Health Plan Performance Improvement Project (PIP)

Health Plan: UnitedHealthcare LA (UnitedHealthcare Community Plan of Louisiana)

PIP Title: Improve Chronic Hepatitis C Virus (HCV) Pharmaceutical Treatment Initiation Rate

PIP Implementation Period: January 1, 2022-December 31, 2022

Submission Dates:

	Proposal/Baseline	Interim/Final
Version 1	1/31/2022	12/8/22
Version 2		12/29/22

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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[PERSON(S) RESPONSIBLE IN THE EVENT THAT THE PRINCIPAL CONTACT PERSON IS UNAVAILABLE]

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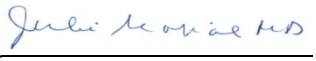
3. External Collaborators (if applicable):

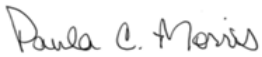
Attestation

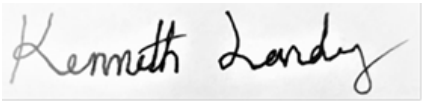
Plan Name: UnitedHealthcare Community Plan of Louisiana (UHCCP LA)
Title of Project: Improve Chronic Hepatitis C Virus (HCV) Pharmaceutical Treatment Initiation Rate

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

Medical Director signature: 
First and last name: Julie Morial, MD
Date:12/29/22

CEO signature: 
First and last name: Karl Lirette
Date: 12/29/22

Quality Director signature: 
First and last name: Paula Morris MSN, RN
Date: 12/29/22

IS Director signature (if applicable): 
First and last name: Kenny Landry
Date:12/29/22

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	Jan 2022	☒ Methodology ☐ Barrier Analysis ☐ Intervention ☐ Intervention Tracking Measure (ITM)	The leads of the HCV PIP noted when comparing the OPH listing from Jan 2022 to the October 2021 listing that there was significant member movement in and out of the health plan due to open enrollment. With this in mind, the PIP leads applied clinical, logically based exclusionary criteria and members were excluded from the performance indicator reporting if they met two criteria (member deemed cured by OPH and there was no historical pharmacy claims of HCV antivirals). The logic being that with a member deemed cured there is no actionable intervention that needs to occur and if the member is cured with no antiviral's pharmacy claims on file the member could have been either a legacy HCV historically cured case or have been treated while at another health plan. Members who termed eligibility from the health plan were also excluded. This exclusionary criterion was discussed with IPRO, and the health plan was advised to address the logic in this footnote as such and also apply the criteria retroactively back through 2021 to give more meaningful "apples to apples" comparison and thus tracking the projects progress. The Jan

			2022 OPH listing was received by our analytics team and criterion was applied retroactively back through 2021. New targets were adjusted accordingly. This change in measurement reporting methodology will also be addressed in the final reporting as well. Going forward UHCCP LA will apply this criterion to each subsequent quarter based on the most recent OPH listing on hand and will identify which listing correlates with subsequent quarters for more meaningful measurements, impactful tracking, and reporting purposes.
Change 2	January 2022	☐ Methodology ☐ Barrier Analysis ☒ Intervention ☒ Intervention Tracking Measure (ITM)	Discussions regarding the intervention surrounding the cojoined outreach of HCV members who are eligible for the COVID-19 Vaccine began in QTR1 of 2022 due to the continue provider and member feedback analysis. The received feedback indicated that the COVID-19 pandemic is still a concern in the minds of the HCV positive population, as the members are inherently immunocompromised. The lead of the HCV PIP identified a mutual need with the COVID-19 vaccine PIP leads to educate, advocate, and encourage the COVID-19 vaccine to the targeted HCV members. This conjoined message and provider joint listing outreach will meet the needs of two high priority PIPs and also meet the needs of the member. The clinical logic is that once vaccinated, the concern around the pandemic will decline and the member ideally will become more amenable to visiting their provider for HCV treatment.

			An additional ITM was developed to track any inferential correlation between vaccinated members and HCV treated members. Additional opportunities to partner with the COVID-19 vaccine PIP leads will occur through the duration of the project.
Change 3	January 2022	☐ Methodology ☒ Barrier Analysis ☒ Intervention ☐ Intervention Tracking Measure (ITM)	The health plan also identified, through provider feedback, that there is limited knowledge in the primary care setting around resources and supportive services for members with HCV and a diagnosis of HIV. UHCCP LA utilized an ACRN (certified HIV and AIDS certified Registered Nurse) in our provider education strategy. The ACRN developed an HIV provider toolkit to educate providers regarding HIV as well as a regional based referral listing of Ryan White available supportive services to distribute to providers. The ACRN utilized in this strategy works closely with our FQHCs and other providers as necessary as an available educational resource and to assist with any confounding factors.
Change 4	June 2022	☐ Methodology ☒ Barrier Analysis ☒ Intervention ☐ Intervention Tracking Measure (ITM)	Member informed barrier analysis continues to indicate that new members to the health plan may be unaware of benefits available to them. The health plan collaborated with regional pride activities to disseminate information regarding the availability of the programs accessible to members. June was Pride Month and to increase awareness of available programs in the community the health plan proudly and strategically implemented our "UNITED with Pride" series of community events. UHCCP LA collaborated with our

			marketing team and successfully worked with the New Orleans, Shreveport and Baton Rouge community Pride events. The health plan shared member information regarding multiple initiatives such as HCV treatment availability, informational transportation handouts, COVID-19 vaccine information, and colorectal screening information. This enabled information sharing to LGBTQ members and allies which served a need to increase member awareness with a historically disenfranchised population. These three events had a comprehensive attendance total of 4,000 attendees altogether. As a whole strategic plan, UHCCP LA plans to continue these partnerships and serve the needs of this community. Thus, increasing health care equity overall. The health plan will continue its outreach efforts to ensure linkage of care for the targeted HCV population.
Change 5	July 2022	☐ Methodology ☒ Barrier Analysis ☒ Intervention ☐ Intervention Tracking Measure (ITM)	The COVID-19 pandemic and restrictions surrounding the pandemic posed a barrier to the project by limiting member outreach to virtual and telephonic. With restrictions easing in 2022, the health plan was able to redeploy community health workers back into the field. As of July 2022, to supplement our efforts in member outreach and support the goals of the program to educate and encourage targeted HCV members to seek available treatment for HCV and assist with any confounding factors that could adversely affect the mitigating social department of health in an effort to overall

			benefit the member.

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.

Title of Project: Improve Chronic Hepatitis C Virus (HCV) Pharmaceutical Treatment Initiation Rate

Rationale for Project: The hepatitis C virus (HCV) is the most common blood-borne disease and the leading cause for liver transplant in the United States (LDH, 2019a). HCV infection can lead to serious health problems, including liver damage, cirrhosis (scarring of the liver), liver cancer, and even death. HCV prevalence in Louisiana is estimated at 1.6% to 1.8%. There is a marked higher rate among men and women aged 45-54 years of age, urban residents, and African American males aged 45-54 (LA OPH, 2015). Louisiana ranks fifth in the U.S. for HCV/HIV co-infection; an estimated 18% of individuals with HIV as a result of intravenous drug use are also diagnosed with HCV co-infection (LA OPH, 2015).

As of summer, 2019, Healthy Louisiana enrollees have access to safe and effective treatment for hepatitis C. The authorized generic (AG) to which they have access is Epclusa ®, which has proven effective in curing 95% of persons living with HCV (LDH, 2019a). Epclusa is the preferred direct-acting antiviral (DAA) and does not require prior authorization unlike other available treatment regimens (LA Medicaid, 2019).

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

Objectives:

1. **Member Intervention Objective**:
   a. For all eligible members on the OPH listing, outreach and educate members, and facilitate referrals to/schedule appointments with 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):
   b. Persons who use drugs
   c. Persons with HIV

2. **Provider Intervention Objective**: Educate providers on evidence-based recommendations (AASLD/IDSA, 2018) and availability of providers trained in HCV treatment, and coordinate referrals for treatment. Distribute member care gap reports to providers

Methodology:

The performance indicators for the study align with the guidance from the HCV PIP IPRO Guidance Document. For the indicators described, the eligible population includes members who have suspected or confirmed cases of HCV. The cases were identified via the listings from OPH as well as those that fall into high-risk cohort categories identified through stratified claims data. Pharmacy utilization data was also utilized as well as purposeful tracking of provider education.

Interventions:

Enhanced provider education through provider engagement activities, free continuing education credits, HCV clinician support line and engagement through provider facing staff with physicians regarding HCV treatment algorithms, generic Epclusa as the DAA drug of choice and supportive additional resources such as BH regional resource providers and toolkits for HCV and members with

confounding issues such as SUD or SMI. This will increase knowledge for front line providers and treatment options for members with HCV.

- Providers educated on appropriate coding for high-risk groups. This will provide a more in-depth accurate picture of the various confounding conditions of the HCV member and will assist the health plan on intervening accordingly and to proactively address the social determinants of health.
- Developed enhanced materials for case management to increase member engagement and knowledge around HCV diagnosis and treatment.
- Increase member outreach and advocacy for members with HCV or with a history of non-compliance with medication adherence and care through focused case management and outreach initiatives to increase member engagement for treatment.
- Provided education to providers, case management, quality management and utilization management to increase knowledge of generic Epclusa as the DAA drug of choice and has no prior authorization requirement.
- Integration of a BH partnership strategy with the BH PIP lead. Focused HCV provider education and training disseminated to targeted MAT providers, SUD Providers and ER facilities with high opioid presentations.
- Integration of a partnership strategy with the lead of the COVID-19 PIP. Focused HCV provider education and strategy of targeting members who are the highest at risk for disease exacerbation process by sharing of cojoined stratification list of members who need HCV treatment imitation and the COVID-19 vaccination.

Results:

All Performance indicators demonstrated noted improvement from baseline to final measurement year including, 1a) 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}, 1b) 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}, 1c) HCV Treatment Initiation-Persons with HIV: The percentage of the subset of adults ever diagnosed with HIV and a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}. Table 5 shows the measurements between the baseline and final year for each performance indicator.

Conclusions:

Education around HCV and interventions led to noted improvements in all three performance indicators, however the performance indicators did not meet the target ranges of 10 percent above the 2021 end of year baseline. It is however important to note demonstrative and significant improvement was made from the beginning of 2021 and to the current rate in 2022, which is detailed in the quarterly HCV report submissions. While most interventions made traction, several are still in progress and are continually evaluated regarding their successful impact of the target rates. The target rates for this project were based on a baseline of a full calendar year of 2021. There were only eleven months of data available for the final measurement period of this project of 2022. Additionally, the COVID-19 pandemic that occurred in 2020 and continued through 2022 contributed to an ongoing barrier. The significant national disaster of Hurricane Ida that occurred in 2021 which resulted in member displacement that carried a noteworthy challenge into a large part of 2022. The use of indicators as an accurate determination of effectiveness is also complicated by reporting and claims lag. There is limited provider knowledge in a PCP setting around appropriate screening and treatment of members with HCV and referral of members with BH issues or substance abuse disorders. Members are often diagnosed with little knowledge of resources available to assist with confounding factors. The health plan incorporated a BH integration strategy in 2021. UHCCP LA continued this strategy into 2022 with the leads of the BH PIP to target providers such as MAT providers, SUD providers, and ED facilities. The targeted outreach provided education regarding HCV screening and the treatment protocol. This collaborative strategy resulted in an increase in treatment of members with HCV and SUD. It also increased the number of members that fall into this category which in itself resulted in an increased

denominator for this subset. The health plan also identified, through provider feedback, that there is limited knowledge in the primary care setting around resources and supportive services with members with HCV and a diagnosis of HIV. With this in mind, the health plan utilized an ACRN (certified HIV and AIDS certified Registered Nurse) in our provider education strategy. The ACRN developed an HIV provider toolkit to educate providers regarding HIV as well as a regional based referral listing of Ryan White available supportive services to distribute to providers. The ACRN utilized in this strategy works closely with our FQHCs and other providers, as necessary, as an available educational resource and to assist with any confounding factors. In order to increase member and provider engagement, next steps include continuing close strategic partnerships with FQHC's who are equipped to address members with complex comorbidities as well as provide supportive CM supplementation, continue the health plan's BH integration strategy and utilization of the ACRN as a provider resource. Direct Provider feedback indicated a need for a provider incentive which was implemented in 2021 and carried throughout 2022 as an HCV treatment initiation driver for providers who followed the recommended OPH algorithm of initiating member treatment for HCV. Ongoing direct provider feedback barrier analysis indicated that at risk HCV members also present with significant challenges surrounding food and housing insecurities. In addition to the HCV treatment initiation incentive, UHCCP LA has implemented an SDOH incentive for providers to identify at risk members who have issues around housing and food insecurities, etc. These identified risk factors could potentially and adversely contribute as confounding factors that affect member compliance. The health plan also continues to stress the transportation benefit to all members and providers as transportation benefit awareness is a noted barrier across all PIPs. UHCCP LA will also work closely with providers to ensure they have access to the HCV clinician support line, regional resource information for substance abuse disorders and regional resource information regarding HIV supportive services. Member and provider educational materials approved by LDH will continue to be disseminated and telehealth will continue to be promoted due to the complex burden the COVID-19 crisis has presented. The leads of the HCV PIP also will continue to work closely with the leads of the COVID-19 PIP and advocate the COVID-19 vaccine in our education strategy for mutual goal alignment. This helps to meet the needs of the member as they seek treatment for HCV during the ongoing crisis of the COVID-19 pandemic in the overall health plans population health strategy as well as continue partnerships with our external and internal business partners.

