Health Plan Performance Improvement Project (PIP)

Health Plan: United Healthcare

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

PIP Implementation Period: January 1, 2020-December 31, 2021

Submission Dates:

	Proposal/Baseline	Interim	Final
Version 1	02/23/2020	12/10/2020	12/10/2021
Version 2	03/11/2020	12/28/2020	12/29/2021

MCO Contact Information

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Attestation

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

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

Medical Director signature: _____
First and last name: Julie Morial, MD
Date: 12/29/21

CEO signature: _____
First and last name: Karl Lirette
Date: 12/29/21

Quality Director signature: _____
First and last name: Deborah Junot BSN RN
Date: 12/29/21

IS Director signature (if applicable): _____N/A_____
First and last name:
Date:

Updates to the PIP

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

Table 1: Updates to PIP

Change	Date of change	Area of change	Brief Description of change
Change 1	July 2020	☐ Project Topic ☒ Methodology ☐ Barrier Analysis / Intervention ☐ Other	Once the HCV PIP resumed after the 3-month hold due to COVID-19 crisis, focus on provider education adapted to a methodology of multiple modalities such as virtual web-case conferencing when possible.
Change 2	July 2020	☐ Project Topic ☐ Methodology ☐ Barrier Analysis / Intervention ☒ Other	Provider input indicated that strategic partnerships with FQHCs would be beneficial to treating members with complex issues such as HCV and SUD/SMI. CM focused on developing with partnerships with FQHCs and assisting with any confounding factors while conducting CM outreach
Change 3	Feb 2021	☐ Project Topic ☒ Methodology ☐ Barrier Analysis / Intervention ☐ Other	The ITM 2 surrounding CM appointment scheduling for members to receive HCV screening was discontinued and replaced with a CM specific ITM. Plans for the CM specific ITM were discussed with the MCO collaborative and IPRO in an effort to track more meaningful progress and impact of the education of the members regarding HCV specific screening recommendations. Numbers are reflective of quarterly efforts of CM outreach to members who are in active CM. We understand that broader outreach is merited. It is our hope that our texting campaign which went live on July 1st will increase our overall reach of member education of screening recommendations and will positively impact our overall rates of members who successfully completed as evidence through claims analysis and overall performance indicator rates of HCV screening.

Change 4	April 2021	☐ Project Topic ☐ Methodology ☒ Barrier Analysis / Intervention ☐ Other	The health plan recognizes there is a significant proportion of this population based on the CDC statistics that have a comorbid SUD/SMI diagnosis. With this in mind and with direct input from provider feedback, we collaborated with the leads of the IET/FUA/POD PIP and disseminated HCV provider education materials to MAT Providers and ER Facilities with high opioid presentations. BH Provider facing staff were educated shared the provider education materials with these identified providers. 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.
Change 5	May 2021	☐ Project Topic ☐ Methodology ☐ Barrier Analysis / Intervention ☒ Other	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 monetary 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.

Abstract

For Final Report submission only.

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

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 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

Objectives:

1. **Member Intervention Objective**: Outreach and educate eligible members, and facilitate referrals to/schedule appointments with (I) PCPs for screening and (II) HCV providers (priority; per OPH database) or PCPs (per member preference) for treatment, with tailored interventions targeted to high-risk subpopulations (which are not mutually exclusive, as enrollees may have multiple high-risk characteristics)

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

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 IET PIP lead. Focused HCV provider education and training disseminated to targeted MAT providers, SUD Providers and ER facilities with high opioid presentations.

Results:

All Performance indicators demonstrated noted improvement from baseline to final measurement year including, 1a) (Universal Screening): The percentage of Healthy Louisiana enrollees ages 18-79 years {denominator} who were ever screened for HCV {numerator}, 1b) (Birth Cohort Screening): The percentage of Healthy Louisiana enrollees for whom HCV screening is indicated by birth year between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}. 2a) Performance Indicator #2a (Non-Birth Cohort/Risk Factor Screening- ever screened): The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}, 2b) (Non-Birth Cohort/Risk Factor Annual Screening): The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were screened during the measurement year for HCV {numerator}, 3a) (HCV Treatment Initiation-Overall): The percentage of all adults (ages 18 and older) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}, 3b) (HCV Treatment Initiation-Drug Users): The percentage of the subset of adults with current or past drug use and a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}, 3c)(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 appropriate screening and interventions led to noted improvements, whereas most of the performance indicators did meet the target ranges of 10 percent above the 2019 baseline and targets were increased accordingly. 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 2019. There were only eleven months of data available for the final measurement period of this project. It is also important to note that most interventions of this project started with an effective date of 2/1/2020 and due to the COVID-19 crisis this project was put on hold for three months of the year from March 2020 to June of 2020. Additionally, the COVID-19 pandemic continued into 2021 contributed to an ongoing barrier as well as the significant national disaster of Hurricane Ida that occurred in 2021. 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 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. 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. 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 provider supportive CM supplementation, continue our BH integration strategy as well as utilization of the ACRN as a provider resource. Direct Provider feedback indicated a need for a provider incentive which was implemented in 2021 for providers who followed the recommended OPH algorithm of completing member treatment for HCV as well as the follow up SVR-12 confirmatory lab testing. The health plan 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 alignments to meet the needs of the member as they seek treatment for HCV during the ongoing crisis of the COVID-19 pandemic.

Next Steps:

The next steps of the team will continue to expound on spreading success from a plethora of intervention that have significantly contributed to positive outcomes from 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 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 an 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. 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 UHC 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. We will continue to collaborate 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 with these identified providers. 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 as an integral part of the BH integration strategy. 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 going into 2022 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.

