

# Unlocking HCV Care in Key Settings

# Introduction

In September 2023, NASTAD and the National Viral Hepatitis Roundtable (NVHR) convened a two-day virtual summit entitled Unlocking HCV Care in Key Settings. The goals of the virtual summit included showcasing promising models and best practices for integrating hepatitis C virus (HCV) testing and treatment into programs providing medications for opioid use disorder (MOUDs), state correctional facilities, federally qualified health centers (FQHCs), and syringe services programs (SSPs).

These four key settings were selected as critical venues for hepatitis C elimination through a health equity framework. Each setting serves or engages populations with disproportionately high rates of HCV, with multiple overlapping social determinants of health and co-occurring conditions. Collectively, these settings represent important potential arenas for integration of HCV testing and treatment, each with their own combination of demonstrated feasibility through innovative pilots and pioneering models, yet ripe for replication, adaptation, and scale-up.

The virtual summit took place against the [backdrop of mixed results](#) in the nation’s efforts towards achieving elimination of hepatitis C as a public health threat by 2030. While advances in HCV treatment have led to declines in annual HCV-related mortality, the ongoing wave of opioid and stimulant use have driven increases in new cases linked to lack of access to harm reduction services. Moreover, [CDC data](#) suggests that rates of HCV treatment initiation – crucial to achieving cure targets – have been declining since prior to the COVID-19 pandemic, and that roughly one-third of people with chronic hepatitis C have not yet been diagnosed.

In light of the urgency to redouble hepatitis C elimination efforts, NASTAD and NVHR planned the virtual summit and prepared this accompanying meeting report to leverage experience and expertise towards expanding testing and treatment in settings with unmet potential for reducing the burden of HCV and opportunities for high impact in reducing health disparities. NASTAD and NVHR are grateful to our moderators, panelists, subject matter experts, and attendees for a rich discussion, and offer the following key points as a contribution to our collective commitment to HCV elimination. This report summarizes the panelist presentations and panel discussions from the meetings, and should be viewed as a summary of current practices and sciences, not recommendations for best practices or preferred strategies

## Acknowledgments:

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# Integrating Hepatitis C Testing and Treatment Services in MOUD treatment settings



Medications for opioid use disorder (MOUD) include methadone and buprenorphine, as well as naltrexone. Methadone is primarily dispensed through designated opioid treatment programs (OTPs). OTPs are special clinics that require certification and accreditation at the federal level, and may also be subject to state regulation or licensure. A [recent analysis](#) of data from treatment facilities offering MOUD collected by the 2017-2020 National Survey of Substance Abuse Treatment Services demonstrated significant gaps in provision of HCV testing and treatment, and comparable gaps in HIV testing and treatment. The survey analysis found that 65% of OTPs offered HCV testing and only 10.7% offered HCV treatment. Among non-OTPs providing MOUD, 45.8% offered HCV testing and 20.5% offered HCV treatment. For both OTPs and non-OTPs, outpatient facilities reported significantly lower rates of offering HCV and HIV testing and treatment. While OTPs are required to have medical staff and provide counseling, they may be integrated into hospitals or other health clinics, or operate as standalone treatment providers with limited health services. A small proportion of OTPs operate mobile units to dispense methadone; recent policy changes have opened the door to wider use of mobile units for methadone dispensing.

Despite being clinics, OTPs are often viewed as unconventional settings for screening and treatment of HCV. A [recent assessment](#) of Medicaid enrollees across 11 states initiating MOUD treatment between 2016-2019 found that only 24-27% received HCV testing. A [qualitative assessment of barriers](#) to on-site testing at OTPs cited a range of capacity challenges, including payment and billing, electronic health record (EHR) systems, coordination with medical providers, and OTP staffing. Nevertheless, OTPs have an important role to play in the identification of people living with HCV and the provision of care and curative therapy co-located with services already accessed on a routine basis by affected individuals who may otherwise not make contact with traditional systems of care/health care settings.