Next Steps:

The next steps of the team will continue to expound on spreading success from a plethora of interventions that have significantly contributed to positive outcomes for our members. Outcomes for members treated have increased with provider education and CM supplementation in focused FQHCs. Plans to increase the bandwidth of provider knowledge of the HCV program into rural areas with continuous mass fax blast and full integration of the OPH listing into the gap report portal database. Provider facing staff will continue to share OPH targeted list with providers in their top focused list regional portfolio. Full integration of the OPH targeted list into our physician gap report portal database began in April 2021 and has been disseminated to our providers. All physicians will continue to have access to this information. Provider facing meetings will continue with HCV education and review of the OPH listings and any confounding factors to be addressed through collaboration with CM and supportive services. Strong regional partnership focuses will continue with targeted FQHCs Direct provider feedback also indicated that there was need for a provider-based incentive for PCPs who treat members on a primary care basis. With this in mind, the health plan developed an incentive to PCPs who follow the algorithm of treating their HCV positive members with generic Epclusa and supplementation of an SDOH incentive was enhanced in the overall comprehensive strategy. The entire provider directory was educated and informed of this incentive via mailers. The provider facing staff continued to reinforce the incentive during provider meetings as an educational talking point. All providers are continually notified of all Project Echo training opportunities from OPH as well as made aware of additional support from the OPH clinician support line. The leads of the HCV PIP have partnered with the leads of the Covid-19 PIP for mutual goal alignments of member treatment and provider education. The health plan continues to advocate COVID-19 vaccinations to all eligible members as well as distribute face mask to partnered providers. Given the ongoing importance of the burden the COVID-19 pandemic is placing on the population, leads are jointly educating all providers regarding vaccine recommendations and HCV screening recommendations. CM along with the entire

Community and State division at UHCCP LA will also continue to work with members to assess social needs and connect with resources available to overcome adverse variables of social determinants of health. UHCCP LA will continue to collaborate with our behavioral health internal business partners and disseminate HCV provider education materials to MAT Providers and ER Facilities with high opioid presentations. BH Provider facing staff were educated and will continue to share the HCV provider education materials. Going forward, future plans will utilize the BH provider advocates. Advocates will have HCV training that will help to facilitate and enhance provider interactions leading to continuous support and awareness of up-to-date program treatment options. Additionally, provider flyers and emails will continue periodically throughout the duration of the project. The health plan also utilized an ACRN (HIV and AIDS certified Registered Nurse) in our provider education strategy. The ACRN developed an HIV provider toolkit to educate providers regarding HIV as well as a regional based referral listing of Ryan White available supportive services that is distributed to providers via the provider facing staff. The ACRN utilized in this strategy works closely with our FQHCs and other providers as necessary as an available educational resource and to assist with any confounding factors. The ACRN will continue to be utilized as a resource in the overall provider education strategy to assist the providers in meeting the complex special needs of the HIV/HCV dual diagnosis population. It is the intent of the health plan to increase HCV member outcomes while integrating the noted interventions that contributed to the success of the project.

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**: The hepatitis C virus (HCV) is the most common blood-borne disease and the leading cause for liver transplant in the United States (LDH, 2019a). HCV infection can lead to serious health problems, including liver damage, cirrhosis (scarring of the liver), liver cancer, and even death HCV prevalence in Louisiana is estimated at 1.6% to 1.8%. There is a marked higher rate among men and women aged 45-54 years of age, urban residents, and African American males aged 45-54 (LA OPH, 2015). Louisiana ranks fifth in the U.S. for HCV/HIV co-infection; an estimated 18% of individuals with HIV as a result of intravenous drug use are also diagnosed with HCV co-infection (LA OPH, 2015).

  As of the summer 2019, Healthy Louisiana enrollees have access to safe and effective treatment for hepatitis C. The authorized generic (AG) to which they have access is Epclusa ®, which has proven effective in curing 95% of persons living with HCV (LDH, 2019a). Epclusa is the preferred direct-acting antiviral (DAA) and does not require prior authorization unlike other available treatment regimens (LA Medicaid, 2019).

  Many asymptomatic people are unaware that they are chronically infected with HCV, including those born between 1945 and 1965 (USPSTF, 2013). This contributes to significant delays in initiation of treatment and, as a result, can lead to serious clinical consequences, which in turn lead to costly financial expenditures for both the member and the State. Increasing quality of life and driving down cost is our main focus for our members. The United States Preventive Services Task Force (USPSTF) recommends one-time Hepatitis C screening for all adults in this birth cohort (USPSTF, 2013). The USPSTF recommends HCV screening for persons at high risk of chronic Hepatitis C infection, with past or current injection drug use as the most important risk factor (USPSTF, 2013). Professional society guidelines also recommend one-time testing for persons with risk exposures, including persons who were ever on long-term hemodialysis; persons with a history of incarceration; and persons with HIV (AASLD/IDSA, 2018).

- **Describe high-volume or high-risk conditions addressed:**
  According to the CDC (2020), high risk associated factors of HCV are as follows:
  - Adults born from 1945 through 1965 should be tested once (without prior ascertainment of HCV risk factors)
  - HCV testing is recommended for those who:
    - Currently injecting drugs
    - Ever injected drugs, including those who injected once or a few times many years ago
  - Have certain medical conditions, including persons:
    - who received clotting factor concentrates produced before 1987
    - who were ever on long-term hemodialysis
    - with persistently abnormal alanine aminotransferase levels (ALT)
    - who have HIV infection
  - Were prior recipients of transfusions or organ transplants, including persons who:
    - were notified that they received blood from a donor who later tested positive for HCV infection received a transfusion of blood, blood components, or an organ transplant before July 1992

- **Describe current research support for topic (e.g., clinical guidelines/standards):**
  According to the World Health Organization (2020), the generalized use of safe and highly effective direct-acting antiviral (DAA) medicine regimens for all persons improves the balance of benefits to harms of treating persons with little or no fibrosis, supporting a strategy of treating all persons with chronic HCV infection, rather than reserving treatment for persons with more advanced disease. Prior to 2014, HCV treatment involved the use of interferon-based regimens with generally low rates of cure,

long duration of therapy and substantial toxicities. The introduction of highly effective and well tolerated short-course oral DAA therapy that can cure HCV infection with high rates of sustained virological response (SVR) within weeks transformed the treatment landscape for persons with chronic HCV infection.

- **Explain why there is opportunity for MCO improvement in this area (must include baseline and if available, statewide average/benchmarks):**
  United HealthCare's mission is to help people live healthier lives and to help make the health system work better for everyone. We seek to enhance the performance of the health system and improve the overall health and well-being of the people we serve and their communities. Hepatitis C is a national problem effecting 3.5 million collectively. Of those, 39,000 people in Louisiana either on Medicaid or in the prison system have hepatitis C (site reference). We feel, while on the right path, there is still a journey to improvement in front of us for increasing education and awareness to our Providers and Members as we work towards the goal of eradication of this destructive virus.

Aims, Objectives and Goals

Aim

Improve the Healthy Louisiana 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**:

    a. For all eligible members on the OPH listing, outreach and educate members, and facilitate referrals to/schedule appointments with 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):

    b. Persons who use drugs
    c. Persons with HIV

2. **Provider Intervention Objective**: Educate providers on evidence-based recommendations (AASLD/IDSA, 2018) and availability of providers trained in HCV treatment, and coordinate referrals for treatment. Distribute member care gap reports to providers.

Table 2: Goals

Indicators	Baseline Rate[1] Measurement Period: 1/1/21-12/31/21	Target Rate[2] : CY 2022	Rationale for Target Rate[3]
Performance Indicator #1a (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:3,548 D:6,715 R:53%	R:63%	Set by the aim of the LDH HCV PIP. Goals are set at 10 percentage points above baseline data from 2021.
Performance Indicator #1b (HCV Treatment Initiation-Persons who use drugs): ***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:854 D:2,281 R:37%	R:47%	Set by the aim of the LDH HCV PIP. Goals are set at 10 percentage points above baseline data from 2021.
Performance Indicator #1c (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:92 D:176 R:52%	R:62%	Set by the aim of the LDH HCV PIP. Goals are set at 10 percentage points above baseline data from 2021.

[1] Baseline rate: the MCO-specific rate that reflects the year prior to when PIP interventions are initiated. The leads of the HCV PIP noted when comparing the OPH listing from Jan 2022 to the October 2021 listing that there was significant member movement in and out of the health plan due to open enrollment. With this in mind, the PIP leads applied clinical, logically based exclusionary criteria and members were excluded from the performance indicator reporting if they met two criteria (member deemed cured by OPH and there is no historical pharmacy claims of HCV antivirals) with the logic being that with a member deemed cured there is no actionable intervention that needs to occur and if the member is cured with no antivirals pharmacy claims on file the member could have been either a legacy HCV historically cured case or have been treated while at another health plan. Members who termed eligibility from the health plan were also excluded. This exclusionary criterion was discussed with IPRO, and the health plan was advised to address the logic in this footnote as such and also apply the criteria retroactively back through 2021 to give more meaningful "apples to apples" comparison and thus tracking the projects progress. The Jan 2022 OPH listing was taking by our analytics team and criterion was applied retroactively back through 2021. New targets were adjusted accordingly. This change in measurement reporting methodology was also addressed in the quarterly reporting footnotes for 2022. The health plan will continue to apply this criterion to each subsequent quarter based on the most recent OPH listing on hand and will identify which listing correlates with subsequent quarters for more meaningful measurements and impactful tracking and reporting purposes.

[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 (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 #1a
Performance Indicator #1b (HCV Treatment Initiation-Persons who use drugs)	***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 #1b

Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
Performance Indicator #1c (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 B) 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 #1c

Data Collection and Analysis Procedures

Is the entire eligible population being targeted by PIP interventions? If not, why?
The entire listing of OPH members were targeted for the purpose of this project. The outreach team worked diligently to encourage members where applicable to come to their PCP for HCV treatment initiation. In cases where the follow up screening was indicated; members and PCPs were educated on the importance of follow up and adhering to the OPH HCV treatment algorithm. In the absence of confirmatory testing for a cured status, all members were treated as a presumptive positive. This approach was the most effective in increasing our reach to the entire eligible member population on the OPH listing.

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:** N/A

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:** Shnay Wright-Richardson, interim IS director & Stephanie Spivey, Senior Claims Business Process Consultant researched and pulled claims data from United Healthcare SAP Orbit, SMART Analytics, and CSP Facets claims extraction platform in regard to listed ICD-10 codes provided by Office of Public Health for the Improve Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation Performance Improvement Project. The numbers reported for each performance indicator was extracted within the respective claim's platform to the specifications of each corresponding Performance Indicator definition.