Project Topic

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 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

  HCV- testing based on a recognized exposure is recommended for:
  - Healthcare, emergency medical, and public safety workers after needle sticks, sharps, or mucosal exposures to HCV-positive blood
  - Children born to HCV-positive women

- **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):**

  UnitedHealthcare'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 according the Louisiana Department of Health. 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 HCV screening rate and initiation of HCV pharmaceutical treatment rate by ten percentage points by implementing a robust set of interventions to address the following key intervention objectives:

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

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

Table 2: Goals

Indicators	Baseline Rate[1] Measurement Period: 1/1/19-12/31/19	Target Rate[2]	Rationale for Target Rate[3]
Performance Indicator #1a (Universal Screening): The percentage of Healthy Louisiana enrollees ages 18-79 years {denominator} who were ever screened for HCV {numerator}.	N:42,240 D:297,778 R:14%	R:24%	Set by the aim of the LDH HCV PIP. Goals are set at 10 percentage points above baseline data from 2019. Table 5 in the results section goes into detail of goals met and targets that are adjusted accordingly.
Performance Indicator #1b (Birth Cohort Screening): The percentage of Healthy Louisiana enrollees for whom HCV screening is indicated by birth year between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.	N:11,006 D:61,971 R:18%	R:28%	Set by the aim of the LDH HCV PIP. Goals are set at 10 percentage points above baseline data from 2019. Table 5 in the results section goes into detail of goals met and targets that are adjusted accordingly.
Performance Indicator #2a (Non-Birth Cohort/Risk Factor Screening- ever screened): The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.	N:7,355 D:32,948 R:22%	R:32%	Set by the aim of the LDH HCV PIP. Goals are set at 10 percentage points above baseline data from 2019. Table 5 in the results section goes into detail of goals met and targets that are adjusted accordingly.
Performance Indicator #2b (Non-Birth Cohort/Risk Factor Annual Screening): The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were screened during the measurement year for HCV {numerator}.	N:1,466 D:32,948 R:4%	R:14%	Set by the aim of the LDH HCV PIP. Goals are set at 10 percentage points above baseline data from 2019. Table 5 in the results section goes into detail of goals met and targets that are adjusted accordingly.
Performance Indicator #3a (HCV Treatment Initiation-Overall): The percentage of all adults (ages 18 and older) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated	N:789 D:5,351 R:15%	R:25%	Set by the aim of the LDH HCV PIP. Goals are set at 10 percentage points above baseline data from 2019. Table 5 in the results section goes into detail of goals met and targets that are adjusted accordingly.

Indicators	Baseline Rate[1] Measurement Period: 1/1/19-12/31/19	Target Rate[2]	Rationale for Target Rate[3]
{numerator}.			
Performance Indicator #3b (HCV Treatment Initiation-Drug Users): The percentage of the subset of adults with current or past drug use and a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.	N:255 D:2,253 R:11%	R:21%	Set by the aim of the LDH HCV PIP. Goals are set at 10 percentage points above baseline data from 2019. Table 5 in the results section goes into detail of goals met and targets that are adjusted accordingly.
Performance Indicator #3c (HCV Treatment Initiation-Persons with HIV): The percentage of the subset of adults ever diagnosed with HIV and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.	N:28 D:206 R:14%	R:24%	Set by the aim of the LDH HCV PIP. Goals are set at 10 percentage points above baseline data from 2019. Table 5 in the results section goes into detail of goals met and targets that are adjusted accordingly.

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

Methodology

Performance Indicators

Table 3: Performance Indicators

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

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

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

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

Data Collection and Analysis Procedures

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

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:** Edward Coleman III MS, MBA, Medical Clinical Operations Manager & 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 UHCLA 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 UHCLA Analytics Team data validation procedures, the UHCLA 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: 1/1/2019
End date: 12/31/2019

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

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

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

Submission of 1st Quarterly Status Report for Intervention Period from 1/1/21-3/31/21 Due: 4/30/2021
Submission of 2nd Quarterly Status Report for Intervention Period from 4/1/21-6/30/21 Due: 7/31/2021
Submission of 3rd Quarterly Status Report for Intervention Period from 7/1/21-9/30/21 Due: 10/31/2021

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

Final Measurement Period:
Start date: 1/1/2021
End date: 12/31/2021

Submission of Draft Final Report Due: 12/10/2021
Submission of Final Final Report Due: 12/31/2021

Barrier Analysis, Interventions, and Monitoring

Table 4: Alignment of Barriers, Interventions and Tracking Measures[1]

Barrier 1: New Healthy Louisiana HCV treatment benefit may be unknown to enrollee. Method of barrier identification: IPRO HCV PIP guidance document.		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4[2]**
Intervention #1a to address barrier: Enhanced Case Management Outreach for HCV Treatment Initiation **Planned Start Date: 02/01/2020** **Actual Start Date:02/01/2020**	**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: 48 D: 1727 R: 3%	N:102 D:4718 R:2%	N:265 D:5334 R:5%	N:340 D:6155 R:6%	N:207 D:7595 R:3%	N:112 D:5469 R:2%	N:90 D:5342 R:2%	N:107 D:5208 R:2%
Intervention #1b to address barrier: **Planned Start Date:** **Actual Start Date**:	**Intervention #1b tracking measure:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 2: Asymptomatic enrollees may not know they are infected with HCV. Method of barrier identification: IPRO HCV PIP guidance document.		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention #2a to address barrier: Enhanced Case	**Intervention #2a tracking measure:** **N:** # members with appointment	N:0 D:9,009 R:0%	N:0 D:9,288 R:0%	N:0 D:12,984 R:0%	N:0 D:14,121 R:0%[3]	N: D: R:	N: D: R:	N: D: R:	N: D: R:

[1] All date reported in QTR 2021 is partial data based on time of submission and should be interpreted accordingly as such.

