Medicaid and Viral Hepatitis Treatment in Kentucky

Kentucky 5th Annual Viral Hepatitis Conference
Ending the Epidemic: The Role of Professionals in Hepatitis Elimination

Tuesday, July 31st 2018

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Disclosure

Jens Rosenau has received funds for research support by Gilead Sciences

To be covered

- HCV Treatment
  - Treatment Evolution
  - Treatment Benefits
- University of Kentucky: Barriers to Treatment
- The Path to HCV Elimination
- University of Kentucky: Modified ECHO for Kentucky

WHO: Elimination of HCV as a Public Health Threat

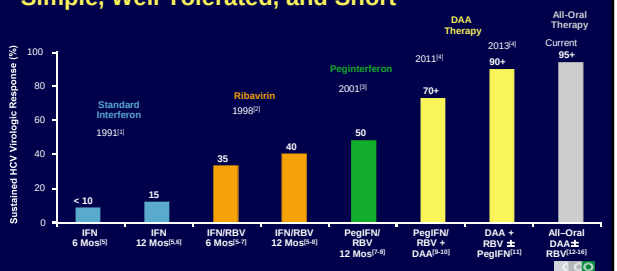
- Defined as achievement of measurable global targets in relation to infection and burden of disease
- Intensity of interventions required will vary by setting
  - Setting-specific model required to determine what is necessary to achieve the impact targets
- WHO targets for global HCV elimination as public health threat

2030 Targets	
90%	Diagnosed
80%	Treated
65%	Reduced Mortality

WHO. Global health sector strategy on viral hepatitis 2016-2021. 2016.

Slide credit: clinicaloptions.com

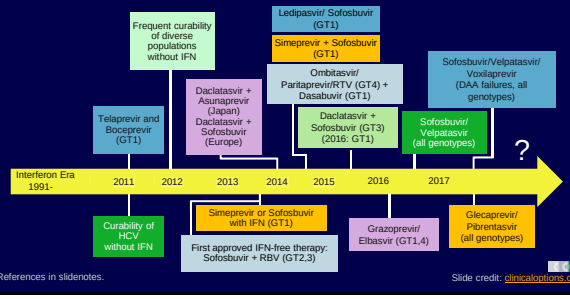
Current All-Oral Therapies Highly Effective, Simple, Well Tolerated, and Short



References in slidenotes.

Slide credit: clinicaloptions.com

The Evolution of HCV Therapy



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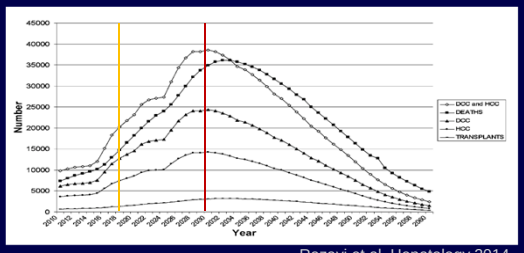
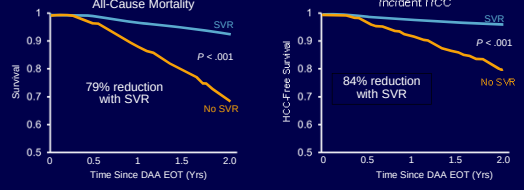
Background: Projected HCV Complications



Razavi et al, Hepatology 2014

SVR With DAA Therapy: Mortality and HCC Risk

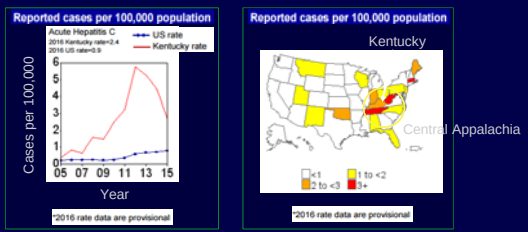
- Patients with HCV infection, FIB-4 > 3.25 in VA HCV Clinical Case Registry (N = 15,059)
  - SVR with DAA therapy significantly lowered all-cause mortality and incident HCC



Backus LI, et al. Hepatology. 2017;[Epub ahead of print].