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:** The UnitedHealthcare Community & State of Louisiana Analytics Team validated data submitted for the Improve Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation Performance Improvement Project by verifying that the data from SMART Analytics, SAP Orbit, and CSP Facets coincided with data that had been entered in ICUE or Community Care (Clinical Documentation Systems); moreover, random sampling and cross reference checks from the claims data extracts ensures validity of what has been entered in either systems. SMART Analytics, SAP Orbit, and CSP Facets are the three databases where all of UHCCP LA Member and Provider data is stored and where the claims data is extracted accordingly. ICUE and Community Care are Clinical Documentation interfaces where our Clinical/Non-Clinical Staff documents a Member's Utilization and Case Management information. As a result of the UHCCP LA analytics team data validation procedures, the health plans analytics team produced accurate and concise data for the Hepatitis C baseline data extracts, adhered to Performance Indicators definition as well as continued to monitor the Intervention Tracking Measures.

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 pulled from the reporting system using internal and state specific requirements. The data is then analyzed and reported accordingly via usage of CSP Facets, SMART Analytics and Orbit.
- **Describe how plan will interpret improvement relative to goal:** Continuous monitoring of performance indicators and trends relative to statewide set goal.
- **Describe how plan will monitor ITMs for ongoing QI:** Collaborations with the Analytics Team with regards to continuous monitoring of performance indicator benchmarks on a quarterly basis

(Tentative) PIP Timeline

Report the baseline, interim and final measurement data collections periods below.
Baseline Measurement Period:
Start date: 1/1/2021
End date: 12/31/2021

Submission of Proposal/Baseline Report Due: 2/3/2022

Interim/Final Measurement Period:
Start date: 1/1/2022
End date: 12/31/2022

PIP Interventions (New or Enhanced) Initiated: 2/1/2022

Submission of 1st Quarterly Status Report for Intervention Period from 1/1/22-3/31/22 Due: 4/30/2022
Submission of 2nd Quarterly Status Report for Intervention Period from 4/1/22-6/30/22 Due: 7/31/2022
Submission of 3rd Quarterly Status Report for Intervention Period from 7/1/22-9/30/22 Due: 10/31/2022

Submission of Draft Final Report Due: 12/10/2022
Submission of Final Report Due: 12/31/2022

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. Each MCO should identify additional barriers for the overall population, as well as barriers unique to persons who use drugs and persons with HIV.[1] Direct member feedback is recommended.**		**2022**			
		Q1	**Q2**	**Q3**	**Q4**
Intervention #1a to address barrier: Enhanced Case Management Outreach for HCV Treatment Initiation for all eligible members. **Planned Start Date: 1/1/2022** **Actual Start Date**:**1/1/2022**	**Intervention #1a tracking measure:** **N:** # members with appointment scheduled with HCV specialist (in OPH database) or PCP for HCV treatment assessment/initiation **D:** # members with confirmed or probable HCV per OPH listing not receiving treatment.	N: 31 D: 3167 R: 1%	N: 59 D: 3007 R: 2%	N:182 D:2941 R:6%	N:63 D:2844 R:2%
Intervention #1b to address barrier: Enhanced Case Management Outreach for HCV Treatment Initiation for all eligible members who also have a history of drug use. **Planned Start Date: 1/1/2022** **Actual Start Date:1/1/2022**	**Intervention #1b tracking measure:** **N:** # members who have a history of drug use with appointment scheduled with HCV specialist (in OPH database) or PCP for HCV treatment assessment/initiation **D:** # members with confirmed or probable HCV and a history of drug use per OPH listing not receiving treatment.	N: 2 D: 1427 R: 0.001%	N: 8 D: 1321 R: 0.006%	N:40 D:1282 R:0.03%	N:18 D:1708 R:1%
Intervention #1c to address barrier: Enhanced Case Management Outreach for HCV Treatment Initiation for all eligible members who also have HIV **Planned Start Date: 1/1/2022**	**Intervention #1c tracking measure:** **N:** # members who have HIV with appointment scheduled with HCV specialist (in OPH database) or PCP for HCV treatment	N: 11 D: 84 R: 13%	N: 8 D: 73 R: 11%	N:14 D:72 R:19%	N:5 D:79 R:6%

[1] CM outreach will be conducted on the entire OPH listing for targeted HCV members. Direct member feedback reports that due to the ongoing COVID-19 pandemic there is noted apprehension regarding seeking treatment during the pandemic crisis. The leads of the HCV PIP have partnered with the leads of the COVID-19 PIP for mutual goal alignment and CM is to educate all HCV members when contacted about the availability and effectiveness of the COVID-19 vaccine. Susceptible sub-population included HCV members who use drugs and HCV members who have a dual diagnosis of HCV/HIV have been noted. A comprehensive provider BH integration strategy has been developed and implemented and noted in a subsequent ITM. The health plan has also developed a comprehensive HIV strategy through the utilization of an ACRN (AIDS Certified Registered Nurse) who developed an HIV toolkit as well as a regional resource listing of Ryan White funded supportive services for provider distribution. The ACRN works as an integral part of the provider education strategy and is available as a resource for providers who are treating HCV positive members with diagnosis of HIV. The comprehensive HIV strategy is addressed is a subsequent ITM as well.

Actual Start Date:**1/1/2022**	assessment/initiation **D:** # members with confirmed or probable HCV and HIV per OPH listing not receiving treatment.				
Barrier 2a: Providers may not be aware that Epclusa does not require prior authorization. **Method of barrier identification: IPRO HCV PIP guidance document/Provider Feedback**		**2022** **Q1**	**Q2**	**Q3**	**Q4**
Intervention #2a to address barrier: Provider education regarding SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) prescription. **Planned Start Date: 1/1/2022** **Actual Start Date**:**1/1/2022**	**Intervention #2a tracking measure:** **N:** # members with SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) dispensed **D:** # members with any DAA dispensed	N: 381 D: 389 R: 98%	N: 399 D: 413 R: 97%	N: 386 D: 405 R: 95%	N:358 D:364 R:98%
Barrier 2b: Providers may not be aware of HCV clinical guidelines, HCV specialists, HCV clinician support line and additional resources available **Method of barrier identification: Each MCO is advised to obtain direct provider feedback about what is working/ not working.**[2]		**2022** **Q1**	**Q2**	**Q3**	**Q4**
Intervention #2b to address barrier: Intervention to outreach providers to educate about HCV CPG and to distribute listing of HCV Treatment Providers, HCV clinician support line, provider incentive and additional resources available. **Planned Start Date: 1/1/2022** **Actual Start Date**:**1/1/2022**	**Intervention #2b tracking measure:** **N:** # Number of providers educated regarding the HCV program including HCV clinician support line, waiver of PA requirements for generic Epclusa, provider incentive and additional resources available **D:** # providers who have members assigned to them with probable or confirmed HCV diagnosis per OPH listing	N: 1082 D: 1082 R: 100%	N: 1082 D: 1082 R: 100%	N: 1082 D: 1082 R: 100%	N:1082 D:1082 R:100%
Barrier 2c: Providers may not be aware of their patients' eligibility for treatment. **Method of barrier identification:**[3] **Direct Provider Feedback**		**2022** **Q1**	**Q2**	**Q3**	**Q4**
Intervention #2c to address barrier: PCP education regarding HCV members assigned to them and associated high-risk cohorts and comorbid conditions	**Intervention #2c tracking measure:** **N:** # providers who were educated regarding members assigned to them with probable or confirmed HCV diagnosis per OPH	N: 557 D: 1082 R: 51.4%	N: 594 D: 1082 R: 54.8%	N:629 D:1082 R:58%	N:654 D:1082 R:60%

[2] Direct provider feedback demonstrated a need for a provider-based incentive which was developed and implemented in 2021 and will continue throughout the duration of the project.

[3] This ITM had noted substantial impact from our comprehensive provider education strategy for the years of 2020-2021. Plans to continue mobilization of this ITM include a comprehensive review of pharmacy claims analysis which identified providers who are HCV champions by the volume of prescriptions written for generic Epclusa. This effectively allowed to health plan to identify and develop a regional based referral system to assist with complex cases and confounding factors. Additionally, the OPH clinician support line is disseminated to the entire provider directory as an additional resource.

Planned Start Date: 1/1/2022 **Actual Start Date**:**1/1/2022**	listing. **D:** # providers who have members assigned to them with probable or confirmed HCV diagnosis per OPH listing				
Barrier 2d: Providers may have a potential of limited knowledge in the primary care setting around resources and supportive services with members with HCV and a co-diagnosis of HIV. **Method of barrier identification: Direct Provider Feedback[4]**		**2022**			
		Q1	**Q2**	**Q3**	**Q4**
Intervention #2d to address barrier: PCP education regarding HCV/HIV members assigned to them and associated HIV associated toolkits and regional based referral listings of Ryan White Supported services. **Planned Start Date: 1/1/2022** **Actual Start Date**:**1/1/2022**	**Intervention #2d tracking measure:** **N:** # providers who were educated regarding HIV and regional based Ryan White Supportive services and have members assigned to them with probable or confirmed HCV diagnosis per OPH listing. **D:** # providers who have members assigned to them with probable or confirmed HCV diagnosis per OPH listing	N: 1082 D: 1082 R: 100%	N: 1082 D: 1082 R: 100%	N: 1082 D: 1082 R: 100%	N:1082 D:1082 R:100%
Barrier 3: Behavioral Health Providers may not be aware of the HCV program the HCV clinician support line and additional resources available **Method of barrier identification: Provider Feedback/Partnership and collaboration with BH internal business partners. [5]**		**2022**			
		Q1	**Q2**	**Q3**	**Q4**
Intervention #3a to address barrier: ITM for provider education regarding the HCV program to targeted ER departments and outpatient substance abuse providers. This ITM was developed as part of the BH integration strategy. **Planned Start Date: 1/1/2022** **Actual Start Date**:**1/1/2022**	**Intervention #3a tracking measure:** **N:** # Number of ER facilities and outpatient substance abuse providers who have been educated regarding the HCV program including HCV clinician support line, waiver of PA requirements for generic Epclusa and additional resources available **D:** # Number of ER facilities and outpatient substance abuse providers	N: 121 D: 121 R: 100%	N: 121 D: 121 R: 100%	N: 121 D: 121 R: 100%	N:121 D:121 R:100%

[4] The health plan also identified through provider feedback that there is limited knowledge in the primary care setting around resources and supportive services with members with HCV and a diagnosis of HIV. With this in mind, the health plan utilized an ACRN (certified HIV and AIDS certified Registered Nurse) in our provider education strategy. The ACRN developed an HIV provider toolkit to educated providers regarding HIV as well as a regional based referral listing of Ryan White available supportive services to distribute to providers. The ACRN utilized in this strategy works closely with our FQHCs and other providers as necessary as an available educational resource and to assist with any confounding factors.

[5] Direct provider feedback indicates that there is limited provider knowledge in a PCP setting around appropriate screening and treatment of members with HCV and referral of members with BH issues or substance abuse disorders. Members are often diagnosed with little knowledge of resources available to assist with confounding factors. The health plan incorporated a BH integration strategy in 2021 with the leads of the IET PIP to target providers such as MAT providers, SUD Providers and ED facilities and with education regarding HCV screening and treatment protocol. Plans for 2022 are the continue the BH integration strategy and reinforce education and availability of the HCV program to the targeted BH providers through recurring fax blast and virtual provider training expos.

Barrier 4: Provider education regarding members who need HCV treatment initiation and COVID-19 Vaccine **Method of barrier identification: Provider Feedback/Member Feedback and collaboration with COVID-19 vaccination PIP lead internal business partners. [6]**		**2022**			
		Q1	**Q2**	**Q3**	**Q4**
Intervention #4 to address barrier: ITM for provider education regarding members who need HCV treatment initiation and COVID-19 Vaccine **Planned Start Date: January 2022** **Actual Start Date**: **January 2022**	**Intervention #4 tracking measure:** **N:** # Number of HCV positive members per the OPH listing who have completed HCV treatment initiation and the COVID19 vaccine **D:** # Number of HCV positive members per the OPH listing who have completed HCV treatment initiation	N: 59 D: 154 R: 38%	N: 75 D: 199 R: 38%	N:58 D:178 R:33%	N:56 D:145 R:39%

[6] Discussions regarding this intervention began in QTR1 of 2022 due to the continue Provider and Member feedback analysis that the COVID-19 pandemics is still a concern in the minds of the HCV positive population as the members are inherently immunocompromised. The lead of the HCV PIP identified a mutual need with the COVID-19 vaccine PIP leads to educated, advocate and encourage the COVID-19 vaccine to the targeted HCV members. This co-joined message and provider joint listing outreach will meet the needs of two high priority PIPs and conjointly meet the needs of the member. The clinical logic is that once vaccinated, the concern around the pandemic will mitigate and the member ideally become more amenable to seeking their provider for HCV treatment. Additional ITM was developed to track any inferential correlation between vaccinated members and HCV treated members. Additional opportunities to partner with the COVID-19 vaccine PIP leads will occur through the duration of the project.