[2] This number should be interpreted as relative in regard to a progressively increasing denominator that increases with each subsequent OPH listing. Additionally, this partial data for QTR4 at the time of submission. Also, during quarter 3 2021, the challenges of the COVID-19 delta variant surge as well as Hurricane Ida posed significant barriers. For example, one of our partnered FQHCS that were directly affected by Hurricane Ida in the Houma region directly reported to the health plan “The GI Clinic is closed and everybody for the last 3 weeks and possibly for 3 more weeks in the future will have to be rescheduled”. Incidentally the outreach team also reported that there were 1,854 members outreached who were UTR and letters sent. Additional claims analysis and review as well as partnerships established between the provider facing staff and the providers will ideally mitigate some of these challenges to a degree. Plans prior to the hurricane season for CM intervention included the mutual goal alignment with the leads of the COVID-19 PIP to educate and advocate members to receive the COVID-19 vaccine. Presumably, this would reduce member abrasion and effectively mitigate any member apprehension surrounding the COVID-19 pandemic to receiving treatment for HCV. The Health plan is closely monitoring the COVID-19 pandemic and has plans to utilize field-based community health workers once it is deemed safe as restrictions surrounding the pandemic are lifted.

Management Outreach for HCV Screening **Planned Start Date: 02/01/2020** **Actual Start Date:07/01/2020**	scheduled with PCP for HCV screening **D:** # members at risk for HCV per MCO claims/encounter data								
Intervention #2b to address barrier: Enhanced Case Management Outreach for HCV Screening Education. **Planned Start Date: 02/01/2021** **Actual Start Date:02/01/2021**	**Intervention #2b tracking measure:** **N:** # members educated about HCV Screening **D:** # members currently enrolled in CM who were not previously educated regarding HCV screening treatment recommendations	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N:266 D:7888 R:3%	N:235 D:7400 R:3%	N:149 D:7251 R:2%	N:105 D:7099 R:1%
Barrier 3: Providers may not be aware that Epclusa does not require prior authorization. **Method of barrier identification:**		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention #3a to address barrier: Provider education regarding SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) prescription. **Planned Start Date: 02/01/2020** **Actual Start Date:02/01/2020**	**Intervention #3a tracking measure:** **N:** # members with SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) dispensed **D:** # members with any DAA dispensed	N:897 D:902 R:99%	N:576 D:584 R:99%	N:562 D:576 R:98%	N:547 D:565 R:97%	N:629 D:655 R:96%	N:640 D:657 R:97%	N:433 D:437 R:99%	N:458 D:468 R:98%
Intervention #3b to address barrier: **Planned Start Date:** **Actual Start Date**:	**Intervention #3b tracking measure:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:

[3] The ITM 2 surrounding CM appointment scheduling for members to receive HCV screening was discontinued and replaced with a CM specific ITM. Plans for the CM specific ITM were discussed with the MCO collaborative and IPRO in an effort to track more meaningful progress and impact of the education of the members regarding HCV specific screening recommendations. Numbers are reflective of quarterly efforts of CM outreach to members who are in active CM. We understand that broader outreach is merited. It is our hope that our texting campaign which went live on July 1st, 2021 will increase our overall reach of member education of screening recommendations and will positively impact our overall rates of members who successfully completed as evidence through claims analysis and overall performance indicator rates of HCV screening.

Barrier 4: Primary Care Providers may not be aware of members with HCV have comorbid conditions such as substance use disorders and IVDA. Method of barrier identification: IPRO HCV PIP guidance document/Provider Feedback		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention #4a to address barrier: PCP education regarding HCV members assigned to them and associated high-risk cohorts and comorbid conditions **Planned Start Date: 02/01/2020** **Actual Start Date:02/01/2020**	**Intervention #4a tracking measure:** **N:** # providers who were educated regarding 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:2 D:1082 R:0.2%	N:166 D:1082 R:15%	N:207 D:1082 R:19%	N:274 D:1082 R:25%	N:362 D:1082 R:33%	N:408 D:1082 R:38%	N:442 D:1082 R:41%	N:509 D:1082 R:47%[4]
Intervention #4b to address barrier: **Planned Start Date:** **Actual Start Date**:	**Intervention #4b tracking measure:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 5: Providers may not be aware of the HCV program the HCV clinician support line and additional resources available Method of barrier identification: IPRO HCV PIP guidance document/Provider Feedback		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention #5a to address barrier: ITM for provider education regarding HCV program including HCV clinician support line and additional resources available. **Planned Start Date: 02/01/2020** **Actual Start Date:02/01/2020**	**Intervention #5a tracking measure:** **N:** # Number of providers educated regarding the HCV program including HCV clinician support line, waiver of PA requirements for generic Epclusa 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%	N:1082 D:1082 R:100%	N:1082 D:1082 R:100%	N:1082 D:1082 R:100%	N:1082 D:1082 R:100%

[4] 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. Additionally, the OPH clinician support line is disseminated to the entire provider directory as an additional resource.

