Hepatitis C in the New Mexico Centennial Care Population: 2016 and Beyond

Centennial Care Medicaid Advisory Council
November 14, 2016 1:15 pm

David Scrase, M.D.
Centennial Care’s goal of treatment for hepatitis C is:

- By 2020, to reduce morbidity and mortality by providing evidence-based treatment for all of our identifiable members with chronic hepatitis C infection, while being responsible fiscal stewards.
Agenda

• Introduction to Hepatitis C Virus
• HCV in the United States and New Mexico
• HCV in our Centennial Care population
  – Population model
  – Current treatment: patients and expenses vs. targets, based on encounter and prior auth data
• Action plan for 2016 and beyond
The Major Hepatitis Viruses

- Hepatitis A is generally transmitted in food and does not create chronic illness
- Hepatitis B and C are transmitted via blood products, IV drug use, hemodialysis
- Hepatitis D and E are rare
Hepatitis C Virus

- The third hepatitis virus, discovered in 1989
- Transmitted by:
  - Healthcare exposure = 55% (especially common in “baby boomers” born between 1/1/1945 and 12/31/1965)
  - Intravenous drug use = 40%
  - Men having sex with men (MSM) = 5%
Hepatitis C Genotypes

- Prominent genotypes vary geographically
- In the United States there are 2.7 – 4.0 M people with chronic HCV infection:
  - Genotype 1 = 70%
    - 1a = 55%
    - 1b = 15%
  - Genotype 2 = 19%
  - Genotype 3 = 10%
  - Genotype 4-6 = 1%

http://www.hepatitisc.uw.edu/go/screening-diagnosis/epidemiology-us/core-concept/all
HCV Disease Progression over 10 – 25 Years (single infection)

100% (100 people)

- Acute Infection
  - 20% (20) Resolved
  - 80% (80) Chronic
    - 35% (28) Stable
    - 65% (52) Slowly Progressive Disease (some symptoms)
      - 70% (36) Some liver damage, no cirrhosis
      - 30% (16) Cirrhosis
        - 75% (12) Slowly progressive cirrhosis
        - 25% (4) Liver failure, cancer, transplant, death
HCV Therapy: A Revolution

Discovery of HCV (Chiron) 1989
HCV Antibody Testing 1992
Approval Ribavirin 1998
Approval pegging- alfa-2b 2001
Approval Genotype-Specific RGT 2005
Telaprevir Boceprevir 2011
Approval Simeprevir Sofosbuvir 2013
Approval Ledipasvir/ Sofosbuvir Ombitasvir/Paritaprevir/r + dasabuvir 2014
Approval More All Oral IFN-Free Regimens * 2016

SVR: 6% 12% 20% 40% 54% 65–75% > 90% > 95%
HCV Viral Eradication Yields Many Benefits

- Sustained Virologic Response (SVR)
  - Improved Liver Histology
  - Improved Clinical Outcomes
    - Improved Quality of Life and Work Productivity
    - ↓ Decompensation
    - ↓ HCC
    - ↓ Extrahepatic Complications
    - ↓ Mortality, including post-transplant
All Oral Therapy Has Many Advantages over Intravenous Treatment

- Minimal pre-testing needed
- Low intensity of monitoring
- Side effects more easily managed
- High efficacy across a broad spectrum of patients
- No injections
- Well-tolerated
- Short duration
- High success
The Backlog Problem

• Because of the lack of effective treatment that could be tolerated, a large backlog of patients needing treatment has accumulated.

• Unfortunately, the majority of these patients are in advanced stages of liver disease.
HCV in the United States and New Mexico
Quiz: What group has the majority of Hepatitis C infections in America?
The wave of HCV Infection heads toward Medicare eligibility

Milliman 2013: Health Care Reform and Hepatitis C: Convergence of Risk and Opportunity (analysis of NHANES, MarketScan 2010, Medicare 5% Sample, and Medicaid Contributor data. Does not include prison population).