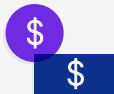
## Integrating HCV in MOUD treatment settings cont.

Buprenorphine can be prescribed in the context of routine health care; some OTPs also prescribe buprenorphine. Buprenorphine prescribing has traditionally required completion of special medical education to acquire a federal waiver, with specific caps on the number of patients to whom a health care provider can prescribe. Recent policy changes have eased the ability to prescribe buprenorphine, and during the COVID-19 pandemic, tele-prescribing of buprenorphine increased. However, analyses have consistently shown [racial/ethnic disparities](#) in likelihood of receiving a buprenorphine prescription.



### Program considerations

- **ON-SITE TESTING AND TREATMENT AT OTPs:** Tony Martinez and Lynn Taylor described models of integrated on-site HCV testing and treatment at OTPs in New York and Rhode Island. Key components include flexible appointments, peer support and patient navigation, an open door policy for patients who return to care after an interruption, collaboration with partners, and a strong and cohesive team.
- **TREATMENT VIA TELEMEDICINE:** While OTP patients may receive HCV screening upon admission as part of a medical examination, many OTPs do not operate with the infrastructure, resources, nor staffing to provide on-site HCV treatment. Referrals to providers treating HCV may not result in high rates of HCV treatment initiation for OTP patients diagnosed with HCV. Novel telehealth arrangements, where an OTP collaborates with an off-site treatment provider for HCV treatment, may increase access and engagement in HCV care.



### Financing considerations

- **MEDICAID BILLING:** Substantial discussion emerged during the virtual convening of the prospects for leveraging Medicaid to finance HCV treatment in OTPs. While not all OTPs accept Medicaid patients, many OTPs do not currently bill Medicaid for physical health services, and may lack both the infrastructure and financial incentives to incorporate the infrastructure required for Medicaid billing. As a result, current business models for OTPs not integrated into larger health systems do not align well with Medicaid reimbursement rates nor traditional health care financing mechanisms through public and private payers. Reimbursement concerns included not only HCV medication costs, but also laboratory testing and clinician and staff time.
- **ALTERNATE FINANCING STRATEGIES:** Other opportunities for HCV treatment integration into OTPs cited during discussion in the virtual convening included potential avenues to leverage opioid settlement funds. [The Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#) also administers and oversees funding which may support some aspects of HCV integration. SAMHSA administers [Minority AIDS Initiative \(MAI\) grants](#) aimed at increasing engagement in substance use disorder care for racial/ethnic minorities living with or at risk for HIV, with an emphasis on syndemic approaches to substance use, HIV, and viral hepatitis. SAMHSA also includes HCV screening in its [criteria](#) for Certified Community Behavioral Health Clinics (CCBHCs), aimed at providing coordinated and comprehensive mental health and substance use disorder care.

## Integrating HCV in MOUD treatment settings cont.



### Other considerations

- **CARE DELIVERY:** Panelists in the virtual convening emphasized the importance of person-centered care in the context of addressing HCV among people with opioid use disorder. Specific approaches and strategies included building multidisciplinary teams, integrating sexual and reproductive health, and incorporating primary care. Patients with opioid use disorder may particularly benefit from flexibility in appointments, transportation assistance, and telehealth options. Walk-in hours and low-threshold access to providers encourage engagement and retention in care.
- **TESTING PROTOCOLS:** [Opt-out HCV testing](#) encourages higher rates of diagnosis. [Screening with anti-HCV antibody test followed by a polymerase chain reaction test for HCV RNA is accurate for identifying patients with chronic HCV](#) which is in alignment with the [CDC's guidance for universal screening of adults for HCV](#). OTPs with limited capacity for phlebotomy may consider partnerships with health departments or community-based organizations.
- **CO-LOCATED CARE AND PEER SUPPORT:** Co-location of care, where HCV testing and treatment are delivered on-site where people with opioid use disorder are already receiving MOUD and other treatment supports, represents an ideal form of integration and access. "One-stop shop" models of care may be particularly important for patients experiencing transportation barriers. MOUD patients also benefit from peer support, and peer navigators and counselors should be incorporated into the treatment team.

