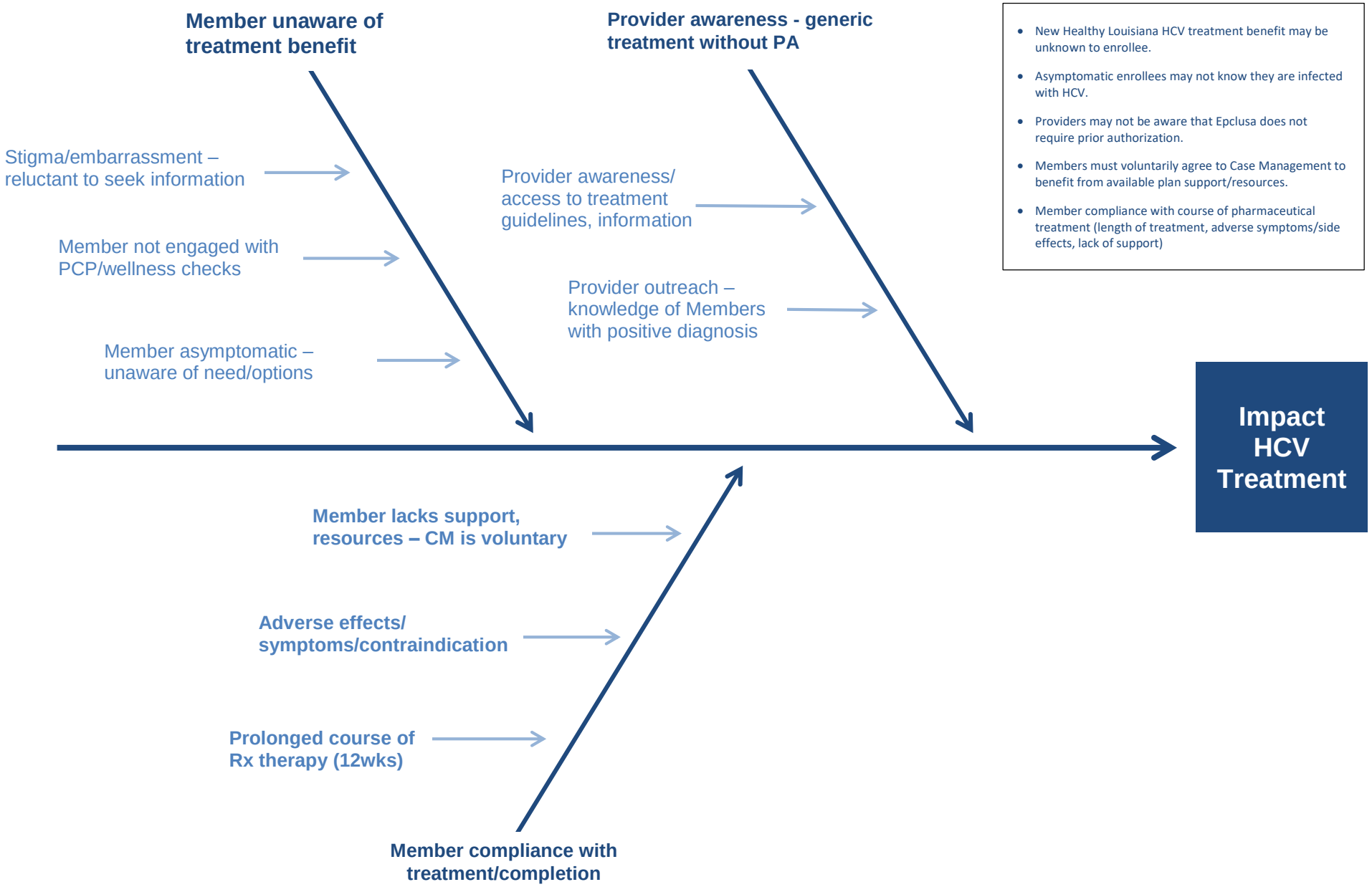
PIP Term	Also Known as…	Purpose	Definition
Aim	• Purpose	To state what the MCO is trying to accomplish by implementing their PIP.	An aim clearly articulates the goal or objective of the work being performed for the PIP. It describes the desired outcome. The Aim answers the questions "How much improvement, to what, for whom, and by when?"
Barrier	• Obstacle • Hurdle • Road block	To inform meaningful and specific intervention development addressing members, providers, and MCO staff.	Barriers are obstacles that need to be overcome in order for the MCO to be successful in reaching the PIP Aim or target goals. The root cause (s) of barriers should be identified so that interventions can be developed to overcome these barriers and produce improvement for members/providers/MCOs. A barrier analysis should include analyses of both quantitative (e.g., MCO claims data) and qualitative (such as surveys, access and availability data or focus groups and interviews) data as well as a review of published literature where appropriate to root out the issues preventing implementation of interventions.
Baseline rate	• Starting point	To evaluate the MCO's performance in the year prior to implementation of the PIP.	The baseline rate refers to the rate of performance of a given indicator in the year prior to PIP implementation. The baseline rate must be measured for the period before PIP interventions begin.
Benchmark rate	• Standard • Gauge	To establish a comparison standard against which the MCO can evaluate its own performance.	The benchmark rate refers to a standard that the MCO aims to meet or exceed during the PIP period. For example, this rate can be obtained from the statewide average, or Quality Compass.
Goal	• Target • Aspiration	To establish a desired level of performance.	A goal is a measurable target that is realistic relative to baseline performance, yet ambitious, and that is directly tied to the PIP aim and objectives.
Intervention tracking measure	• Process Measure	To gauge the effectiveness of interventions (on a quarterly or monthly basis).	Intervention tracking measures are monthly or quarterly measures of the success of, or barriers to, each intervention, and are used to show where changes in PIP interventions might be necessary to improve success rates on an ongoing basis.