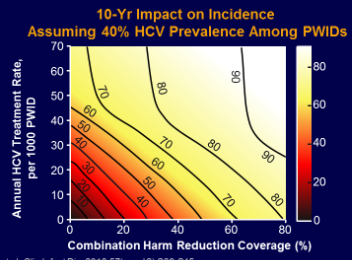
Slide credit: clinicaloptions.com

Acute HCV Disease Burden in Kentucky



Adapted from CDC data reports. Courtesy of Kathy Sanders, Kentucky Department for Public Health.

Modeling: Elimination Among PWIDs Achievable With Combination Treatment and Prevention



White area: > 90% incidence reduction within 10 yrs

Martin NK, et al. Clin Infect Dis. 2013;57(suppl 2):S39-S45.

Slide credit: clinicaloptions.com

University of Kentucky Treatment Data:

Identifying Barriers to Treatment

Patient Characteristics

Characteristics of cohort: n=881 new referrals with chronic Hepatitis C to UK outpatient clinic from 7/2014 to 6/2015, followed until 12/2016

- **Avg age 43 +/- 12**
- **Born after 1965 (64%), Born 1945-1965 (36%)**
- Male (53%)
- **White (93%)**
- Genotype 1 (68%)
- **Low fibrosis (F0-F2) (64%)**
- **Medicaid insurance (73%)**
- Lifetime injection drug use (73%)

Overall HCV Treatment Initiation Rate

Not Treated	Treated	Total
685 (78%)	196 (22%)	881

- 16% started treatment within 12 months of initial visit
- Overall treatment initiation rate over the 17-29 month follow-up period was 22%

Patient Follow-up

Follow-up (1-year)	Total 881
No	**324 (37%)**
Yes	557 (63%)

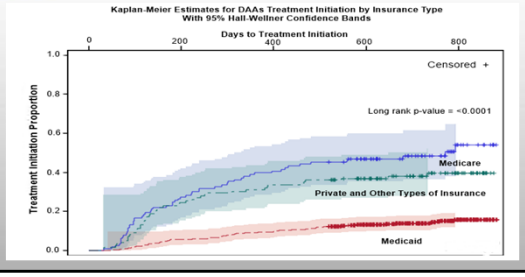
- 37% lost to follow-up at 1-year

Treatment Initiation Rates in Medicaid Patients

Insurance Type	Not Treated	Treated	Total
Total	685 (78%)	196 (22%)	881
Medicare	57 (50%)	56 (50%)	113 (13%)
Medicaid	553 (86%)	93 (14%)	646 (73%)
Private	75 (61%)	47 (39%)	122 (14%)

- Patients with Medicaid:
- 73% of cohort
- 14% of patients initiated treatment

Impact of Insurance Type on Treatment Initiation

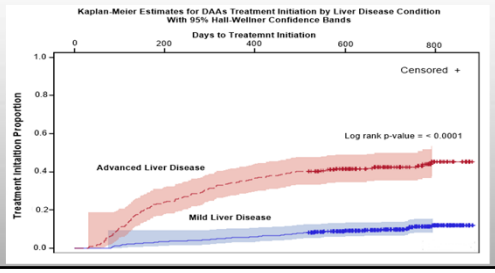


Fibrosis Stage and Treatment Initiation

Fibrosis Stage	Not Treated	Treated	Total
	685 (78%)	196 (22%)	881
Low (F0-2)	503 (90%)	58 (10%)	561 (64%)
*Advanced (F3+F4)	182 (57%)	138 (43%)	320 (36%)

- 43% of patients with advanced fibrosis and cirrhosis started treatment
- 10% of patients with low fibrosis started treatment

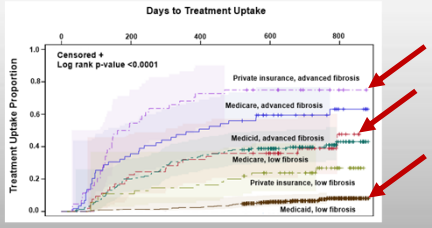
Impact of Fibrosis Stage on Treatment Initiation Rates



Treatment uptake in UK HCV referrals:

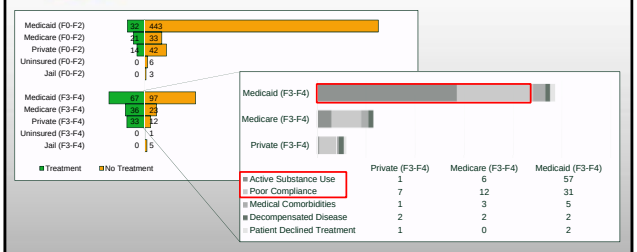
16% within 1 year after initial consult

22% over study period of about 2.5 years



Racho et al. DDW 2017

Barriers to HCV Treatment Uptake



	Private (F3-F4)	Medicare (F3-F4)	Medicaid (F3-F4)
Active Substance Use	1	6	57
Poor Compliance	7	12	31
Medical Comorbidities	1	3	5
Decompensated Disease	2	2	2
Patient Declined Treatment	1	0	2

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Conclusions

- Treatment uptake was **overall** low
  - only 16% started treated within 12 months
  - only 22% started treatment within observation period of up to 2.5 years
- Treatment uptake in **advanced fibrosis/cirrhosis** group was unsatisfactory
  - only 43% of patients with stage 3-4 fibrosis initiated treatment
  - about 1/3 had *ongoing* substance use, another 1/3 was lost to follow up

  ⇨ **Key Barrier: Medicaid - Illicit Drug Use Restrictions, Patient related - Compliance**
- Treatment uptake in **low fibrosis** group with Medicaid insurances was sporadic only about 3% within 12 months

  ⇨ **Key Barrier: Medicaid - Fibrosis Stage Restrictions**

Medicaid Managed Care Members with no Hepatitis C Drug Claims

intake period April 1, 2015-March 31, 2016

TOTAL Kentucky MMC adult population with chronic hepatitis C by outcome	N = 10,491 % All Kentucky MMC members: 1.8% n (Column %)	Members with No Hepatitis C Drug Treatment N = 10,159 % Members with Hepatitis C: 96.8% n (Row %)
Demographic factors		
Birth cohort		
Born after 1965	6,829 (65.1%)	6,644 (97.3%)*
Born 1945–1965	3,626 (34.6%)	3,479 (96.0%)
Born before 1945	36 (0.3%)	36 (100%)
Sex		
Male	4,947 (47.2%)	4,770 (96.4%)*
Female	5,544 (52.9%)	5,389 (97.2%)
Race/Ethnicity		
Black	504 (4.8%)	493 (97.8%)
White	6,616 (63.1%)	6,388 (96.6%)
Other	57 (0.5%)	55 (96.5%)
Unknown	3,314 (31.6%)	3,223 (97.3%)
County type/residence		
Appalachian	4,698 (44.8%)	4,549 (96.8%)
Non-Appalachian rural	1,188 (11.3%)	1,151 (96.9%)
Non-Appalachian urban	4,584 (43.7%)	4,438 (96.8%)
Unknown	21 (0.2%)	21 (100%)

National: 89.9%

Factors TOTAL Kentucky MMC adult population with chronic hepatitis C by outcome	Total Members with Chronic Hepatitis C: N = 10,491 % All Kentucky MMC members: 1.8% n (Column %)	Members with No Hepatitis C Drug Treatment N = 10,159 % Members with Hepatitis C: 96.8% n (Row %)
MCO		
Aetna Better Health of Kentucky	1,847 (17.6%)	1,785 (96.6%)*
Anthem BCBS Medicaid	744 (7.1%)	706 (94.9%)
Humana-CareSource	1,335 (12.7%)	1,264 (94.7%)
Passport Health Plan	2,385 (22.7%)	2,273 (95.3%)
WellCare of Kentucky	4,180 (39.8%)	4,131 (98.8%)

Source: Focused Study: Risk Factors for Lack of Access to Pharmaceutical Treatment for Chronic Hepatitis C Infection Report 4/2017 prepared on behalf of the Commonwealth of Kentucky, Department for Medicaid Services, Division of Program Quality and Outcomes