### Resources:

#### **BILLING GUIDANCE:**

[CMS Billing and Payment:](#) OTP Payments Rates and Office-Based Opioid Use Disorder (OUD) Treatment Billing

[New York State Billing Guidance Template:](#) NYS Department of Health, Office of Addiction Services and Supports: Ambulatory Patient Group (APG) Billing Guidance for HCV Treatment in OTPs.

[HCV CURRENT:](#) a national initiative from SAMHSA's Addiction Technology Transfer Center (ATTC) Network "to increase hepatitis C (HCV) knowledge among medical and behavioral health professionals."

[HCV TREATMENT IN OTPS:](#) Webinar with presentations for health care providers, billing staff, financial managers, and administrators. Guidance on the importance of addressing HCV in OTPs and guidance on providing HCV treatment and services in OTPs.

[HEPATITIS C TELEHEALTH TOOLKIT:](#) a practical guide to the implementation of HCV telehealth as a client-centered approach intended to support both the non-traditional health care setting interested in providing HCV treatment via telehealth and the telehealth agency itself.

[INTEGRATING HCV SERVICES:](#) The California Department of Public Health developed guidance to provide answers to questions on integrating HCV services into Narcotic Treatment Programs (NTPs), including testing, navigation, treatment, and training.

# Integrating Hepatitis C Testing and Treatment Services into State Correctional Settings



[Roughly one-third of people with chronic hepatitis C](#) are estimated to pass through jails or prisons each year. According to [recently published analysis](#), the prevalence of HCV is roughly nine times higher in state prisons than in the general population. Out of a total number of roughly one million people held in state correctional facilities, an estimated 91,090 persons with hepatitis C were incarcerated in state prisons at the end of 2021. A high proportion of people sentenced to incarceration in state prisons meet the [criteria for a substance use disorder](#).

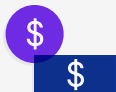
Access to health care varies widely across state prison systems, and access to HCV care in state prisons has [come under scrutiny](#) in several states. While health care generally falls under the purview of state departments of corrections (DOC), some states contract health care out to private firms. In general, people who are incarcerated are largely excluded from Medicaid coverage, and health care in state prisons is primarily financed through state budget allocations, leading to significant differences across states in approaches to hepatitis C treatment. Several states have been subject to litigation for withholding hepatitis C treatment, with some courts mandating that state DOCs implement broader access to treatment. Behavioral health care, [including medications for opioid use disorder \(MOUD\)](#), is also inconsistent across facilities, though the overdose crisis has prompted recent pushes in some states for wider access to methadone and buprenorphine.

