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Primary Care Treatment of HCV in Medicaid Patients

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Primary Care Treatment of HCV in Medicaid Patients

Stephanie Kulaga

Family Medicine Rotation ♦ September 2017

Community Health Center Burlington

Mentors: Steven Lidofsky, MD, Charles MacLean,
MD, Scott Strenio, MD

Problem Identification

- As of 2010, there were 7,200 HCV+ people living in VT (1)
- The 2014 reported mortality rate in VT for HCV was 5.2 per every 100,000 persons (1)
- Newly reported cases of HCV in VT have been increasing as a result of the heroin epidemic (2)
- HCV is a leading cause of cirrhosis, HCC, and liver transplant (3)
- With new, safer drug regimens, increased management of HCV by primary care providers makes sense. However, majority of patients still managed by specialists.
- Since there is provider interest in treating HCV at CHCB, how can we implement a model to treat HCV there?
- Policy change in Dec 2016 increased coverage to Medicaid patients with fibrosis scores of F2 or higher; requirement for 6 mos drug & alcohol abstinence also removed (4)

Public Health Cost

- In 2014 the total cost associated with chronic HCV was estimated at \$6.5 billion and estimated to peak in 2024 at \$9 billion (3)
- Lifetime cost of an individual infected with HCV estimated at \$64,490 (3)
- 2010-2011 Hospitalization rates for HCV related problems increased 190% from 2004-2011 at an estimated total cost of \$3.5 billion (5)

Community Perspective

Charlie MacLean, MD

Professor of Medicine, General Internal
Medicine & Geriatrics
Department of Medicine
Associate Dean for Primary Care

- **What are some existing models for treatment of HCV in primary care settings and how successful have those been?** The ECHO program in New Mexico started about 20 years ago. Essentially, primary care physicians in rural areas were trained by specialists to manage Hep C – all they needed were some computers and webcams. One of the benefits to this is that once a week, all the providers conference and present their patients. That gives you the benefit of seeing consults on maybe 50-100 patients per week rather than just your own. This model was next adopted to WAMI states, and now there are over 1,000 hubs across the US. It has expanded to treat multiple diseases, including chronic pain and opiate addiction treatment. ECHO's goal is to be reaching 1 billion patients by the year 2020. In Vermont, no matter where you live you're never more than an hour and fifteen minutes from a major hospital, so there's less of a travel barrier for seeing a specialist. The reverse of this model, which has also been successful, is to send a specialist out into a rural area 1 day a week. So you could send a gastroenterologist out to an underserved community for one clinic each week and schedule HCV patients then.
- **What barriers would you anticipate to setting up a treatment protocol for HCV in primary care settings, and how might those barriers be overcome?** If I wanted to start treating HCV patients at CHBC tomorrow, my guess is that the greatest pushback would be from insurance or other administrative barriers. The other question is, are there enough cases to stay up on the literature? There are a couple of ways to address this. One is to have a close linkage to an expert (ie: a gastroenterologist at UVM) who would be attending the major research meetings and keeping up with trends in the field, and communicating that knowledge to primary care providers. Another is to have HCV treatment be a niche area for one provider in the practice, and that person would keep up with developments in the field and serve as a resource for the practice.
- **How could the success of a program like this be measured?** You could create a patient registry to collect data on treatment response, adverse effects, adherence to protocol, and monitoring, and then compare that to metrics on patients at a medical center like UVMMC.
- **Do you have any suggestions in terms of prioritizing patients who haven't yet been screened?** Looking back over the years, I've found that screening yield has decreased when testing patients who always had normal LFTs. Looking at those trends can be a way to prioritize testing.