Intervention #5b to address barrier: **Planned Start Date:** **Actual Start Date:**	**Intervention #5b tracking measure:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 6: 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 the leads of the IET PIP.**		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention #6a 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: 04/01/2021** **Actual Start Date:04/01/2021**	**Intervention #6a 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: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N:25 D:119 R:21%	N:121 D:121 R:100%	N:121 D:121 R:100%
Intervention #6b to address barrier: **Planned Start Date:** **Actual Start Date:**	**Intervention #6b tracking measure:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:

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: 1/1/2019-12/31/2019	**Interim Period** Measure period: 1/1/2020-12/31/2020	**Final Period** Measure period: 1/1/2021-12/31/2021	**Target Rate[1]**
Performance Indicator #1a (Universal Screening): The percentage of Healthy Louisiana enrollees ages 18-79 years {denominator} who were ever screened for HCV {numerator}.	N:42,240 D:297,778 R:14%	N: 44,906 D: 288,581 R: 15%	N: 71,894 D: 304,873 R: 24%	Rate Initial target rate of 24% met and new goal will be increased to 34% accordingly.
Performance Indicator #1b (Birth Cohort Screening): The percentage of Healthy Louisiana enrollees for whom HCV screening is indicated by birth year between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.	N:11,006 D:61,971 R:18%	N: 11,759 D: 60,244 R: 20%	N: 20,411 D: 71,962 R: 28%	Rate: Initial target rate of 28% met and new goal will be increased to 38% accordingly.
Performance Indicator #2a (Non-Birth Cohort/Risk Factor Screening- ever screened): The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.	N:7,355 D:32,948 R:22%	N: 9,169 D: 39,478 R: 23%	N: 14,998 D: 45,725 R: 33%	Rate: Initial target rate of 32% met and new goal will be increased to 42% accordingly.

Indicator	Baseline Period Measure period: 1/1/2019-12/31/2019	Interim Period Measure period: 1/1/2020-12/31/2020	Final Period Measure period: 1/1/2021-12/31/2021	Target Rate[1]
Performance Indicator #2b (Non-Birth Cohort/Risk Factor Screening- Annual Screening): The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were screened during the measurement year for HCV {numerator}.	N:1,466 D:32,948 R:4%	N: 7,143 D: 39,961 R: 17%	N: 13,133 D: 45,725 R: 29%	Rate: Initial target rate of 14% met and new goal was increased to 24% which was also met and exceeded. New target rate increased to 34% accordingly.
Performance Indicator #3a (HCV Treatment Initiation-Overall): The percentage of all adults (ages 18 and older) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.	N:789 D:5,351 R:15%	N: 1,489 D: 6,770 R: 22%	N: 3,496 D: 9,035 R: 39%	Rate: Initial target rate of 25% met and new goal was increased to 35% which was also met and exceeded. New target rate increased to 45% accordingly.
Performance Indicator #3b (HCV Treatment Initiation-Drug Users): The percentage of the subset of adults with current or past drug use and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.	N:255 D:2,253 R:11%	N: 315 D: 1,492 R: 21%	N: 579 D: 3,797 R: 15%[5]	Rate:21%

[5] 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 2021 and therefore the target rate should be interpreted with some relativity due to the increased identification of more members. The health plan has developed a comprehensive BH integration strategy with the leads of the IET PIP to assist with this particular performance indicator.

Indicator	Baseline Period Measure period: 1/1/2019-12/31/2019	Interim Period Measure period: 1/1/2020-12/31/2020	Final Period Measure period: 1/1/2021-12/31/2021	Target Rate[1]
Performance Indicator #3c (HCV Treatment Initiation-Persons with HIV): The percentage of the subset of adults ever diagnosed with HIV and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.	N:28 D:206 R:14%	N: 61 D: 219 R: 28%	N: 118 D: 701 R: 17%[6]	Rate:24%

[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.

[6] 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 elicited in a slightly decreased rate for 2021 and therefore the target rate should be interpreted with some relativity due to the increased identification of more members. 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.

Discussion

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.

The majority of the performance indicators had noted improvement over the course of the project and five of the seven performance indicators either met or exceeded the baseline target rate at this present time. It is anticipated given the progressive trajectory of HCV screening rates a fifth performance indicator target will be met once claims for HCV screenings have been processed for the end of 2021. 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 interpretative relatively and accordingly in relation to the increased denotator. 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 we monitor for continuous improvement. Sustained improvement can be inferred to a degree over the course of the duration of this PIP, however it is noted full data for 2021 is not available at this present time. It is also worth noting that due to the COVID-19 crisis that the HCV PIP was placed on hold for a duration of three months from March of 2020 to June 2020. Multiple Barriers were noted for 2021 as well including the continuation of the COVID-19 pandemic and the natural disaster of Hurricane Ida which 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 (Universal Screening): The percentage of Healthy Louisiana enrollees ages 18-79 years {denominator} who were ever screened for HCV {numerator} was 14%. The goal for this measure was set at 24% The final rate for this measure was 24%. While the year is not complete, we did have a notable increase in our rate for this measure and our membership increased as well. We did meet this target for 2021 and will increase the subsequent target rate to 34% accordingly. The baseline target rate was 24% and the final target rate was noted at 34%. The target was increased ten percentage points from baseline to final as goals were met accordingly.

The baseline rate for Performance Indicator #1b (Birth Cohort Screening): The percentage of Healthy Louisiana enrollees for whom HCV screening is indicated by birth year between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator} was 18%. The goal for this measure was set at 28%. The final rate for this measure was 28%. While the year is not complete, we did meet the target rate for this measure and will increase the subsequent target rate to 38% accordingly. The baseline target rate was 28% and the final target rate was noted at 38%. The target was increased ten percentage points from baseline to final as goals were met accordingly.

