Health Plan Performance Improvement Project (PIP)

Health Plan: Louisiana Healthcare Connections

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	02/03/2022	12/09/2022
Version 2		12/30/2022

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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2. Additional Contact(s)

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

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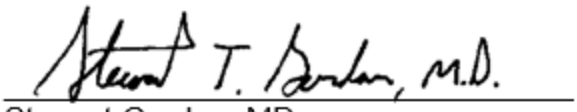
3. External Collaborators (if applicable):

Attestation

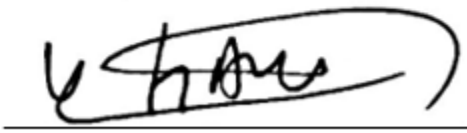
Plan Name: Louisiana Healthcare Connections
Title of Project: Improve Chronic Hepatitis C Virus (HCV) Pharmaceutical Treatment Initiation Rate

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

Medical Director signature: 
First and last name: Stewart Gordon, MD
Date: 12/9/2022 Chief Medical Officer

CEO signature: 
First and last name: Jamie Schlottman
Date: 12/9/2022 Chief Executive Officer

Quality Director signature: 
First and last name: Yolanda Wilson
Date: 12/9/2022 Sr. Vice President, Quality Improvement

IS Director signature: 
First and last name: Michel Hanet
Date: 12/9/2022 Director, Reporting & Business Analytics

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	08/01/2022	☐ Methodology ☒ Barrier Analysis ☒ Intervention ☒ Intervention Tracking Measure (ITM)	Additional barriers added to address to Barrier #1; ITMs (#1c, #1d) added to track medication refill reminders and RNA lab follow-up reminders post treatment
Change 2	10/25/2022	☒ Methodology ☐ Barrier Analysis ☐ Intervention ☐ Intervention Tracking Measure (ITM)	Performance indicator data revised for consistent reporting and quarter-over-quarter/year-over-year comparison in collaboration with LDH/IPRO
Change 3		☐ Methodology ☐ Barrier Analysis ☐ Intervention ☐ Intervention Tracking Measure (ITM)	
Change 4		☐ Methodology ☐ Barrier Analysis ☐ Intervention ☐ Intervention Tracking Measure (ITM)	

Abstract

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

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

Project Topic/Rationale/Objectives

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

Rationale: The Hepatitis C virus (HCV) is the most common blood-borne disease and the leading cause for liver transplant in the United States (LDH, 2019). HCV prevalence in Louisiana is estimated at 1.6 to 1.8 percent. Of particular relevance to our member population, the increased prevalence of HCV among baby boomers (born between 1945-1965), urban residents, and African American males aged 45-54 years underscores the importance of focused intervention for the benefit of our members (LDH, 2019). Research indicates an overlap of members with a history of incarceration and HIV populations due to the prevalence of past or current intravenous drug use in these groups (Spaulding, et al, 2017). Additionally, individuals with a co-occurring HIV infection are three times more likely to experience cirrhosis or symptomatic liver disease (HIV.gov, 2021) creating importance for timely initiation of treatment. As of summer 2019, Healthy Louisiana enrollees have access to safe and effective treatment for Hepatitis C. Thus, interventions and initiatives in this project are intended to increase linkage to treatment for members with a probable or confirmed HCV diagnosis (per OPH listing) and educating providers regarding evidence-based treatment guidelines and the Healthy Louisiana billing guidelines.

Objectives: 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:

- **Member Intervention Objective**: for all eligible members on the OPH listing, outreach and educate members, and facilitate referrals for appointment scheduling 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): Persons who use drugs, Persons with HIV
- **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

Eligible population: Healthy Louisiana adults ages 18 years of age and older with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing omitting anyone with a cured/cleared interpretation status.

Description of Annual Performance Indicators: Treatment related performance indicators included the percentage of members for whom treatment for HCV was initiated based on 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 and whether member had a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listings provided, current or past drug use, and HIV subcategories.

Sampling Method: No sampling used; PIP interventions target the entire eligible population.

Baseline and Re-measurement Periods: Baseline measurement period: 1/1/2021-12/31/2021; Interim/Final Measurement Period: 1/1/2022-12/31/2022

Data Collection Procedures: Performance indicator and intervention tracking measure data were collected through administrative claims/encounter data, Centene's Enterprise Data Warehouse, and additional data collection and/or abstraction programs such as SQL Server Management Studio, Teradata, Microstrategy, Interpreta, Impact Pro and clinical and other document software applications like TruCare, Sharepoint,. Supplemental data provided by the Louisiana Department of Health, Office of Public Health, through its Hepatitis C file was utilized for indicators, as instructed.

Interventions: Interventions developed to address the member needs and barriers include:

- Care management teams utilized the OPH list targeting members who needed treatment initiation or follow-up providing recommendations for screening, availability of curative treatment without prior authorization required. Staff provided appointment scheduling assistance, sharing the importance of the follow-up RNA test, and providing coordination of care with providers. Outreach by care management teams included members in the DOJ population who are known to be medically complex with both chronic physical health and behavioral health conditions.
- Member outreach campaigns with targeted communications to members on the OPH list (excluding cured/cleared members) via telephonic and face-to-face outreach. Outreach efforts also included sharing printed materials at community events, education on social media platforms, digital billboard advertising and radio advertising promoting importance of screening, evaluation for treatment, risks associated with delaying treatment, and offering assistance with linkage to provider.
- Targeted outreach by dedicated Quality staff providing education on importance of completion of treatment, refill reminders, assistance with refills when needed, RNA follow-up reminders, and assistance with appointment scheduling.
- Targeted outreach by Quality staff providing telephonic outreach to HIV/HCV co-infected members, educating on the importance of screening and availability of treatment in addition to assistance with appointment scheduling.

