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Health Equity Coverage Recommendation Form

Title:	**Health Equity in Chronic Liver Disease**
Date of Last Review:	2/1/25

Research Section

Background

Chronic liver disease is a progressive deterioration of liver functions.[1] Liver functions include the production of clotting factors and other proteins, detoxification of harmful products of metabolism, and the excretion of bile. Chronic liver disease is a larger category of disease that includes diagnoses such as alcoholic liver disease, non-alcoholic fatty liver disease (NAFLD/NASH), and chronic viral hepatitis. Chronic liver disease can also be caused by genetic variations, autoimmune disease, or can be linked to other causes.

Inequities discussed on the Office of Minority Health Website[2]

Chronic Liver Disease and Hispanic/Latino Americans:[3]

- In 2019, chronic liver disease was the seventh leading cause of death for all Hispanic Americans, and the fourth leading cause of death for Hispanic men, ages 45-64.
- Both Hispanic American men and women have a chronic liver disease rate that is twice that of the non-Hispanic white population.
- Hispanic American men and women are 1.6 and 1.7 times more likely to die respectively from liver and intrahepatic bile duct cancer than their non-Hispanic white counterparts.

Chronic Liver Disease and American Indians/Alaska Natives:[4]

- In 2019, chronic liver disease was the fourth leading cause of death for all American Indians/Alaska Natives, and the second leading cause of death for American Indian/Alaska Native men, ages 35-44.
- In 2018, American Indians/Alaska Natives were 1.6 times more likely to be diagnosed with chronic liver disease as compared to non-Hispanic whites.
- The overall death rate for American Indians/Alaska Natives is almost four times higher than the non-Hispanic white population.

- American Indian/Alaska Native women are 2.2 times more likely to be diagnosed with chronic liver disease and 4.8 times more likely to die from chronic liver disease as compared to non-Hispanic white women.

Chronic Liver Disease and Black/African Americans:[5]

- In 2020, chronic liver disease was the ninth leading cause of death for non-Hispanic Black Americans, ages 45-64 years old.
- African American/Black men are 60 percent more likely to have liver and intrahepatic bile duct cancer and to die from this disease as compared to non-Hispanic white men.
- African American/Black women are 30 percent more likely to die from liver and intrahepatic bile duct cancer than non-Hispanic white women.

Chronic Liver Disease and Asian Americans:[6]

- In 2019, chronic liver disease was the sixth leading cause of death for Asian/Pacific Islanders, 25-44 years old.
- Asian American men have higher incidence rates of liver cancer as compared to Hispanic, non-Hispanic white, or Asian/Pacific Islander men.
- Asian male subgroups have higher mortality rates for liver cancer, specifically 54.3 for Vietnamese, 33.9 for Koreans, 23.3 for Chinese, 16.8 for Filipino and 9.3 for Japanese descended men.
- Asian American men are 60 percent more likely to die from liver and intrahepatic bile duct cancer, as compared to non-Hispanic white men.
- The incidence rate for liver and intrahepatic bile duct cancer is 1.8 times higher for Asian American women as compared to non-Hispanic white women.

Review of current, peer-reviewed evidence from established sources

- In 2023, Kardashian and colleagues published a review of health disparities in chronic liver disease.[7] Authors reported that the syndemic of hazardous alcohol consumption, opioid use, and obesity has led to important changes in liver disease epidemiology that have exacerbated health disparities. There have been large increases in alcohol use disorder in women, racial and ethnic minorities, and those experiencing poverty in the context of poor access to alcohol treatment, leading to increasing rates of alcohol-associated liver diseases. Rising rates of NAFLD and associated fibrosis have been observed in Hispanic persons, women aged > 50, and individuals experiencing food insecurity. Access to viral hepatitis screening and linkage to treatment are suboptimal for racial and ethnic minorities and individuals who are uninsured or underinsured, resulting in greater liver-related mortality and later-stage diagnoses of hepatocellular carcinoma. Data from more diverse cohorts on autoimmune and cholestatic liver diseases are lacking, supporting the need to study the contemporary epidemiology of these disorders in greater detail.