The baseline rate for Performance Indicator #2a (Non-Birth Cohort/Risk Factor Screening- ever screened): The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is

indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator} was 22%. The goal for this measure was set at 32%. The final rate for this measure was 32%. While the year is not complete, we did meet our target rate and will increase the target rate to 42% accordingly. The baseline target rate was 32% and the final target rate was noted at 42%. The target was increased ten percentage points from baseline to final as goals were met accordingly.

The baseline rate for Performance Indicator #2b (Non-Birth Cohort/Risk Factor Screening- Annual Screening): The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were screened during the measurement year for HCV {numerator} was 4%. The goal for this measure was set at 14%. The final rate for this measure was 29%. While this year is not complete, we did meet our goal for this measure and will continuously adjust our target rate in subsequent reporting going forward accordingly as we strive for continuous improvement. New target rate will be increased to 34% accordingly. The baseline target rate was 14% and the final target rate was noted at 34%. The target was increased twenty percentage points from baseline to final as goals were met accordingly.

The baseline rate for Performance Indicator #3a (HCV Treatment Initiation-Overall): The percentage of all adults (ages 18 and older) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator} was 15%. The goal for this measure was set at 25%. The final rate for this measure was 40%. While this year is not complete, we did meet our goal for this measure and will continuously adjust our target rate in subsequent reporting going forward accordingly as we strive for continuous improvement. New target rate will be increased to 45% accordingly. The baseline target rate was 25% and the final target rate was noted at 45%. The target was increased twenty percentage points from baseline to final as goals were met accordingly.

The baseline rate for Performance Indicator #3b (HCV Treatment Initiation-Drug Users): The percentage of the subset of adults with current or past drug use and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator} was 11%. The goal for this measure was set at 21%. The final rate for this measure was 15%. While this year is not complete, we 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 baseline target rate was 21% and the final target rate was noted at 21%. 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 2021 and therefore the target rate should be interpreted with some relativity due to the increased identification of more members. The health plan has developed a comprehensive BH integration strategy with the leads of the IET PIP to assist with this particular performance indicator.

The baseline rate Performance Indicator #3c (HCV Treatment Initiation-Persons with HIV): The percentage of the subset of adults ever diagnosed with HIV and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator} was 14%. The goal for this measure was set at 24%. The final rate for this measure was 18%. While this year is not complete, we 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 baseline target rate was 14% and the final target rate was noted at 14%. 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 elicited in a slightly decreased rate for 2021 and therefore the target rate should be interpreted with some relativity due to the increased identification of more members. 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 #1 one specific area that we 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 increased between 1% and 6% throughout duration of the project. The data for the end of the year 2021 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 denotator which resulted from increased screening and identified HCV positive cases. COVID-19 also placed a hold on CM outreach for three months out of the year of 2020. As of the time of this report the CM department has successfully scheduled appointments for 449 members for a year to date total in 2021 and it is also noteworthy that since the advent of this PIP, the CM department conducted a project-to date total of 51,413 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. 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.

The next area that we identified through barrier analysis as it related to ITM #2 was that asymptomatic enrollees may not know they are infected with HCV. The method of barrier identification of this ITM was derived from the IPRO HCV PIP guidance document. Enhanced Case Management Outreach for HCV Screening was conducted for members who may be at risk for HCV due to falling into one of the high-risk cohort groups. Over the course of the project with an abundance of challenges, UHC focused most of the CM action and efforts toward reaching members that were identified by OPH