MMC Members with no Hepatitis C Drug Claims Multiple Logistic Regression

- Demographic factors
  - Birth cohort born after 1965 (relative to birth cohort both between 1945 and 1965): odds ratio (OR)= 1.4; 95% confidence interval (CI) = 1.1, 1.8
  - Black race/ethnicity (relative white race/ethnicity): OR = 2.4; 95% CI = 1.3, 4.6
  - Race/ethnicity not reported (relative to white race/ethnicity): OR = 1.5; 95% CI = 1.1, 1.9
  - Rural county of residence (relative to Appalachian county of residence): OR = 1.5; 95% CI = 1.0, 2.2
  - Urban county of residence (relative to Appalachian county of residence): OR = 1.6; 95% CI = 1.2, 2.1
- Clinical factors
  - SUD: OR = 1.3; 95% CI = 1.0, 1.7
  - Alcohol abuse: OR = 1.4; 95% CI = 1.0, 1.9
- Health care access-related factors
  - MCO (relative to the MCO with the lowest hepatitis C drug non-receipt rate), with ORs ranging from1.6 (95% CI = 1.1, 2.2) to 5.1 (95% CI = 3.4, 7.4)
  - Without any outpatient liver-related specialist visit: OR = 2.4; 95% CI = 1.8, 3.2

Focus Report 4/2017 prepared on behalf of the Commonwealth of Kentucky Department for Medicaid Services, Division of Program Quality and Outcomes

The Path to HCV Elimination

Major Barriers to HCV Elimination in Kentucky - Perspective of the treating provider

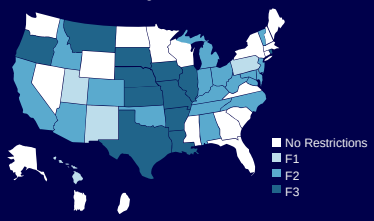
- Structural barriers in reimbursement requirements
  - Fibrosis stage, substance use disorders
- Patient-level barriers
- Lack of access to clinician who is prepared to provide comprehensive management

Major Barriers to HCV Elimination in Kentucky

- **Structural barriers in reimbursement requirements**
  - **Fibrosis stage, substance use disorders**
- Patient-level barriers
- Lack of access to clinician who is prepared to provide comprehensive management

2017 NVHR Update: Reduced Treatment Access in Many Settings for Pts With Mild Liver Disease

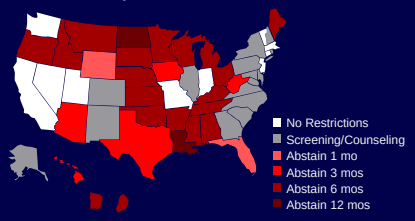
2017 Medicaid FFS Liver Damage Restrictions for HCV Treatment



NVHR State of Hepatitis C State of Medicaid Access Report. Oct 23, 2017. https://stateofhepc.org/ Slide credit: clinicaloptions.com

2017 NVHR Update: Drug/Alcohol Use Leads to Reduced Treatment Access in Some Settings

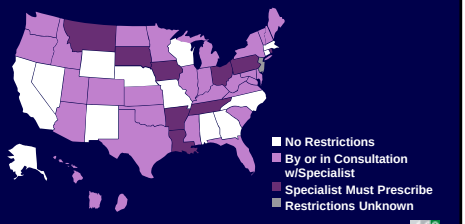
2017 Medicaid FFS Sobriety Restrictions for HCV Treatment



NVHR State of Hepatitis C State of Medicaid Access Report. Oct 23, 2017. https://stateofhepc.org/ Slide credit: clinicaloptions.com

2017 NVHR Update: Reduced Treatment Access for Pts Receiving Care From Non-Specialists

2017 Medicaid FFS Prescriber Restrictions for HCV Treatment



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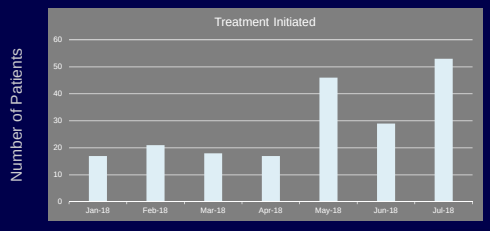
Treatment initiations UK Hepatology January 2018 to July 2018

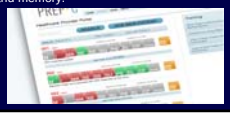


Major Barriers to HCV Elimination in Kentucky

- Structural barriers in reimbursement requirements
  - Fibrosis stage, substance use disorders
- **Patient-level barriers**
- Lack of access to clinician who is prepared to provide comprehensive management

Psychosocial Readiness Evaluation and Preparation for Hepatitis C Treatment: PREP-C

- **Motivation:** Reasons client wants to begin HCV treatment, concerns about treatment, and importance of treatment.
- **Information:** Knowledge about HCV treatment and one's own HCV disease status.
- **Medication Adherence:** Current prescribed medications and adherence to them in prior month.
- **Self-Efficacy:** Self-confidence about adhering to HCV treatment.
- **Social Support and Stability:** Stability of financial, housing, and social support resources.
- **Alcohol and Substance Use:** Alcohol and substance use behaviors and current treatment.
- **Psychiatric Stability:** Current psychiatric status, previous and current treatment.
- **Energy Level:** Sleep and fatigue.
- **Cognitive Functioning:** Perceived difficulty with communication in health care setting, problem-solving ability, and memory.



