

7th Annual Monitoring Report on HIV/HCV Co-Infection - 2022



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HIV/HCV Co-Infection Watch: 2021-2022 Update

Jen Laws
Community Access National Network

Wednesday, September 21, 2022



DISCLOSURE OF CONFLICT OF INTEREST (IF ANY)

No conflicts of interest to disclose.



AIDS Drug Assistance Programs (ADAPs) Coverage Trends, January 2015–July 2022

January 2015:

- States offering Expanded Coverage – 7 (CA, CO, HI, IA, MA, MN, NJ)
- States and Territories offering only Basic Coverage – 24 (Basic Only – AL, AK, AZ, CT, DE, IN, ME, MD, MI, MS, MO, NY, NC, OK, OR, PA, RI, SC, SD, WA, WV, WI, WY, D.C.; No Coverage [25] – AS, AR, FM, FL, GA, GU, ID, IL, KS, KY, LA, MT, NE, NV, NH, NM, ND, OH, PR, TN, TX, UT, VI, VT, VA)

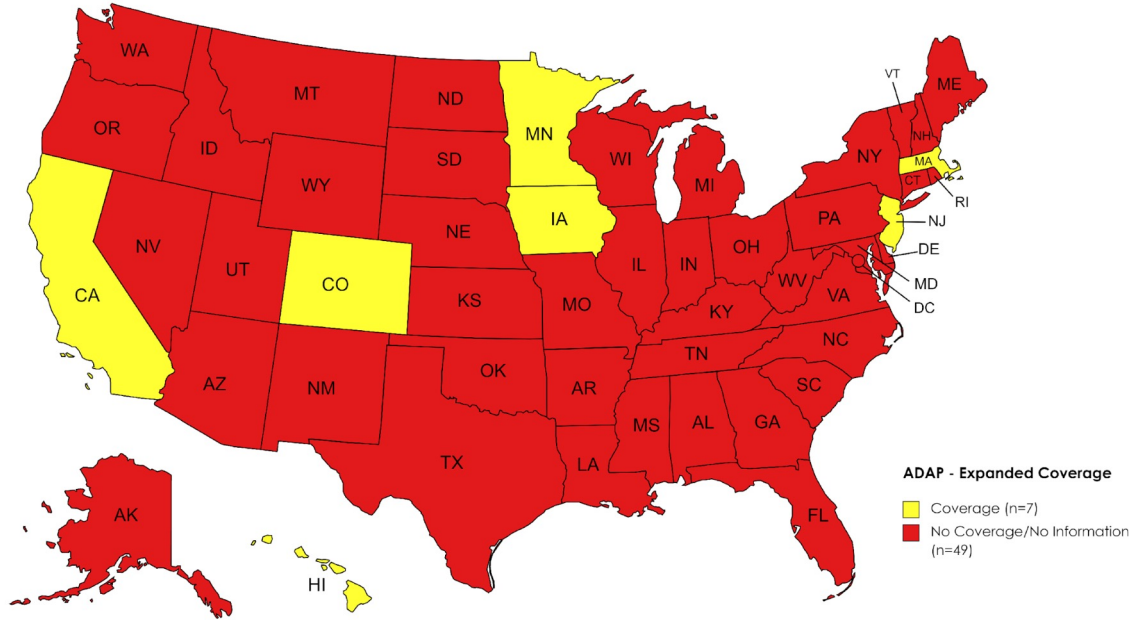
July 2021:

- States and Territories offering Expanded Coverage – 45 (AL, AZ, AR, CA, CO, CT, DE, FL, GA, HI, ID, IL, IN, IA, LA, ME, MD, MA, MI, MN, MO, MS, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OK, OR, PA, PR, SD, TN, TX, VA, WA, WV, WI, WY, D.C.)
- States and Territories offering only Basic Coverage – 3 (Basic only – AK, SC, RI; No coverage [9] – AS, FM, GU, KS, KY, OH, UT, VI, VT)