Interventions developed to address provider needs and barriers include:

- Provider network teams promoting resources and information, including but not limited to the following:
    - updated USPSTF recommendations
    - HCV toolkit (located in the provider resources section of the LHCC website)
    - availability of generic Epclusa without prior authorization
    - distribution of the HCV care gap reports located in the secure provider portal (updated to display recommendations by OPH for treatment, follow-up, and screening needs)
    - list of specialists shared with providers who prefer to refer members to specialists for treatment/follow-up
- Offering physician-presented provider education 'lunch and learn' event addressing HCV treatment initiation by PCPs. Education included updated clinical practice guidelines for screening, evaluation, treatment, and follow-up including the State Hepatitis C Virus Elimination Plan; as well as promoting the availability of the preferred generic Epclusa without prior authorization. CEUs were provided for attendees and an on-demand recorded version was made available on the provider education portal and promoted by the provider network teams.
- Online distribution of HCV education through the provider newsletter.

Results

Annual rates are pending year-end aggregation and review; all available performance indicator data YTD are included. HCV treatment rates improved YTD, though not meeting the target rates set at the onset of the project. YTD treatment rates for the various cohorts are as follows:

- Indicator 1a: HCV Treatment Initiation - Overall, YTD 8.63 percent, increased 6.49 percentage points since Q1, and 0.42 percentage points below baseline
- Indicator 1b: HCV Treatment Initiation - Persons who use drugs, YTD 8.69 percent, increased 6.22 percentage points since Q1, and 0.66 percentage points below baseline
- Indicator 1c: HCV Treatment Initiation - Persons with HIV, YTD 11.50 percent, increased 7.94 percentage points since Q1, and 1.47 percentage points above baseline

Conclusions and Next Steps

Pending continuation of the OPH HCV file distribution, LHCC will continue to share care gap reports with providers of paneled members which highlights the recommendation by OPH for treatment, RNA follow-up testing, or routine screening of members. Our provider network teams will continue to highlight the use of the HCV toolkit on the website for providers who are screening, treating, and following members on the HCV care gap report. Our care management teams will continue to promote linkage to providers for evaluation, treatment, and follow-up in their communications with members who are at risk or known to have Hepatitis C virus.

Project Topic

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

Describe Project Topic and Rationale for Topic Selection

- **Describe how PIP Topic addresses your member needs and why it is important to your members:**

  Louisiana Healthcare Connections (LHCC) is committed to the mission of improving the health of our community one member at a time. Prevalent infectious disease trends throughout the state and the nation are particularly relevant to our membership and ultimately impact the health and wellbeing of our members. As LDH has emphasized, the Hepatitis C virus (HCV) is the most common blood-borne disease and the leading cause for liver transplant in the United States, with Louisiana prevalence estimated at 1.6 percent to 1.8 percent. Of particular relevance to our member population, the increased prevalence of HCV among baby boomers (born between 1945-1965), urban residents, and African American males aged 45-54 years underscores the importance of focused intervention for the benefit of our members (LDH, 2019). Additional research indicates an overlap in members with a history of incarceration and HIV populations due to the overlapping prevalence of past or current intravenous drug use in these groups (Spaulding, et al, 2017). Also noted, individuals with a co-occurring HIV infection are three times more likely to experience cirrhosis or symptomatic liver disease (HIV.gov, 2021) increasing the importance of timely intervention and treatment initiation. As of summer 2019, Healthy Louisiana enrollees have access to safe and effective treatment for Hepatitis C. Thus, interventions and initiatives in this project are intended to increase linkage to treatment for members with a probable or confirmed HCV diagnosis (per OPH listing) and educating providers regarding evidence-based treatment guidelines and the Healthy Louisiana billing guidelines.

- **Describe high-volume or high-risk conditions addressed:**

  HCV infection is a high-risk condition leading to chronic liver disease, including liver cancer and liver failure, and related concurrent conditions such as past or current drug use and/or HIV infection increase the likelihood of HCV infection and reinfection. Though the volume of members identified by the Office of Public Health with a probable or confirmed HCV infection represents only a small percentage of our enrollment, LHCC is pleased to partner with LDH and other participants in this performance improvement project to increase Hepatitis C Virus (HCV) Pharmaceutical Treatment Initiation.

- **Describe current research support for topic (e.g., clinical guidelines/standards):**

  Current treatment recommendations support a standard curative treatment of direct-acting, oral antiviral (DAA) regimens without interferon (AASLD, 2021; USPSTF, 2020) as outlined in the Louisiana Hepatitis C Elimination Plan and the toolkit included on the Provider Resources section of our website. HCV screening and treatment is recommended for individuals with a co-occurring HIV infection in order to identify and slow liver disease progression (HIV.gov, 2021), while HCV treatment recommendations remain largely unchanged due to HIV co-infection (Abutaleb, 2018). This thoughtful and deliberate focus on optimal strategies is intended to increase HCV screening and treatment compliance to improve health outcomes for infected populations.

- **Explain why there is opportunity for MCO improvement in this area (must include baseline and if available, statewide average/benchmarks):**

  Immediate efforts towards initiating this performance improvement project included data aggregation and analysis to determine scope of current membership affected, as well as a review of best practices and recommendations from leading healthcare advisory groups including the Louisiana Hepatitis C Elimination Plan. The preliminary review of membership and OPH data completed in January 2022 indicated approximately 4,000 members are in the treatment-eligible population for this HCV treatment initiative; 2,500 of these members were identified with past or current drug use, and 150 with a co-occurring HIV infection. The additional benefit of pharmaceutical treatment options, and the generic Epclusa treatment available without authorization, further support the ability to impact outcomes for those with positive diagnosis.

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: 583 D: 6,445 R: 9.05%	R: 19.05%	10 percentage point increase from baseline measurement
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: 363 D: 3,884 R: 9.35%	R: 19.35%	10 percentage point increase from baseline measurement
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: 35 D: 349 R: 10.03%	R: 20.03%	10 percentage point increase from baseline measurement

[1] Baseline rate: the MCO-specific rate that reflects the year prior to when PIP interventions are initiated. Baseline data updated for consistent reporting and quarter-over-quarter/year-over-year comparison.
[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. Target rate updated based on updated baseline rate adjustments made for consistent reporting and quarter-over-quarter/year-over-year comparison.
[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/OPH list	Healthy Louisiana adults with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	Excluded members who were "cured/cleared" on OPH list prior to measurement period	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/OPH list	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	Excluded members who were "cured/cleared" on OPH list prior to measurement period	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/OPH list	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	Excluded members who were “cured/cleared” on OPH list prior to measurement period	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 eligible population was targeted by PIP interventions.