![Graph showing the prevalence of HCV infection by birth year and gender. Those born in 1950 will turn 65 in 2015.]
Quiz on Hepatitis C

- I think that the US cost of treating those “bumps” in the curves to the right will be
  - $165 thousand
  - $165 million
  - $165 billion
  - $165 trillion
2013 Screening Recommendations from the US Preventive Services Task Force and CDC

- Screen those born between 1/1/1945 and 12/31/1965 because the incidence of chronic HCV infection is twice as high
- Only 50% of have history of
  - Blood transfusion
  - Sexual exposure
  - IV drug use
  - “Non-professional” tattoo
New Mexico has the highest prevalence of HCV in the US
Milliman 2013: *Health Care Reform and Hepatitis C: Convergence of Risk and Opportunity* (analysis of NHANES, MarketScan 2010, Medicare 5% Sample, and Medicaid Contributor data. Does not include prison population).
### 2013 HCV Prevalence by Health Insurance Type

Milliman 2013: *Health Care Reform and Hepatitis C: Convergence of Risk and Opportunity* (analysis of NHANES, MarketScan 2010, Medicare 5% Sample, and Medicaid Contributor data)

<table>
<thead>
<tr>
<th>Health Insurance Type</th>
<th>Total U.S. Population (Thousands)</th>
<th>Estimated Prevalence of HCV-RNA+ (%)</th>
<th>Estimated Number of HCV-RNA+ (Thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured</td>
<td>48,600</td>
<td>2.08%</td>
<td>1,012</td>
</tr>
<tr>
<td>Veteran Affairs</td>
<td>5,600</td>
<td>5.40%</td>
<td>302</td>
</tr>
<tr>
<td>Commercial</td>
<td>164,200</td>
<td>0.47%</td>
<td>779</td>
</tr>
<tr>
<td>Dual Medicare and Medicaid</td>
<td>6,900</td>
<td>2.91%</td>
<td>201</td>
</tr>
<tr>
<td>Medicare (non dual)</td>
<td>37,600</td>
<td>0.31%</td>
<td>117</td>
</tr>
<tr>
<td>Medicaid</td>
<td>43,300</td>
<td>0.87%</td>
<td>377</td>
</tr>
<tr>
<td>Other Military</td>
<td>2,200</td>
<td>0.47%</td>
<td>10</td>
</tr>
<tr>
<td>Prison</td>
<td>1,500</td>
<td>30.0%</td>
<td>450</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>310,000</strong></td>
<td><strong>1.05%</strong></td>
<td><strong>3,249</strong></td>
</tr>
<tr>
<td><strong>Total without Prison</strong></td>
<td><strong>308,500</strong></td>
<td><strong>0.91%</strong></td>
<td><strong>2,799</strong></td>
</tr>
</tbody>
</table>
In 2013, half of HCV infected patients were undiagnosed and many were without insurance.

Milliman 2013: Health Care Reform and Hepatitis C: Convergence of Risk and Opportunity (analysis of NHANES, MarketScan 2010, Medicare 5% Sample, and Medicaid Contributor data. Does not include prison population).
Prevalence of HCV is higher among lower-income individuals

Milliman 2013: *Health Care Reform and Hepatitis C: Convergence of Risk and Opportunity* (analysis of NHANES, MarketScan 2010, Medicare 5% Sample, and Medicaid Contributor data).
Portion of Diagnosed and Undiagnosed HCV Patients by Percent Federal Poverty Level

Milliman 2013: *Health Care Reform and Hepatitis C: Convergence of Risk and Opportunity* (analysis of NHANES, MarketScan 2010, Medicare 5% Sample, and Medicaid Contributor data).

![Diagram showing portion of diagnosed and undiagnosed HCV patients by percent federal poverty level. The diagram indicates that lower income is associated with more HCV and more undiagnosed HCV.](image)
HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C (at www.hcvguidelines.org)

• The American Association for the Study of Liver Diseases and the Infectious Disease Society of America (AASLD/IDSA) initially recommended treatment for high risk and highest risk HCV positive individuals (about 25-30% of all Americans who are HCV positive).