PIP Term	Also Known as…	Purpose	Definition
Limitation	• Challenges • Constraints • Problems	To reveal challenges faced by the MCO, and the MCO's ability to conduct a valid PIP.	Limitations are challenges encountered by the MCO when conducting the PIP that might impact the validity of results. Examples include difficulty collecting/ analyzing data, or lack of resources / insufficient nurses for chart abstraction.
Performance indicator	• Indicator • Performance Measure (terminology used in HEDIS) • Outcome measure	To measure or gauge health care performance improvement (on a yearly basis).	Performance indicators evaluate the success of a PIP annually. They are a valid and measurable gauge, for example, of improvement in health care status, delivery processes, or access.
Objective	• Intention	To state how the MCO intends to accomplish their aim.	Objectives describe the intervention approaches the MCO plans to implement in order to reach its goal(s).

Appendix A1: Fishbone (Cause and Effect) Diagram



Appendix A2: Fishbone (Cause and Effect) Diagram



Appendix B: Priority Matrix*

Which of the Root Causes Are . . .	Very Important	Less Important
Very Feasible to Address	• Awareness of HCV status; (establish data sourcing for identification of members in at risk categories for screening outreach) • Prioritization of members for proactive outreach vs ongoing CM support (review available OPH data for initiation of outreach) • Provider engagement in education and implementation of clinical guidelines	
Less Feasible to Address	• Face to Face engagement of Providers – geographic scope • Stigma limiting member engagement in screening and/or treatment services	

Appendix C: Strengths, Weaknesses, Opportunities, and Threats (SWOT) Diagram

	Positives	**Negatives**
INTERNAL ***under your control***	***build on*** **STRENGTHS** • Pharmacy identification/reporting of members on treatment already in place; partnering with CM to share member lists to initiate outreach. • Community Health Workers in place; have ability to expand their services to support face to face intervention if feasible. • Plan and department leadership engagement and support of PIP initiative • Education/resource availability, online distribution and access platforms	***minimize*** **WEAKNESSES** • CM currently only outreaching to members on medication therapy; additional resource allocation needed to expand outreach • Unknown frequency of OPH data updates • Provider Outreach/dissemination of member lists – HIPAA caution, provider reluctance to access secure portals – seek alternative options to compliantly deliver value added information to providers
EXTERNAL ***not under your control, but can impact your work***	***pursue*** **OPPORTUNITIES** • Consider ease of access to information resources; currently provider portal is log in access – expand to a HCV focus site to promote LDH/LA program materials • Inquire – is LDH considering a custom measure for any of these risk categories/populations? (would ensure standardization/consistency in data)	***protect from*** **THREATS** • Provider reluctance to log into available portal (access to resources) • Member intolerance/adverse reaction or contraindication to generic approved medication (rebate available) • Regional/geographic scope – ability for face to face outreach for both member and providers across all regions

