

→ CASE STUDIES:

CASE STUDIES: MEDICAID MANAGED CARE PLAN BEST PRACTICES IN HEPATITIS C LINKAGE TO CARE, TREATMENT, AND RETENTION

OVERVIEW

As more states consider initiatives to eliminate hepatitis C, Medicaid managed care organizations (MCOs) have an important role to play in developing best practices for delivery of hepatitis C treatment, linkage to care, and retention.

MCOs are insurance companies, many local and not-for-profit, that contract with state Medicaid agencies to provide benefits to Medicaid beneficiaries. MCOs accept a set per member per month (capitation) payment from the state Medicaid agency for these services, although some services, such as behavioral health and prescription drugs, may be “carved out” of the capitated rate and reimbursed to MCOs on a fee-for-service basis.

The managed care model allows states to reduce program costs and better manage utilization of health services. More than two-thirds of all Medicaid beneficiaries nationally receive most or all of their care from risk-based MCOs, and many states are moving to expand their use of MCOs to serve more medically complex beneficiaries, deliver long-term services and supports, and serve low-income adults newly eligible for Medicaid under the Affordable Care Act’s Medicaid expansion.¹ In 2017, 38 states and the District of Columbia contracted with at least one MCO to provide comprehensive services to Medicaid beneficiaries.²

The hepatitis C disease burden among Medicaid beneficiaries is particularly high compared with the general population and is estimated at 7.5 times that of commercially insured populations.³ Due to the high prevalence of hepatitis C among Medicaid populations, along with budgeting constraints that

limit state Medicaid programs’ ability to manage use of costly treatments among large populations of patients,⁴ Medicaid MCOs play a leading role in care provision for people living with hepatitis C. This paper highlights policies and practices implemented by non-profit MCOs across the country, and is a resource for governmental public health hepatitis programs and MCOs seeking to develop innovative practices for the delivery of hepatitis C services.

This project was supported by the Centers for Disease Control and Prevention (CDC) Center for State, Territorial, Local, and Tribal Support (CSTLTS). NASTAD partnered with the Association for Community Affiliated Plans (ACAP) to identify plans and best practices. ACAP’s membership consists of safety net Medicaid managed care plans, many of which are committed to implementing unique payment and delivery models for hepatitis C care.

Among the plans interviewed, several common themes emerged:

- 1) In addition to public and individual health benefits, there is a clear cost incentive for MCOs to ensure people living with hepatitis C are identified and cured. Hepatitis C direct acting antivirals (DAAs) are notoriously costly but, when compared to the cost of care for an individual who remains untreated and develops advanced chronic health conditions, it remains significantly more cost-effective to cure members living with hepatitis C with the treatments currently available on the market.⁵ Additionally, plans have a financial incentive to ensure that every member

¹ *Medicaid Managed Care Market Tracker*, KAISER FAMILY FOUNDATION, <https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/> (last visited Aug. 20, 2019).

² *Total Medicaid MCOs*, KAISER FAMILY FOUNDATION (July 2017), <https://www.kff.org/medicaid/state-indicator/total-medicicaid-mcos/>. Data reflect only capitated MCOs providing comprehensive services to Medicaid beneficiaries.

³ See, e.g., Joshua M. Liao, MD, MSc and Michael A. Fischer, MD, MS, *Restrictions of Hepatitis C Treatment for Substance-Using Medicaid Patients: Costs Versus Ethics*, 107 AM. J. PUB. HEALTH 893 (2017).

⁴ *Id.*

⁵ See, e.g., M. Christopher Roebuck and Joshua N. Liberman, PhD, Report, *Assessing the Burden of Illness of Chronic Hepatitis C and the Impact of Direct-Acting Antiviral Use on Healthcare Costs in Medicaid*, 25 AM. J. MANAGED CARE S131 (2019); HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C: Overview of Cost, Reimbursement, and Cost-Effectiveness Considerations for Hepatitis C Treatment Regimens, AM. ASS’N FOR THE STUDY OF LIVER DISEASES AND INFECTIOUS DISEASES SOC’Y OF AM., <https://www.hcvguidelines.org/evaluate/cost> (last visited June 27, 2019).

⁶ See, e.g., Stephen D. Shafran, MD, *The Hepatitis Genotype 1 Paradox: Cost Per Treatment Is Increasing, But Cost Per Cure Is Decreasing*, 29 CAN. J. GASTROENTEROLOGY & HEPATOLOGY 46, 47 (2015).

who initiates treatment completes the course of treatment and is successfully cured on their first attempt. The financial incentive is twofold: plans avoid the high costs of treatment failure,⁶ while also controlling costs and improving population health by preventing further transmission in the communities they serve. MCOs, like public health departments, are therefore motivated to develop innovative strategies that maximize adherence, improve health outcomes, and promote prevention. These efforts include case management, care coordination, rapid treatment initiation, and other services that, historically, have lacked robust infrastructure in the hepatitis C space. In addition to cost-related factors, plans also emphasized the important public health benefits of ensuring members are cured as states work towards eliminating hepatitis C in their jurisdictions.