• However, in October of 2015, AASLD/IDSA issued this press release recommending treatment for all “3 to 4 million Americans” with chronic HCV infection

• The cost for such treatment nationally will be ~ $400 billion
National attention focused on new guidelines: Treat Everyone!
HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C at www.hcvguidelines.org

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Number of Chronic HCV</th>
<th>Estimated Cost to Treat</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>“3 – 4 million”</td>
<td>$300 - $400 billion</td>
</tr>
<tr>
<td>New Mexico</td>
<td>~35,000</td>
<td>~$3.5 billion</td>
</tr>
<tr>
<td>Centennial Care</td>
<td>10,000 – 15,000</td>
<td>$1.0 - $1.5 billion</td>
</tr>
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Since the budgets of each of the above entities cannot bear the cost of treatment of all these patients all at once, what are the appropriate policy decisions to effectively treat all patients over time?
The Benefits of Earlier Treatment

• October 2015 study from Health Affairs, in which the authors modeled three (of many possible) scenarios for the treatment of chronic HCV positive individuals

• Substantial long-term socio-economic benefit from treatment was established
The Benefits of Earlier Treatment


Current approach in many Medicaid plans (including NM prior to 12/1/2015)

Recommended by AASLD/IDSA Guidance in October 2015
The Benefits of Earlier Treatment


Common approach in many Medicaid plans (including NM prior to 11/17/2015) recommended by AASLD/IDSA Guidance in October 2015.
$1 Trillion Societal Benefit to Earlier Treatment

• “A policy of treating every patient with new agents, regardless of the extent of his or her liver damage, would generate $0.8–$1.5 trillion in total social value ... or roughly ten times the social value of treating only patients with advanced disease.”

• Over fifty years:
  – $0.6–$1.2 trillion from improved health
  – $139 billion from reduced medical spending by preventing costly liver damage
  – $100-200 billion in manufacturers’ profits
The treatment of HCV in America has been a challenge, and prior experience has been poor due to the toxicity of the treatment regimens and their lack of efficacy.

It is expected that the oral treatments now available will result in a much higher percentage of patients being treated.
August 2015: Much Lower Centennial Care Approval Numbers than Planned

Centennial Care Treatment Requests and Approvals (ALL MCOs)
12/1/14 Data Point = all of 2014

- 475 treated 1/14-10/15
- Average = 259/year
- Annual Target =

Requests | Approvals | Projected Year End Approvals
Hepatitis C in the US

Distribution of HCV Patients by Severity

- Acute
- Fibrosis 0
- Fibrosis 1
- Fibrosis 2
- Fibrosis 3
- Fibrosis 4
- Decomp Cirrhosis
- Liver Cancer

Benefit in many Medicaid plans (including NM prior to 12/1/2015)
In October 2015: MAD Convenes MCOs to Increase Treatment Rates

- Centennial Care Goal presented: *By 2020, to reduce morbidity and mortality by providing evidence-based treatment for all of our identifiable members with chronic hepatitis C infection, while being responsible fiscal stewards.*

- Survey of Plans performed:
  - 4 hour meetings with each plan
  - Extensive review of approval processes and treatment data
  - Feedback received on proposed Letter of Direction with *very specific* treatment guidance
Hepatitis C in the US

Distribution of HCV Patients by Severity

Benefit in many Medicaid plans (including NM prior to 12/1/2015)

Expanded Centennial Care Benefit on 12/1/2015
As we finalized our proposal, we received help from CMS in a November 5, 2015 Letter to States

• “Consistent with the regulation at 42 CFR §438.210, services covered under Medicaid managed care contracts (with MCOs, prepaid inpatient health plans, and prepaid ambulatory health plans) must be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services for beneficiaries under FFS Medicaid.”
## Comparison of CMS Letter to Centennial Care Plan

<table>
<thead>
<tr>
<th>CMS Letter</th>
<th>Centennial Care Plan</th>
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<tbody>
<tr>
<td>Can’t restrict prescribing to specialists</td>
<td>Can’t restrict prescribing to specialists</td>
</tr>
<tr>
<td>Can’t deny treatment due to concurrent drug use</td>
<td>Can’t deny treatment due to concurrent drug use</td>
</tr>
<tr>
<td>Can’t restrict treatment to only those with advanced disease</td>
<td>Expand treatment to the many more people (5 of 7 possible groups)</td>
</tr>
<tr>
<td>Reference to AASLD/IDSA guidelines</td>
<td>Concern re some portions of AASLD/IDSA guidelines</td>
</tr>
</tbody>
</table>
More “News” on HCV Drug Pricing from the Senate Finance Committee