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: 1/1/21-12/31/21	**Final Period** Measure period: **1/1/22-12/31/22**	**Target Rate**[1]
Performance Indicator #1a (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:3,548 D:6,715 R:53%	N: 4,227 D: 6,983 R: 61%	Rate:63%
Performance Indicator #1b (HCV Treatment Initiation-Persons who use drugs): ***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:854 D:2,281 R:37%	N: 1,179 D: 2,849 R: 41%	Rate:47%
Performance Indicator #1c (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:92 D:176 R:52%	N: 112 D: 191 R: 59%	Rate: 62%

[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.

OPTIONAL: Additional tables, graphs, and bar charts can be an effective means of displaying data that are unique to your PIP in a concise way for the reader. If you choose to present additional data, include only data that you used to inform barrier analysis, development, and refinement of interventions, and/or analysis of PIP performance.

In the results section, the narrative to accompany each table and/or chart should be descriptive in nature. Describe the most important results, simplify the results, and highlight patterns or relationships that are meaningful from a population health perspective. ***Do not*** interpret the results in terms of performance improvement in this section.

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.

All of the of the performance indicators had noted improvement over the course of the project. The performance indicators surrounding HCV positive members who have current or past IVDA and HCV positive members who have HIV did increase over baseline. However, the targets were not met, and this is relative to an increased identification of members who fall into these cohort groups. Extensive provider education regarding proper coding identified a larger group of members who fall into these denominators thus increasing the denominators accordingly and impacting the overall 2021 rates. The rates should be interpreted relatively and accordingly in relation to the increased denominator. Overall progress was still noted over the baseline and improvement was noted. The health plan intends to continue the utilization of the BH integration strategy as well as the utilization of an ACRN (HIV/AIDS Certified Registered Nurse) into its overall provider educational resource strategy to address these two performance indicators and optimally will anticipate continued improvement. Going forward the target rates will be adjusted accordingly as the health plan will monitor for continuous improvement. Sustained improvement can be inferred to a degree over the course of the duration of this PIP. It is noted full data for 2022 is not available at this present time. It is also worth noting that due to the COVID-19 crisis was a relevant barrier throughout the duration of this project. Multiple Barriers were noted for 2022 as well. The continuation of the COVID-19 pandemic and the natural disaster of Hurricane Ida that occurred in late 2021 which resulted in significant member displacement and posed an ongoing barrier leading well into 2022. All of the barriers noted also played a role in confounding factors and barriers that potentially affected overall rates.

The overall goal of the project was to 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. Key performance indicator strategies for this project were implemented by guidance from the HCV PIP IPRO document as well as input from our internal multi-disciplinary team. The team took feedback from providers as well as members to focus and strategize on optimal ways to achieve our goals and navigate through any challenges or barriers presented.

The baseline rate for Performance Indicator #1a 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} was 53%. The goal for this measure was set at 63%. The final rate for this measure was 61%. While this year is not complete, UHCCP LA did not meet the goal for this measure and will continuously monitor our target rate in subsequent reporting going forward. Data available at present time is partial for 2022 as full claims lag is pending runout for the 2022 calendar year and therefore partial data is only available at this current time. It is important to note that the baseline of 53% was derived from the end of year 2021. However, when comparing the treatment rates respectively this indicator was 25% at the end of QTR 1 2021 and this explicitly supports noted continuous improvement was made in terms of HCV treatment initiation throughout the course of 2021 as well as 2022.

The baseline rate for Performance Indicator #1b 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} was 37%. The goal for this measure was set at 47%. The final rate for this measure was 41%. While this year is not complete, UHCCP LA did make notable progress over the baseline. Additionally, the denominator for this performance indicator subsequently increased as the health plan educated providers on proper coding resulting in an increase of identified members that fall into this cohort and the metric should interpreted relative to this increase of identified members. The target was not met, however considerable progress was made with regards to this performance indicator. Direct provider feedback indicated that there was limited knowledge from the PCPs regarding proper coding of members with current and past IVDA. The health plan incorporated education of proper coding in the provider education strategy which resulted in effectively identifying more members with current and past IVDA. This resulted in an increased denominator which elicited in a slightly decreased rate for 2022 and therefore the target rate should be interpreted with some relativity due to the increased identification of more members. It is important to note that the baseline for this metric of 37% was derived from the end of year 2021, however when comparing the treatment rates respectively this performance indicator was 29% at the end of QTR 1 2021 and this explicitly supports noted continuous improvement was made in terms of HCV treatment initiation for members with HCV and a history of SUD subset throughout the course of 2021 as well as 2022. The health plan has developed a comprehensive BH integration strategy with the leads of the BH PIP to assist with this particular performance indicator.

The baseline rate Performance Indicator #1c 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} was 52%. The goal for this measure was set at 62%. The final rate for this measure was 59%. While this year is not complete, the health plan did make notable progress over the baseline. Additionally, the denominator for this performance indicator subsequently increased as the health plan educated providers on proper coding resulting in an increase of identified members that fall into this cohort and the metric should interpreted relative to this increase of identified members. The target was not met, however considerable progress was made with regards to this performance indicator. Direct provider feedback indicated that there was limited knowledge from the PCPs regarding proper coding of members with HIV. The health plan incorporated education of proper coding in the provider education strategy which resulted effectively identifying more members with HIV. This resulted in an increased denominator which effected the overall rate for 2022 and therefore the target rate should be interpreted with some relativity due to the increased identification of more members. It is important to note that the baseline for this metric of 52% was derived from the end of year 2021, however when comparing the treatment rates respectively this performance indicator was 43% at the end of QTR 1 2021 and this explicitly supports noted continuous improvement was made in terms of HCV treatment initiation for members with HCV and a dual diagnosis of HIV subset throughout the course of 2021 as well as 2022. The health plan has developed a comprehensive HIV strategy through the utilization of an ACRN (AIDS Certified Registered Nurse) who developed an HIV toolkit as well as a regional resource listing of Ryan White funded supportive services. The ACRN works as an integral part of the provider education strategy and is available as a resource for providers who are treating HCV positive members with diagnosis of HIV.

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

Intervention tracking measures were identified that were thought to be feasible ways to target key areas that may improve outcomes with member engagement and follow up with HCV screening and treatment. Although some interventions experienced notable limitations due to COVID-19 and other natural disasters throughout the study period, there were some preliminary improvements in rates (pending Q4 complete data). Barriers were identified through direct feedback from providers and members, as well as from internal staff direct interactions and guidance from The Louisiana Department of Health.

For ITM #1a one specific area that the health plan identified through barrier analysis was that the New Healthy Louisiana HCV treatment benefit may be unknown to enrollee and this analysis was derived from IPRO HCV PIP guidance document/member feedback. Focused ITM Enhanced Case Management Outreach was conducted for HCV Treatment Initiation to members identified on the OPH listing.

Preliminary analysis of members on the OPH listing indicated that 20 percent of the members on the OPH listing of HCV Confirmed or suspected cases had a cofounding substance abuse disorder. CM developed close strategic partnerships with regional FQHCs to better assist in meeting the needs of the member with multiple comorbidities such SUD/SMI. Member input also indicates that some members were apprehensive about attending appointments due to the COVID-19 pandemic. The health plan worked with the regional FQHCs to assist in facemask distribution to help ameliorate member reported apprehension to attending appointments and seeking treatment. The ITM rate for this measure fluctuated between 1% and 5% throughout duration of the project. The data for the end of the year 2022 is not complete however it is important to note that the denominator for this ITM continuously and subsequently increased with each subsequent OPH listing through additional identified cases which significantly increases the denominator of identified members, and the rates should be interpreted relative to an increasing denominator which resulted from increased screening and identified HCV positive cases. COVID-19 pandemic also continued to be a barrier throughout the duration of the project. As of the time of this report the CM department has successfully scheduled appointments for 317 members for a year to date total in 2022 and it is also noteworthy that since the advent of this PIP and HCV outreach overall, the CM department conducted a inception of project-to date total of 59,779 CM interventional activities around identifying and outreach members through a variety of methods including claims analysis and review of pharmacy utilization as well as contacting members PCP and retail pharmacy for updated contact information. Noted barriers include accurate contact information for members. The natural disaster of Hurricane Ida also caused a significant barrier resulting in notable member displacement as well as adversely affecting staffing issues for treating providers. Specific direct provider feedback from one FQHC provider in the Houma Region stated to the health plan that Hurricane Ida cased a six back up of appointment scheduling due to staffing issues as well as challenges in member displacement which carried through barriers well into 2022. The health plan will continue to work closely with our providers and assist in addressed any cofounding factors and needs as they arise. Additionally, the health plan will review pharmacy claims for up-to-date contact information and outreach. In Quarter 1 of 2022, CM outreach efforts continued to include telephonic only outreach to members and providers out of precaution and safety for our members and staff amidst the COVID-19 pandemic. The team has continued a small-scale outreach to the following FQHCs; Excelth, InclusivCare, RKM and SLMA. There were 31 successful appointments made by CM during Quarter 1. Incidentally in previous quarters the project was supplementally supported by a dedicated three-person outreach call team. This team was repurposed to support the HEDIS project in the first quarter of 2022. Now that the HEDIS project is winding down, plans are in place for supplemental outreach assistance to resume. Also, internal discussions are occurring regarding implementing IVR calls targeting OPH identified members requiring treatment initiation. Additional outreach in QTR 1 2022 was supplemented by the ACRN (HIV/AIDS certified nurse) to address dual diagnosis members. The ACRN's primary role is provider education but the ACRN did outreach members when available for Q1 2022 implementing motivational interviewing techniques for this subset HCV/HIV dual diagnosis population. Going forward the ACRN will serve as a backup resource to those conducting outreach calls and help continue to educate and reinforce motivational interviewing techniques. Member informed barrier analysis indicates that not all members are aware of their transportation benefit and cite transportation as an issue to appointment adherence. With this in the mind the leads of the HCV PIP are partnering with the leads of the TOC PIP and the COVID-19 pip to develop one pager member information and an additional resource guide as transportation has also been cited as a member barrier throughout all of the projects. The leads of all the PIP's will work closely together to address confounding factors and the needs of the members across all projects. In quarter 2 of 2022, CM outreach efforts continued to include telephonic outreach to members to members on the OPH listing. The health plan utilized a dedicated outreach coordinator as well as two community health workers dedicated to the project. The ACRN who oversees the project educated the outreach team on motivational interviewing techniques and engagement strategies as well as resources to available to members. Member informed barrier analysis continues to indicate that new members to the health plan may be unaware of benefits available to them. The health plan collaborated with regional pride activities to disseminate information regarding the availability of the programs accessible to members. June was Pride Month and to increase awareness of available programs in the community the health plan proudly and strategically implemented our "UNITED with Pride" series of community events and where UHCCP LA collaborated with the internal marketing team which successfully worked with the New Orleans, Shreveport, and Baton Rouge community pride events. UHCCP LA has shared member information regarding multiple initiatives such as HCV treatment availability, transportation informational handouts, COVID-19 vaccine information

and Colorectal screening information. This enabled information sharing to LGBTQ members and allies and service a need to increase member awareness with a historically disenfranchised population. These three events had a comprehensive attendance total of 4,000 attendees altogether. UHCCP LA plans to continue these partnerships and serve the needs of this community and thus increase health care equity overall as a whole strategic approach. The health plan will continue its outreach efforts to ensure linkage of care for the targeted HCV population. In quarter 3 of 2022, CM continued their outreach efforts to targeted HCV members on the OPH listing via telephonic outreach. Additionally, community health workers were redeployed into the field starting July 2022 as boots on the ground workers as part of the comprehensive outreach strategy. The health plan also utilized a dedicated outreach coordinator, The entire outreach team has been trained in motivational interviewing techniques as well as availability of BH resources and Ryan White supported services to assist in referrals for linkage to care. Additionally, the health plan continues to monitor claim information as well as partnering with Audacious Inquiry for ADT notifications of targeting HCV members. This allows our outreach team to effectively employ a multi-prong outreach approach in engaging targeted members through up-to-date contact information. Our entire outreach team continues to be supported by ACRN (HIV/AIDS certified registered nurse) who oversees the entire project and available to assist as a resource with complex cases. The health plan also utilized Eliza calls in this quarter to supplement outreach with the option to connect member a to a live agent to assist with appointment scheduling. The Eliza calls implemented in this quarter resulted in a total of 92 members successfully outreached and connected to a live agent for appointment scheduling. The health plan will continue its outreach and utilization of a dedicated outreach coordinator, two community health workers with an ACRN for support in its comprehensive member outreach strategy.