## Integrating HCV into State Correctional Settings cont.



### Program considerations

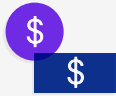
- **OPT-OUT HCV TESTING:** Universal opt-out HCV screening (as opposed to opt-in and/or risk-based screening), as [recommended by CDC](#), has been a cornerstone of HCV efforts in state corrections. During the virtual summit, each state represented on the panel (Indiana, New Mexico, and Tennessee) described some form of a universal opt-out testing protocol. For example, in Tennessee, people entering the state correctional system are screened for HCV upon initial intake, when transferred to another facility, during HCV treatment, and at personal request.
- **PEER EDUCATION:** New Mexico and Indiana panelists discussed the value and role of peer education programs, where incarcerated individuals are trained to educate their peers on different aspects of HCV, including transmission and treatment. Successful peer education programs can play a unique role in providing information and strategies about preventing HCV transmission and reinfection, encouraging consideration of treatment, and breaking through the stigma of HCV behind bars.
  - [Indiana Peer Education Program ECHO](#)
  - [New Mexico Peer Education Project](#)
- **SAFER TATTOOING:** The prevalence of unlicensed tattooing during incarceration poses a substantial risk of HCV transmission. In response, a [prison in Minnesota](#) is developing a training program for a supervised tattooing program, designed to avoid the risks of bloodborne transmission of HCV from unsterile tattoos.
- **CARE TRANSITIONS:** Indiana outlined its [Connect to Cure](#) program, a statewide initiative that includes a pathway to link incarcerated people to HCV care coordination prior to release. For those persons who do not receive HCV treatment while incarcerated, transitional health services will focus on care coordination and linkage efforts prior to and following return to the community.
- **DATA DASHBOARDS:** Efforts to track and monitor HCV treatment rates across state correctional settings are vital to coordinating care, allocating resources, and improving quality. [Tennessee's Department of Health](#) uses laboratory-reported data, including both positive and negative RNA tests, to analyze progress in treating HCV in state prisons. [California Correctional Health Care Services](#) has a model dashboard that includes key HCV indicators by facility.



### Financing considerations

- **340B PRICING:** While state prisons are not, in themselves, considered as 'covered entities' eligible for 340B drug pricing discounts, some state facilities have partnered with their state's health department prevention programs and other eligible entities such as hospitals and STD clinics to achieve discounted rates on purchase of direct-acting antivirals for HCV treatment.
  - [Demystifying 340B for Correctional Institutions](#), Webinar, NHCN, 2021
  - [STD 340B Correctional Facility Partnerships](#), Fact Sheet, NASTAD 2023
- **STATE BUDGET INVESTMENTS:** Several states – often, in response to litigation – have allocated specific funding in state budgets for the provision of HCV care and the purchasing of HCV medications.
- **SUBSCRIPTION MODELS:** States including Louisiana and Washington have implemented [innovative payment models](#) to contract directly with pharmaceutical companies for the purchase of HCV medications for Medicaid recipients and people incarcerated in state prisons. These subscription-based models potentially incentivize state purchasers to expand access to HCV treatment by allowing states to purchase an unlimited amount of medication at a fixed cost.

## Integrating HCV into State Correctional Settings cont.



### Financing considerations cont.

- **MEDICAID REENTRY SECTION 1115 WAIVERS:** In 2023, California became the first state to receive approval from the Centers for Medicare and Medicaid Services (CMS) for Medicaid billing of certain services provided to incarcerated persons in the 90 days prior to release. CMS subsequently issued guidance to state Medicaid programs on the design of similar reentry 1115 waivers, with specific inclusion of HCV treatment as an example of an optional component.
  - [Medicaid Access Brief Guide](#): Pre-Release Medicaid Coverage and New Opportunities to Combat Hepatitis C
  - [Medicaid Section 1115 Waivers](#), Webinar, NVHR 2023



### Other considerations

- **LITIGATION:** Lawsuits have been a significant driver of policy changes to HCV testing and treatment in state correctional systems. Courts have made various rulings on the required standard of care for people who are incarcerated with HCV in the custody of state prisons. In some cases, state DOCs have entered into consent decrees, stipulating specific actions and commitments to HCV care and treatment subject to court monitoring for a certain period of time. A recent whitepaper from [University of Michigan Law School's Civil Litigation Clearinghouse](#) synthesizes the results of these lawsuits to provide a set of recommendations on HCV testing and treatment policies in state corrections.
- **HARM REDUCTION AND PREVENTION:** Multiple panelists and discussants focused on the challenges of harm reduction in state correctional settings. State correctional systems generally regard tattooing and drug injection equipment as contraband, and some panelists and discussants reported concerns about reinfection risks and rates following successful HCV treatment in the absence of effective harm reduction and prevention interventions. Suggestions included the sanctioned tattooing model being piloted in Minnesota, peer education programs offering risk reduction information, and research into incorporation of harm reduction strategies (such as transitions from injection to smoking) into correctional settings.
- **COLLABORATION AND PARTNERSHIPS:** A key theme of the virtual panel discussion revolved around the importance of collaboration with multiple partners. Partnerships between Departments of Correction and health departments, potentially including embedding health department personnel in correctional institutions, can be essential for improving policies, monitoring outcomes, and coordinating care. In addition, collaboration with private contractors providing health care in state prisons, along with engagement and consultation with people who are currently and formerly incarcerated in HCV program planning, design, and implementation, are vital to sustained success.