- 2) The second common theme is the importance of collaboration among stakeholders. MCOs in many states have come together with other important stakeholders, including state Medicaid agencies, public health departments, healthcare providers, advocates, and community-based organizations, to develop policies and practices to ensure

Medicaid enrollees receive timely treatment, remain adherent to treatment regimens, and avoid re-infection following cure. MCOs in some states have also participated in advocating for state-level policies that improve public health prevention efforts and increase access to treatment and care.

- 3) The third theme is the importance of innovative ways to engage patients living with hepatitis C, including those living with other chronic conditions and those who also have behavioral and mental health needs. As states and MCOs have moved away from restrictions on DAA access based on both fibrosis scores and sobriety requirements, models have emerged that focus on linkage to care and adherence to treatment.

The case studies below highlight different elements of MCO programs designed to improve services for members living with hepatitis C. Although some the practices highlighted in this paper involved small groups of plan members, they may serve as models for governmental public health programs or other Medicaid, Medicare, and commercial plans seeking to implement similar initiatives on a larger scale.

→ **AMIDA CARE:**

TREATMENT ADHERENCE COORDINATOR PROGRAM (NEW YORK)



State managed care pharmacy policies:

Pharmacy benefit is covered through managed care (“carved-in”) for MCO enrollees.⁷

Total Medicaid MCOs in the state (September 2018):⁸

22

Total Medicaid enrollment in the state (May 2019):¹⁰

5,847,562

Total Medicaid MCO enrollment in the state (July 2017):⁹

4,520,640

HCV prevalence estimate in the state:¹¹

116,000

A mida Care is a non-profit community health plan serving over 7,000 members throughout the five boroughs of New York City. Amida Care launched in 2003 as a Medicaid Special Needs Plan (SNP) for people living with HIV. Since then, Amida Care has adopted a specialized model of care to provide individualized attention and support to people living with HIV/AIDS, hepatitis C, and other complex health issues, as well as to individuals experiencing homelessness. As of 2017, the plan has expanded to provide access to all transgender individuals.

An important component of Amida Care’s strategy for serving people living with hepatitis C is its team of treatment adherence coordinators, who are peer navigators assigned to work one-on-one with members to overcome unique individual challenges to adherence and retention in care. This initiative is consistent with the plan’s goals of treating as many people living with hepatitis C as possible and preventing future transmission, while also ensuring that costly DAAs paid for by the plan are used properly and avoiding the high long-term costs of caring for members with untreated hepatitis C.

The treatment adherence coordinator program is part of Amida Care’s Comprehensive HCV Management

Program, managed by the plan’s Pharmacy Program, which additionally includes timely prior authorization review, staff and provider education, formulary management, and adherence and lab tracking. Treatment adherence coordinators primarily work with members who face unique personal obstacles to adherence, such as housing instability, substance use, food insecurity, or mental health issues. Most of Amida Care’s membership consists of individuals co-infected with HIV and hepatitis C, although treatment adherence coordinators do not work exclusively with co-infected members. In order to identify these higher-need members, Amida Care has adopted an assessment tool originally developed¹² by the hepatitis C program at Mount Sinai Health System in New York. Treatment adherence coordinators are not social workers, but rather experienced staff that have been trained in motivational interviewing, case management, and health education related to HIV, hepatitis C, substance use, and mental health. They come from varying backgrounds and typically have prior experience with health navigation. Treatment adherence coordinators work with members one-on-one to assess each member’s individual needs, discuss shared experiences related to adherence challenges and identify solutions tailored to each member, and engage in motivational interviewing.

⁷ The Medicaid Pharmacy Benefit, N.Y. HEALTH ACCESS, <http://www.wnyc.com/health/entry/91/> (last visited June 27, 2019).
⁸ Total Medicaid MCOs, *supra* note 2. Data reflect only capitated MCOs providing comprehensive services to Medicaid beneficiaries.
⁹ Total Medicaid MCO Enrollment, KAISER FAMILY FOUNDATION (July 2017), <https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22:%22sort%22:%22asc%22%7D>. Data reflect only capitated MCOs providing comprehensive services to Medicaid beneficiaries.
¹⁰ May 2019 Medicaid & CHIP Enrollment Data Highlights, MEDICAID.GOV (May 2019), <https://www.medicaid.gov/medicaid-program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>. Data are reported for each calendar month. Monthly enrollment data may be updated in subsequent CMS Eligibility and Enrollment Reports.
¹¹ Eli S. Rosenberg et al., *Prevalence of Hepatitis C Virus Infection in US States and the District of Columbia, 2013-2016*, JAMA NETWORK OPEN, Dec. 2018.
¹² PREP-C, <https://prepc.org/> (last visited June 26, 2019).