Appendix D: Driver Diagram

Aims	Primary Drivers	Secondary Drivers	Specific Ideas for Interventions to Test/ Implement (Change Concepts)
Aim 1. Increase the HCV screening rates among Healthy Louisiana adults at risk for HCV by 10 percentage points from CY 2019 to CY 2020.	PCPs screen the following high risk Healthy Louisiana adults for HCV antibody: a. Beneficiaries born between the years 1945 and 1965 b. Beneficiaries with Current or past injection drug use c. Beneficiaries ever on long term hemodialysis d. Persons who were ever incarcerated e. Beneficiaries with HIV infection	Educate PCPs about evidence-based guidelines (EBGs) for HCV screening: -U.S. Preventive Service Task Force Guidelines -American Association for the Study of Liver Diseases (AASLD)/ Infectious Diseases Society of America (IDSA). -Office of Public Health streamlined test and treat strategy (forthcoming) -Medicaid reimbursable CPT/HCPCS codes	-Notify providers regarding Provider Portal access to HCV EBGs -Medical Director and Provider Relations face-to-face Outreach for Education -Incorporate USPSTF and AASLD/IDSA HCV screening guidelines into Clinical Practice Guideline repository -Disseminate Office of Public Health streamlined test and treatment strategy (forthcoming) -Develop and disseminate billing guidelines for HCV screening and Medicaid reimbursement - Encourage providers to participate in OPH-provided HCV treatment training [this covers screening as well]
		Identify adult members at risk for HCV	-Utilize HCV PIP specifications to identify at risk members using historical and current claims -Develop PCP lists of members eligible for screening -Develop Care Coordinator lists of members eligible for HCV screening
		Inform PCPs of their patients who are at risk/ eligible for screening	-Distribute to each PCP their listing of eligible members with instructions to contact patients to schedule an appointment for HCV screening
		Educate at risk members about HCV screening	-Care Coordinators Outreach, educate and counsel members at risk who are eligible for HCV screening
		Refer at risk members to PCPs and facilitate appointment scheduling for HCV screening	-Care Coordinators refer and schedule appointments with PCPs for HCV screening

Aims	Primary Drivers	Secondary Drivers	Specific Ideas for Interventions to Test/ Implement (Change Concepts)
Aim 2. Increase the HCV pharmaceutical treatment initiation rate among Healthy Louisiana adults ever diagnosed with HCV by 10 percentage points from CY 2019 to CY 2020.	HCV Providers identified in the OPH database (e.g., gastroenterologists, infectious disease specialists) and/or PCPs prescribe LDH-approved Hepatitis C Virus Direct Acting Antiviral Agent {DAA} for beneficiaries diagnosed with HCV	Educate PCPs about evidence-based guidelines (EBGs) for HCV diagnosis and treatment: -Office of Public Health streamlined test and treat guideline -American Association for the Study of Liver Diseases (AASLD)/ Infectious Diseases Society of America (IDSA).	-Provider Portal notification regarding access to HCV EBGs -Medical Director and Provider Relations face-to-face Outreach for Education -Incorporate the Office of Public Health streamlined test and treat guideline into Clinical Practice Guideline repository -Educate providers that prior authorization is not required for Epclusa generic for any Medicaid member -Develop and disseminate billing guidelines for HCV DAA agents and Medicaid reimbursement -Disseminate existing LDH resources to providers, including (1) the DAA Agent Medication Therapy Worksheet, (2) the HCV Treatment Agreement for Louisiana Medicaid Recipients, and (3) the Louisiana Medicaid Hepatitis C Direct-Acting Antiviral (DAA) Agents criteria, and (4) Office of Public Health (OPH) streamlined test and treatment guideline. - Encourage providers to participate in OPH-provided HCV treatment training
		Foster collaboration between PCPs, behavioral health and HCV specialists	-Develop and implement new processes to facilitate communication and coordinate care between PCPs, behavioral health and HCV providers listed in the OPH database (e.g., gastroenterologists, infectious disease specialists)
		Identify all members diagnosed with HCV	-Utilize the Office of Public Health listing of members with probable or confirmed HCV PIP to identify members with HCV diagnosis -Collaborate with OPH to develop PCP-specific listings of their patients who are potential candidates for HCV treatment -Develop Care Coordinator lists of members with HCV diagnosis for referral to PCPs for treatment
		Inform PCPs of their patients with HCV	-Distribute to each PCP their listing of members with HCV for medical assessment of appropriate treatment and/or referral to/ coordination with HCV specialist for treatment
		Educate and refer members with HCV for treatment assessment	-Care Coordinators Outreach, educate, refer and schedule member's appointment with HCV provider on OPH listing or PCP for treatment assessment.

Appendix E: Plan-Do-Study-Act Worksheet (use power point template)

	Pilot Testing	Measurement #1	Measurement #2
Intervention #1:			
Plan: Document the plan for conducting the intervention.	□	□	□
Do: Document implementation of the intervention.	□	□	□
Study: Document what you learned from the study of your work to this point, including impact	□	□	□
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis	□	□	□
Intervention #2:			
Plan: Document the plan for conducting the intervention.	□	□	□
Do: Document implementation of the intervention.	□	□	□
Study: Document what you learned from the study of your work to this point, including impact	□	□	□
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	□	□	□