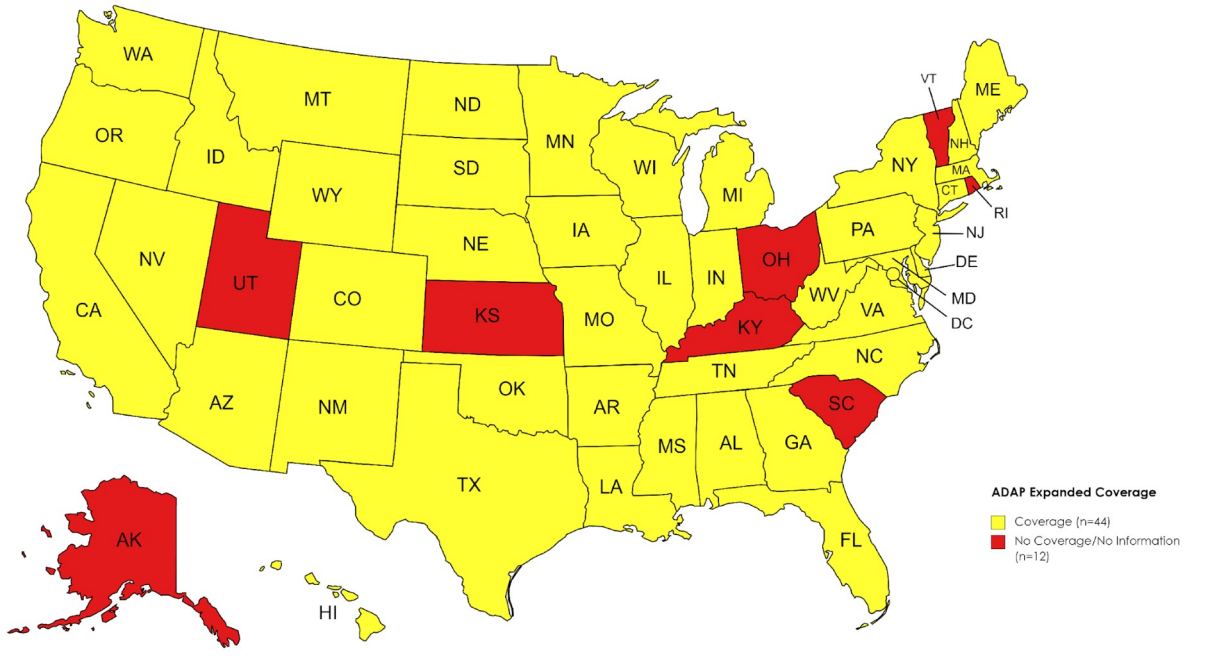
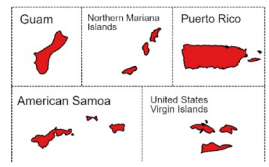
ADAPs Coverage Trends, January 2015–July 2022 (Con't.)

- States have continued to expand coverage as newer, cheaper HCV DAAs hit the market.
- Authorized generics of Harvoni and Epclusa hit the market in January 2019
- Mavyret has become the fastest and most widespread adopted drug (has the widest adoption in ADAPs with just 11 states not covering the drug)
- In 2022, Idaho added DAAs has expanded coverage, previously had not.
 - Tx has reduced to coverage to Epclusa (brand) only.
 - Ga website notes the following: “Georgia ADAP Hepatitis C Program is currently on HOLD until future funding is available. Please utilize Patient Assistance Programs (PAP’s) for Hepatitis C medications.”