Sampling Procedures

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

- **Describe sampling methodology:**

  No sampling; PIP interventions targeted the entire eligible population.

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:**

  Performance indicator and intervention tracking measure data will be collected through administrative claims/encounter data, Centene's Enterprise Data Warehouse, and additional data collection and/or abstraction programs such as SQL Server Management Studio, Teradata, Microstrategy, and clinical and other document software applications like TruCare, SharePoint, Interpreta, and Impact Pro. Member and provider feedback, as well as outreach and clinical encounter data, will be aggregated and analyzed for discussion and root-cause analysis, and will be used to enhance existing interventions or develop new initiatives. While most data elements will be collected monthly for consistency in process and workflows, some PIP data may be aggregated and reported on a quarterly basis. Supplemental data provided by the Louisiana Department of Health, Office of Public Health, through its Hepatitis C file will also be utilized for indicators, as instructed. Those who collect the data include Data Analysts, Quality Improvement, Case Management, Provider Network, and/or Pharmacy team members who track and trend their department's data.

Validity and Reliability

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

- **Describe validity and reliability:**

  For data reliability, treatment initiation rates are compared to number of claims in our data warehouse for the same time period, hence a correlation ratio is derived to check data consistency. Data validation is conducted using various methods, including consultation with medical director, case management, provider network, and quality teams. Additional validation methods include enrollment checks to ensure timely treatment continuity of HCV-diagnosed population. In addition to above methods, statistical methods (experimental design) are used to compare number of HCV related claims received and unique number of Medicaid members.

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 will be analyzed by Data Analysts, Quality Improvement Abstractors, Provider Network, and Case Management staff who track and trend their department's data. Data is then compiled and presented to key internal stakeholders monthly for review and analysis in comparison to baseline data from the previous measurement year(s), month-over-month measurement periods, and target goals, to determine intervention effectiveness and/or identification of barriers. Data is stratified using demographic and clinical factors to support implementation of interventions and evaluation of outcomes. Denominators and numerators are checked for inclusion of all eligible populations and any identified discrepancies are investigated. Data is compared to all sources and histories available to produce the most valid data possible.

- **Describe how plan will interpret improvement relative to goal:**

  Improvement will be monitored via internal benchmarking against established baseline thresholds (as described above). Any stagnating or decreasing trends identified will result in a root-cause analysis and interventions will be modified as needed based on the information gathered.

- **Describe how plan will monitor ITMs for ongoing QI:**

  ITMs will be monitored at minimum monthly to evaluate positive improvement, plateaus, or identify adverse trends for prompt investigation, analysis and/or action to modify interventions if indicated. Bi-weekly and monthly monitoring of enrollees who are HCV diagnosed will be conducted using Business Intelligent tools to support initiatives promoting increased awareness, screening, and treatment for HCV.

(Tentative) PIP Timeline

Report the baseline, interim and final measurement data collections periods below.

Baseline Measurement Period:
Start date: 1/1/2021
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: 4/29/2022
Submission of 2nd Quarterly Status Report for Intervention Period from 4/1/22-6/30/22 Due: 7/29/2022
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; [8/1/2022] members need assistance with refilling treatment regimen timely to achieve curative status; members are unaware of need for RNA testing after completion of treatment regimen to verify curative status. **Method of barrier identification:** Direct member feedback; [8/1/2022] analysis of treatment refill records; analysis of members on OPH list that require RNA lab testing post treatment		**2022**			
		Q1	**Q2**	**Q3**	**Q4** ***(Partial)***[4]
Intervention #1a to address barrier: Enhanced MCO Outreach for HCV Treatment Initiation **Planned Start Date:** 2/1/2022 **Actual Start Date**:2/1/2022	**Intervention #1a tracking measure:** (non-cumulative) **N:** # members with appointment scheduled with HCV specialist (in OPH database) or PCP for HCV treatment assessment/initiation **D:** # treatment-eligible members with confirmed or probable HCV per OPH listing	N: 30 D: 5,186 R: 0.58%	N: 48 D: 5,382 R: 0.89%	N: 110 D: 5,400 R: 2.04%	N: 30 D: 5,688 R: 0.53%
Intervention #1b to address barrier: Targeted case management outreach for HCV treatment initiation for members in DOJ population **Planned Start Date:** 5/1/2022 **Actual Start Date**:5/1/2022	**Intervention #1b tracking measure:** (non-cumulative) **N:** # members with appointment scheduled with HCV specialist (in OPH database) or PCP for HCV treatment assessment/initiation **D:** # treatment-eligible members in DOJ population with confirmed or probable HCV per OPH listing	*Began Q2*	N: 11 D: 534 R: 2.06%[5]	N: 10 D: 564 R: 1.77%	N: 1 D: 386 R: 0.26%
Intervention #1c to address barrier: Targeted member outreach for HCV treatment refill reminders **Planned Start Date:** 8/1/2022 **Actual Start Date**: 8/1/2022	**Intervention #1c tracking measure:** (non-cumulative) **N:** # members with refill reminder/timely refill completed **D:** # members with HCV medication refill due	*Began Q3*	*Began Q3*	N: 235 D: 259 R: 90.73%[6]	N: 174 D: 198 R: 87.88%

[4] Data represents outcomes collected 10/1/22-12/9/22; holiday impacts on access, availability, and data collection taken into consideration.
[5] Outcome reflective of partial quarter data; intervention began 5/1/2022.
[6] Outcome reflective of partial quarter data; intervention began 8/1/2022.