Community Perspective

Steven Lidofsky, MD
Director of Hepatology, UVM

- **There were some discrepancies in guidelines I reviewed regarding when to order bi-annual ultrasounds to look for HCC versus an annual Fibroscan. sDo you recommend ultrasounds at that interval for all patients being treated for HCV, or only if there is a specific indication for it?** HCC surveillance is generally reserved for individual with known cirrhosis. Transient elastography is not a tool for HCC evaluation, but it is used to evaluate the extent of hepatic fibrosis. There is no consensus about its use in any surveillance program.
- **If our goal is to treat patients in-house at CHBC, how much and in what capacity do you think GI would need to be involved?** HCV treatment eligibility is determined by health plans, and the landscape is shifting. I know that VT Medicaid demands HCV management by subspecialists currently and restricts medication access based upon hepatic fibrosis stage. This may all disappear within the next few years.
- **What thoughts do you have regarding involvement of gastroenterologists in primary care HCV treatment, and about having a provider here “subspecialize” to a degree in HCV?** The best reason to consider GI evaluation is to exclude the presence of cirrhosis (since this requires specific management and beyond HCV treatment). About 20-25% of patients with chronic HCV have cirrhosis, and the question is how best to screen. One strategy is to send all HCV patients to GI for initial evaluation prior to HCV treatment, and another is to use tools like the FIB-4 score to avoid sending GI referrals when the probability of advanced hepatic fibrosis is low. Having a knowledgeable in house HCV “expert” would be a plus to ensure high quality HCV treatment.

Community Perspective

Scott Strenio, MD
CMO, Medicaid VT

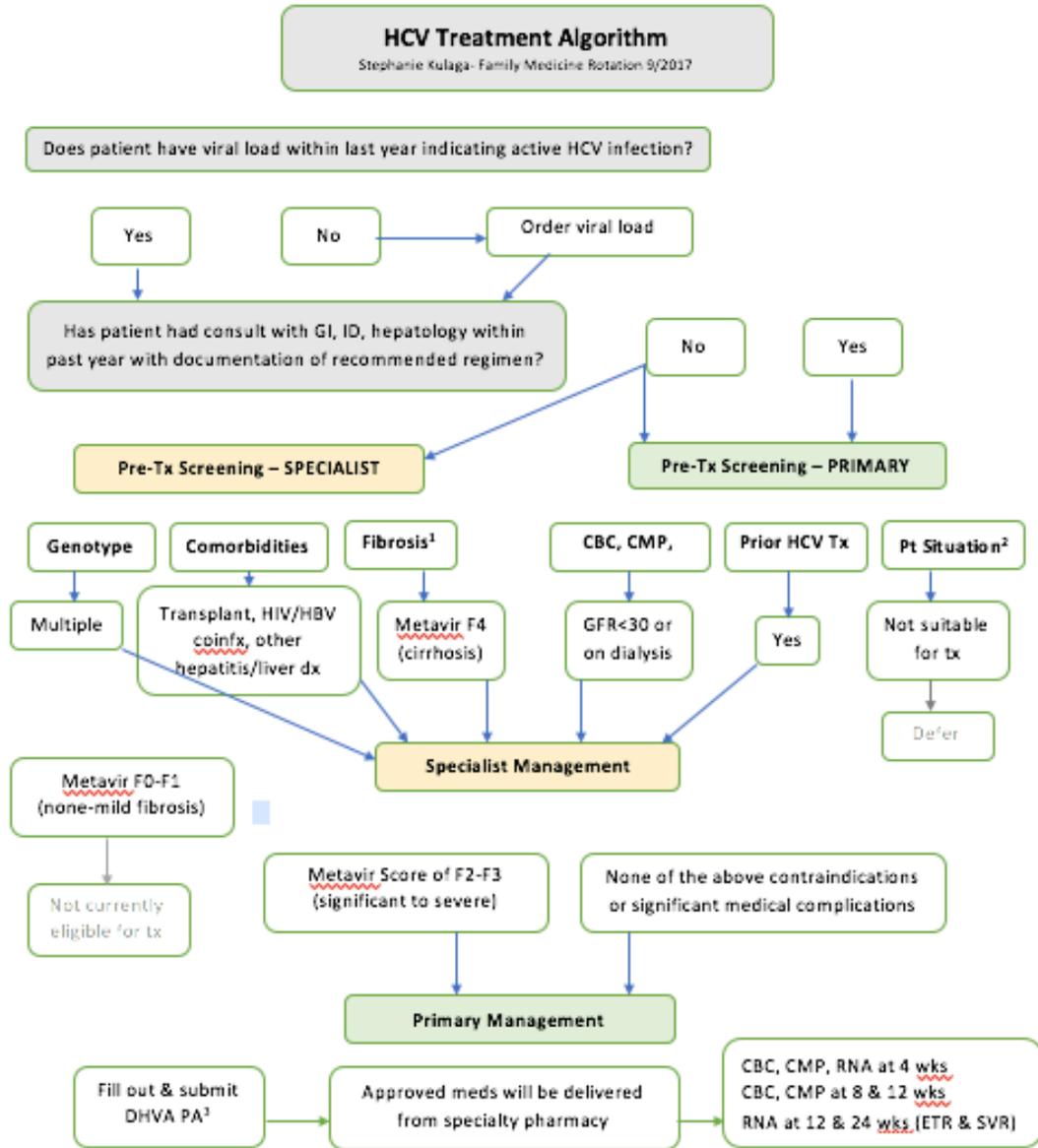
- **What are the current DHVA pharmacy guidelines for HCV treatment?** All patients require a prior authorization for treatment, which is available online and spells out all the different treatment regimens. In terms of the steps for primary care, all you need is one consultation with a specialist (either ID or GI) and evidence of fibrosis grade 2 or 3 – that can be established by any of the listed means, including a Fibrosure. A Fibroscan is not necessary for every patient.
- **How would you suggest primary care providers collaborate with specialists to treat Medicaid patients?** I would recommend finding a specialist who is interested in working with the clinic and supporting treatment in primary care. A pharmacist is also a good resource.
- **Can you foresee any potential barriers to treating CHCB patients?** The medications are delivered, so if a patient doesn't have stable housing that could be a barrier.