### Resources:

[NATIONAL HEPATITIS CORRECTIONS NETWORK \(NHCCN\)](#): a network supporting a public health approach to hepatitis education, prevention, testing, and treatment in prisons and jails.

[THE INTERNATIONAL NETWORK ON HEALTH AND HEPATITIS IN SUBSTANCE USERS](#) – Prisons Network (INHSU Prisons): a special interest group who engage in scientific knowledge and information exchange, knowledge translation, and advocacy for enhanced hepatitis care in custodial settings formed to connect the global community working to enhance access to hepatitis care for people in prisons.



# Integrating Hepatitis C Testing and Treatment Services into Federally Qualified Health Centers (FQHCs)



Federally Qualified Health Centers (FQHCs), also known as community health centers, are non-profit outpatient clinics providing comprehensive care to medically underserved populations in medically underserved urban and rural areas. FQHCs receive federal funding from the Bureau of Primary Health Care (BPHC) of the Health Resources & Services Administration (HRSA), along with a special form of reimbursement for services provided to Medicaid and Medicare beneficiaries. There are nearly [1,400 HRSA-funded FQHCs with over 15,000 service delivery sites across the nation](#), providing care to over 30 million patients.

FQHCs are required to provide care to patients regardless of their ability to pay using a sliding fee scale to offer discounts on services. FQHCs also support patients' access to health care through services including translation and transportation. FQHCs have a critical role to play in efforts to eliminate HCV. They are uniquely positioned to address this epidemic because they serve a patient population with a high burden of HCV and they are intentionally located in medically underserved areas. According to [HRSA's Uniform Data System](#), in 2022, FQHCs conducted over 2.1 million HCV tests, with care delivered to nearly 130,000 patients with an HCV-related diagnostic code for their visit.

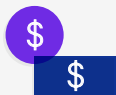
FQHCs commonly have a physical ("brick-and-mortar") clinic site, and some FQHCs operate clinics in multiple locations. Some FQHCs also operate mobile health clinics; the recent passage in Congress of the [MOBILE Health Care Act](#), which goes into effect in 2024, was aimed at facilitating the expansion of mobile health care offered and delivered by FQHCs..

## Integrating HCV into Federally Qualified Health Centers (FQHCs) cont.



### Program considerations

- **LOCATIONS AND SETTINGS:** during the virtual summit, panelists described a variety of approaches to care delivery. Andrew Seaman outlined the work of Central City Concern in Portland, OR, a homeless services organization with a clinic providing primary care to over 4,000 patients, with a high proportion reporting risk factors for HCV. The clinic implemented a universal HCV screening strategy and has treated a high proportion of patients, facilitated by the removal of prior authorization requirements for HCV medications in Oregon's state Medicaid program. Another initiative discussed by Andrew Seaman utilizes community health workers to provide screening (including utilization of dried-blood spot tests) in outreach settings, coupled with a [simple questionnaire](#) (in the process of validation) aimed at ruling out the presence of decompensated cirrhosis to facilitate rapid initiation of HCV treatment.
- **MOBILE HEALTH:** Stephanie Constantino of Family Health Centers of San Diego (CA) discussed their mobile health program, which visits homeless shelters and syringe services programs. The mobile unit provides HCV testing and treatment as well as low-barrier buprenorphine for treatment of opioid use disorder, and uses a Fibrosan device to assess degree of liver damage. Community partnerships are essential to the success of their mobile health program, allowing them to reach medically underserved patients who would not otherwise present at their clinics.
- **LEVERAGING PRIMARY CARE:** Stacey Trooskin of the Mazzone Center in Philadelphia, PA, underscored the importance of integrating HCV into FQHC workflows through routine opt-out HCV screening policies at first appointment, leveraging electronic health records (EHR) systems and developing visit templates and laboratory order sets. Given appropriate systems and support, primary care providers are capable of treating HCV. Ideally, all services – including phlebotomy, medications for opioid use disorder, and pharmacy – should be integrated and coordinated on-site.
- **PEER NAVIGATION:** The panelists stressed the value and importance of peer navigation in supporting patients through the HCV diagnosis and treatment journey. Navigators can support patients in retention and reengagement in care, assist in coordination and reminders of appointments and medication refills, and provide support on addressing other health care and social needs.