December 1, 2015: “WASHINGTON – Senate Finance Committee Ranking Member Ron Wyden, D-Ore., and senior committee member Chuck Grassley, R-Iowa, today released the results of an 18-month investigation into the pricing and marketing of Gilead Sciences’ Hepatitis C drug Sovaldi and its second-wave successor, Harvoni. Drawing from 20,000 pages of internal company documents, dozens of interviews with health care experts, and a trove of data from Medicaid programs in 50 states and the District of Columbia, the investigation found that the company pursued a marketing strategy and final wholesale price of Sovaldi – $1,000 per pill, or $84,000 for a single course of treatment – that it believed would maximize revenue. Building on that price, Harvoni was later introduced at $94,500. Fostering broad, affordable access was not a key consideration in the process of setting the wholesale prices.”
Letters from eight states to the Senate Finance Committee expressing concerns regarding the cost of treatment of new oral agents
HCV in our Centennial Care Population
HCV in Centennial Care: a Population Model

“All models are wrong. Some are useful.”

W. Edwards Deming
(1900-1993), American engineer, professor, statistician, author, lecturer, management consultant
The Importance of the Model

- The cost to treat all Centennial Care members with chronic HCV is likely > $1 billion
- Being over budget by even 100 courses of treatment in a single year = $10,000,000, a factor with equal impact to Health Plans, MAD/HSD, and New Mexico
- The budgetary problem is primarily short-term (5 years) while we treat the backlog of previously untreated HCV-positive individuals
- Once the backlog has been treated, the “run rate” expense may be in the $20 - $50 M per year range for New Mexico
Key Model Conclusions

• NM HCV + individuals ≈ 38,000
• CC HCV + individuals ≈ 13,800
• CC known HCV + individuals = 6,918
• CC known HCV + individuals likely to get treatment (if no restrictions = 3,585)
  – F0 = 580
  – F1 = 1,255
  – F2 and greater = 1,721
• Target for 2016 = 1,750
  – Remaining 29 may be accounted for by extrahepatic HCV manifestations and other high risk groups
Additional Calculations by Kimberly Page, PhD at UNM
Prevalence of HCV in New Mexico

- NHANES (1% prevalence)
  - 20,856

- Populations not included in NHANES (2014):

<table>
<thead>
<tr>
<th>Population</th>
<th>Estimated Size</th>
<th>Lower Estimate</th>
<th>Upper Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prison (incl. probation/parole)</td>
<td>25,336</td>
<td>23.0%</td>
<td>41.1%</td>
</tr>
<tr>
<td>Homeless</td>
<td>2,746</td>
<td>1.0%</td>
<td>36.7%</td>
</tr>
<tr>
<td>Hospitalized</td>
<td>2,198</td>
<td>1.0%</td>
<td>17.0%</td>
</tr>
<tr>
<td>Nursing homes</td>
<td>n/a</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Active-duty military</td>
<td>n/a</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Indian reservations</td>
<td>121,636</td>
<td>1.0%</td>
<td>11.5%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>7,092</td>
<td>27,176</td>
</tr>
</tbody>
</table>
Additional Calculations by Kimberly Page, PhD at UNM

Prevalence of HCV in New Mexico

28,000 to 67,500 HCV Antibody positive in NM

23,000 to 55,000 currently infected!
HCV in our Centennial Care Population: Current Treatment
New Mexico Data

• The four Centennial Care health plans have been submitting data regarding all members for whom there was a request for HCV treatment in 2014-2016 YTD

• Health plans provided genotype for each patient, and a level of fibrosis when available

• Southwest Care Center also provided genotype data
New Mexico Genotype Data (through 10/31/2015)

Distribution of HCV Genotype
US (NHANES data) vs. New Mexico (MCO data 2014-2015 YTD)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>US (NHANES)</strong></td>
<td>72%</td>
<td>16%</td>
<td>12%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>NM (MCO data)</strong></td>
<td>71%</td>
<td>11%</td>
<td>16%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
New Mexico Fibrosis Stage Data
(through 10/31/2015)

Distribution of Fibrosis Stage
US (NHANES data) vs. New Mexico (MCO data 2014-2015 YTD)

<table>
<thead>
<tr>
<th>Stage</th>
<th>US (NHANES)</th>
<th>NM (MCO data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>16%</td>
<td>16%</td>
</tr>
<tr>
<td>1</td>
<td>35%</td>
<td>25%</td>
</tr>
<tr>
<td>2</td>
<td>22%</td>
<td>14%</td>
</tr>
<tr>
<td>3</td>
<td>14%</td>
<td>11%</td>
</tr>
<tr>
<td>4</td>
<td>6%</td>
<td>25%</td>
</tr>
<tr>
<td>DC</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td>HCC</td>
<td>3%</td>
<td>1%</td>
</tr>
</tbody>
</table>
Centennial Care’s goal of treatment for hepatitis C is:

• By 2020, to reduce morbidity and mortality by providing evidence-based treatment for all of our identifiable members with chronic hepatitis C infection, while being responsible fiscal stewards.
Goals of Treatment for Hepatitis C

• **Centennial Care:** By 2020, to reduce morbidity and mortality by providing evidence-based treatment for all of our identifiable members with chronic hepatitis C infection, while being responsible fiscal stewards.
  – **BCBS:** To use limited resources in a reasonable/responsible manner to successfully treat as many members as possible, focusing on those who will receive the greatest clinical benefit.
  – **Molina:** To have transparent, easily accessible, consistent, up to date and evidence-based criteria which will permit greater and more equitable access to hepatitis C drugs.
  – **PHP:** To treat all clinically appropriate individuals with chronic Hepatitis C with evidence-based treatment protocols, prioritizing the patient’s clinical status and financial resources.
  – **UHC:** To treat the members most in need.
Best Practices from Centennial Care Health Plans

• BCBS – had been treating Fibrosis level 2 patients for all of 2015, (now treating all stages of HCV)
• Molina – Care Coordination role starts at the first receipt of treatment request
• PHP – through communication between finance and medical, opportunity to treat additional patients was identified and treatment guidelines expanded; 340B pricing
• UHC – communication regarding enhanced HCV screening to providers
Action Plan for 2016
Action Plan Highlights for 2016

• Treatment criteria specified via a Letter of Direction on 12/1/2015, updated 7/27/2016
• Revised “checklist” and provider network education
• Expanded role of care coordination
• New data collection and staging requirements
• Expanded screening efforts
• Financial changes
Treatment Criteria Explicitly Specified

• TREAT all patients over age 18, all genotypes, with F2 level or greater of fibrosis (or equivalent):
  – APRI score greater than 0.7 (use 40 for AST ULN), OR
  – FIB-4 greater than 1.45, OR
  – Transient elastography (Fibroscan®) score greater than or equal to 7.1 kPa, OR
  – Liver biopsy confirming a METAVIR score F2 or greater, OR
  – Imaging study that shows cirrhosis, OR
  – Although not widely used in New Mexico, a FibroSure® score of greater than or equal to 0.49 is also consistent with F2 level fibrosis
Why Not Treat Everyone Now?

- Budgetary constraints suggest that we will be more effective in being able to treat everyone by 2020 if we continue to prioritize those patients with significant fibrosis, who are most likely to benefit from treatment.
- The references for the treatment of F0-F1 patients provided in the guidance from AASLD/ASIM still do not contain a single published article (there are two posters and two abstracts from 2015 conferences).
Why Not Treat Everyone Now?

• These references do not allow any peer reviewed critique of experimental methodology that is so valued in the medical research community

• The Medical Assistance Division feels that it is important to have an evidence based approach to our decision making, particularly given the > $1 billion cost of treatment
Treatment Criteria Specified

• TREAT all patients with extrahepatic manifestations of HCV infection:
  – type 2 or 3 essential mixed cryoglobulinemia with end-organ manifestations (e.g. vasculitis), or
  – kidney disease
    • proteinuria
    • nephrotic syndrome or
    • membranoproliferative glomerulonephritis
  – lymphoma
Treatment Criteria Specified

- Specifically, TREAT those with decompensated cirrhosis and hepatocellular carcinoma unless requesting physician certifies that patient life expectancy is < 12 months
- No restriction of prescribing provider to specific subspecialties is allowed
- No restriction of treatment based on active alcohol or other drug use is allowed
Treatment Criteria Specified

• TREAT Other High Risk Populations with Level A or B Evidence for Treatment
  – Pre- and post-liver transplant, or other solid organ transplant
  – HIV-1 co-infection
  – Type 2 diabetes mellitus (insulin resistant)
  – Debilitating fatigue impacting quality of life (e.g., secondary to extra-hepatic manifestations and/or liver disease)
Treatment Criteria Specified

• Retreatment after failed all-oral therapy: same criteria as for treatment, with ECHO consultation
Treatment Criteria To Be Revisited Retroactively