Major Barriers to HCV Elimination in Kentucky

- Structural barriers in reimbursement requirements
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- Patient-level barriers
- **Lack of access to clinician who is prepared to provide comprehensive management**

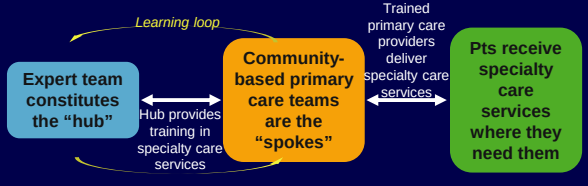
Multiple Models for Supporting Nonspecialists in Expanding HCV Treatment Provision

- **Project ECHO:** virtual networks link interdisciplinary specialist teams with primary care clinician teams
- **Cotreatment:** specialist sees the pt, makes suggestions for a treatment regimen and the primary care provider/nonspecialist prescribes and follows the pt
- **Telemedicine:** specialist manages pt remotely
- **CME programs** to provide education for nonspecialty HCV treatment
- **Fellowships/preceptorships**

Slide credit: clinicaloptions.com

Project ECHO: Extension for Community Healthcare Outcomes

- Addresses critical gap in availability of specialty care for pts with complex health conditions in rural and underserved settings



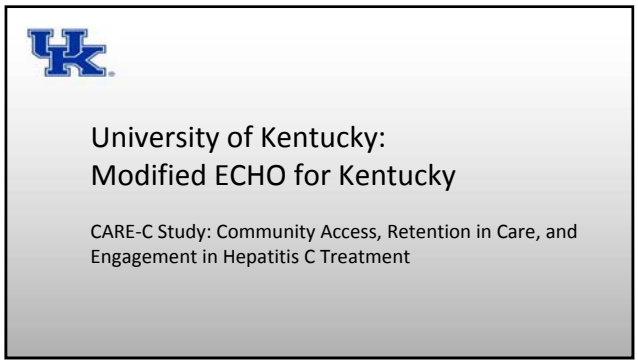
https://echo.unm.edu/about-echo/

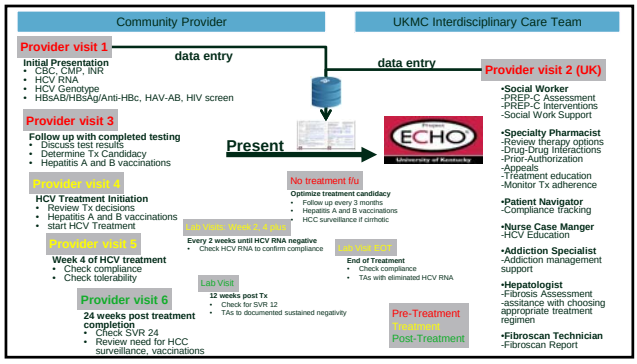
Slide credit: clinicaloptions.com

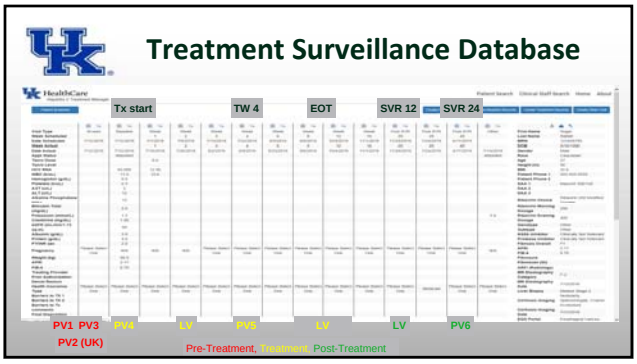
Project ECHO: Extension for Community Healthcare Outcomes