- In 2023, Jones and colleagues proposed actionable solutions to achieve health equity in chronic liver disease.[8] Authors argued that to achieve health equity, we must address the root

causes that drive these inequities. Understanding the role that social determinants of health play in the disparate health outcomes that are currently observed is critically important. They recommend forging and/or strengthening collaborations between patients, community members, other key stakeholders, health care providers, health care institutions, professional societies, and legislative bodies. Herein, they provide a high-level review of current disparities in chronic liver disease and describe actionable strategies that have potential to bridge gaps, improve quality, and promote equity in liver care.

Review of clinical practices guidelines from professional associations and societies in regard to these findings

No relevant clinical practice guidelines were identified.

Do any of these findings relate to any of our current policies?

None of the above findings are applicable to any of our current medical policies at this time.

Summary

Medical Policy:
Chronic liver disease disproportionately affects minority populations in the United States and is a leading cause of death among Asian, Black, Hispanic, and Native Americans. While the cause is not always known, some cases can be initiated by conditions such as chronic alcoholism, obesity, and exposure to hepatitis B and C viruses. Despite these health disparities, no evidence-based clinical practice guidelines were identified that clarify optimal approaches for reducing chronic liver disease risk in high-risk populations. Further research is required to determine the best methods for reducing care gaps for these populations. For this reason, there are no distinct utilization and medical necessity criteria for vulnerable populations regarding chronic liver disease care.

Pharmacy Policy:
Improving health equity in liver disease from the pharmacy side of health insurance requires addressing access to medications, affordability, and culturally competent care. Ways to achieve this include:

- Improving medication access and affordability:
    - Expand coverage and reduce prior authorization barriers for key liver disease medications.[7,8] Ensure direct acting antivirals for hepatitis C, treatments for nonalcoholic fatty liver disease, and immunosuppressants for liver transplant patients are included in formularies. Lower cost-sharing for essential drugs to reduce out-of-pocket expenses for lower income patients.[7] Reduce or eliminate Medicaid disparities.[7] Individuals on Medicaid often face stricter eligibility criteria and limitations on treatment options compared to private insurance, leading to poorer access to liver disease care.[9]

        - Immunosuppressants: cyclosporine, tacrolimus (IR and ER), sirolimus, azathioprine, mycophenolic acid are all available on the formulary without restriction, on low, generic cost-sharing tiers (exception is everolimus which is a specialty medication). Thymoglobulin, Atgam, Simulect are available under the medical benefit without restriction.
        - Direct acting antivirals for hepatitis C: We have several of these agents on formulary. For Commercial and Medicare, these are on a specialty cost-sharing tier due to the high cost and need for additional monitoring through specialty pharmacy services. Additionally, these mediations require prior authorization in part due to cost, but also due to the importance of treatment history, cirrhosis status, and genotype, for example, to ensure treatment success. The policy for the Medicaid population is slightly more restrictive than the one for our Commercial line of business. A suggestion has been documented to consider aligning the Medicaid policy with the Commercial policy to eliminate burden and reduce unnecessary denials for patients while ensuring we are in alignment with Medicaid rules. This policy will be up for review in December.
- <u>Address social determinants of health in pharmacy services.</u>
    - Offer mail-order and home delivery services for patients in rural or underserved areas.[10] Ensure specialty medications are available through pharmacies in marginalized communities, not just large health systems.[10]
        - These are services already offered through Providence Health Plan, with some benefits allowing for reduced copays when utilizing mail order.
    - Train pharmacists to address language barriers, health literacy issues, and cultural perceptions around liver disease.[7,10] Educate patients on insurance navigation and help them understand benefits and patient assistance programs.[10]
        - Employees in the call center are available to discuss benefits and programs we offer. Programs include the Rx Savings Solutions, which is a tool that finds prescription drug savings opportunities for our members, notifies members of the opportunity, and helps them through the process of changing to the lower cost solution. Additionally, we utilize interpreter, video interpreter, and document translator services for members with language barriers. Several people in the pharmacy department are currently in the process of completing a health literacy certificate program. Upon completion, findings will be discussed as a group to see what we are doing well and what changes we can implement.

Recommendation:	For Pharmacy Policy a recommendation has been documented to consider aligning the Medicaid policy with the Commercial policy to eliminate burden and reduce unnecessary denials for patients while ensuring we are in alignment with Medicaid rules. This policy will be up for review in December.

References

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CORE Revision History Section

DATE	SUMMARY OF CHANGES
08/23/2023	CORE creation date.
01/27/2025	Annual update. No changes.