AMIDA CARE: TREATMENT ADHERENCE COORDINATOR PROGRAM (NEW YORK)

The plan notifies providers when one of their patients begins working with a treatment adherence coordinator, and coordinators provide regular updates to providers. This engagement enables the health plan to support each member in addressing barriers to adherence—for example, by escorting members to doctor visits or the pharmacy, monitoring and coordinating mental health care for members, identification of food insecurity issues, and providing enhanced case management services. The plan also refers members to existing local programs that provide a multitude of support services within the community. Once a member has completed treatment, the treatment adherence coordinator will continue working with the member to provide ongoing education on re-infection. The relationship continues until the member receives blood work 12 weeks after treatment (i.e., sustained viral response, or SVR12) to confirm a successful treatment outcome.

Amida Care's treatment adherence coordinator program is not reimbursable by Medicaid and is currently funded by the plan as an administrative expense, although the plan has received some grant funds from the state to partially fund other treatment adherence efforts. Representatives from Amida Care and other plans that participate in New York State's Hepatitis C Elimination Workgroup have developed a number of recommendations for the state, including allowing for Medicaid reimbursement of

peer navigation services and increasing state funding to support patient navigation activities and other ancillary services. Additionally, New York amended its Medicaid State Plan in 2018 to allow Medicaid reimbursement to MCOs for Harm Reduction Services, a covered benefit which includes HIV and hepatitis C treatment adherence counseling provided at authorized Syringe Exchange Programs.¹³ The State Plan Amendment presents an opportunity for public health stakeholders and plans to improve care coordination services for Medicaid members living with hepatitis C who use drugs. Amida Care's coordinators assess members for referral to syringe exchange programs and the plan can cover treatment adherence counseling provided by syringe exchange programs to its members, although most members eligible for this benefit to date have not yet been ready to begin hepatitis C treatment.

In addition to its treatment adherence coordinator program, Amida Care is in the process of implementing a value-based payment structure to encourage providers to test more patients for hepatitis C. The plan is also exploring opportunities to increase linkage and retention for individuals leaving incarceration, and to partner with methadone clinics to improve hepatitis C care coordination for their patients.

POLICY SPOTLIGHT

NEW YORK MEDICAID STATE PLAN AMENDMENT: HARM REDUCTION SERVICES BENEFIT

In 2018, the Centers for Medicare & Medicaid Services (CMS) approved a State Plan Amendment permitting New York State Medicaid to offer reimbursement for specific harm reduction services. Medicaid members in the state's Managed Care and fee-for-service systems who use or have used drugs will have access to these services at authorized Syringe Exchange Programs.

The Harm Reduction Services Benefit includes the following reimbursable services:

- Plan of care: Members work with a harm reduction specialist to complete intake and assessment to identify the member's service needs, including supportive services that can help improve their quality of life. The harm reduction specialists links the member to services they are interested in exploring further.
- Individual and/or group counseling.
- Psycho-educational support groups.
- Medicaid management and treatment adherence counseling: Members receive support for treatment adherence for medication assisted treatment (MAT), HIV, hepatitis C, mental health, or PrEP.

¹³ Medicaid Harm Reduction Services Benefit, N.Y. DEPT OF HEALTH, https://www.health.ny.gov/diseases/aids/consumers/prevention/medicaid_harm_reduction.htm (last visited June 26, 2019).

SAN FRANCISCO HEALTH PLAN:

HEALTHRIGHT360 GRANT FUNDING FOR RAPID HEPATITIS C TREATMENT INITIATION IN RESIDENTIAL SUD TREATMENT SETTING (CALIFORNIA)



State managed care pharmacy policies:

Pharmacy benefit is covered through managed care (“carved-in”) for MCO enrollees. Plans are required to adhere to uniform clinical protocols for hepatitis C antivirals.¹⁴

Total Medicaid MCOs in the state (July 2017):¹⁵

23

Total Medicaid enrollment in the state (May 2019):¹⁷

10,414,669

Total Medicaid MCO enrollment in the state (July 2017):¹⁶

10,798,374

HCV prevalence estimate in the state:¹⁸

318,900

San Francisco Health Plan is a non-profit health maintenance organization (HMO) serving more than 145,000 Medi-Cal enrollees in San Francisco. In 2017, San Francisco Health Plan provided a three-year grant to HealthRIGHT360, a family of integrated health programs that provide care and treatment to over 38,000 individuals per year through more than 65 culturally competent programs in San Francisco and eight other counties in California. The grant enabled HealthRIGHT360 to hire a full-time Care Coordinator/Rapid Hep C tester to coordinate all aspects of hepatitis C care for clients receiving residential substance use disorder (SUD) treatment. San Francisco Health Plan, like other MCOs that have implemented innovative strategies for engaging hepatitis C patients, is motivated to invest in initiatives that yield long-term cost-savings while also improving individual and public health. While the investment had a significant impact on San Francisco Health Plan enrollees, the program was designed to have broader delivery system impact beyond just the MCO’s members.