• Health plans were required to go back and offer reconsideration to all patients who meet the new criteria, but were denied using previous criteria prior to December 1, 2015
Revised “Checklist” and Provider Network Education

• One page checklist to focus on most common scenarios; ask only for information that will influence decision

• Provider Network Education
  – Health plan visits to key (top 5 requesting) provider groups to explain new criteria and new checklist
  – Longer term efforts between MAD, health plans and ECHO to develop a strategy for provider education
  – Stronger connection with ECHO program for retreatment for those who do not respond to, or relapse with, all oral therapy
New Checklist

• Key changes:
  – F2 level of fibrosis defined for major testing modalities; only one test required
  – Lab work must be done in the past 3 months
  – Interferon questions removed
  – Many (but not all) previous Checklist “requirements” now changed to recommendations to comply with CMS
Expanded Role for Care Coordination

• Refer all patients to care coordination or community healthcare worker when request for medication received, per best practices within Centennial Care
  – Help to gather missing data for auth decision
  – Help verbally explain decision to patient
  – Help explain the need for medical follow up for patients denied care
  – Help with medication delivery and adherence, and follow up testing, for patients with care approved.
    • Some of these functions can also be met by health plan pharmacists, PBM and pharmaceutical company care management programs
Data Collection Requirements

• “Stage” all patients as part of authorization process (whether approved or denied)
• Keep a sortable database so denied patients can be reconsidered when coverage guidelines change
Quarterly reporting of members treated and prescription costs

- Plans submit quarterly reports of Prior Authorization data by genotype and fibrosis stage
- Plans are now provided their comparative data to all of Centennial Care after data submission complete
- If the number of Centennial Care HCV patients treated is significantly below target, MAD will re-evaluate treatment criteria
Expanded Screening Efforts

• All plans required to develop screening program to include:
  – Publication of guidelines based on USPSTF (2013) or CDC (2013) or AASLD/ASID (2015)
  – Distribution to provider network
  – Distribution to members

• Considering member rewards for screening
Align Financial Incentives

• Created a Delivery System Improvement Fund target to ensure that health plans are incentivized to provide treatment:
  – 2016: exceed 50% of treatment target
  – 2017: exceed ??% of treatment target
  – 2018: reach 100% of treatment target
7/27/2016 LOD Update

• Clarify Delivery System Improvement Fund for Hep C related to *number of members* treated

• Request a further 20% reduction in cost per treatment course by 6/30/2017
Quarterly MCO Meetings

• Review treatment data
• Review progress on DSIF treatment targets
• Discussion with ECHO experts
• Discuss benefit expansion timelines
Fall 2016 Update:
So, what actually happened as a result?

• Significant increase in those treated in the last two months of 2015
• Near tripling of numbers treated on a monthly basis in the first 9 months of 2016
• 13% reduction in cost per treatment course
Dramatic Increase in Approval Rates

Centennial Care Treatment Requests and Approvals (ALL MCOs)
12/1/14 Data Point = all of 2014

- 475 treated 1/14-10/15
- 825 treated 11/15-9/16

259/year
1009/year
3.9 x increase

Requests
Approvals
Projected Year End Approvals
What About Lawsuits in Other States?

- 5/27/2016: The **Washington** State Medicaid Program “is hereby ENJOINED from continuing to apply its February 25, 2015 HCV treatment policy, including its exclusion of all treatment based on fibrosis score, and is required to return to providing coverage for prescription medications to treat Hepatitis C virus (“HCV”) without regard to fibrosis score, consistent with existing state and federal Medicaid requirements. The parties are hereby ORDERED to submit a joint status report to the Court sixty (60) days after the date of this order with an update as to the implementation of these changes.”

- 5/27/2016: The **Florida** Agency for Health Care Administration announced Friday that it is taking corrective measures to ensure that state Medicaid recipients will have proper and timely access to Hepatitis C (HCV) treatment, including coverage of Direct-Acting Antiretrovirals. Florida was spurred to change course after the Florida Legal Services, Inc., Legal Aid Society of Palm Beach County, Inc., and the National Health Law Program (NHeLP) discovered that the Florida health agency’s policies were violating patients’ rights pursuant to the Medicaid Act.