as having a positive or probable diagnosis of Hepatitis C and educating providers about Hepatitis C treatment and screening. (Project-to-date, UHC has had 51,413 CM activities in attempts to reach UHC members identified on the OPH Hep C list as positive or probable.) UHC focused on this population because we believed there could be more success with partnering with the member's providers and FQHCs to link these members to treatment. Still, UHC planned and prepared for a CM screening outreach. In quarter 1 2020, UHC submitted a script for state approval (HARC outreach for CM outreach for screening) but was understandably directed that the Hep C PIP would be placed on hold temporarily in order for everyone to direct and prioritize activities related to fighting COVID. Once the PIP was resumed and the state approved the script, UHC was able to implement the CM screening outreach for a targeted member screening in October/early Quarter 4. UHC made 900 telephone calls to attempt to reach the targeted 300 members but there were zero successful member contacts (135 voicemails only). In Quarter 4, the team has submitted plans for a texting campaign directed toward members related to Hepatitis C screening and treatment. Modifications to ITM #2 were discussed with the MCO collaborative and IPRO. The directive received stated ITM #2a should be modified as needed for meaningful and feasible measurement of the progress of the intervention to drive HCV screening. Acceptable alternatives discussed included substitution of a numerator to monitor CM outreach plus member education about HCV screening and/or substitution of a denominator that is not based upon claims/encounter data but a more meaningful, feasible outreach group of members. Changes to ITM#2a were indicated in the ITM table of both the quarterly report as well as in the table of revisions in the full PIP report. The denominator selected included members enrolled in CM as a starting point and working feasible number due to the large volume of the entire membership that falls into the 18 or above category. Plans would essentially evolve to include education initiatives to all members above 18 and at risk as CM continue to educate all members they come in contact with. In Quarter 1 of 2021 modifications to ITM#2 were implemented. CM teams began to educate all members who are currently in existing CM programs, regarding the Center for Disease Control's (CDC) recommendation that all adults 18 years and older be screened for Hepatitis C. Reporting was created to specifically capture the education our CM teams provide to our members. The members educated, are members identified for various medical and behavioral CM programs. An average of 7,888 members were enrolled in CM in Quarter 1 2021. In Quarter 1 2021, 266 educational actions were recorded for 253 members. Each activity reported exemplifies outreach to a member 18 years of age or older. The team will continue to look and evaluate potential methods of outreach and capturing date for members who need HCV screening. In Quarter 2 2021, the CM team continued to educate all members who are currently in existing CM programs, regarding the Center for Disease Control's (CDC) recommendation that all adults 18 years and older be screened for Hepatitis C. Reporting was created to specifically capture the education our CM teams provide to our members. The members educated, are members identified for various medical and behavioral CM programs. An average of 7,901 members were enrolled in CM in Quarter 2 2021. In Quarter 2021, 249 educational actions were recorded for 235 members. Each activity reported exemplifies outreach to a member 18 years of age or older. The texting campaign met approval in the second quarter and began July 2021. A total of 2,543 members who opted into the SMS text program were sent text messages and reminders regarding HCV screening. In Quarter 3 2021, the CM team continued to educate all members who are currently in existing CM programs regarding the Center for Disease Control's (CDC) recommendation that all adults 18 years and older be screened for Hepatitis C. 3,181 members were outreached in CM in Quarter 3 2021. In Quarter 3 2021, 149 educational actions were recorded for 149 members. While QTR 4 2021 data is not complete as of the time of this report, the CM department has educated a total of 47 members enrolled CM regarding HCV screenings in QTR 4 2021. Barrier analysis from direct provider feedback indicates that member contact information is a barrier as well as the ongoing burden of the COVID-19 pandemic and the circumstances surrounding the natural disaster of Hurricane Laura in 2020 and Hurricane Ida in 2021. To address these barriers, the health plan will continue to conduct claims analysis and work closely with the PCPs for up-to-date contact information. As for the noted barrier of the COVID-19 pandemic, the health plans worked closely with the FQHCs and distributed facemask to provider to give to members. The health plan also explored options of utilizing HCV home test kits through an approved vendor as a result of direct member feedback that there was reported apprehension of members maintaining provider appointments due to the ongoing pandemic. To further ameliorate member apprehension regarding seeking treatment for HCV in an ongoing pandemic, the leads of the HCV PIP partnered with the leads of the COVID-19 vaccine pip for a mutual goal alignment of education

providers and members on the importance and availability of the COVID-19 vaccine. Increasing our reach of getting members vaccinated will optimally mitigate some of the reported member feedback of potential apprehension of seeking necessary treatment for HCV. The health plan will also work closely with our providers as they navigate through the staffing challenges and member displacement issues that resulted from the hurricanes. The analysis and interventions of the health plan however did overall positively impact screening rates as indicated in the Performance Indicators that relate to screenings where we are close and exceeded the majority of these noted performance indicators target rates.

With regards to ITM #3, Our third 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. We 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 97% to 99%. 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.

For the purposes of ITM #4, One specific area we 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 483 of the 1082 identified providers on the OPH listing producing a rate of 45% 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 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. 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 into 2022 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.

As it relates to ITM #5, The area we 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, we are jointly educating all providers regarding vaccine recommendations and HCV screening recommendations. CM along with the entire Community and State division at UHC 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.

With regards to ITM #6, the last area we 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 IET 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 IET/FUA/POD 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. BH staff started tracking their progress in QTR 2 2021. 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. In Q2 2021, the UHC 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 UHC; 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 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 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 throughout the duration of the project.

- **PIP Highlights:**

The health plan notes that Intervention 4 and 5 (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. We understand 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 3 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

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 2021 calendar year just as it did in 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.

- **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 2021. 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 2021 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.

  2020 and 2021 have proven to be a challenging year for our Hep C PIP; the 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. 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 and providers remained on hold

Next Steps

Table 6: Next Steps

Description of Intervention	Lessons Learned	System-Level Changes Made and/or Planned	Next Steps
Intervention 1: 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 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 began 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 2: Enhanced Case Management Outreach for HCV Screening Target Members who are at risk for HCV based on claims data and need case management outreach to schedule and assist with appointments PCPs or HCV specialist for appropriate screenings. Intervention tracking measure is percentage of the number members with appointments scheduled with a PCP for HCV screening over the number of members at risk for HCV per MCO claims/encounter data	The team ran a report of all members who were born between 1945-1965 and removed those members who were already listed on the OPH list. This report was identified for another CM outreach attempt to educate and schedule members for HCV screening per the CDC guidelines. The script for this additional outreach was submitted to LDH but was placed on hold due to the COVID pandemic. Once the PIP was no longer on hold, the script was approved with LDH for the additional CM outreach to the specific UHC population born between 1945-1965. Considering our review of Q1 and Q2 the CM department is proposed a modified HARC outreach to just those members born between 1945-1965 AND who have comorbid conditions of SUD. In Quarter 4, the team began the Hepatitis C screening outreach with CM using the HARC team: to just those members born between 1945-1965 and who have comorbid conditions of SUD. HARC team made 900 calls to 300 members with zero successful contact with a member to educated them on Hep C screening. Of the 300 members there were 135 voicemails. This notes the challenges of outreach to at risk members and the team will need to look for alternative and innovative methods for screening and outreach to at risk members.	The CM department will continue to investigate innovative ways to target at risk members to schedule HCV screening. The health plan will continue to work closely with local FQHCs and outreach at risk members to schedule appointments for at risk members for HCV screenings. Pharmacy claims reviewed and PCPs contacted for up-to-date member contact information and telehealth promoted as needed, LDH approved member educational material will continue to be disseminated to at risk members. Modifications to ITM #2 were discussed with the MCO collaborative and IPRO. The directive received stated ITM #2a should be modified as needed for meaningful and feasible measurement of the progress of the intervention to drive HCV screening. Acceptable alternatives discussed included substitution of a numerator to monitor CM outreach + member education about HCV screening and/or substitution of a denominator that is not based upon claims/encounter data but a more meaningful, feasible outreach group of members. Changes to ITM#2a were indicated in the ITM table of both the quarterly report as well as in the table of revisions in the full PIP report. The denominator selected included members enrolled in CM as a starting point and working feasible number due to the large volume of the entire membership that falls into the 18 or above category. Plans would essentially evolve to include education initiatives to all members above 18 and at risk as CM continue to educate all members they encounter.	Enhanced Case Management Outreach for HCV screening as well as screening for SUD, IVDA and other associated comorbid conditions. The health plan will continue to follow the project echo model for best practices for member outreach and engagement. Identify providers who are high utilizers of Generic Epclusa through a review of pharmacy claims and refer members who may not be linked to a PCP. Will advocate referrals to FQHCs when available. Continue the text campaign to reach many members notifying them of the importance of HCV screening and encouraging members who are at risk to be tested. 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 monitor HCV screenings.