The project was inspired by the success of San Francisco’s Rapid ART Program Initiative for HIV Diagnoses (RAPID) HIV program, which created a network of “hubs”

throughout the city where persons newly diagnosed with HIV can rapidly access antiretroviral therapy as soon as possible following diagnosis. Since 2013, the RAPID HIV program has led to more rapid treatment initiation and viral load suppression. HealthRIGHT360 sought grant funding from San Francisco Health Plan to apply the successful RAPID model to hepatitis C treatment for individuals receiving residential SUD treatment. The grant funding enabled HealthRIGHT360 to rapidly initiate treatment for patients entering the residential recovery program who were deemed to be at high risk for falling out of care after leaving residential treatment.

HealthRIGHT360 used the grant funds to hire a full time Care Coordinator/Rapid Hep C tester to coordinate all aspects of hepatitis C care for clients receiving residential SUD treatment, from diagnosis through sustained virologic response testing, allowing clients to receive hepatitis C treatment in a supportive environment. Among the approximately 1,200 clients receiving residential substance use disorder (SUD) treatment from HealthRIGHT360 per year, hepatitis C prevalence was approximately 15 percent at the time of grant application.

¹⁴ States Focus on Quality and Outcomes Amid Waiver Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2018 and 2019, KAISER FAMILY FOUNDATION, 76 (Oct. 2018), <http://files.kff.org/attachment/Report-States-Focus-on-Quality-and-Outcomes-Amid-Waiver-Changes-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2018-and-2019>. The state plans to transition to a carve-out model by January 2021. Exec. Order No. N-01-09 (Jan. 7, 2019).

¹⁵ Total Medicaid MCOs, *supra* note 2. Data reflect only capitated MCOs providing comprehensive services to Medicaid beneficiaries.

¹⁶ Total Medicaid MCO Enrollment, *supra* note 9. Data reflect only capitated MCOs providing comprehensive services to Medicaid beneficiaries.

¹⁷ May 2019 Medicaid & CHIP Enrollment Data Highlights, *supra* note 10. Data are reported for each calendar month. Monthly enrollment data may be updated in subsequent CMS Eligibility and Enrollment Reports.

¹⁸ Rosenberg et al., *supra* note 11.

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All incoming clients are offered opt-out rapid HIV and hepatitis C testing upon intake. With the grant funds from San Francisco Health Plan, clients who screen positive for hepatitis C upon intake will immediately have confirmatory HCV RNA testing, along with a hepatitis C genotype, Complete Blood Count, and Complete Metabolic Panel. The Care Coordinator/Rapid Hep C tester then identifies clients who are candidates for hepatitis C treatment and implements rapid treatment initiation.

The majority of HealthRIGHT360 clients are enrolled in or eligible for Medi-Cal, and every effort is made to enroll uninsured clients in an insurance plan as soon as possible. Although HealthRIGHT360 routinely provides benefits navigation, the dedicated hepatitis C Care Coordinator has increased the success of these efforts for hepatitis C patients. HealthRIGHT360 also uses the grant funds to cover lab costs for uninsured patients, but otherwise sees uninsured patients without requiring payment and helps patients apply for assistance programs if they lack any other payer source for hepatitis C treatment. Although medication costs are covered by insurance or patient assistance programs, the grant funding helped close a significant funding gap because most services provided to patients receiving hepatitis C treatment consists of linkage to care, engagement, retention, and care coordination—most of which are not reimbursable by Medicaid, despite being essential to providing patients with the best hepatitis C care and ensuring they are cured. Due to limitations on Medicaid reimbursement for these types of services, the grant is funded by the plan as an administrative expense.

The funds are also used to provide financial incentives to patients in the program who complete their hepatitis C course of treatment and SVR12 assessment (\$50 after completing treatment and another \$50 after the client the SVR12 assessment). For most clients, hepatitis C treatment can be completed during the 90-day period that the client is housed in HealthRIGHT360's residential SUD program. Clients are eligible to extend their 90-day stay, and those receiving hepatitis C treatment will be prioritized to lengthen their stay. Clients leaving the

facility are offered follow-up care with experienced hepatitis C treating providers at a HealthRIGHT360 clinic, or follow-up can be arranged with the client's primary care provider. For clients who leave the facility prior to completing hepatitis C treatment, the Coordinator will identify and address barriers to treatment adherence and coordinate linkage to follow-up care and hepatitis C navigation.