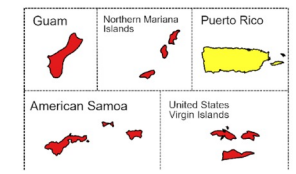
ADAPs – Expanded Coverage



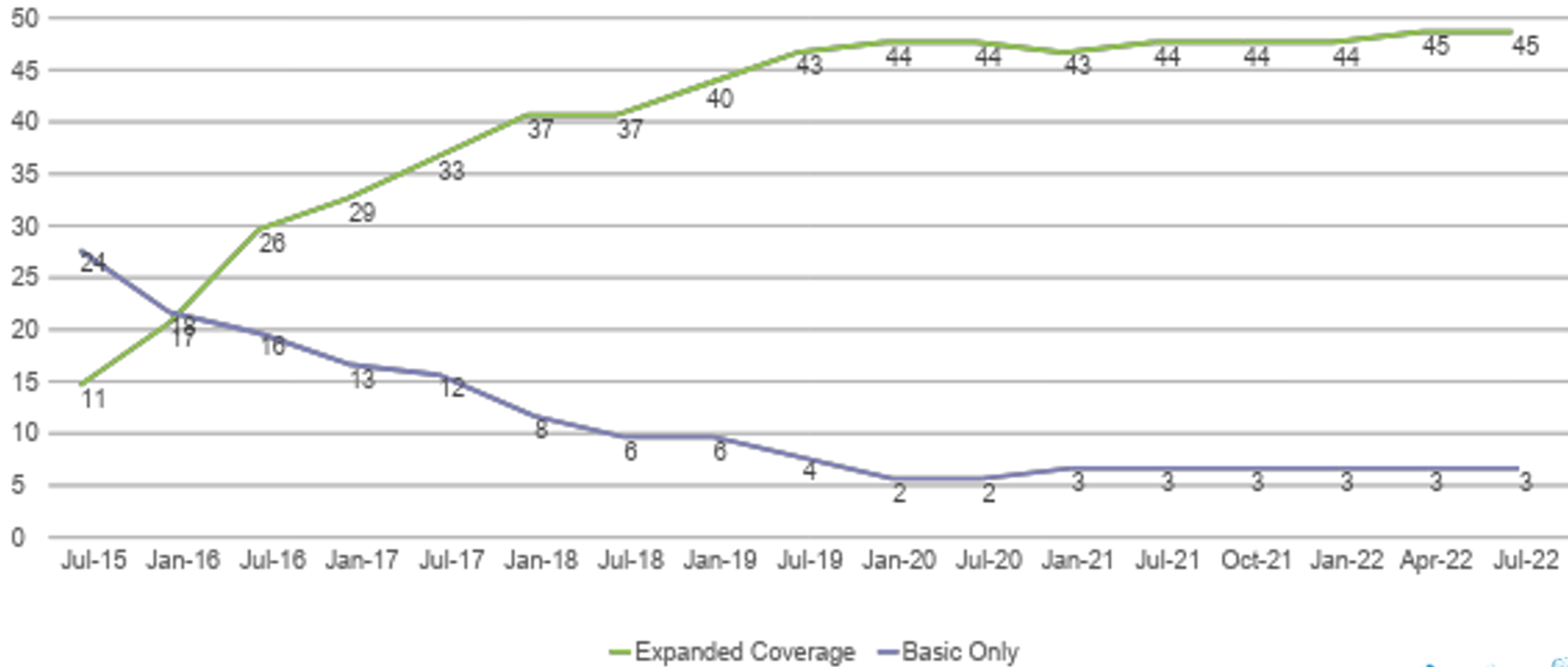
2015



2022



ADAP HCV Drug Utilization January 2015–July 2022



COVID Impacts on HCV Rates and Surveillance*

Ten Highest Rates of HCV Infection (2019)

1	Indiana	4.8
2	West Virginia	4.4
3	Utah	4
4	South Dakota	3.2
5	Maine	3.2
6	Tennessee	3
7	Kentucky	2.9
8	Florida	2.9
9	Ohio	2.4
10	Massachusetts	2.3
National Rate		1.3 (per 100K)

Ten Highest Rates of HCV Infection (2020)

1	Maine	11.9
2	Florida	6.1
3	Louisiana	6
4	West Virginia	5.3
5	Indiana	3.6
6	Utah	3.2
7	Kentucky	3.2
8	Tennessee	2.5
9	Massachusetts	2.2
10	Arkansas	2.1
National Rate		1.5 (per 100K)

