Payment and Reimbursement Models for Integrated Hepatitis C Services

Preliminary Findings from a Comprehensive Environmental Scan

The U.S. Department of Health and Human Services (HHS) Office of Infectious Disease and HIV/AIDS Policy (OIDP) is leading a new initiative aimed at improving the integration of viral hepatitis prevention and care services into clinical and non-clinical settings. Guided by The Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination (2021-2025), this initiative focuses on identifying payment, reimbursement, and other systemic barriers to integrated viral hepatitis services and identifying, scaling up or developing new models or policies that address these barriers.

OIDP conducted foundational research, inclusive of literature reviews, focus groups, and stakeholder interviews, to identify current and historical barriers to hepatitis C payment and service delivery. This document presents an overview of this initiative and preliminary findings that may inform final recommendations for financing models and/or policies that support integrated viral hepatitis service provision. The information below is not intended to be a final policy or programmatic recommendation. Next steps include development of recommendations, including financing and payment models, derived from real-world experience, that can be applied to new and existing integrated service programs. Integrated hepatitis C service provision spans a diverse array of settings, provider types, patient and community demographics, payer coverage, geographical region, and legislative landscape. As a result, the final recommendations will be presented in the context of these and other factors, as well as their feasibility for replication or adaptation for effective implementation.

Dynamics Impacting Hepatitis C Payment and Delivery of Hepatitis C Services

Barriers along the Hepatitis C Care Cascade

SCREENING & DIAGNOSIS

- Limited use/availability of reflex testing (due to laboratory practices and/or limited reimbursement options) lengthens the diagnostic timeline by requiring additional sample collection
- Lack of reimbursement for confirmatory RNA testing poses financial challenges on care sites to obtain diagnoses without supplemental funds
- Out-of-pocket costs associated with testing (e.g., for uninsured patients) can deter patients and preclude diagnosis
- Non-traditional testing locations such as syringe service programs, behavioral health programs, and mobile clinics often lack the infrastructure to retain or re-engage patients for secondary testing

LINKAGE TO CARE

- Lack of reimbursement options exist for patient navigators, care coordinators, community health workers, etc.
- Lack of reimbursement for sites to provide needed support services (e.g., harm reduction support) to link and retain patients in care hinders integrated service provision
- Uncertainty of future 340B program funding, used to close financial gaps, threatens programs' sustainability
- Services provided at non-traditional sites may face further barriers to reimbursement (e.g., credential requirements for site management, limited reimbursement outside of "brick and mortar facilities")

TREATMENT

- Unnecessary payer restrictions on patient medical or behavioral status require time-intensive (and often non-reimbursable) efforts to secure DAAs
- Provider-type requirements (e.g., infectious disease, liver specialist) to fill DAA prescriptions impedes medication access
- Treatment delays, caused by pre-authorization requirements, increase the likelihood of patients being lost to follow-up

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Select Hepatitis C Financing/Payment Model Findings

The models featured below were identified through literature review, focus group discussions, interviews, and a partner meeting. These models address payment/reimbursement of services for the different steps or the entirety of the hepatitis C care cascade and will be further evaluated in the next steps of the project.

SCREENING & DIAGNOSIS

The Massachusetts FQHC model
Massachusetts allocated funds for HCV-related services and required third-party billing by the state public health laboratory, resulting in substantial increases in chronic HCV diagnoses and increased linkage to care.[1]

LINKAGE TO CARE

The Ryan White HIV/AIDS Program (RWHAP)
RWHAP funds coordination of care services for HCV and HIV co-infected persons by supporting integrated care, reducing access barriers, and driving innovative approaches to deliver HCV treatment.

Project Inspire (NYC)
A comprehensive HCV care coordination program for newly diagnosed Medicaid and Medicare beneficiaries utilized a cost-reimbursement model, resulting in a monthly cost of less than $95 per patient.[2]

TREATMENT

Louisiana's "Netflix" model
Louisiana contracted with Gilead Sciences to pay a flat rate for unrestricted access to treatment for Medicaid and justice-involved beneficiaries, leading to a substantial increase in prescription fills.[3]

Medicaid drug rebate program (MDRP)
Manufacturers participating in MDRP are required to pay statutory rebates to states for outpatient medication (e.g., DAAs) dispensed to Medicaid beneficiaries, thus offsetting drug costs for Medicaid beneficiaries.[4]

National Treatment Programs
Australia established a volume-based risk-sharing agreement with DAA manufacturers to secure five years of unlimited medication as part of national HCV elimination efforts.[5] The program resulted in DAA initiation in nearly one-half of those living with chronic HCV.[6]

Potential HCV Quality Measures
If developed, CMS quality measures, similar to those developed for HIV-related services, could enhance clinical service provision and drive improved patient outcomes.

HRSA's 340B program
The 340B program supports covered entities in providing medication at significantly reduced prices. Covered entities can also leverage medication cost-savings and supplemental funds to fund non-treatment services (e.g., screening, care coordination services).

The Department of Veterans Affairs (VA) model
The VA has cured over 100,000 veterans with chronic HCV infection through a coordinated model of screening and treatment, supported in large part by Congressional actions and advocacy efforts. By 2019, an estimated 85% of veterans at risk for chronic HCV infection had been tested and less than 25,000 remained in need of treatment.[7,8]

The Cherokee Nation Health Services (CNHS) model
The CNHS implemented a comprehensive community-based HCV elimination program with three-year targets for HCV screening, confirmatory testing, linkage to care, treatment, and achievement of cure. The program met or approached targets for HCV cure and linkage to care.[9]

The Bureau of Prisons' (BOP) HCV micro-elimination model leverages pharmacy providers to increase screening and treatment rates among incarcerated persons. Since its implementation in 2022, progress has been made towards goals of screening 90% of persons in custody and treating 95% of diagnosed persons.

The North Dakota Department of Corrections and Rehabilitation (DOCR), with support from the North Dakota Department of Health (NDDOH), implemented a program in which universal opt-out HCV testing was provided upon arrival. Confirmatory HCV testing is underwritten by the NDDOH, resulting in a cost far below what DOCR would pay in the private market.[10]

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