Intervention #1d to address barrier: Targeted member outreach for RNA lab testing after completion of HCV treatment regimen **Planned Start Date:** 8/1/2022 **Actual Start Date**: 8/1/2022	**Intervention #1d tracking measure:** (non-cumulative) **N:** # members provided HCV RNA lab reminder post-treatment **D:** # members with HCV RNA lab test due post-treatment	*Began Q3*	*Began Q3*	N: 11 D: 97 R: 11.34%[7]	N: 23 D: 113 R: 20.35%
Barrier 2a: Providers may not be aware that Epclusa does not require prior authorization. **Method of barrier identification:** Direct provider feedback		**2022**			
		Q1	**Q2**	**Q3**	**Q4 *(Partial)*[8]**
Intervention #2a to address barrier: Provider education regarding SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) prescription. **Planned Start Date:** Ongoing **Actual Start Date**: 3/1/2020	**Intervention #2a tracking measure:** (non-cumulative) **N:** # members with SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) dispensed **D:** # members with any DAA dispensed	N: 293 D: 309 R: 94.82%	N: 351 D: 362 R: 96.96%	N: 368 D: 381 R: 96.59%	N: 239 D: 252 R: 94.84%
Barrier 2b: Providers may not be aware of HCV clinical guidelines, HCV specialists, and their patients' eligibility for treatment. **Method of barrier identification:** Direct provider feedback		**2022**			
		Q1	**Q2**	**Q3**	**Q4 *(Partial)*[9]**
Intervention #2b to address barrier: Intervention to outreach providers to educate about HCV CPG and to distribute listing of HCV Treatment Providers and HCV Care Gap Reports **Planned Start Date:** 2/1/2022 **Actual Start Date**: 1/1/2022	**Intervention #2b tracking measure:** (non-cumulative) **N:** # of providers outreached by Provider Network to educate about HCV CPG and to distribute listing of HCV Treatment Providers and HCV Care Gap Reports **D:** # of providers targeted for outreach	N: 367 D: 729 R: 50.34%	N: 136 D: 729 R: 18.66%	N: 235 D: 738 R: 31.84%	N: 148 D: 730 R: 20.27%

[7] Outcome reflective of partial quarter data; intervention began 8/1/2022.
[8] Data represents outcomes collected 10/1/22-12/9/22; holiday impacts on access, availability, and data collection taken into consideration.
[9] Data represents outcomes collected 10/1/22-12/9/22; holiday impacts on access, availability, and data collection taken into consideration.

Barrier 3: Challenges with engaging high-risk subpopulations including members with HCV/HIV co-infection **Method of barrier identification:** Member outreach analysis; clinical encounter feedback		**2022**			
		Q1	**Q2**	**Q3**	**Q4** ***(Partial)***[10]
Intervention #3a to address barrier: Targeted member identification and outreach for linkage to community partners and alternative care providers/settings for treatment **Planned Start Date:** 3/1/2022 **Actual Start Date**: 3/1/2022	**Intervention #3a tracking measure:** (non-cumulative) **N:** # of successful member engagements resulting in linkage to treatment provider **D:** # treatment-eligible members with confirmed or probable HCV and HIV co-infection	N: 29 D: 136 R: 21.32%	N: 5 D: 136 R: 3.68%	N: 53 D: 142 R: 37.32%	N: 37 D: 135 R: 27.41%
Sub measure #3b to address barrier: Targeted member identification and outreach for linkage to community partners and alternative care providers/settings for treatment **Planned Start Date:** 3/1/2022 **Actual Start Date**: 3/1/2022	**Sub measure #3b:** (non-cumulative) **N:** # of successful member engagements resulting in treatment initiation **D:** # of successful member engagements resulting in linkage to treatment provider	N: 2 D: 29 R: 6.90%	N: 6 D: 31 R: 19.35%	N: 13 D: 53 R: 24.53%	N: 4 D: 37 R: 10.81%

[10] Data represents outcomes collected 10/1/22-12/9/22; holiday impacts on access, availability, and data collection taken into consideration.

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[11] Measure period: 1/1/21-12/31/21	Final Period Measure period: 1/1/22-12/9/22[12]	Target Rate[13]
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: 583 D: 6,445 R: 9.05%	N: 491 D: 5,688 R: 8.63%	R: 19.05%
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: 363 D: 3,884 R: 9.35%	N: 305 D: 3,508 R: 8.69%	R: 19.35%
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: 35 D: 349 R: 10.03%	N: 33 D: 287 R: 11.50%	R: 20.03%

[11] Baseline rate: the MCO-specific rate that reflects the year prior to when PIP interventions are initiated. Baseline data updated for consistent reporting and quarter-over-quarter/year-over-year comparison.
[12] Final 2022 data will not be available for reporting until 2023; data displayed represents the results of outcomes collected through 12/9/2022.
[13] 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). 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.

<u>OPTIONAL</u>: 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.*

Performance indicators showed continued growth throughout the measurement year; however, performance did not meet the target rates established for 2022. Prior to Q3 quarterly reporting, performance indicator data was revised for consistent reporting and quarter-over-quarter/year-over-year comparison. The indicator for HCV treatment initiation – Persons with HIV showed the most improvement, exceeding the MY2021 baseline rate.

Final 2022 performance indicator data will not be available for reporting until 2023; data reported and displayed represents outcomes collected YTD as of 12/9/2022. Outcomes for the performance indicators demonstrating 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 for whom pharmaceutical treatment for HCV was initiated are, as follows:

- **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 for whom pharmaceutical treatment for HCV was initiated is 8.63 percent, increasing 6.49 percentage points YTD. Beginning in Q1 with a rate of 2.14 percent, this rate more than doubled to 4.81 percent in Q2 and increased to 7.26 percent in Q3. Currently, this rate is 0.42 percentage points below baseline.

- **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 for whom pharmaceutical treatment for HCV was initiated is 8.69 percent, increasing 6.22 percentage points YTD. Beginning in Q1 with a rate of 2.47 percent, this rate more than doubled to 5.14 percent in Q2, and 7.52 percent in Q3. Currently, this rate is 0.66 percentage points below 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 for whom pharmaceutical treatment for HCV is 11.50 percent, increasing 7.94 percentage points YTD. Beginning in Q1 with a rate of 3.56 percent, this rate increased to 6.44 percent in Q2, and 9.36 percent in Q3, and has exceeded the MY2021 baseline rate by 1.47 percentage points.