Ten Highest Increases - Rates of HCV Infection

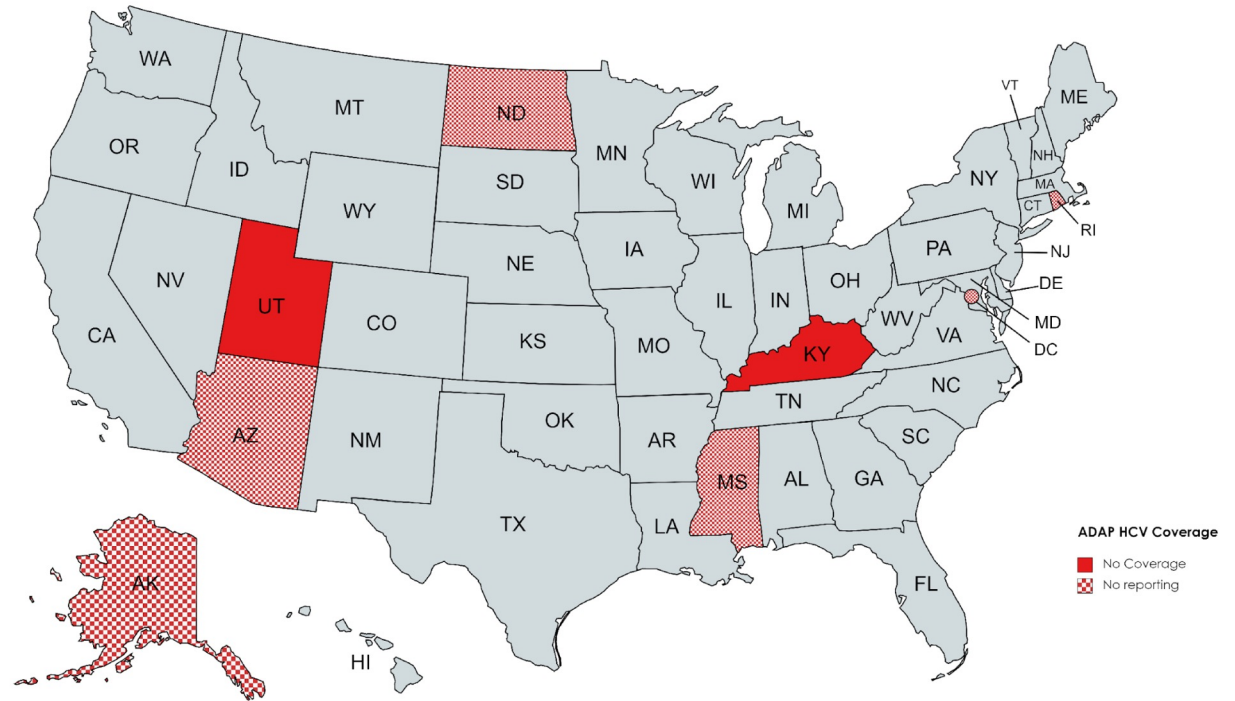
1	Maine	+8.7
2	Louisiana	+5.8
3	Florida	+3.2
4	West Virginia	+0.9
5	Alabama	+.08
6	Georgia	+.07
7	Illinois	+.04
8	Washington	+.03
9	Nebraska	+.03
10	Maryland	+.03
National Rate		+0.2 (per 100K)

*CDC Notes COVID-19 Disruptions for 2020, data should be assessed cautiously

Top 10 HCV Rates Compared to Expanded Coverage*

Ten Highest Rates of HCV Infection (2019)

1	Indiana	4.8
2	West Virginia	4.4
3	Utah	4
4	South Dakota	3.2
5	Maine	3.2
6	Tennessee	3
7	Kentucky	2.9
8	Florida	2.9
9	Ohio	2.4
10	Massachusetts	2.3
National Rate		1.3 (per 100K)



Created with mapchart.net

*2019 HCV Surveillance by State The Centers for Disease Control and Prevention has not yet published 2020 data.

Medicaid Coverage Trends January 2015–July 2022

January 2015:

- States offering Expanded Coverage – 38 (AL, AZ, CO, DE, GA, HI, ID, IL, IN, IA, LA, ME, MD, MA, MN, MS, MO, MT, NE, NV, NH, NJ, NY, NC, OH, OK, OR, PA, SD, TN, UT, VT, VA, WA, WV, WI, WY, D.C.)
- States offering only Basic Coverage – 12 (AK, AR, CA, CT, FL, KS, MI, NM, ND, RI, SC, TX)

July 2021:

- States offering Expanded Coverage – 50 (and the District of Columbia)