For ITM #1b one specific area that the health plan identified through barrier analysis was that the New Healthy Louisiana HCV treatment benefit may be unknown to enrollee as well as barriers specific to members with a history of SUD and this analysis was derived from IPRO HCV PIP guidance document/member feedback. ITM #1b is a carve out subset of #1a. This subset measures appointment assistance scheduling for HCV treatment initiation of members on the OPH listing who also have a history of SUD. Focused ITM Enhanced Case Management Outreach was conducted for HCV Treatment Initiation to members identified on the OPH listing who also have a history of SUD. The ITM rate for this measure fluctuated between 0.001% and 3% throughout duration of the project. The data for the end of the year 2022 is not complete however it is important to note that the denominator for this ITM continuously and subsequently increased with each subsequent OPH listing through additional identified cases which significantly increases the denominator of identified members, and the rates should be interpreted relative to an increasing denominator which resulted from increased screening and identified HCV positive cases. COVID-19 pandemic also continued to be a barrier throughout the duration of the project. Outreach to members who have a history of SUD/SMI continue to be a challenge due to a plethora of issues not limited to accurate contact information and members willingness to engage with the program. Collaborations with the internal BH advocate staff and Provider feedback as well barrier analysis suggested to the team that analysis of ADT feed information and possibly working with Audacious Inquiry for notifications may allow the team to become aware of members who are recently in case and allow the team to identify and work with the provider on meeting the needs of the member as it relates to the HCV program. Continuing workgroup discussion are ongoing in terms of strategic approach and will continue throughout the duration of the project. The health plan continued their collaboration with Audacious Inquiry to monitor ADT feeds of inpatient notifications of targeted members. The two leads and SME of HCV assigned to the project will continue to monitor ADT feeds and when available notify the provider as well as work with CM to initiate referrals to address the transitions care aspect of recently admitted members. It is the intent of the health plan to increase our reach of at-risk members who are challenge to reach and allow for the health plan to assist in initiation of treatment of HCV and assist with any mitigating or confounding factors. The health plan will continue to partner with Audacious Inquiry and monitor ADT feeds of inpatient notification of targeted members throughout the duration of the project

For ITM #1c one specific area that the health plan identified through barrier analysis was that the New Healthy Louisiana HCV treatment benefit may be unknown to enrollee and barriers specific to members with a dual diagnosis of HCV and HIV and this analysis was derived from IPRO HCV PIP guidance document/member feedback. ITM #1c is a carve out subset of #1a. This subset measures the appointment assistance scheduling with HCV treatment initiation of members on the OPH listing who also have a history

of HIV. Focused ITM Enhanced Case Management Outreach was conducted for HCV Treatment Initiation to members identified on the OPH listing who also have a history of HIV. The ITM rate for this measure fluctuated between 11% and 19% throughout duration of the project. The data for the end of the year 2022 is not complete however it is important to note that the denominator for this ITM continuously and subsequently increased with each subsequent OPH listing through additional identified cases which significantly increases the denominator, and the rates should be interpreted relative to an increasing denominator of identified members which resulted from increased screening and identified HCV positive cases. COVID-19 pandemic also continued to be a barrier throughout the duration of the project The ACRN (AIDS/HIV Certified RN) whose primary role is provider outreach and education did assist when available in making outreach to targeting HIV/HCV members just for Q1 2022. Going forward the ACRN will serve as a SME expert and back up resource to our call outreach team regarding motivational interviewing of HCV/HIV dual diagnosis members and reinforce knowledge of Ryan White regional based resources to support connecting of members with available resources that could impact their SDOH. Some member reported barriers that the ACRN noted in his targeted outreach were that members were not aware of the HCV programs availability. The ACRN who is also the HIV PIP lead is looking into working with marketing and the leads of the COVID-19 PIP to increase member awareness in the community and exploring the possibility of co-joining community information events and member newsletters. For QTR 2 2022, the ACRN whose primary role is provider outreach continued to work as a resource and SME to the outreach team conducting calls to members for appointment scheduling. The ACRN worked with the outreach team regarding reinforcement of motivation interviewing and engagement techniques for at risk members. The ACRN also ensured that the outreach team had the regional based resource listings of Ryan White supported resources to assist members with any confounding factors and ensure linkage to care of the member with a treating provider. Additionally, the transportation benefit is reinforced on all successful outreach contact with members who cite transportation as potential barrier to appointment completion. For QTR 3 2022 and throughout the project in its entirety, the ACRN whose primary role is provider outreach will continue to oversee the entire project throughout the duration of the PIP as support to the outreach team and continue to assist with complex cases as an additional resource

With regards to ITM #2a, this particular ITM tracked the rate of the number of members who were prescribed generic Epclusa as a preferred drug of choice for DAA therapy. This measure was based on both pharmacy and encounter claims data. UHCCP LA provided targeted education to all PCPs and HCV specialist which included a variety of methodologies such as fax blast, web-based conferencing and in person when available. The physicians were also provided with the OPH clinician support line for additional educational opportunities and support as needed. Providers were also provided with LDH approved education on evidence-based screening and treatment for HCV and generic Epclusa. The rate for this ITM stayed consistent for throughout the duration of the PIP and ranged from 95% to 98%. Provider feedback indicated that providers were satisfied with the removal of the prior authorization requirement and if providers had any concerns regarding treating members with HCV on a PCP basis, the providers were subsequently provided materials from the health plan as well as presented with information regarding OPH's clinician support line. The health plan also utilized two SME HCV nurses to track and review pharmacy utilization claims and any physicians who did not utilize generic Epclusa were individually reached out to for further education regarding generic Epclusa as a preferred drug of choice. The team will continue to work closely with our providers and provide education and support as needed as all as monitor pharmacy utilization claims.

As it relates to ITM #2b, the area UHCCP LA identified through barrier analysis provider feedback and IPRO HCV PIP guidance document was that providers may not be aware of the HCV program the HCV clinician support line and additional resources available. This intervention began in QTR1 of 2020 via fax blast to our entire provider directory. This was halted due to COVID-19 and interventions resumed after the June 2020 meeting with LDH and will occur via fax blast on a monthly basis to our entire provider directory for the duration of the PIP. Through input from our providers and multi-disciplinary team it was determined that sending out our HCV informational educational materials increased provider awareness regarding the HCV elimination program and allowed providers to reach out to the health plan for any additional questions they may have. The providers also indicated that having this information available also supplemented the in person and web-based conference meetings our provider facing staff had with our providers therefore enhancing understanding of the program. The fax blast method approach remained at 100% as it was the

most effective and tangible way to reach all our providers given the challenges of the COVID-19 crisis as well as the multiple natural disasters that occurred throughout the year. The leads of the HCV PIP have partnered with the leads of the Covid-19 PIP for mutual goal alignments of member treatment and provider education. The health plan continues to advocate COVID-19 vaccinations to all eligible members as well as distribute face mask to partnered providers. Given the ongoing importance of the burden the COVID-19 pandemic is placing on the population, UHCCP LA is jointly educating all providers regarding vaccine recommendations and HCV screening recommendations. CM along with the entire Community and State division at UHCCP LA will also continue to work with members to assess social needs and connect with resources available to overcome adverse variables of social determinants of health. The health plan will continue to send out HCV information on a recurring bases to ensure the providers are up to on all resource information available.

For the purposes of ITM #2c, one specific area the health plan identified through our barrier analysis was to conduct provider education on the assessment, treatment protocols for HCV and appropriate coding of high-risk cohort groups as well as educate providers on additional resources such as the HCV clinician support line that is provided by the Louisiana Office of Public Health. This education included information on HCV in the form of concise toolkits and LDH approved provider education fliers which included appropriate billing codes for high-risk cohorts. The provider facing flier also included information regarding generic Epclusa as the preferred drug of choice with no prior authorization requirement. The intervention included a resource packet that was delivered by a Population Health Care Consultant Nurse and SME or a transformation consultant from the quality department. This information was presented in several ways, including via web-based conferencing, breakout sessions with several federally qualified health clinics, in person meetings when available and through virtual provider expos. Additionally, provider facing resource flyers and toolkits regarding SUD/SMI were disseminated to assist providers with treatment and referral resources for members with complex comorbidities. Strong partnerships were established with regional FQHCs, and referrals were encouraged to FQHCs when possible, to assist the needs of the member who may potentially have multiple social determinants of health adversely affecting potential outcomes. Target member list from OPH regarding members who have confirmed or suspected HCV diagnosis and were shared with the assigned provider. The Clinical transformation consultant provider facing team-engaged and provided education regarding the HCV elimination program and disseminated targeted OPH member list with 74 PCP practices across the state that include large scale practices. The engagement with these large-scale practices occurs monthly and throughout the year which included FQHCs-Access Health Louisiana, Baptist Community Health Services, Care South, Case Community Health Institute, David Raines Community Health Center, DePaul Community Health Centers, EXCELth, Iberia Comprehensive Community Health Center, Primary Care Providers for a Healthy Feliciana (RKM Primary Care) Health Systems-FMOL, LCMC, Willis Knighton. The health plan is also utilizing two designated SME Nurses to educate PCP’s regarding the HCV elimination program. One covers the north region of the state, and one covers the southern region. To date these two SME nurses along with the clinical transformation consultants and population health team have collectively educated 642 of the 1082 identified providers on the OPH listing producing a rate of 59% of PCPs educated via WebEx and in person when available as well as maintained relationships with the PCPs as support and direct to the HCV clinician support line from OPH as needed. Outcomes for members treated have increased with provider education and CM supplementation in focused FQHCs. Plans to increase the bandwidth of provider knowledge of the HCV program into rural areas with continuous mass fax blast and full integration of the OPH listing into the gap report portal database. Provider facing staff will continue to share OPH targeted list with providers in their top focused list regional portfolio. Full integration of the OPH targeted list into our physician gap report portal database began in April 2021 and have been disseminated to our providers. All physicians will have access to this information. Provider facing meetings will continue with HCV education and review of the OPH listings and any confounding factors to be addressed through collaboration with CM and supportive services. Strong regional partnership focuses will continue with targeted FQHCs. Direct provider feedback also indicated that there was need for a provider-based incentive for PCPs who treat members on a primary care basis. With this in mind, the health plan developed a $20 incentive to PCPs who follow the algorithm of initiating treatment of their HCV positive members with generic Epclusa. The entire provider directory was educated and informed of this incentive via mailers. The provider facing staff continued to reinforce the incentive during provider meetings as an educational talking point. All providers are

continually notified of all Project Echo training opportunities from OPH as well as made aware of additional support from the OPH clinician support line. This ITM notes substantial impact from our comprehensive provider education strategy. Plans for more effective mobilization of this ITM prior to hurricane season included a comprehensive review of pharmacy claims analysis which identified providers who are HCV champions by the volume of prescriptions written for generic Epclusa. This effectively allowed to health plan to identify and develop a regional based referral system to assist with complex cases and confounding factors. Direct provider feedback indicated that there was limited knowledge from the PCPs regarding proper coding of members with HIV. The health plan incorporated education of proper coding in the provider education strategy which resulted effectively identifying more members with HIV. The health plan has developed a comprehensive HIV strategy through the utilization of an ACRN (AIDS Certified Registered Nurse) who developed an HIV toolkit as well as a regional resource listing of Ryan White funded supportive services that is disseminated to our providers as part of the provider education strategy. The ACRN works as an integral part of the provider education strategy and is available as a resource for providers who are treating HCV positive members with diagnosis of HIV. This strategy will continue by the health pan to assist in meeting the complex needs of the members with a dual diagnosis of HCV/HIV. Additionally, the OPH clinician support line is disseminated to the entire provider directory as an additional resource.