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

Utilization of a multidisciplinary approach was used to drive the interventions, supporting the goal of increased treatment initiation of adult members with a confirmed diagnosis of Hepatitis C Virus included on the OPH list. Additional focus was placed on supporting members through treatment and follow-up to assist members in achieving curative status. Teams representing case management, provider network, community health services, and quality collaborated and customized plans to address known barriers and adapted efforts as new barriers were discovered or stagnation in rates occurred. Diligent efforts were made to outreach all members in the HCV population to provide education regarding HCV screening recommendations, plan benefits, available treatments,

need for RNA follow-up and assist with appointment scheduling. Member and provider outreach and education were crucial in efforts to increase awareness regarding updated guidelines for screening and treatment recommendations and the availability of a curative treatment (generic Epclusa) with no prior authorization required.

Member outreach:
In Q1, HCV appointment scheduling with HCV specialist or PCP for HCV treatment assessment/initiation (*ITM 1a*) resulted in a rate of 0.58 percent. In Q2, this lower percentage outcome prompted the addition of alerts incorporated into each member record within the clinical documentation system for members who were on the OPH list and had not yet reached a curative status. The use of these alerts was designed to minimize missed opportunities to address a member's HCV needs when contacted for any other identified needs, such as HEDIS care gaps. Enhancements were also made in the clinical documentation platform to expand data collection points allowing for improved data extrapolation related to member HCV education and appointment scheduling assistance. With these enhancements, appointment scheduling increased to 0.89 percent in Q2. To further increase outcomes, community health service workers targeted members who had not yet initiated HCV treatment, increasing appointment scheduling outcomes to 2.04 percent in Q3 and 0.53 percent YTD representing partial data for Q4. The greatest barrier for appointment scheduling was the inability to successfully reach members both telephonically and face-to-face; challenges with current and accurate member contact information presented a barrier to successful contact, despite coordination efforts with providers, pharmacies, and review of alternate sources of member contact information such as authorizations and claims related to other services (if available). LHCC's community engagement teams also reinforced the importance of updating contact information with the Medicaid office, including such messaging in notifications, education, and printed materials throughout the measurement year. Member feedback received during successful outreach encounters revealed some lacked awareness of the HCV diagnosis, hence limiting the conversation regarding member's status as reflected on the OPH list. Concerns for erroneous disclosures prompted the outreach teams to shift the discussion with unaware members to offer updated screening recommendations and assist with appointment scheduling for further discussion with their provider. *ITM 1b*, initiated in Q2, targeted the DOJ population for appointment scheduling with a HCV specialist or PCP for HCV treatment assessment and initiation; the initial rate was 2.06 percent with a slight decline noted in Q3 at 1.77 percent and a YTD rate of 0.26 percent (partial Q4 data). This population is known to be medically complex, with physical and behavioral health conditions considered to be high risk and needing increased care. Barriers were similar to the *ITM 1a* population with ongoing challenges with successful outreach, both telephonic and face-to-face - again due to challenges with current, accurate member contact information. Additionally, this high-risk population may have increased difficulty with communication due to medical/behavioral health conditions as well as multiple medical appointments and increased inpatient stays, making contact more difficult.

In Q3, an additional position was added to support members throughout treatment, encouraging completion of treatment and RNA follow-up testing to achieve curative status. This resource was dedicated to outreach of members for whom treatment was initiated, reminding members to refill medication, and offering education, assisting with refills if needed, coordinating care with providers, and assisting with appointment scheduling for additional needs or reported side effects. This staff member also outreached members from the OPH list who had not received an RNA follow-up post treatment, providing education on the importance of RNA follow-up to obtain curative status and offering assistance with appointment scheduling to address the need with their provider. While these interventions did not directly impact treatment initiation, it is important to note the significance of completing the treatment regimen in order to meet the intention of the project and assist these members to a cured/cleared status on the OPH list. *ITM 1c*, initiated in Q3, measures the number of members with timely refills or refill reminders provided for each month that the refills were due. Outcomes for this measure indicate an average of nearly 90 percent of the members' prescribed treatment regimens were impacted monthly. *ITM 1d* measures the number of members provided with an HCV RNA lab reminder post treatment, increasing the baseline of 9.09 percent to 20.35 percent in Q4. Barriers identified include challenges with successful outreach due to incorrect contact information, no answer, no available voicemail, or refusal of assistance. Efforts to obtain, verify and/or update member contact information included coordination of care with providers and pharmacies and reviewing alternate documentation submitted by providers for authorization of other services.

Targeting outreach for members coinfected with HIV and HCV on a quarterly basis, *ITM 3a* measures successful engagements resulting in linkage to a treatment provider. In Q1, initial outreach to this group resulted in a rate of

21.32 percent which dropped to 3.68 percent in Q2, with follow-up to members who did not initiate treatment after outreach. Unsuccessful outreaches were again attributed to outdated contact information, no answer, no ability to leave voicemail, or member refusal to engage. In Q3, successful outreach was supplemented with additional claims data validating linkage with a provider for treatment initiation, resulting in an improved rate of 37.32 percent and 27.41 percent YTD representing partial data for Q4. Sub-measure *ITM 3b* measures the resulting treatment initiation from these outreaches and linkage to treatment. These rates improved quarter-over-quarter, beginning with a rate of 6.90 percent in Q1, increasing to 19.35 percent in Q2, 24.53 percent in Q3 and 10.81 percent YTD (partial Q4 data).

Social media platforms were also utilized to disseminate information and promote awareness to members who were unable to be reached directly, with posts reaching 7,119 users. There were a total of 645 visits to LHCC's Hepatitis C educational member blog which was shared through social media posts. Additionally, Hepatitis C informational flyers were distributed at multiple community events including homeless outreach events, re-entry fairs for members re-entering the community post incarceration, senior events, and events held at recovery houses.