### Financing considerations

- **340B DRUG PRICING:** FQHCs are eligible (as 'covered entities') for purchasing medications, including HCV medications, at reduced prices. The savings from discounted prices can be reinvested by FQHCs to support comprehensive care for medically underserved patients, which may include additional care coordination and peer navigation services for HCV treatment or other needs. [NASTAD's 340B Drug Pricing Program Guidance for Viral Hepatitis Programs](#) is a valuable resource for understanding how to leverage and navigate the [340B Drug Pricing Program](#).
- **FUNDING CHALLENGES:** Where available, grant funding can supplement FQHC billing revenue and support the build out of HCV integration into clinic workflows, though currently no specific federal grant programs are dedicated to expanding HCV care in FQHCs. Costs of laboratory tests can be challenging, particularly for uninsured patients, though patient assistance programs may be helpful. Central City Concern reported success in offering [modest financial incentives](#) for HCV testing in its field outreach program.

## Integrating HCV into Federally Qualified Health Centers (FQHCs) cont.



### Other considerations

- **PRIOR AUTHORIZATION:** [complex prior authorization requirements](#) imposed by state Medicaid programs can pose daunting barriers for FQHCs, which may not have large administrative staff to navigate denials and appeals, thereby diverting health care providers' time away from patient care. Removal of prior authorization requirements for patients meeting the criteria for simplified treatment effectively expands the capacity of FQHCs to treat more patients.
- **LEADERSHIP:** several panelists and commenters stressed the need for a clinical champion for HCV care within an FQHC and the necessity of securing leadership buy-in. FQHCs are generally under-resourced, and both providers and patients may have multiple competing priorities. However, commitment and dedication, coupled with drawing upon existing clinical education and guidance resources, can make a compelling case for both how and why an FQHC should integrate HCV testing and treatment.
- **SUBSTANCE USE AND MENTAL HEALTH:** for patients with unmet treatment needs related to opioid use, integration of medications for opioid use disorder (MOUD) can facilitate better health outcomes and support HCV care. FQHCs can also serve as a 'hub' for primary care, including HCV care and MOUD, for partner 'spokes' such as syringe services programs, shelters, jails, and substance use treatment programs. These partnerships may leverage mobile health, telehealth, or collocated care.

### Resources:

#### [HEALTH HCV 20X20 RESOURCE GUIDE:](#)

Increasing HCV screening and linkage to care in your respective organization with sections highlighting HCV care basics, navigation, screening, removing barriers, and serving priority populations.

#### [HEPATITIS C TESTING AND LINKAGE TO CARE DEMONSTRATION PROJECTS, CALIFORNIA, 2016-2018, EVALUATION REPORT:](#)

The CA Department of Public Health awarded funding to five demonstration sites to improve their HCV testing to linkage to care. The evaluation details opportunities to enhance HCV testing and linkages to care in clinical and non-clinical settings.