The San Francisco Health Plan has additionally made efforts to streamline its prior authorization requirements for hepatitis C treatment, which has reduced the burden of obtaining prior authorization for HealthRIGHT360 and other providers. The plan developed its prior authorization requirements¹⁹ in collaboration with medical providers to ensure clinical alignment with the treating community, and then widely distributed the prior authorization criteria to providers in an easy-to-use checklist format. After the plan approves a request for prior authorization, the documentation is sent directly to the specialty pharmacy and added to the pharmacy's records for that member. This eliminates the need for providers to duplicate efforts by resubmitting documentation for the same patients. The plan has also facilitated conversations between treating providers and pharmacies, allowing them to identify and address unique communication and delivery issues.

HealthRIGHT360's model to immediately start individuals on treatment upon diagnosis is similar to emerging public health-funded rapid treatment initiation models for HIV (see Figure 1 below).²⁰ However, because there is no state or federally funded public health medication program for hepatitis C, programs that support rapid initiation of treatment either have to identify an insurance source immediately, or wait for an insurance denial and help clients navigate the manufacturer patient assistance program. The partnership between San Francisco Health Plan and HealthRIGHT360 illustrates how health plans can increase investments in population health by modeling innovative public health models.

¹⁹ Prior Authorization Criteria for Hepatitis C, SAN FRANCISCO HEALTH PLAN (Feb. 2019), available at [https://www.dhcs.ca.gov/Documents/DHCS_Hep_C_Policy_7_1_18.pdf](https://client.formularynavigator.com/Search.aspx?siteCode=9743708353&targetScreen=3&drugBrandListBaseTC=anti-infective%2Bagents%257chcv%2Bprotease%2Binhibitor%2Bantivirals; Treatment Policy for the Management of Chronic Hepatitis C, SAN FRANCISCO HEALTH PLAN (July 2018), <a href=).

²⁰ Leveraging the Ryan White Program to Make Rapid Start of HIV Therapy Standard Practice, O'NEILL INST. (Dec. 2018), http://oneill.jaw.georgetown.edu/media/ONL_Gilead_B2_Rapid_P4.pdf.

SAN FRANCISCO HEALTH PLAN: HEALTHRIGHT360 GRANT FUNDING FOR RAPID HEPATITIS C TREATMENT INITIATION IN RESIDENTIAL SUD TREATMENT SETTING (CALIFORNIA)

FIGURE 1:

→ SUCCESSFUL RAPID START/SAME-DAY START MODELS FOR HIV TREATMENT

New York – JumpstART
San Francisco – RAPID ART
Arizona – FAST TRaC

PROGRAM FEATURES:

- Treatment begins as soon as possible after testing—same day or within 5 days
- Immediate referrals to community providers to continue treatment after initiation
- Benefits navigation to identify payers for uninsured patients
- In-depth counseling from providers and patient navigators to educate patients about treatment, identify barriers to care and engagement
- Partnerships between public health agencies, CBOs, medical and non-medical providers, and clinics to develop a network for referral, support, and patient navigation
- Initial medication funding sources: ADAP or manufacturer assistance programs

OUTCOMES:

- Shortened times to viral suppression
- Immediate linkage to care
- Higher rates of retention
- Rapid enrollment in health insurance

CONSIDERATIONS FOR APPLICATION OF THESE MODELS TO HEPATITIS C RAPID INITIATION:

- Identifying funding for initial medication for uninsured patients may be more challenging
- Prior authorization requirements are more common for hepatitis C treatments

→ VIRGINIA PREMIER HEALTH PLAN: SPECIALTY PHARMACY CLINICAL PROGRAM FOR HEPATITIS C (VIRGINIA)



State managed care pharmacy policies:

Pharmacy benefit is covered through managed care (“carved-in”). Plans are required to adhere to uniform clinical protocols for hepatitis C antivirals.²¹

Total Medicaid MCOs in the state (July 2017):²²

6

Total Medicaid Enrollment in the state (May 2019):²⁴

1,155,830

Total Medicaid MCO enrollment in the state (July 2017):²³

722,399

HCV prevalence estimate in the state:²⁵

110,000-157,000

Virginia Premier is a non-profit HMO serving approximately 265,000 Medicaid members throughout Virginia, and is the second largest Medicaid plan in the state. The company began in 1995 as a partnership between the Virginia Commonwealth University (VCU) Medical Center and PCP Healthcare Corporation. Approximately 20 years ago, Virginia Premier became a wholly owned entity of the VCU Health System. Virginia Premier has established a specialty pharmacy clinical program for hepatitis C, which includes an exclusive specialty care network. This model enables Virginia Premier to play an active role in members’ hepatitis C care, identify and respond to member needs, and provide support to members to ensure positive treatment outcomes.