Intervention 3: 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 UHC 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 4: 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	Provider engagement for new material was limited at time due to high volume of new material being released around COVID-19. Dissemination of available information to providers was difficult due to multiple avenues for distribution. Providers are not utilizing appropriate billing codes, which	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

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 resources available D: Number providers who have members assigned to them with probable or confirmed HCV diagnosis per OPH listing	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. 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. To date these two SME nurses along with the transformation consultants have collectively educated to date 483 providers and disseminated targeted OPH listing of suspected/confirmed members cases as of the end of the third quarter of PCPs 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. treatment compliance and medication adherence. 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. 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 into 2022 to assist in meeting the complex needs of the members with a dual diagnosis of HCV/HIV.	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 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. 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.

Intervention 5: 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 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 D: Number providers who have members assigned to them with probable or confirmed HCV diagnosis per OPH listing	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 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.	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 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 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 UHC 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 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. 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 6: ITM for provider education regarding HCV program to targeted ER departments and outpatient substance abuse providers. This ITM was developed as part of the BH integration strategy.	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 IET 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 IET/FUA/POD 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 UHC 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 UHC; 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.	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.

		In Q3 2021 our effort to educate Behavioral Health Providers 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 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.	

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

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

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

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

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

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

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

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

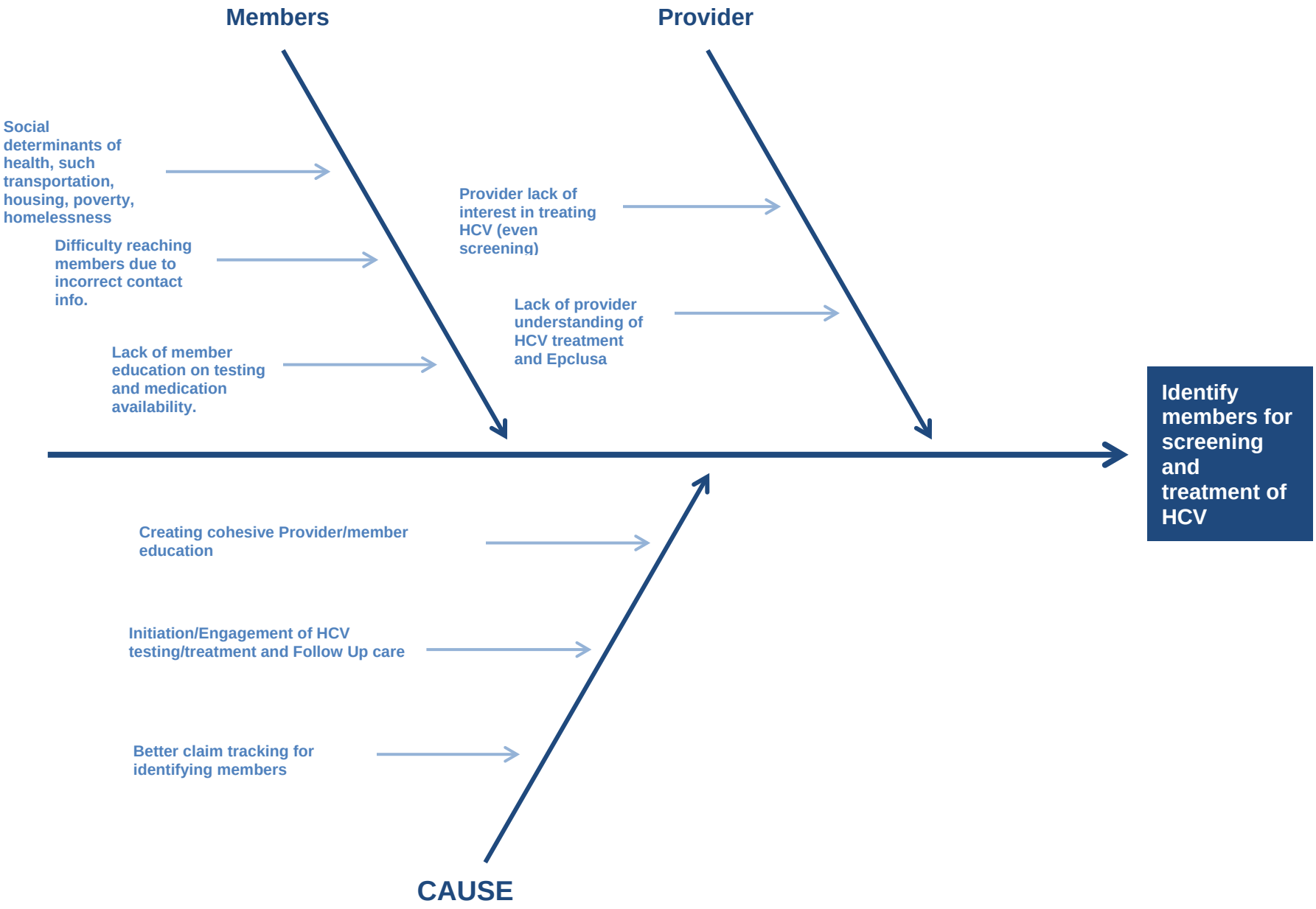
Glossary of PIP Terms

Table 7: PIP Terms

PIP Term	Also Known as…	Purpose	Definition
Aim	• Purpose	To state what the MCO is trying to accomplish by implementing their PIP.	An aim clearly articulates the goal or objective of the work being performed for the PIP. It describes the desired outcome. The Aim answers the questions "How much improvement, to what, for whom, and by when?"
Barrier	• Obstacle • Hurdle • 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 □ COVID-19 Crisis and multiple hurricanes and natural disasters.

Appendix D: Driver Diagram

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

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

Appendix E: Plan-Do-Study-Act Worksheet

	Pilot Testing	Measurement #1	Measurement #2
Intervention #1: Provide enhanced case management services through strong collaborations with FQHCs and identify barriers that impede them from engaging in treatment.			
Plan: Document the plan for conducting the intervention.	CM software was used to determine if the number of Members were outreached with completed contact (telephonic or face-to-face) to provide education regarding risk for HCV and HCV treatment and to facilitate provider appointments. Our Case managers and CHWs along with outside vendors document face-to-face visits, outreach, and telephone calls. Plan report utilized as an additional data source.	CM ITM rates increased from 0.44% (denominator d=5,042) in June to 1.30% (d=4,936) in August 2020	Screening rates showed between 1 and 3 percentage point increases from QTR 1 to QTR 3 2020. From QTR 1 to October, the Non-Birth Cohort/Risk Factor Annual Screening rate showed a 5-percentage point increase.