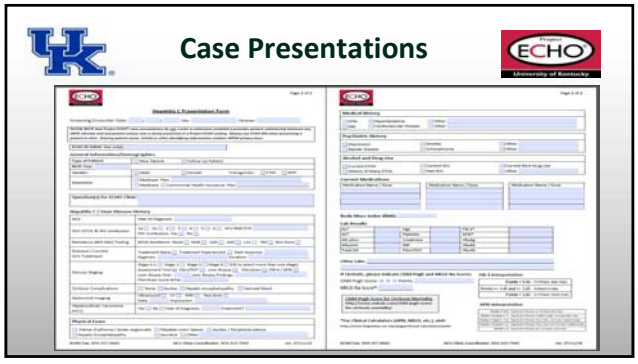
University of Kentucky: Modified ECHO for Kentucky

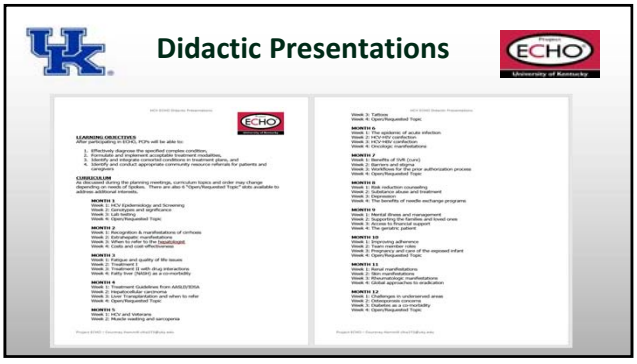
CARE-C Study: Community Access, Retention in Care, and Engagement in Hepatitis C Treatment











Fibrosis Assessment: Fibroscan

Disease	F0-F1	F2	F3	F4
HCV	<= 7.0	> 7.0	>= 9.6	>= 12.0

Partnership Benefits (1)

- **Education and Training for Hepatitis C management including treatment**
  - access to weekly teleECHO clinics
    - access to interdisciplinary specialty team (including hepatologist, addiction specialist)
    - contact with other community providers
  - weekly case presentations with case based learning
  - weekly 15 minute didactic presentations
  - Free **CME Credits**
- **Preferred fast access to UK appointment within 2 weeks**

Partnership Benefits (2)

- **Comprehensive support package to provide high quality care with minimal effort**
  - **Specialty Pharmacy Support**
    - Review therapy options
    - Drug-Drug interaction assessment
    - Prior-Authorization and appeals
    - Treatment education
    - Monitor Tx adherence
  - **Social Worker Support**
    - initial patient readiness assessment (PREP-C), UK will provide report
    - continuous support to overcome treatment barriers
    - support with transportation to UK appointment
  - **Patient Navigator Support**
    - continuous support with retention in care
  - **Fibroscan Report**
    - UK will perform Fibroscan and provide report
  - **Access to database and management tools**
    - database will track treatment uptake and outcomes, helps to manage patients with minimal effort,
    - access to information materials

ECHO Partnership Benefits

PROJECT ECHO OVERVIEW

WHAT IS PROJECT ECHO?

WHY PROJECT ECHO?

WHAT ARE THE BENEFITS FOR PARTICIPATING?

RESEARCH

OUR APPROACH

FREQUENTLY ASKED QUESTIONS

Modified HCV ECHO for Kentucky -

CARE-C: Community Access, Retention in Care, and Engagement for Hepatitis C Treatment

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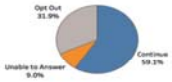
UK HealthCare ED Adult Universal HCV Screening and Linkage to Care

- Universal screening began 7/16/18
- All adult patients are screened with hard-stops built into nursing triage notes
- Opt-out methodology
- HCV Ab and reflex RNA are ordered if other blood work was obtained as part of routine ED care
- NOT age cohort or risk targeted screening
- ED Linkage to Care team follow up results minimizing ED workflow interruptions

HealthCare

Results

Screening



HCV Ab+

HCV RNA+

772 Ab tests performed
96 Antibody Positive (12.4 %)
Of those Ab +; 76% RNA positive

HealthCare

UK HealthCare ED's likely encounter ~7200 HCV Ab + patients annually*

*60,000 unique adult ED patients with a seroprevalence of 12%

Source: Daniel Moore MD, FACEP, UK EM