Intervention & Methodology

- 1 – Spoke with providers at CHCB to assess interest and feasibility of treating HCV patients there, and to identify barriers to doing so
- 2 – Reviewed AASLD HCV treatment guidelines and guidelines presented to CHCB providers by local gastroenterologists, and identified discrepancies
- 3 – Clarified discrepancies in treatment guidelines and questions regarding Medicaid coverage with UVM physicians and CMO of Medicaid Vermont
- 4 – Created a treatment algorithm for providers at CHCB to determine when and how to treat Medicaid patients with HCV.

Results

- Learned that HCV treatment via primary care for VT Medicaid patients is very feasible with current guidelines
- Created treatment algorithm and resource sheet for CHCB providers & presented at weekly provider meeting



¹ Approved methods include, but are not limited to, Fibroscan, Fibrotest, biopsy, etc.

² Good timing, not planning pregnancy, currently stable & likely to adhere to regimen, etc.

³ Drug & alcohol abstinence requirement has been removed from prior authorization

Evaluation

- The effectiveness of HCV treatment for Medicaid patients through primary care could be evaluated by establishing a patient panel at CHCB and tracking the lab monitoring, medication adherence, treatment response, and other pertinent variables. This could be compared to similar data collected at UVMHC or other centers where specialists treat HCV.
- This algorithm can also be evaluated through qualitative feedback from the providers utilizing it.
- Limitations include time restriction that did not allow for as much input from specialists in the development of the algorithm as would be ideal, however it can be updated in the future. It may also be that many patients eligible for treatment are already being followed by specialists and therefore are likely to be managed by them.

Future Recommendations

- In order to implement the use of the HCV treatment algorithm, CHCB will need to identify specialists interested in collaboratively managing patients with primary care.
- Collaborating specialists can serve as a resource for CHCB, regularly updating providers on new literature, national meetings, etc.
- One or more providers at CHCB may also choose to adopt HCV treatment as a niche area, and also stay abreast of updates in the field to serve as an educational resource to the practice.
- Invite Dr. Scott Strenio of Medicaid for a meeting at CHCB for any further clarification needed re: Medicaid regulations, and to collaborate further on ideas for expanding HCV treatment.

References

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- Yes / No If not consenting as above: please add the interviewee names here for the department of Family Medicine information only.