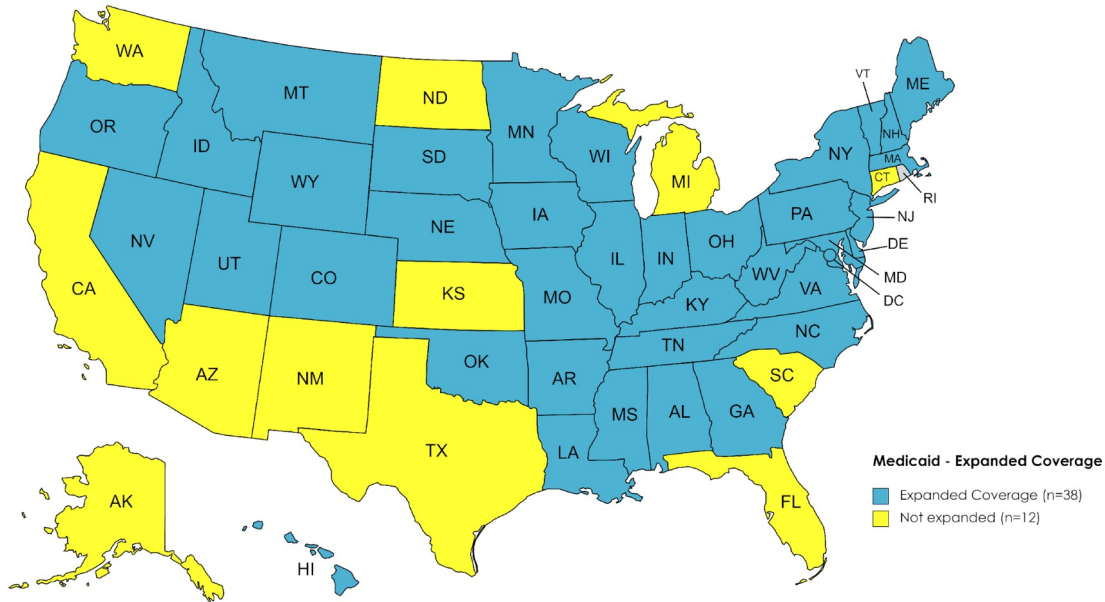


Medicaid Coverage Trends January 2015–July 2022 (Con't.)

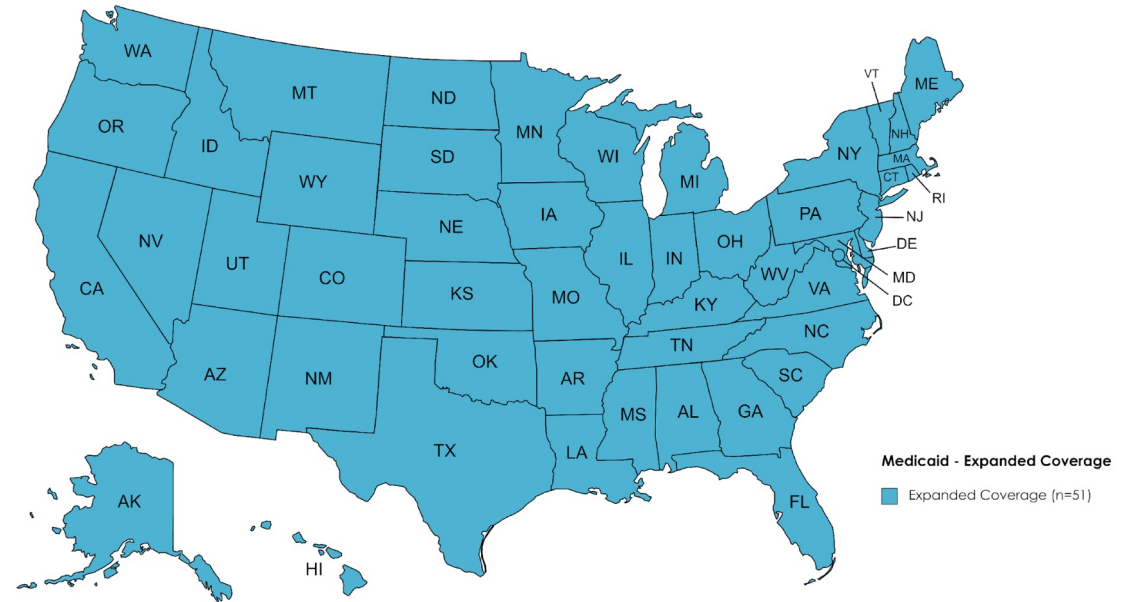
- All states currently offer Expanded Coverage for HCV drugs
- Medicaid programs quicker to adopt HCV drugs than ADAPs
 - VT ADAP not expanded because of Medicaid expanded coverage
 - Could become a trend in future years
- States with multiple Managed Care Organization plans are likelier to have plans offering only one or two HCV DAAs
- Prior authorization, sobriety, and other program requirements continue to serve as a barrier to treatment in many states.
- New, creative restrictions are developing (past adherence to other prescriptions, prohibition on replacing lost or stolen medication, etc)