With regards to ITM #2d, an additional barriers identified through direct provider feedback indicates that providers may have a potential of limited knowledge in the primary care setting around resources and supportive services with members with HCV and a co-diagnosis of HIV. The health plan continues to utilize an ACRN (HIV and AIDS Certified Registered Nurse) to assist in educating providers on the special needs of this population and working with HIV community resource centers to collaboratively increase provider awareness of region-specific resources that are available. This strategy has attributed to the increase in identification of HCV positive members with a comorbidity of HIV due to proper screening and coding and an increase in the treatment of members that fall into the category and special needs of a dual diagnosis of HCV and HIV. The HIV developed provider toolkit is disseminated to the entire provider directory as well as the regional based referral sheets of Ryan White supportive services. The fax blast method approach remained at 100% as it was the most effective and tangible way to reach all our providers given the challenges of the COVID-19 crisis as well as the multiple natural disasters that occurred throughout the course of the project. The entire provider directory is notified of the integrated gaps in care portal of the targeted HCV members and the provider directory is notified of the ACRN's availability to them as a consultative resource and will be reminded as such throughout the duration of the project.

As it relates to ITM #3, UHCCP LA identified though barrier analysis through direct Provider Feedback was that behavioral Health Providers may not be aware of the HCV program the HCV clinician support line and additional resources available which led to the development of a partnership and collaboration with the leads of the BH PIP. The leads recognize there is a significant proportion of this population based on the CDC statistics that have a comorbid SUD/SMI diagnosis. With this in mind, the HCV lead collaborated with the leads of the BH PIP and disseminated HCV provider education materials to MAT Providers and ER Facilities with high opioid presentations. BH Provider facing staff were educated and shared the HCV provider education materials with these identified providers. In Q2 2021, the UHCCP LA Behavioral Health Staff strategic initiative to track the provider engagement and training on HCV began. The phased-in educational approach targets three Provider Types: ER Facilities, SUD Providers, and MAT providers. The education thus far has been "Live Virtual Trainings" in which there is interaction between providers and UHCCP LA; this gives the provider an opportunity to ask questions and interact with our Subject Matter Experts. In addition, the health plan will be sending out a mass communication to these targeted three Provider Types on our HCV initiative. In Q3 2021 our effort to educate Behavioral Health Providers on Hepatitis C Screening continued. In Q3, UHCCP LA outreached to 100% of the following provider types: Distinct Part Psychiatric Unit, Free Standing Psychiatric Hospital, Substance Abuse and Alcohol Abuse Center (Outpatient) and. Substance Use Residential. There was a total of 121 providers at 177 locations. The education was provided as a "Live Virtual Training". In addition, an educational handout was sent via email to these providers on our HCV Initiative. This education was reinforced through continuous fax blast and live and virtual provider expos. The fax blast method approach remained at 100% as it was the most effective and tangible way to reach all our providers given the challenges of the COVID-19 crisis as well as the multiple natural disasters that occurred throughout the course of the project. Plans going forward are

for Behavioral Health Provider advocates to include HCV training in their provider interactions for continuous support and awareness of the program. Additionally, provider flyers and emails will continue periodically to reinforce availability of resources and information regarding the program.

With regards to ITM #4 the leads of the HCV PIP identified through Provider Feedback/Member Feedback and collaboration with COVID-19 vaccination PIP lead internal business partners of the need for the COVID-19 vaccination PIP and HCV treatment initiation goal alignment. Discussions regarding this intervention began in QTR1 of 2022 due to the continued Provider and Member feedback analysis that the COVID-19 pandemics is still a concern in the minds of the HCV positive population as the members are inherently immunocompromised and are the greatest risk for disease complication exacerbation. The lead of the HCV PIP identified a mutual need with the COVID-19 vaccine PIP leads to educated, advocate and encourage the COVID-19 vaccine to the targeted HCV members. This co-joined message and provider joint listing outreach met the needs of two high priority PIPs and conjointly meet the needs of the member. The clinical logic is that once vaccinated, the concern around the pandemic will mitigate and the member ideally become more amenable to seeking their provider for HCV treatment. This additional ITM was developed to track any inferential correlation between vaccinated members and HCV treated members. The rate for this ITM fluctuated between 29% to 38 % thus supporting there is a positive inferential correlational relationship of the mutual goal alignment of the two PIPs. Additional opportunities to partner with the COVID-19 vaccine PIP leads will occur through the duration of the project.

The majority of the ITM's were quarter specific unless otherwise noted. All member related ITMs were quarter specific the provider face to face educational ITM was noted as cumulative as well as the additional ITM's surrounding provider education. In instances when information was disseminated to providers and 100% was achieved, the information would still be reinforced by routine send out of information via multiple communication methods such as fax blast, email, and provider expo trainings. Education and resources available were continually reinforced throughout the duration of the project.

- **PIP Highlights:**

The health plan notes that Intervention 2b and 2c (Develop member gap reports, stratify by provider, and distribute to providers, fax blast and provider facing staff meeting with providers and virtual where possible) were the most effective of the interventions in the provider interventional educational strategy. The full integration and incorporation of members with open care gaps for HCV treatment into the PCOR physician online gap portal received increased levels of attention from the provider based on direct provider feedback and all providers have access to this information. Due to continued challenges posed by the COVID-19 pandemic and Hurricane Ida, the financial relief provided by the CP-PCPi Incentive program was greatly appreciated by the providers and the addition of HCV Treatment incentive sweetened the opportunities and drove engagement of providers to treat HCV members according to the HCV protocol.

The health plan partners and collaborates with targeted FQHCs through the duration of the project. Direct member feedback indicated that members reported some apprehension to seek treatment due to the concerns surrounding the COVID-19 pandemic. To address and help ameliorate some of these concerns the health plan distributed face masks and antibacterial hand sanitizer to these provider groups to give to members. The leads of the HCV PIP also partnered with the leads of the COVID Vaccination PIP to ensure consistent messaging is disseminated to our providers and members. The health plan understands and acknowledge the member reported concerns of the HCV positive member who is immunocompromised and navigating health choices in the midst of a pandemic. The leads of the PIPS will continue to work together and advocate the COVID-19 vaccine to our targeted HCV members and continue to distribute face mask and antibacterial gel to the FQHCs to share with members. The FQHCs reported that the dissemination of facemask and hand sanitizer did help ameliorate member concerns and treatment numbers did increase through the duration of the project. ITM 2a which reflects pharmacy fills is an empirical data point that supports consistent treatment numbers throughout the duration of the project even in the midst of all of the challenges noted such as an ongoing pandemic and natural hurricane disasters.

- **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.

Some Interventions were in place for a limited amount of time, which could have contributed to their lack of efficacy over the course of the project. Additionally, some interventions could not be fully implemented due to both internal and external delays. Results of intervention tracking measures and interventions were reviewed in at least bi-weekly multi-disciplinary work group meetings to address any stagnation or declining rates. Some factors associated with limited success included restrictions around communication and interactions with providers and members, as well as the flood of information that members and providers had to absorb during the ongoing pandemic which is still a present concern in 2022 as the health care system addresses the COVID-19 variants that posed a threat to the population.

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.

  Typical claims lag can be up to 90 calendar days. Claims continue to be submitted for the 2022 calendar year just as it did in 2021 and 2020, which impact the final measurement rates, the key indicators for this study. A full evaluation of the impact of interventions cannot be determined until final measurement rates are completed

  Per the UHC analytics team, having an updated OPH listing allowed UHC to run the data against current member listing. UHC used only active members from the OPH listing when reporting to ensure reliability and validity during the reporting period.

- **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).

  Lower rates in the final quarterly measurement could be attributed to claims only being available through November 2022. This does not consider claims that may be submitted later or are still processing. Lower rates are based on a full calendar year of data, which 2022 complete data rates are not available at this time

- **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.

  Results must be interpreted with some caution due to several factors including the short timeframe for the study, the data lags around claims and the key indicators used to determine efficacy being reliant on an entire year's worth of data. The ability to draw true conclusions around the data cannot be determined to be final.

  2022 has proven to be a challenging year for our Hep C PIP; the ongoing COVID pandemic has caused many people to choose to stay home or were hesitant to go to a provider's office or even out into the community. Hurricanes Marco, Laura, Zeta, Delta and Sally in 2020 and Hurricane Ida in 2021 caused significant destruction throughout the state of Louisiana and increased barriers to care that were already in place due to COVID and caused significant member displacement. CM continued to outreach members using a new program and job aid/process and new reporting was created just for

this PIP. When more members were identified by OPH, these new members would need to be added to reporting and the process. The team continued to be flexible, adapt, re-evaluate, and implement continued CM outreach with each new change and/or barrier. CM outreach efforts continued to include telephonic only outreach to members and providers out of precaution and safety for our members and staff amidst the COVID-19 pandemic. Face to face outreach attempts to members remained on hold until July of 2022 when restrictions started to ease and thus Community Health workers were redeployed back into the field to assist members.

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
Intervention 1a: Enhanced Case Management Outreach for HCV Treatment Initiation Target Members on the OPH list of confirmed or suspected HCV cases for case management outreach to schedule and assist with appointments PCPs or HCV specialist Intervention Tracking Measure is the percentage of the number of members with appointments scheduled with HCV specialist (in OPH database) or PCP for HCV treatment assessment/initiation by a Case Manager over the number of members with confirmed or probable HCV per OPH listing not receiving treatment	Due to limitations in face-to-face contact during the COVID-19 crisis, Case Management and community health workers outreach was done primarily by phone during part of the study and may not have been as effective Boots on the ground CHWs were not allowed to resume field visits until July of 2022 due to Covid-19 restrictions. Members were difficult to reach during natural disasters, such as hurricanes, and had more immediate case management needs (i.e., housing support, financial resources, food) which was addressed first. Member apprehension to attending appointments was reported due to concerns surrounding the COVID-19 crisis members who are confirmed HCV or at risk.	The team established and maintained strong collaborations with local FQHCs and the health plan provided CM outreach supplementation. Pharmacy claims reviewed and PCPs contacted for up-to-date member contact information and telehealth promoted as needed, Quality and CM staff collaborated and developed LDH approved member education material to disseminate to members who are confirmed HCV or at risk. Quality Department disseminated facemasks to local FQHCs to distribute to at risk members and confirmed/suspected HCV members to help ameliorate concern for attending appointments due to the COVID-19 crisis. COVID-19 Crisis continues to be a burden to members. Direct Provider and Member feedback led to a direct alignment with the leads of the COVID-19 Vaccine PIP to educated members on the importance and availability of the COVID-19 Vaccine. This will help mitigate HCV positive members apprehension to seek treatment for HCV during the ongoing pandemic and increase overall vaccination rated of the population thus being mutually beneficial to the members and assisting in achieving goals of both PIPs. Mutual goal alignment between the PIP also reduces potential member abrasion as it relates to multiple contact addressing healthcare priorities.	Continue to supplement CM outreach and support external FQHC organizations with strong collaborations. FQHCs are equipped to address the multiple needs of the HCV member as well as address and BH or SUD and refer to services as needed. MCO to continue to follow the Project Echo model and evaluate best practices and approach for CM member outreach. MCO to continue to work with large group providers to ensure HCV screening is part of the standard order set for members ages 18 and above. Continue to distribute LDH approved member education material as well as face mask to targeted members who are confirmed or high risk. The team has begun a targeted CM outreach to those members who have been identified as having filled oral hepatitis C medication 1 or 2 times and did not fill a 3rd month of medication. CM will attempt to successfully outreach these members and/or their providers to help overcome barriers in fulfilling the full medication therapy. Evaluate additional tools/materials that can be used to engage members In treatment through direct CM feedback/input and address the complexity of any confounding issues such BH/SUD. Regional referral resources to be continued to be shared with the member as well as the treating provider.