Provider outreach:
Provider network teams outreached providers whose paneled members were listed on the OPH file, sharing information and resources to providers including:

- updated USPSTF recommendations
- HCV toolkit (located in the provider resources section of the LHCC website)
- availability of generic Epclusa without prior authorization
- distribution of the HCV care gap reports located in the secure provider portal (updated to display recommendations by OPH for treatment, follow-up, and screening needs)
- list of specialists shared with providers who prefer to refer members to specialists for treatment/follow-up

Provider education is an ongoing process, allowing for the exchange of provider experiences, barriers, and best practices identified through similar conversations with other provider groups. *ITM 2b* measures the number of providers outreached by provider network teams. In Q1, the rate was 50.34 percent; a drop in this rate was noted in Q2 to 18.66 percent, primarily attributed to competing priorities as provider network teams prioritized State provider portal registration assistance. Additional focus on HCV educational topics resumed in Q3, resulting in growth in the rate to 31.84 percent and a rate of 20.27 percent YTD representing partial data for Q4.

LHCC hosted a Provider Education Series targeting primary care physicians in Q2 with physician 'peer messengers' presenting updated clinical practice guidelines for screening, evaluation, treatment, and follow-up including the State HCV elimination plan and availability of the preferred generic Epclusa without prior authorization. CEUs were offered for this event, with a resulting 46 providers in attendance. A recorded version was made available on-demand on LHCC's provider education portal for those unable to attend the live session; this was also promoted during provider education visits and in provider newsletters. *ITM 2a* measures generic Epclusa utilization in comparison to all available direct acting antiviral medications, thus supporting effective provider education and messaging. Results of this intervention indicate generic Epclusa was dispensed over other direct acting antivirals 95 percent or more of the time (Q1 rate: 94.82 percent, Q2 rate: 96.96 percent, Q3 rate: 96.59 percent, and Q4: 94.84 percent (partial quarter data)). Monitoring the utilization of generic Epclusa through analysis of pharmacy claims and monthly review of prior authorizations revealed that providers chose alternate treatments for members, primarily for those who previously failed Epclusa therapy or have potential for drug interaction with other maintenance medications in the member's medication regimen.

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*.

Several factors were identified as contributing to the limited progress with performance indicators and intervention outcomes. The greatest barrier identified for member outreach was the inability to contact members both telephonically and face-to-face due to lack of updated contact information. Efforts to locate updated contact

information were made through coordination of care with providers and pharmacies as well as review of recent attached provider documentation in the clinical documentation system. Additionally, members' lack of awareness of HCV diagnosis created challenges with education efforts and a shift in focus to education regarding updated screening guidelines with recommendations to follow-up with a provider were made and included providing assistance with appointment scheduling. It was anticipated that the inclusion of alerts in the member's clinical documentation file would increase outcomes by highlighting the need for follow-up on the members listed in the OPH file with any outreach made to these members. The ongoing challenges with successful outreach limited the full potential of this intervention through increased opportunities to assist members who were in need for follow-up. Enhancements made to the screening assessment fields in the clinical documentation system were intended to increase data extrapolation capabilities, however this was inhibited by ongoing challenges with unsuccessful outreach and valid member contact information (despite efforts to coordinate with other providers and locate alternate demographic data as available). Efforts to support members through treatment and follow-up were also inhibited by the ability to successfully reach this member population (i.e., outreach to provide medication refill reminders and reinforce importance of post treatment RNA lab testing). Although continued growth was observed in each performance indicator quarter over quarter, the rate of treatment initiation was limited, with feedback from providers indicating that members did not attend appointments or stated that they had already been treated. Due to the smaller size of this population, attempts to overlap outreach with HEDIS adult outreach and education were not as successful as it had been in broader outreach campaigns (i.e., COVID, Fluoride Varnish) and did little to increase successful outcomes. Feedback from provider network teams indicated that many providers reported that although HCV care gap information is helpful, their lack of internal resources and numerous individual health plan portals limited their ability to regularly access care gap reports.

Limitations

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

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

  No internal validity issues were noted; however, in October, performance indicator data was revised in collaboration with LDH/IPRO for consistent reporting and quarter-over-quarter/year-over-year comparison to previous PIP results.

  It was also noted that while free text assessment data collection streamlines outreach processes, it can impede the ability to extract targeted information regarding newly evolving barriers that may have been addressed during successful outreach.

- **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).

  Additional descriptive data was incorporated into the OPH quarterly HCV report in mid-2021. This additional information offered more detail regarding enrollees' specific HCV treatment status and allowed for more targeted intervention. This data was subsequently incorporated into the performance indicator methodology, excluding enrollees who reached a "Cured/Cleared" status prior to the baseline and interim measurement periods, for consistent reporting and quarter-over-quarter and year-over-year comparison.

Additionally, potential threats to the external validity of the findings may include accuracy in provider coding/documentation practices, impacting the validity of administrative measure rates.

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

  The greatest challenge in data collection was the ability to successfully reach members both telephonically and through face-to-face efforts for assessment of needs and collection of relevant information required to guide interventions despite ongoing efforts to obtain updated contact information. In efforts to reach those who could not be outreached by staff, utilization of social media platforms, radio and digital billboard advertising and distribution of Hepatitis C printed education at community events were ongoing to provide education on the updated screening guidelines, curative treatment availability, and promoting follow-up with providers to address member needs. Barriers identified through successful outreach were reviewed monthly and included refusal of engagement in discussions with case management staff, refusal of enrollment in case management, declined offers to assist with linkage for care, member's reporting completion of treatment perceiving no further follow-up necessary, members preference to self-schedule appointments, members unaware of positive HCV result and unwillingness to discuss further with plan staff, or members expressing wishes not to share sensitive health information with plan staff.