Medicaid – Expanded Coverage

January 2015

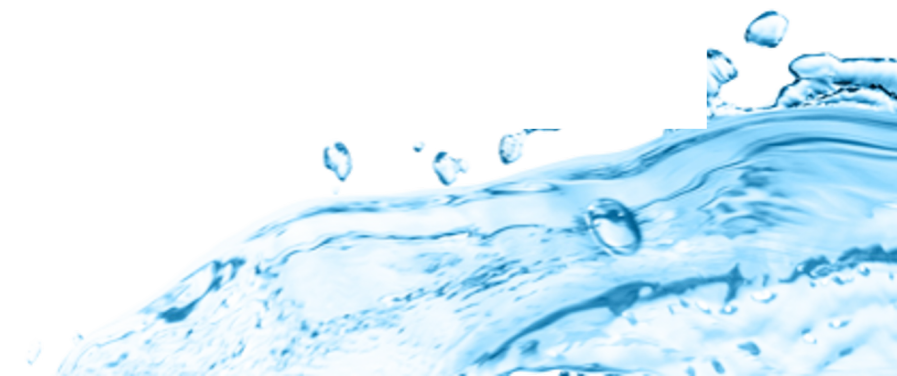


July 2022



Created with mapchart.net

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CDC Vital Signs Report

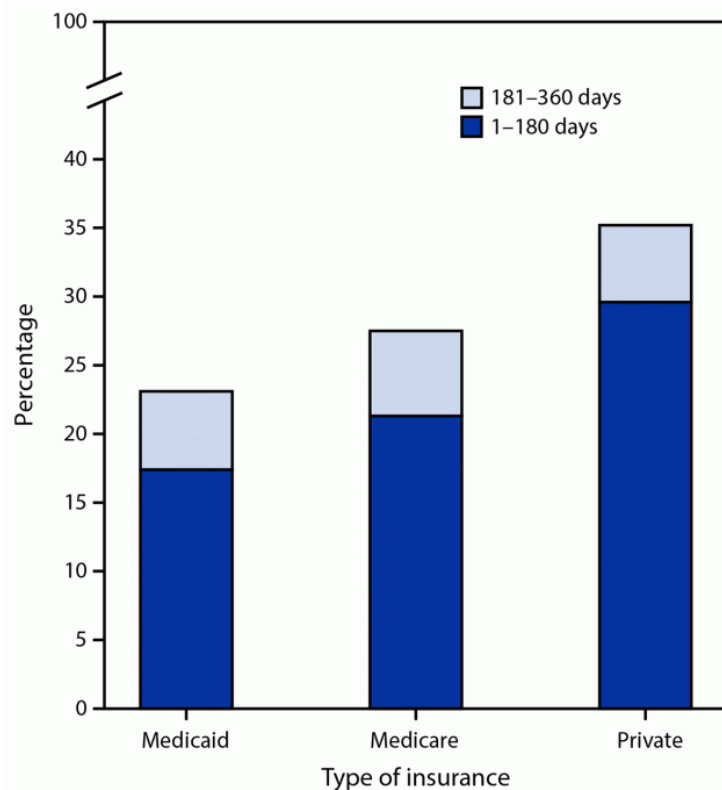


FIGURE 1. Percentage of adults with hepatitis C initiating direct-acting antiviral treatment within 360 days of diagnosis, by number of days after diagnosis and insurance type — United States, 2019–2020