Almost all members enrolled in Virginia Premier’s Medicaid managed care plan access medications through one of three in-network entities—VCU, the University of Virginia (UVA), or Amber specialty pharmacy. Members that access medications through VCU and UVA’s specialty pharmacies also receive medical services and clinical support from VCU or UVA, allowing these entities to serve all member needs throughout the course of their hepatitis C care. Patients who access medications through Amber specialty pharmacy receive hepatitis C care from other providers within the MCO’s network.

UVA and VCU serve Virginia Premier members in Charlottesville and Richmond, respectively. Each health system has numerous clinics where patients can see medical providers and fill prescriptions, sometimes in the same location. Nurses at UVA and VCU are in close contact with Virginia Premier and communicate regularly about patient issues—for example, if a patient is experiencing barriers to adherence or needs to switch to a different type of treatment. If the patient has not adhered to treatment, the plan’s care coordinators reach out to the patient and provider to determine whether the patient needs to restart therapy and, if necessary, provide patient education about the importance of adherence. Amber specialty pharmacy, on the other hand, does not have its own clinical program and does not provide medical care directly to members. Patients who access medications through Amber specialty pharmacy therefore receive medical care from other in-network providers. For these members, the plan relies on Amber to engage the provider and patient, set up medication delivery and begin treatment, monitor adherence, and manage patient care closely to ensure outcomes. For members who struggle with adherence, Amber works with the plan and the medical provider to identify and address barriers. Amber shares case management

²¹ States Focus on Quality and Outcomes Amid Waiver Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2018 and 2019, KAISER FAMILY FOUNDATION, 76 (Oct. 2018), <http://files.kff.org/attachment/Report-States-Focus-on-Quality-and-Outcomes-Amid-Waiver-Changes-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2018-and-2019>.

²² Total Medicaid MCOs, *supra* note 2. Data reflect only capitated MCOs providing comprehensive services to Medicaid beneficiaries.

²³ Total Medicaid MCO Enrollment, *supra* note 9. Data reflect only capitated MCOs providing comprehensive services to Medicaid beneficiaries.

²⁴ May 2019 Medicaid & CHIP Enrollment Data Highlights, *supra* note 10. Data are reported for each calendar month. Monthly enrollment data may be updated in subsequent CMS Eligibility and Enrollment Reports.

²⁵ This prevalence estimate aims to account for populations that are underestimated for in the National Health and Nutrition Examination Survey (NHANES). Data does not account for the number of people who were treated for hepatitis C. More information about the methodology used to determine this estimate is on file with the author.

VIRGINIA PREMIER HEALTH PLAN: SPECIALTY PHARMACY CLINICAL PROGRAM FOR HEPATITIS C (VIRGINIA)

information with the plan, and coordinates with medical providers and the plan's case managers to identify and meet patient needs.

The result is an integrated clinical program that allows the plan to effectively monitor patient adherence and provide responsive case management. The plan works collaboratively with UVA, VCU, and Amber to take a patient-centered approach to addressing patient needs and barriers to care. For example, the plan provides transportation to members as a covered service, which ensures better clinical outcomes because patients are more likely to access care from their medical provider on a regular basis. For other types of ancillary services not covered as a plan benefit—for example, housing, nutrition assistance, or spiritual support—the plan's care

coordinators, social workers, and nurse case managers work closely with members to identify needed supports and connect them with local services in their communities.

In addition to enhanced care coordination, this partnership between the plan and its small network of trusted specialty pharmacies has enabled Virginia Premier to collect comprehensive data about member progress and outcomes, including but not limited to information about how many patients have completed treatment, SVR12 lab results confirming cure, and the number of patients using each type of medication.

CONSIDERATIONS FOR MCOs, GOVERNMENTAL PUBLIC HEALTH PROGRAMS, AND OTHER STAKEHOLDERS

Public health departments are uniquely positioned to engage with MCOs to pursue mutual goals of eliminating hepatitis C in their jurisdictions. The case studies discussed above highlight a number of ways in which MCOs can invest in strategies for improving hepatitis C outcomes in their jurisdictions and present some opportunities for collaboration with governmental public health entities to enhance these efforts.