#### [HEPATITIS C COMMUNITY NAVIGATION,](#)

Webinar and Toolkit, NASTAD and HepFreeNYC, 2020

# Integrating Hepatitis C Testing and Treatment Services into Syringe Services Programs (SSPs)



Image Credit: [Building Healthy Online Communities](#)

Syringe services programs provide people who inject drugs (PWID) with information, education, support, and injection equipment to reduce their risk for transmission of hepatitis C and other infectious diseases. The [North American Syringe Exchange Network \(NASEN\)](#) identified just over 500 SSPs operating across the United States in 2020 or 2021 for which NASEN had contact information. SSPs operate under a variety of state laws and local ordinances, vary in program model and size, and generally provide additional services including overdose education and naloxone distribution as well as referral to substance use disorder treatment.

SSPs operate in the majority of states, but SSP availability and density varies considerably across the country. SSPs exist in urban, suburban, and rural locations, and may provide services through a storefront or fixed location, through a mobile health unit, via street outreach, or by home delivery. Additional modes of service delivery include outreach tents, vending machines, and mail order. In addition to infectious disease and overdose prevention, SSPs may provide a range of social services, low-threshold clinical services (such as wound care and vaccination), and assistance with housing and legal services.

SSPs play a distinct role in engaging PWID in a range of services, and present substantial opportunities for HCV testing and treatment integration outside of clinical settings. However, the diversity of program models, coupled with capacity constraints related to funding and staffing alongside legal constraints in several states, require specific consideration for planners and implementers.

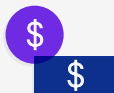
## Integrating HCV into Syringe Services Programs (SSPs) cont.

According to [a survey](#) led by the University of Washington in collaboration with NASEN, across 2020 and 2021, 75% of responding SSPs provide on-site HCV antibody testing and 47% provide confirmatory HCV RNA testing; 31% provide on-site HCV treatment. In addition, referrals to HCV testing and treatment are offered by 39% and 50% of SSPs, respectively. Nearly three-quarters of SSPs described themselves as community-based organizations, while 30% were affiliated with a state, county, or local health department; fewer than 5% reported affiliation with a health care provider such as a clinic or hospital. Two thirds of responding SSPs reported annual budgets of \$250,000 or less, with over a third reporting no paid full-time staff. The median number of unique individuals served per SSP was 432 in 2021 (with an interquartile range of 150-1394).



### Program considerations

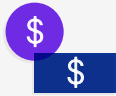
- **ROUTINE OPT-OUT HCV TESTING:** In the virtual summit, Tyler Bartholomew of Miami, [Florida's IDEA Exchange](#) reviewed data demonstrating a significant and sustained increase in uptake of bundled HCV and HIV testing upon SSP enrollment, following a policy change from opt-in testing (upon SSP participant's request) to opt-out testing (offered as routine, unless the SSP participant declined). Prior to the policy change, fewer than 40% of new SSP enrollees opted into HCV testing; following the shift to a routine opt-out policy, over 90% received HCV testing.
- **COLOCATED CARE:** Many SSPs report significant challenges in finding an appropriate and culturally competent health care provider able to treat HCV in people currently injecting drugs. In addition, SSP participants frequently report medical mistrust or previous negative and stigmatizing experiences in health care settings, deterring them from seeking care in traditional venues. In response, some SSPs provide care and treatment on-site, often through collaboration with health care providers. For SSPs that are fully community-based, these collaborations may require grant funding, as relatively few SSPs are designed or equipped for direct billing to Medicaid or other payers.
- **TELEHEALTH:** In the virtual summit, Abigail Hunter of Mount Sinai Hospital in New York City described a collaboration with a local SSP, [VOCAL-NY](#), to leverage telehealth to provide HCV treatment to SSP participants. The flexibility of the telehealth model meant that SSP participants did not have to attend a clinic to receive treatment, and allowed for treatment of participants seen during outreach encounters, in collaboration with VOCAL-NY program staff. The flexibility of telehealth arrangements provides additional opportunities to “meet people where they're at” through engaging their health needs outside of traditional settings.
- **PEER SUPPORT AND NAVIGATION:** Presenters from [Virginia Harm Reduction Coalition](#) described the context and impact of their HCV peer navigation program. Due to the cumulative effects of stigma, discrimination and medical mistrust, SSP participants may benefit from peer support and patient navigation. An affirming, non-judgmental stance from health care providers and SSP staff is critical in building trust and rapport; providers and staff may benefit from training on stigma and trauma-informed harm reduction approaches. Extensive consultation with people who use drugs across the spectrum of program planning, implementation, and evaluation increases the likelihood of acceptability and success for HCV testing and treatment integration efforts.