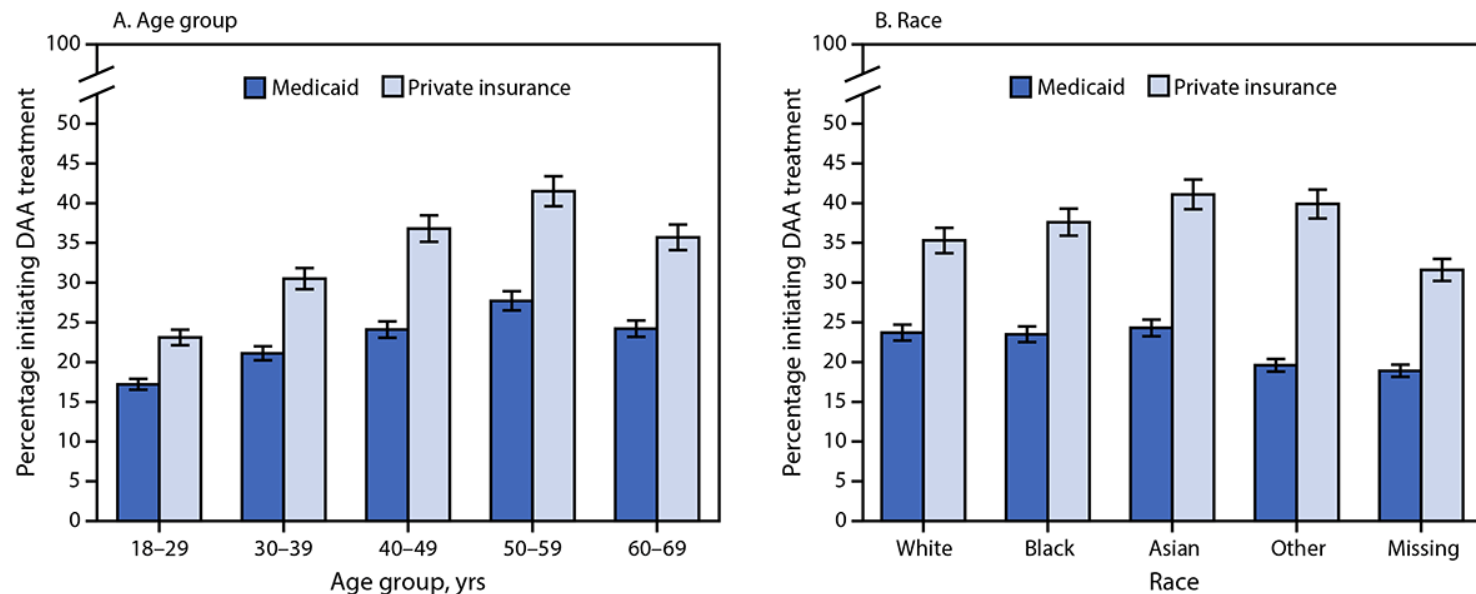


FIGURE 2. Percentage of adults* with hepatitis C initiating direct-acting antiviral treatment, by insurance type, age group (A), and race (B) — United States, 2019–2020