- 8/17/2016: **Colorado** board recommends expanded coverage for hepatitis C drug - ACLU threatens lawsuit over coverage policy
From the Hep C Coalition 2016 Strategic Plan

On December 12th 2015, New Mexico’s Medicaid program being very forward-thinking and strategic in complying with and going beyond this guidance, to ensure broader access ... To go beyond treating only the sickest of individuals infected with HCV (treating only those with a liver fibrosis score of F3 & F4), New Mexico’s Medicaid program also increased treatment to include more recent infections with a liver fibrosis score of F2. These changes to providing a cure will further ensure that all New Mexicans who are living with HCV will be treated within the next 5 years.
$500 Million of Good News for NM: Cost Per Treatment is Rapidly Declining

Graph showing the total cost for 1750 members and the average cost per treatment from 2014 to 2017, with a decline in cost per treatment over time.
Effect of Declining Prices

- Cost of treating 13,800 CC members at 2014 prices = $1.341 B
- Cost of treating 13,800 CC members at estimated 2017 prices = $828 M
- Savings 2017 vs 2014 = $513 M
Additional Benefits

• What will the additional benefit be of moving from treating only the most advanced patients to treating all appropriate patients over the next 10 and 50 years?
The Benefits of Earlier Treatment


Current approach in many Medicaid plans (including NM prior to 11/17/2015)

Medicaid moving to this approach Over 2 to 4 years
Projected 10-year **Centennial Care** Results  
(in $ millions, QUALY = $150,000/year)

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<tbody>
<tr>
<td>Rx Cost</td>
<td>$(175)</td>
<td>$(500)</td>
<td>$(325)</td>
</tr>
<tr>
<td>Other Medical Costs</td>
<td>$(44)</td>
<td>$394</td>
<td>$438</td>
</tr>
<tr>
<td>QUALYs</td>
<td>$102</td>
<td>$570</td>
<td>$467</td>
</tr>
<tr>
<td>Total</td>
<td>$(117)</td>
<td>$112</td>
<td>$580</td>
</tr>
</tbody>
</table>

Centennial Care Hepatitis C Strategy Summary

• Goal to expand coverage to treat all chronic and active HCV patients by 2020

• Goal to provide evidence based coverage
  – Expand coverage to F1 fibrosis patients in 2017
  – Reduce cost per treatment course by 20% by 7/1/2017
  – Expand coverage to F0 fibrosis / all patients when financially feasible

• Continue to partner with Hepatitis C advocacy community
Summary of Centennial Care Benefit

Expansion Timeline

Distribution of HCV Patients by Severity

<table>
<thead>
<tr>
<th>Severity</th>
<th>% Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>1%</td>
</tr>
<tr>
<td>Fibrosis 0</td>
<td>16%</td>
</tr>
<tr>
<td>Fibrosis 1</td>
<td>35%</td>
</tr>
<tr>
<td>Fibrosis 2</td>
<td>22%</td>
</tr>
<tr>
<td>Fibrosis 3</td>
<td>14%</td>
</tr>
<tr>
<td>Fibrosis 4</td>
<td>6%</td>
</tr>
<tr>
<td>Decomp Cirrhosis</td>
<td>3%</td>
</tr>
<tr>
<td>Liver Cancer</td>
<td>3%</td>
</tr>
</tbody>
</table>

Benefit in many Medicaid plans (including NM) prior to 12/1/2015
Expanded Centennial Care Benefit on 12/1/2015
Next Expansion of Centennial Care Benefit: Early 2017
Final Expansion of Centennial Care Benefit: 2018-2019
Key Challenge: Enhanced Screening

Number Treated per Year

- 2014: 1,000 (est)
- 2015: 200
- 2016 (est): 1,200
- 2017 (est): 1,600
- 2018 (est): 1,800
- 2019 (est): 2,000
- 2020 (est): 2,000

HUMAN SERVICES DEPARTMENT
Two Important Obligations

• To treat all patients with active, chronic Hepatitis C infection
• To be faithful stewards of the state’s limited financial resources
Special Thanks to...

- Nancy Smith-Leslie, Director of the Medical Assistance Division
- Andrew Gans and Laine Snow from the DOH for their help with the population model
- The Hepatitis C Coalition for their collaborative development of a statewide strategy
- Karla Thornton, MD, with Project ECHO, for her help at every stage of this project
- All of the Health Plan Medical Directors and pharmacists who provided research articles and significant input and data to help us to make evidence based decisions
- This group, for supporting the efforts of Centennial Care with your time and talents.
Questions? Comments?