DATA-SHARING. Health department data often lacks important care-related components that MCOs are well-positioned to collect via claims data. In states where hepatitis C is not a reportable condition, MCO claims data is especially important. In San Francisco, for example, the San Francisco Health Plan collects medical care data that the health department does not have. The plan's data lets the health department know how many of the plan's members are receiving treatment, and how many have been diagnosed but have not yet initiated treatment. Although the plan cannot share individual data with the health department, the plan can share clinic-level data that lets the health department know

which clinics need additional support to increase treatment capacity—for example, clinics that have diagnosed patients but have not aggressively pursued treatment. Additionally, due to the health department's involvement with the EndHep C SF initiative, data-sharing between the plan and the health department enables EndHep C SF to track overall progress towards hepatitis C elimination in the city, target clinics for additional support, identify providers treating high numbers of patients for academic detailing, and provide technical assistance to providers and clinics, including those within the plan's network. A number of plans interviewed also cited challenges with obtaining laboratory data from providers and health departments; this data can help MCOs monitor treatment compliance and outcomes.

Similarly, a number of data-sharing policies are currently under consideration by the New York State Department of Health, which houses both the state Medicaid agency and the state public health department, including policies that would facilitate

CONSIDERATIONS FOR MCOS, GOVERNMENTAL PUBLIC HEALTH PROGRAMS, AND OTHER STAKEHOLDERS

data-sharing between public health entities, medical and non-medical service providers, and other individuals and entities involved in providing care and collecting relevant data; enable health departments to collect additional hepatitis C data, including surveillance data; track statewide progress towards hepatitis C elimination outcomes; and target services and increase resources for engaging and treating higher-risk and vulnerable populations.

COLLABORATION BETWEEN STAKEHOLDERS TO IMPROVE OUTCOMES, SHAPE POLICY, AND ELIMINATE BARRIERS TO CARE. Generally, public health departments and MCOs have not had close working relationships. However, in the context of hepatitis C, MCOs and public health departments can work together to achieve the mutual goal of eliminating hepatitis C. In Virginia and Rhode Island, for example, the state Medicaid agency convened all MCOs operating in the state to address best practices for managing the high costs of hepatitis C treatments. In both states, all plans agreed to adopt the same formulary, prior authorization criteria, and other policies, ensuring seamless transitions for members who switch between plans and improving treatment outcomes. This alignment has been especially important for members that churn between plans following release from incarceration. In New York State, a Hepatitis C Elimination Workgroup consisting of health plans, state and local health department representatives, community-based organizations, clinical providers, advocates, and other stakeholders has developed a set of recommendations for the New York State Department of Health to improve hepatitis C prevention, surveillance, and care. Workgroups such as those in Virginia, Rhode Island, and New York that include MCO leadership and state officials are opportunities for health departments and MCOs alike to participate in setting policies that apply statewide to all MCOs and fee-for-service Medicaid. As described above, the San Francisco health department’s involvement with the EndHep C SF initiative—comprised of 33 organizations, including MCOs and other health plans—has led to increased data-sharing with the San Francisco Health Plan that enables the health department to target clinics and providers for additional support and academic detailing. Public health agencies can also work with state Medicaid agencies and MCOs to identify higher-prevalence areas across the state and promote screening, awareness, and prevention

initiatives that reduce overall disease burden in the communities that MCOs serve.

MCO-FUNDED OR -SUPPORTED INITIATIVES. MCOs may be positioned to provide funding or other support for initiatives that health departments may lack the resources to implement. In San Francisco, for example, the department of public health provides care for about 60% of the San Francisco Health Plan’s members. However, fewer than 20% of those members fill prescriptions at health department pharmacies; instead, these members primarily rely on chain for-profit pharmacies that do not provide the care coordination needed for high-quality hepatitis C care, resulting in lost revenue for the health department and missed opportunities for managing patient care. The San Francisco Health Plan therefore hired a consultant to identify opportunities to improve service delivery for plan members that receive care through the health department, with the ultimate goal of developing a pharmacy network within the health department that better serves patient needs. MCOs are also positioned to implement value-based reimbursement agreements to encourage providers to increase hepatitis C screening.

MCOs – working in collaboration with public health stakeholders – can also negotiate inclusion of certain services in their contracts with state Medicaid agencies, thus authorizing Medicaid reimbursement for additional benefits that are necessary for delivering high-quality hepatitis C care. For example, the Rhode Island health department worked with the state Medicaid agency and MCOs to expand targeted case management for people living with or at risk of HIV and to include it in MCO contracts as a covered Medicaid service.²⁶ The health department facilitated building infrastructure and capacity at the provider level to manage and monitor patient care, and helped MCOs develop processes for collecting Ryan White HIV/AIDS Program provider data for the purposes of satisfying MCO reporting requirements imposed by the state. MCOs have also partnered with state Medicaid programs and providers to test innovative ways of integrating community health workers into care delivery, and to reimburse as a covered Medicaid service various support services that community health workers provide to members.²⁷

²⁶ NASTAD, *Rhode Island: Reimagining Medicaid Case Management to Include High-Risk HIV Negative Individuals*, in FINANCING HIV PREVENTION SERVICES: COLLABORATION AND INNOVATION BETWEEN PUBLIC HEALTH AND MEDICAID AGENCIES, at 12, <https://www.nastad.org/sites/default/files/NASTAD-HIV-Prevention-Financing-Final.pdf>.