Intervention 1b: Enhanced Case Management Outreach for HCV Treatment Initiation for all eligible members who also have a history of drug use. Target Members on the OPH list of confirmed or suspected HCV cases who also have a history of drug use for case management outreach to schedule and assist with appointments PCPs or HCV specialist Intervention Tracking Measure is the percentage of the number of members with appointments scheduled with HCV specialist (in OPH database) or PCP for HCV treatment assessment/initiation by a Case Manager over the number of members with confirmed or probable HCV who also have a history of drug use per OPH listing not receiving treatment	Outreach to members who have a history of SUD/SMI continue to be a challenge due to a plethora of issues not limited to accurate contact information and members willingness to engage with the program. Collaborations with the internal BH advocate staff and Provider feedback as well barrier analysis suggested to the team that analysis of ADT feed information and possibly working with Audacious Inquiry for notifications may allow the team to become aware of members who are recently in case and allow the team to identify and work with the provider on meeting the needs of the member as it relates to the HCV program.	The health plan continued their collaboration with Audacious Inquiry to monitor ADT feeds of inpatient notifications of targeted members. The two leads and SME of HCV assigned to the project will continue to monitor ADT feeds and when available notify the provider as well as work with CM to initiate referrals to address the transitions care aspect of recently admitted members. It is the intent of the health plan to increase our reach of at-risk members who are challenge to reach and allow for the health plan to assist in initiation of treatment of HCV and assist with any mitigating or confounding factors The health plan also partnered with the internal BH business partners and the leads of the BH PIP to identify informational opportunities and multiple avenues for information dissemination.	Continuing workgroup discussion are ongoing in terms of strategic approach and will continue throughout the duration of the project. Continue to partner with internal BH business partners for dissemination of information to our BH providers. The health plan will continue to monitor claims information and partner with Audacious Inquiry to monitor ADT notification which effectively employs a multiprong approach to identify up to date information to assist with members who are the most challenging to get in contact with. The health plan will discuss and explore the possibility of implementing Peer support specialist and needle exchange programs to further support the members.
Intervention 1c: Enhanced Case Management Outreach for HCV Treatment Initiation for all eligible members who also have HIV. Target Members on the OPH list of confirmed or suspected HCV cases who also have HIV for case management outreach to schedule and assist with appointments PCPs or HCV specialist Intervention Tracking Measure is the percentage of the number of members with appointments scheduled with HCV specialist (in OPH database) or PCP for HCV treatment assessment/initiation by a Case Manager over the number of members with confirmed or probable HCV who also have a HIV per OPH listing not receiving treatment	Direct member and provider feedback indicated that there is a potential of limited knowledge around HIV resources and Ryan White supported services. The health plan utilized an ACRN (certified HIV and AIDS certified Registered Nurse) in our provider education strategy and member outreach strategy and provide extra focus on the dual diagnosis HCV/HIV subset population. The ACRN developed an HIV provider toolkit to educated providers regarding HIV as well as a regional based referral listing of Ryan White available supportive services to distribute to providers	The ACRN whose primary role is provider outreach and education did assist when available in making outreach to targeting HIV/HCV members just for Q1 2022. Going forward the ACRN will serve as a SME expert and back up resource to our call outreach team regarding motivational interviewing of HCV/HIV dual diagnosis members and reinforce knowledge of Ryan White regional based resources to support connecting of members with available resources that could impact their SDOH. Some member reported barriers that the ACRN noted in his targeted outreach were that members were not aware of the HCV programs availability. The ACRN who is also the HIV PIP lead is looking into working with marketing and the leads of the COVID-19 PIP to increase member awareness in the community and exploring the possibility of co-joining community information events and member newsletters. The ACRN whose primary role is provider outreach continued to work as a resource and SME to the outreach team conducting calls to members for appointment scheduling. The ACRN worked with the outreach team regarding reinforcement of motivation interviewing and	The ACRN whose primary role is provider outreach will continue to oversee the entire project throughout the duration of the PIP as support to the outreach team and continue to assist with complex cases as an additional resource.

		engagement techniques for at risk members. The ACRN also ensured that the outreach team had the regional based resource listings of Ryan White supported resources to assist members with any confounding factors and ensure linkage to care of the member with a treating provider. Additionally, the transportation benefit is reinforced on all successful outreach contact with members who cite transportation as potential barrier to appointment completion.	
Intervention 2a: Provider education regarding SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) prescription. Target Provider Education to PCPs and HCV specialist who prescribes DAA and reinforce education that Generic Epclusa is the preferred drug of choice with no prior authorization requirement Intervention tracking measure is the percentage of the number members with SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) dispensed over the number of members with any DAA dispensed	The entire provider directory was sent via fax blast on a monthly basis information from LDH including HCV clinical support line and OPH continuing education. Information was also provided indicating that generic Epclusa was the preferred drug of choice for treating HCV. Information included the removal of the prior authorization requirement as well as supplemental Epclusa pharmacological information. Additionally, the provider facing staff would also reinforce generic Epclusa through web conference meetings and emails and highlight the removal of the prior authorization requirement. A small number of providers verbalized some apprehension regarding treating HCV on a primary care basis. The providers were given information for OPH HCV support line as well as CME opportunities provided by OPH on how to become HCV champion providers.	Continue monthly fax blast to entire provider directory which would include HCV clinician support line and LDH approved provider education regarding generic Epclusa and the removal of the prior authorization requirements. Provider facing staff including population health nurses and clinical transformation consultants to reinforce education to providers via multiple modalities such as web-based conferencing, fax, email and face to face, when possible, given the constraints of the COVID-19 crisis. Two SME HCV Population Health nurses review monthly DAA pharmacy utilization claims and identify the small number of providers who prescribe DAA meds other than generic Epclusa. The SME nurses outreach these outlier providers and provide necessary education and reinforcement regarding generic Epclusa being the drug of choice.	Multi-disciplinary team of case management, quality, pharmacy, analytics, behavioral health, and leadership to continue to meet in weekly workgroups to collaborate on ways to continue to reinforce the messaging that generic Epclusa is the preferred DAA drug of choice with no prior authorization requirement. Provider facing staff monthly meetings will continue with key large-scale providers and FQHCs with HCV as a monthly agenda item. Two SME HCV Population Health nurses will continue to review DAA pharmacy utilization claims and identify any providers who require additional education regarding generic Epclusa and will provide education and resource materials accordingly. Two SME HCV Population Health nurses will also participate in virtual UHCCP LA provider expo trainings as an additional method or increasing awareness and education regarding generic Epclusa being the preferred DAA for HCV with no prior authorization requirement. Multi-disciplinary team will continue to work closely with OPH and distribute information regarding additional educational opportunities and HCV clinician support accordingly.
Intervention 2b: Provider Education regarding the HCV program including the HCV clinician support line and additional resources available. Target Providers to include PCPs and HCV specialist on the OPH listing who have members	The entire provider directory was sent fax blast on a monthly basis information from LDH including HCV clinical support line and OPH continuing education. Information was also provided indicating that generic Epclusa was the preferred drug of choice for treating HCV. Information	HCV educational information, HCV clinical support line and supporting materials such as BH resources sent to entire provider directory via monthly recurring fax blast. Provider advocates and Network account managers work	Multi-disciplinary team of case management, quality, pharmacy, analytics, behavioral health and leadership to continue to meet in weekly workgroups to collaborate on ways to increase and strategize provider education and reinforcement of program.

assigned to them with confirmed or suspected HCV diagnosis. Intervention tracking measure is the percentage providers who have members assigned to them from the OPH listing of suspected or confirmed cases educated regarding the HCV program including HCV clinician support line, waiver of PA requirements for generic Epclusa and additional resources available over the number providers who have members assigned to them with probable or confirmed HCV diagnosis per OPH listing	included the removal of the prior authorization requirement as well as supplemental Epclusa pharmacological information. COVID-19 Crisis presented a burden of shifting prioritization of treatment focus for providers Multiple Hurricanes also presented challenges in terms of prioritization of provider focus.	with multi-disciplinary team to update provider directory and contact and fax information accordingly. The fax blast method approach remained at 100% as it was the most effective and tangible way to reach all our providers given the challenges of the COVID-19 crisis as well as the multiple natural disasters that occurred throughout the year. The leads of the HCV PIP have partnered with the leads of the Covid-19 PIP for mutual goal alignments of member treatment and provider education. The health plan continues to advocate COVID-19 vaccinations to all eligible members as well as distribute face mask to partnered providers. Given the ongoing importance of the burden the COVID-19 pandemic is placing on the population; we are jointly educating all providers regarding vaccine recommendations and HCV screening recommendations. CM along with the entire Community and State division at UHCCP LA will also continue to work with members to assess social needs and connect with resources available to overcome adverse variables of social determinants of health. The health plan will continue to send out HCV information on a recurring bases to ensure the providers are up to on all resource information available.	Multi-disciplinary team to continue to work closely with provider advocates and network account managers to ensure providers contact information is up to date. Two HCV SME nurses to also continue to work as a resource guide for providers who have additional inquiries regarding the HCV elimination program, HCV clinician support line and continuing medical education opportunities provided by OPH. Continue mutual goal alignment with the leads of the Covid-19 vaccination PIP in overall provider education strategy
Intervention 2c: Primary Care provider education regarding members assigned to them from the OPH listing with HCV as well as associated comorbid conditions and high-risk cohorts such as SUD, IVDA, and HIV Target Providers to include PCPs and HCV specialist on the OPH listing who have members assigned to them with confirmed or suspected HCV diagnosis. Intervention tracking measure is the percentage of providers educated regarding the HCV program including HCV clinician support line, waiver of PA requirements for generic Epclusa and additional	Provider engagement for new material was limited at time due to high volume of new material being released around COVID-19 and competing PIPs priority. Dissemination of available information to providers was difficult due to multiple avenues for distribution. Providers are not utilizing appropriate billing codes, which led to low reported data for the for various high-risk cohort groups. COVID-19 Crisis presented a burden of limiting in person interaction with providers for face-to-face meetings and education.	Clinical transformation consultant provider facing team-engaged, provided education regarding the HCV elimination program and disseminated targeted OPH member list with 74 PCP practices across the state that include: FQHCs-Access Health Louisiana, Baptist Community Health Services, Care South, Casse Community Health Institute, David Raines Community Health Center, DePaul Community Health Centers, EXCELth, Iberia Comprehensive Community Health Center, Primary Care Providers for a Healthy Feliciana (RKM Primary Care) Health Systems-FMOL, LCMC, Willis Knighton.	Continue to provide HCV training to both medical and HCV specialist providers through various avenues. Collaborate with other MCOs to reduce provider abrasion and duplicative trainings Health Plan to continue provider outreach and dissemination of member list to providers. Clinical transformation consultants and population health nurse consultants and HCV SME expert nurses to continue reinforcement of education, providing updated member list, clinical pathways and treatment algorithms, LDH provider approved informational fliers, SUD toolkits and regional

resources available over the number providers who have members assigned to them with probable or confirmed HCV diagnosis per OPH listing	Multiple Hurricanes and natural disasters and the COVID-19 presented challenges in terms of prioritization of provider focus	The health plan is also utilizing two designated SME Nurses to educate PCP's regarding the HCV elimination program. One covers the north region of the state, and one covers the southern region. . Full integration of the OPH targeted list into our physician gap report portal database began in April 2021 and have been disseminated to our providers. All physicians will have access to this information. Direct provider feedback also indicated that there was need for a provider-based incentive for PCPs who treat members on a primary care basis. The health plan developed a $20 incentive to PCPs who follow the algorithm of treating their HCV positive members with generic Epclusa and a follow up completion of the SVR-12 lab post treatment. The entire provider directory was educated and informed of this incentive via mailers. The provider facing staff continued to reinforce the incentive during provider meetings as an educational talking point. All providers are continually notified of all Project Echo training opportunities from OPH as well as made aware of additional support from the OPH clinician support line.	specific information for resources and referrals sources for complex members with confounding issues such as SUD/SMI or housing instability issues that affect the members SDOH. Continue to make provider aware of the HCV targeted members via the online gaps in care portal through continues support of usage of the online gaps in care portal which all providers will have access to targeted OPH listing due to full integration of this listing into the provider portal. Continue to educate and advocate the provider incentive for PCPs who treat HCV members per the OPH treatment algorithm.
Intervention #2d: PCP education regarding HCV/HIV members assigned to them and associated HIV associated toolkits and regional based referral listings of Ryan White Supported services. Target Providers to increase education of management of dual diagnosis members with HCV/HIV and availability of toolkits, resources and regional specific Ryan White supported facilities. Intervention tracking measure is the percentage of providers who were educated regarding HIV and regional based Ryan White Supportive services and have members assigned to them with probable or confirmed HCV	Direct member and provider feedback indicated that there is a potential of limited knowledge around HIV resources and Ryan White supported services. The health plan utilized an ACRN (certified HIV and AIDS certified Registered Nurse) in our provider education strategy and member outreach strategy and provide extra focus on the dual diagnosis HCV/HIV subset population. The ACRN developed an HIV provider toolkit to educated providers regarding HIV as well as a regional based referral listing of Ryan White available supportive services to distribute to providers	Direct provider feedback indicated that there was limited knowledge from the PCPs regarding proper coding of members with HIV. The health plan incorporated education of proper coding in the provider education strategy which resulted effectively identifying more members with HIV. The health plan has developed a comprehensive HIV strategy through the utilization of an ACRN (AIDS Certified Registered Nurse) who developed an HIV toolkit as well as a regional resource listing of Ryan White funded supportive services that is disseminated to our providers as part of the provider education strategy. The ACRN works as an integral part of the provider education	Continue to utilize the ACRN (HIV/AIDS Certifies Registered Nurse) into the provider education strategy and educate providers on availability of Ryan White supported resource services for members with dual diagnosis of HCV/HIV.