### Financing considerations

- **RELIANCE ON GRANT FUNDING:** The majority of SSPs currently lack the capacity to implement and administer traditional billing for HCV-related health services. As a result, most SSPs rely on grant funding, including funding from state or local health departments, for HCV-related services. These points from session discussants find corroboration in a 2016-2017 NASEN survey on [availability of HIV and HCV on-site testing and treatment](#) at SSPs. Among 127 respondents, fewer than 3% of SSPs reported any reimbursement from insurers. That survey also found that SSPs providing on-site testing tended on average to have higher budgets and receive public funding; however, SSPs reported more grants or contracts to support HIV-related services than HCV services. In general, grant funding and/or government contracts (including in-kind donations of testing supplies) are a necessary foundation for integrating and expanding HCV testing at SSPs.

## Integrating HCV into Syringe Services Programs (SSPs) cont.



### Financing considerations cont.

- **REIMBURSEMENT FOR TREATMENT:** Embedding clinical services within SSPs would allow for health care providers that treat HCV to bill for their time and services. Billing potential may vary by setting; for example, payers such as Medicaid may limit reimbursement to care provided in licensed health care settings according to specific criteria which office- and storefront-based SSPs may not meet. In addition, laboratory expenses for confirmatory HCV RNA tests, or – where still required by prior authorization – expensive genotype tests and other pre-treatment assessments may be cost-prohibitive for SSP participants, and particularly challenging in states that have not expanded Medicaid eligibility. Planning for integration of HCV treatment into SSPs must account for not only clinical workflows but also benefit navigation and billing/reimbursement strategies.



### Other considerations

- **MEDICATION STORAGE:** A significant proportion of SSP participants experience housing instability and may lack a means for secure storage of medications. Some SSPs ([including IDEA Exchange](#)) offer lockers, to aid participants in stable access to and storage of their belongings without risk of loss or theft. Regulations regarding the storage of controlled and non-controlled medications vary by state and setting. Organizations need to consider consulting their state Board of Pharmacy and legal counsel to ensure compliance with state laws and mitigate risk. Additionally, protocols about access, confidentiality, safety and security, as well as participant consent forms need to be developed.
- **LOW-BARRIER ENGAGEMENT:** HCV testing and treatment protocols and workflows for SSP participants should allow for flexible engagement. Specifically, many SSP participants benefit from flexible walk-in/drop-in hours rather than adherence to rigid appointment windows, and may prefer engaging through street outreach contacts, home visits, or mobile health rather than traveling to particular fixed locations (e.g. SSP offices, health clinics). In addition, consideration needs to be given to the potential need for multiple engagements over a longer period of time to support some SSP participants through the treatment process, with accommodation for “no explanations needed” re-engagement if a participant is temporarily lost to follow up.
- **DATA COLLECTION:** While some degree of data collection may be necessary to satisfy funder requirements and program improvement, every effort should be made to streamline and limit the data collection burden on both SSP staff and participants. For the majority of SSPs, budget constraints limit administrative capacity for data entry and management, while operational considerations (such as street outreach or mobile programs) may limit the feasibility of in-depth enrollment and follow-up questionnaires. Similarly, PWID may be wary of extensive or probing questions about stigmatized or criminalized topics related to risk behavior or reluctant to provide detailed information not clearly related to the service they seek to access.