PIP Highlights

Member interventions relied on successful contact with members both, telephonic and face-to-face, with broader messaging provided through social media, digital billboard advertising, radio advertising, and dissemination of printed materials at community events. Focused topics included education regarding updated screening guidelines, availability of curative treatment with no prior authorization required, assisting with appointment scheduling with a provider, and the importance of completing the treatment regimen and obtaining the follow-up RNA lab test. The most effective member intervention, *ITM 3a*, measuring targeted quarterly outreach to members coinfected with HCV and HIV resulting in linkage to a provider. In Q1, 21.32 percent of these members were linked to providers. This rate dropped to 3.68 percent in Q2, and notably improved in Q3 to 37.32 percent as additional claims data was used to validate linkage with a provider. *ITM 3b* measured treatment initiation for members from the HCV/HIV coinfected population quarterly outreach. In Q1, 6.90 percent of those outreached initiated treatment, in Q2, 19.35 percent of members initiated treatment, and in Q3, 24.53 percent of members initiated treatment. This is in alignment with the growth seen in Performance Indicator #1c which gained 8 percentage points since Q1.

Provider network teams shared information with providers regarding USPSTF recommendations for screening, treatment algorithms, Medicaid reimbursement, and recommended therapy in accordance with LDH guidance. Member care gap reports were updated providing details regarding members' need for screening, treatment, or RNA lab results. Promotion of the HCV toolkit, located in the provider resources section of the provider website, and the Provider Education Series webinar addressing PCP management of HCV supported efforts to increase PCPs comfort level with treatment for HCV. The most effective provider intervention was *ITM 2a*, monitoring the utilization of generic Epclusa, averaging 95.88 percent for the measurement year (partial data through 12/09/2022) with a Q1 rate of 94.82 percent, 96.96 percent in Q2, and 96.59 percent in Q3. The current rate of 94.84 represents data available through 12/09/2022. Through analysis of the monthly pharmacy claims and prior authorization reports, it was noted that most members who required alternative treatment regimens had either a previously failed generic Epclusa regimen or the treatment posed a potential for a drug interaction with another medication in the member's regimen. Consistent messaging with providers yielded growth in performance indicators measuring treatment initiation. Performance Indicator 1a increased 6.49 percentage points since Q1, Performance Indicator 1b increased 6.22 percentage points since Q1, and Performance Indicator 1c increased 7.94 percentage points since Q1.

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
Enhanced MCO Outreach for HCV Treatment Initiation	Members unaware of treatment availability Members unaware of the HCV diagnosis The population was difficult to reach, limiting opportunities for engagement	Alerts placed in clinical documentation system to minimize missed opportunities for engagement Enhancements made to the health assessment tool to allow extrapolation of data Exploring provider partnership to include HCV education with susceptible populations	Continue case management outreach and supplemental outreach methods, promoting linkage to providers for treatment and follow-up Expanding outreach modalities to include/ incorporate digital communications (SMS/texting, email)
Targeted case management outreach for HCV treatment initiation for members in DOJ population	Medically complex members, difficulty with engagement, other medical needs prioritized. Member engagement challenging due to inability to contact members, no answer lack of updated contact information, no voicemail, refusal of assistance, incorrect addresses when attempting face-to-face visits	Robust efforts made to obtain updated contact information including coordination of care with providers/pharmacies, review of attached recent clinical documentation for authorization of services	Continue case management outreach and supplemental outreach methods, promoting linkage to providers for treatment and follow-up Expanding outreach modalities to include/ incorporate digital communications (SMS/texting, email)
Targeted member outreach for HCV treatment refill reminders	Some members unaware of the importance of completing treatment to reach curative status Most members who initiated treatment refilled the prescription timely	Hired FTE pharmacy technician to provide outreach and education, assist with appointment scheduling, assist with development of questions for provider, provide refill reminders, screen for barriers to completion of treatment, educate on need for RNA follow-up	Continue case management outreach and supplemental outreach methods, promoting linkage to providers for treatment and follow-up Expanding outreach modalities to include/ incorporate digital communications (SMS/texting, email)

Targeted member outreach for RNA lab testing after completion of HCV treatment regimen	Members unaware of need for RNA follow-up; when outreach was successful, members were receptive to information and more members agreed to discuss RNA follow-up with providers	Hired FTE pharmacy technician to provide outreach and education, assist with appointment scheduling, assist with development of questions for provider, provide refill reminders, screen for barriers to completion of treatment, educated on need for RNA follow-up	Continue case management outreach and supplemental outreach methods, promoting linkage to providers for treatment and follow-up Expanding outreach modalities to include/ incorporate digital communications (SMS/texting, email)
Provider education regarding SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) prescription	Limited provider awareness of availability of treatment with no PA required	Ongoing provider outreach and education promoting the use of the care gap report, updated clinical practice guidelines and availability of generic Epclusa without PA required	Continued provider outreach highlighting the updated screening/ treatment recommendations
Intervention to outreach providers to educate about HCV CPG and to distribute listing of HCV Treatment Providers and HCV Care Gap Reports	PCPs express preference to refer to specialists Limited utilization of care gap reports	Update made to care gap report to include OPH recommendation for treatment/RNA follow-up, or annual screening	Continued provider outreach highlighting the updated screening/ treatment recommendations
Targeted member identification and outreach for linkage to community partners and alternative care providers/settings for treatment	Challenges with successful telephonic outreach yielded lower outcomes than anticipated	Multiple attempts made to outreach population Exploring provider partnership to include HCV education with susceptible populations	Collaborate with providers who specialize in high-risk populations promoting continued evaluation/ treatment/follow-up
Sub measure to track treatment initiation on members successfully outreached	Many members linked to providers with recent claims noted for office visits	Multiple attempts made to outreach population	Continue case management outreach and supplemental outreach methods, promoting linkage to providers for treatment and follow-up

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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