diagnosis per OPH listing over the number of providers who have members assigned to them with probable or confirmed HCV diagnosis per OPH listing		strategy and is available as a resource for providers who are treating HCV positive members with diagnosis of HIV. This strategy will continue throughout 2022 to assist in meeting the complex needs of the members with a dual diagnosis of HCV/HIV	
Intervention 3: ITM for provider education regarding the HCV program to targeted ER departments and outpatient substance abuse providers. This ITM was developed as part of the BH integration strategy. Intervention tracking measure is the percentage of ER facilities and outpatient substance abuse providers who have been educated regarding the HCV program including HCV clinician support line, waiver of PA requirements for generic Epclusa and additional resources available over the number of ER facilities and outpatient substance abuse providers	Direct Provider Feedback indicated that behavioral Health Providers may not be aware of the HCV program including the HCV clinician support line and additional resources available which led to the development of a partnership and collaboration with the leads of the BH PIP. We recognize there is a significant proportion of this population based on the CDC statistics that have a comorbid SUD/SMI diagnosis. With this in mind, we collaborated with the leads of the BH PIP and disseminated HCV provider education materials to MAT Providers and ER Facilities with high opioid presentations	We recognize there is a significant proportion of this population based on the CDC statistics that have a comorbid SUD/SMI diagnosis. With this in mind, we collaborated with the leads of the IET/FUA/POD PIP disseminated HCV provider education materials to MAT Providers and ER Facilities with high opioid presentations. BH Provider facing staff were educated and shared provider education materials with these identified providers. BH staff started tracking their progress in QTR 2 2021. In Q2 2021, the UHCCP LA Behavioral Health Staff strategic initiative to track the provider engagement and training on HCV began. The phased-in educational approach targets three Provider Types: ER Facilities, SUD Providers, and MAT providers. The education thus far has been “Live Virtual Trainings” in which there is interaction between providers and UHCCP LA; this gives the provider an opportunity to ask questions and interact with our Subject Matter Experts In addition, we will be sending out a mass communication to these targeted three Provider Types on our HCV initiative. In Q3 2021 our effort to educate Behavioral Health Providers on Hepatitis C Screening continued. In Q3, we outreached to 100% of the following provider types: Distinct Part Psychiatric Unit, Free Standing Psychiatric Hospital, Substance Abuse and Alcohol Abuse Center (Outpatient) and. Substance Use Residential. There was a total of 121 providers at 177 locations. The education was provided as a “Live Virtual Training”. In addition, an educational handout	It is our hope that this will increase provider knowledge and further expand our reach in servicing at risk members in terms of screening and treatment. Plans going forward are to continue the BH integration strategy throughout the duration of the project with continued educational reinforcement from our internal BH business partners for a fully integrated and strategic approach to assist in meeting the complex needs of the HCV positive member who may have potentially confounding BH issues.

		was sent via email to these providers on our HCV Initiative. We are in hopes to see an increase in Hepatitis C screening among these providers. Plans going forward are to include Behavioral Health Provider advocates to include HCV training in their provider interactions for continuous support and awareness of the program. Additionally, provider flyers and emails will continue periodically throughout the duration of the project.	
Intervention 4. ITM for provider education regarding members who need HCV treatment initiation and COVID-19 Vaccine Intervention tracking measure is the percentage of ER facilities and outpatient substance abuse providers who have been educated regarding the HCV program including HCV clinician support line, waiver of PA requirements for generic Epclusa and additional resources available over the number of ER facilities and outpatient substance abuse providers Intervention tracking measure is the percentage of HCV positive members per the OPH listing who have completed HCV treatment initiation and the COVID19 vaccine over the number of HCV positive members per the OPH listing who have completed HCV treatment initiation	HCV positive members who are unvaccinated have reported concern regarding the pandemic and its potential effects on an immunocompromised population Discussions regarding this intervention began in QTR1 of 2022 due to the continue Provider and Member feedback analysis that the COVID-19 pandemics is still a concern in the minds of the HCV positive population as the members are inherently immunocompromised	The lead of the HCV PIP identified a mutual need with the COVID-19 vaccine PIP leads to educated, advocate and encourage the COVID-19 vaccine to the targeted HCV members. This co-joined message and provider joint listing outreach will meet the needs of two high priority PIPs and conjointly meet the needs of the member. The clinical logic is that once vaccinated, the concern around the pandemic will mitigate and the member ideally become more amenable to seeking their provider for HCV treatment. Additional ITM was developed to track any inferential correlation between vaccinated members and HCV treated members	Additional opportunities to partner with the COVID-19 vaccine PIP leads will occur through the duration of the project. The health plan will continue to emphasize cojoined messaging and outreach to meet the needs of the population who are unvaccinated and also need treatment for HCV initiation which effectively addresses a dual need for this at-risk population.

References

American Association for the Study of Liver Diseases (AASLD)/ Infectious Diseases Society of America (IDSA). HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C. May 24, 2018.

Louisiana Department of Health (LDH). Letter from Jen Steel, Medicaid Director, to All Louisiana Medicaid Providers with Subject: Louisiana Fee for Service (FFS) Medicaid and Managed Care Organizations (MCOs) Hepatitis C Virus (HCV) Direct-Acting Antiviral (DAA) Agents Clinical Prior and Pre-Authorization Criteria Revision, April 24, 2018.

Louisiana Department of Health (LDH). Hepatitis C. http://ldh.la.gov/index.cfm/page/1012 [4 November 2019a].

Louisiana Department of Health (LDH). Direct-Acting Antiviral Agents (DAA) Used to Treat Hepatitis C Virus (HCV) Medication Therapy Worksheet For Louisiana Medicaid Recipients. Revised May 2019b.

Louisiana Medicaid. Authorization Criteria for Hepatitis C DAA Agents for Medicaid July 2019.

Louisiana Office of Public Health (LA OPH). Epidemiologic Profile of Hepatitis C Virus Infection in Louisiana – 2015. Louisiana Office of Public Health – Infectious Disease Epidemiology Section- Hepatitis C Infection Epidemiologic Profile. http://ldh.la.gov/assets/oph/Center-PHCH/Center-CH/infectious-epi/Hepatitis/HepC/HepCEpiProfile.pdf [4 November 2019].

Appendix 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)

Appendix B. 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

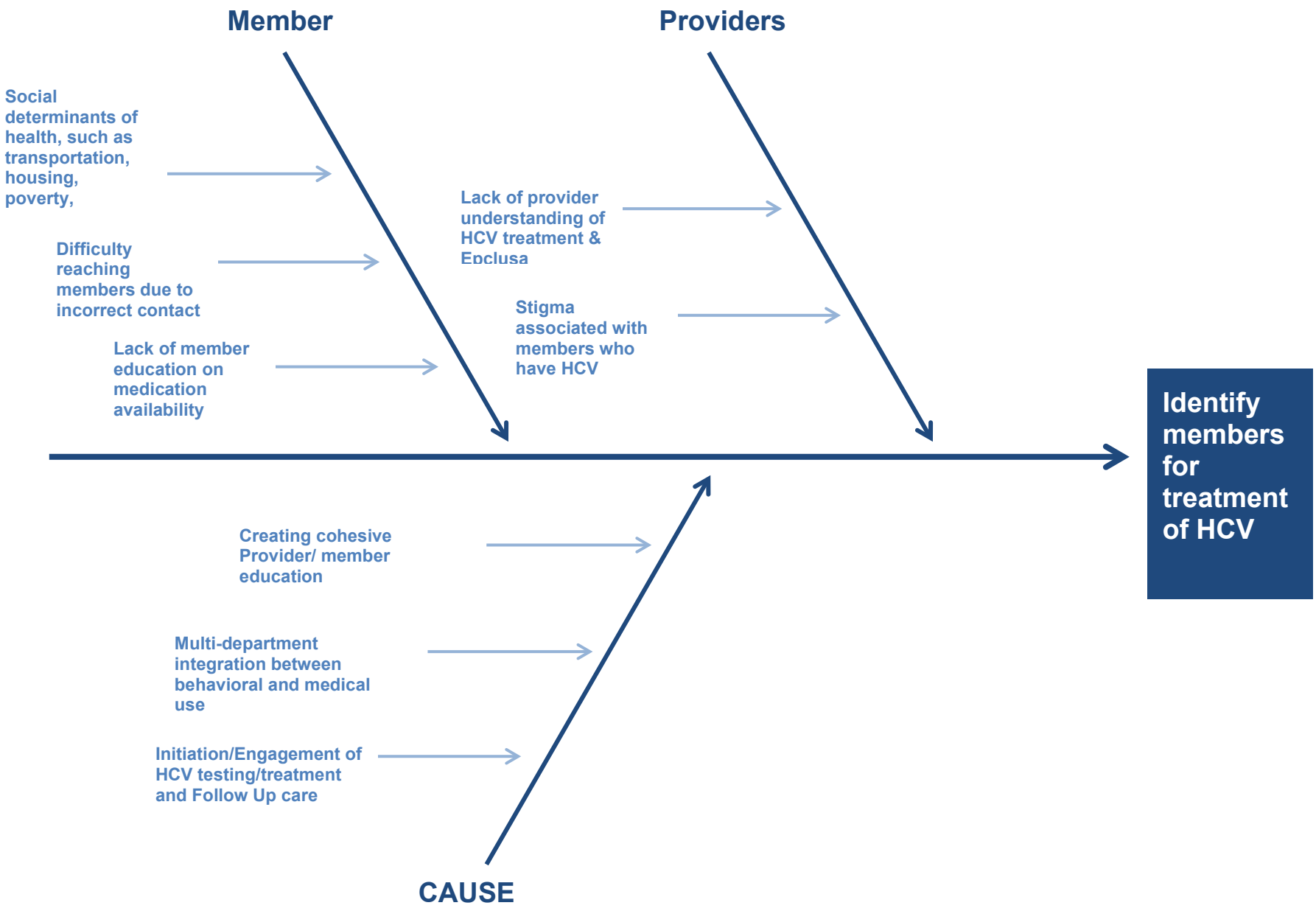
Glossary of PIP Terms

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 • Roadblock	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 A: Fishbone (Cause and Effect) Diagram



Appendix B: Priority Matrix

Which of the Root Causes Are . . .	Very Important	Less Important
Very Feasible to Address	Members Providers MCO/Internal	
Less Feasible to Address	Regulated data issues	

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

	Positives	Negatives
INTERNAL ***under your control***	***build on*** **STRENGTHS** ***Examples:*** □Increased access and availability of HCV treatment. □Historical data confirms members who are actively engaged with CM have higher rates of successful treatment □Provider educational materials have been effective in raising awareness and knowledge around appropriate assessment, triage, and referral of HCV treatment	***minimize*** **WEAKNESSES** ***Examples:*** □Communication between UM/CM □Data limitations around ADT feeds
EXTERNAL ***not under your control, but can impact your work***	***pursue*** **OPPORTUNITIES** ***Examples:*** □Provider education □Member engagement with case management □Provider engagement with case management	***protect from*** **THREATS** ***Examples:*** □Difficulties engaging with rural facilities □ITMs/performance indicators are based on administrative data and will be lagged, making it difficult to reassess the impact of interventions throughout a study with a brief measurement period

Appendix D: Driver Diagram

Aim: **Increase the HCV pharmaceutical treatment initiation rate among Healthy Louisiana adults ever diagnosed with HCV by 10 percentage points from CY 2021 to CY 2022.**	**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) Agent's 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 on secondary drivers.	•	•	•
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	•	•	•
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 on secondary drivers.	•	•	•
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	•	•	•