Do: Document implementation of the intervention.	The health plan met with the leadership teams of select FQHCs and developed a collaborative outreach approach to their associated targeted member list of the OPH listing of members assigned to them with confirmed or suspected HCV cases. It is the intent of the health plan that with close strategic partnerships with our providers and dissemination of targeted member list as well as supplementation of CM outreach that we will see an increase in members treated for Hepatitis and on generic Epclusa. Data for the small-scale test were restricted to members on the OPH listing with confirmed or suspected HCV diagnosis.	□	□

Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	Our encounter claims are comparable to the data in our internal systems. Using the information gained from our internal systems, the data was adequate to begin achieving our intended goals of viewing our members. We were able to determine the need to consider alternative processes. We predicted we would see an increase in numbers of members reached based on additional contact information received from the provider. This supports the secondary drivers of informing PCPs of members with HCV and referrals to treatment	□	□
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	CMs will continue to assess members willingness to participate in treatment given the barrier that COVID-19 pandemic continues to present. Continue the current process and make modifications if necessary, will advocate for telehealth. Continue to engage with our Population Health team, CM team, Pharmacy team, and Analytics team to assist with any confounding factors. Continue provider education regarding available therapies. Purposeful activity tracking related to scheduling, CM scheduling provider appointments and monitoring of appointment compliance. CM department is working closely with OPH linkage to care supervisor and collaborations are ongoing for effective partnerships with outreach to members.	□	□
Intervention #2: Provide education to providers, case management, and utilization management to increase knowledge of generic Epclusa as the preferred DAA with no prior authorization.			

Plan: Document the plan for conducting the intervention.	Targeted education was provided to entire physician directory of PCP and HCV specialist regarding generic EPCLUSA as the DAA drug of choice with no prior authorization requirement. We predicted an increase in members who were prescribed generic Epclusa as a DAA drug of choice. Data for the small-scale test were inclusive of all UHC members for had been prescribed a DAA through an extensive review of pharmacy utilization claims.	The AG Epclusa ITM increased from 96% in June to 99% in September	Treatment rates showed between 4 and 6 percentage point increases from QTR 1 to QTR 3. From QTR 1 to October, the HCV Treatment Initiation-Overall rate showed a 5-percentage point increase.
Do: Document implementation of the intervention.	Training was offered to staff our entire provider directory via fax blast. Additionally, provider facing staff reinforced education with key target providers and large FQHCs through multiple modalities given the COVID-19 crisis such as web-based conferencing and when available in person.	□	□

Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	The education of member and provider facing staff appeared to have a positive effect on the percentage rate of generic Epclusa utilization as the rate remained 96% to 99% all three quarters. Staff also responded positively to the training. This directly impacted the secondary drive related to barriers for educating providers on evidence-based HCV treatment guidelines. We predicted that we would see an increase in the number of members who would engage in care or engage with a provider regarding HCV treatment once Epclusa was made available without a PA requirement. Additionally, we would see in increase in members treated as targeted provider education is conducted and collaborations with providers are ongoing with dissemination of member specific lists and supplementation of case management resources	□	□
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	Going forward, the generic Epclusa utilization rate will continue to be monitored to ensure rates do not decrease. Additional trainings will be offered if needed, to account for new providers who require any additional education and any changes in authorization processes.	□	□