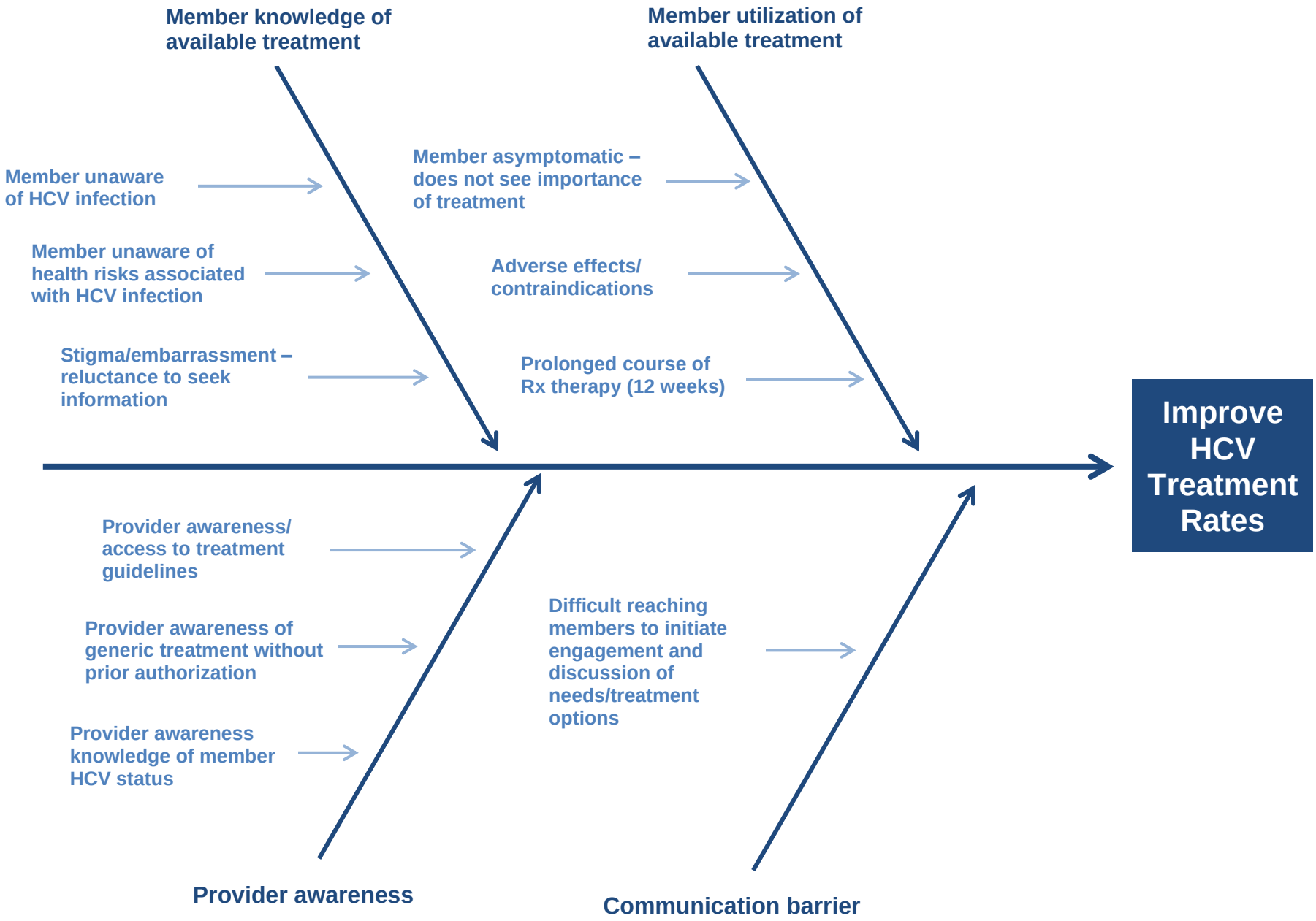
Glossary of PIP Terms

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	• Member outreach to provide education and linkage to treatment • Provider engagement in education, implementation of clinical practice guidelines, and increasing awareness of generic treatment option • Provider awareness of member HCV status through member care reports in secure portal	• Collaboration with Community Based Organizations (CBOs) to assist in messaging to treatment-eligible members with identified health inequities
Less Feasible to Address	• Stigma limiting member engagement in treatment services • PCP willingness to initiate treatment of complex health issues	

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

	Positives	Negatives
INTERNAL ***under your control***	***build on*** **STRENGTHS** • Strong provider network relationships • Established member care gap report in secure provider portal • Extensive marketing and communications platform to support messaging and resources/collaterals	***minimize*** **WEAKNESSES** • Alternative member outreach methodologies to supplement traditional communication
EXTERNAL ***not under your control, but can impact your work***	***pursue*** **OPPORTUNITIES** • Established relationships with Community Based Organizations (CBOs)	***protect from*** **THREATS** • Member response to outreach efforts, outdated member contact information, limited successful contacts

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) Agents criteria, and (4) Office of Public Health (OPH) streamlined test and treatment guideline. • Encourage providers to participate in OPH-provided HCV treatment training
		Foster collaboration between PCPs, behavioral health, and HCV specialists	• Develop and implement new processes to facilitate communication and coordinate care between PCPs, behavioral health and HCV providers listed in the OPH database (e.g., gastroenterologists, infectious disease specialists)
		Identify all members diagnosed with HCV	• Utilize the Office of Public Health listing of members with probable or confirmed HCV PIP to identify members with HCV diagnosis • Collaborate with OPH to develop PCP-specific listings of their patients who are potential candidates for HCV treatment • Develop Care Coordinator lists of members with HCV diagnosis for referral to PCPs for treatment
		Inform PCPs of their patients with HCV	• Distribute to each PCP their listing of members with HCV for medical assessment of appropriate treatment and/or referral to/ coordination with HCV specialist for treatment
		Educate and refer members with HCV for treatment assessment	• Care Coordinators Outreach, educate, refer, and schedule member's appointment with HCV provider on OPH listing or PCP for treatment assessment.

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

	Pilot Testing	Measurement #1	Measurement #2
Intervention #1:			
Plan: Document the plan for conducting the intervention.	□	□	□
Do: Document implementation of the intervention.	□	□	□
Study: Document what you learned from the study of your work to this point, including impact 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.	□	□	□