CONSIDERATIONS FOR MCOS, GOVERNMENTAL PUBLIC HEALTH PROGRAMS, AND OTHER STAKEHOLDERS

Additionally, federal regulations allow MCOs flexibility to contract with non-clinical community-based providers to provide “value-added services” that are not covered by traditional Medicaid.²⁸ In Chicago, for example, a non-clinical community-based organization successfully negotiated contracts with MCOs to provide “Reach and Engage” services to members that the health plan has been unable to locate.²⁹ The community-based organization connected and re-engaged members who had not yet connected with their primary care providers or had fallen out of care, enabling members to access services and appropriate treatment on a timely basis. The MCO pays the community-based organization for “Reach and Engage” services on a fee-for-service basis, but does not receive reimbursement from Medicaid. Value-added services not covered by Medicaid are excluded from MCO capitation rates, since capitation rates are

based only on services included in the Medicaid state plan; however, MCOs may provide such services using administrative funds and include them in their medical loss ratio calculations.³⁰ These services are provided at the MCO’s discretion, subject to state policy that may place limits on the set of services that MCOs can provide, and seek to improve health outcomes and reduce costs by reducing the need for more expensive care.³¹ Funding for value-added services is more limited because it is not included in the MCO’s capitation rate, and must instead be paid for with other MCO funds; however, MCOs have more flexibility to innovate and work with non-traditional providers to furnish these services because they are not limited to providing benefits that have been approved in the Medicaid state plan.

LESSONS LEARNED

- MCOs are positioned, and motivated, to fund innovative projects and initiatives that improve access and outcomes for people living with hepatitis C—for example, intensive case management and other initiatives that take a patient-centered approach to improving treatment adherence and retention in care.
- Community-based clinical and non-clinical providers can partner with MCOs to serve unique populations and reach members in low-treatment settings, such as residential SUD programs.
- MCOs can engage providers in developing prior authorization requirements and processes that are less burdensome and enable treatment to begin more quickly, while still complying with state-imposed restrictions. MCOs can also work with state Medicaid agencies to develop uniform prior authorization requirements across all MCOs operating in a state.
- MCOs can leverage administrative funds to provide “value-added” non-reimbursable Medicaid services to improve linkage to care, retention in care, and treatment outcomes among members living with hepatitis C. The flexibility to provide value-added services is an opportunity for MCOs to invest creatively in their enrollees’ health, address social needs, and improve health outcomes by providing services not otherwise covered by Medicaid.
- MCOs seeking to develop exclusive hepatitis C specialty care networks can partner with health systems providing comprehensive medical and pharmacy services in integrated settings within their members’ communities. This can enable the plan to establish close working relationships with medical and clinical providers, play an active role in member care, identify and respond to member needs, and provide patient-centered support to members to ensure positive treatment outcomes.

²⁷ *How States Can Fund Community Health Workers Through Medicaid to Improve People’s Health, Decrease Costs, and Reduce Disparities*, FAMILIES USA 16 (July 2016), http://familiesusa.org/sites/default/files/product_documents/HE_HST_Community_Health_Workers_Brief_v4.pdf.

²⁸ 42 C.F.R. § 438.3(e) (2018); Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27,498, 27,526 (May 6, 2016); *Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstrations*, ASS’N FOR CMTY. AFFILIATED PLANS & CTR. FOR HEALTH CARE STRATEGIES, INC. 18 (Dec. 2018), <https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf>.

²⁹ NASTAD, *Chicago: Making the Case for Inclusion of Community-Based Organizations in Medicaid Managed Care Payment and Delivery Systems*, in FINANCING HIV PREVENTION SERVICES: COLLABORATION AND INNOVATION BETWEEN PUBLIC HEALTH AND MEDICAID AGENCIES, *supra* note 26, at 16.

³⁰ 42 C.F.R. § 438.3(e); Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. at 27,526.

³¹ Michelle Herman Soper, *Providing Value-Added Services for Medicare-Medicaid Enrollees: Considerations for Integrated Health Plans*, CTR. FOR HEALTH CARE STRATEGIES, INC. 2 (Jan. 2017), http://www.chcs.org/media/PRIDE-Value-Added-Services_012617.pdf; *Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstrations*, *supra* note 28, at 18.

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