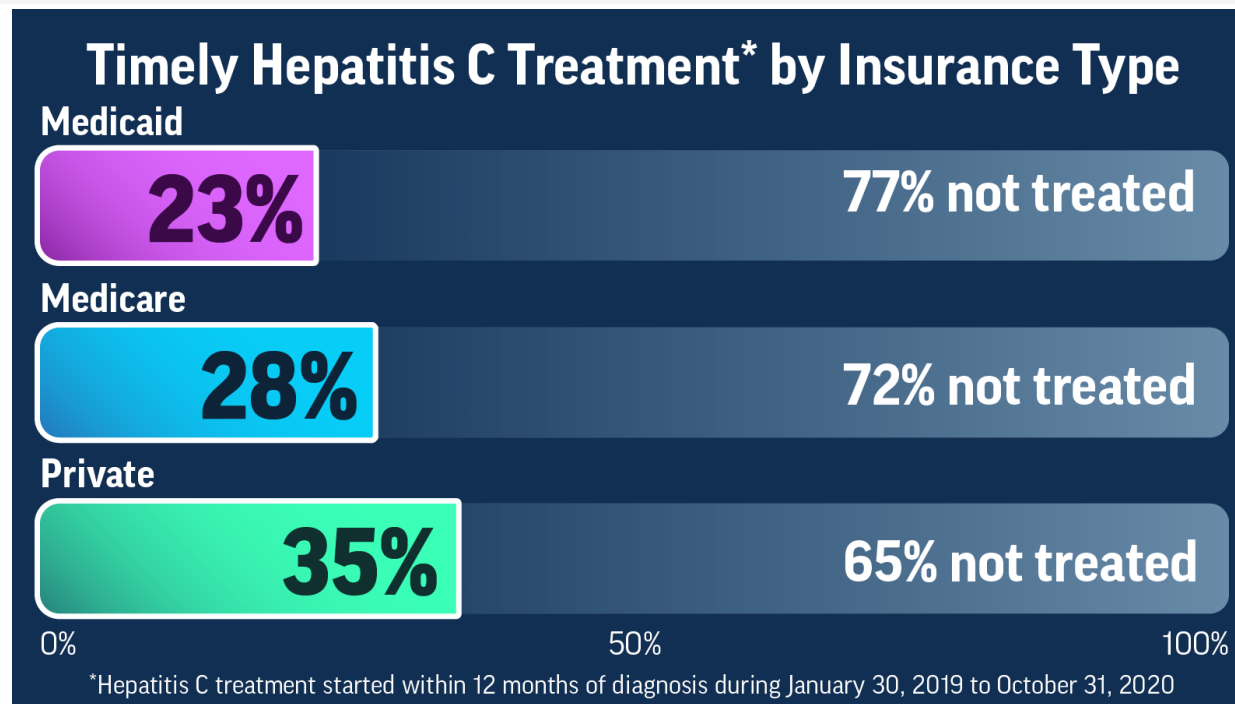
Thompson WW, Symum H, Sandul A, et al. *Vital Signs: Hepatitis C Treatment Among Insured Adults — United States, 2019–2020*. MMWR Morb Mortal Wkly Rep 2022;71:1011-1017. DOI: <http://dx.doi.org/10.15585/mmwr.mm7132e1>

CDC Vital Signs Report (Con't.)

1 in 3 Only about 1 in 3 people with insurance get timely treatment.

46% People with Medicaid were 46% less likely to receive treatment than those with private insurance.

27% Medicaid recipients of other races were up to 27% less likely to get timely treatment than White Medicaid recipients.



Thompson WW, Symum H, Sandul A, et al. *Vital Signs: Hepatitis C Treatment Among Insured Adults — United States, 2019–2020*. MMWR Morb Mortal Wkly Rep 2022;71:1011-1017. DOI: <http://dx.doi.org/10.15585/mmwr.mm7132e1>

Veterans Affairs Coverage Trends

- The Watch began covering VA HCV coverage in March 2016
- Coincided with VA announcement of universal coverage for all eligible VA members
- Since 2016, the VA has cured 100,000 Veterans of HCV (U.S. Department of Veterans Affairs, 2019). Estimated fewer than 25K in VA care left to be tested for HCV.
- Most-used drugs: Zepatier, Mavyret, Harvoni, Epclusa, Vosevi (in treatment experienced)
- March 2021 VA updated treatment guidelines to include more specific therapies per genotype, treatment initiation guidelines, and emphasis on treatment even if re-infected.
- VA continues to provide most effective treatment program in government-funded healthcare



Harm Reduction Trends (2022)

Syringe Services Programs (SSPs) continue to be met with community/official backlash

- Despite longer-running and recent legalization of SSPs in many states and CDC “best practices”, local communities continue to voice opposition against SSPs – notably in Indiana, West Virginia, New Jersey, North Carolina, and even California
- Despite increased support from law enforcement, local counties and municipalities continue to shut down existing SSPs citing dubious reports of increased needle waste, failures to keep adequate exchange records, enabling/“attracting the wrong crowd”, and lack of oversight.
- Where banning SSPs has failed, states and localities are introducing new barriers to establishing or maintaining SSPs (particularly with including new licensing requirements)

Biden Administration Policy and Investment Shift to Harm Reduction



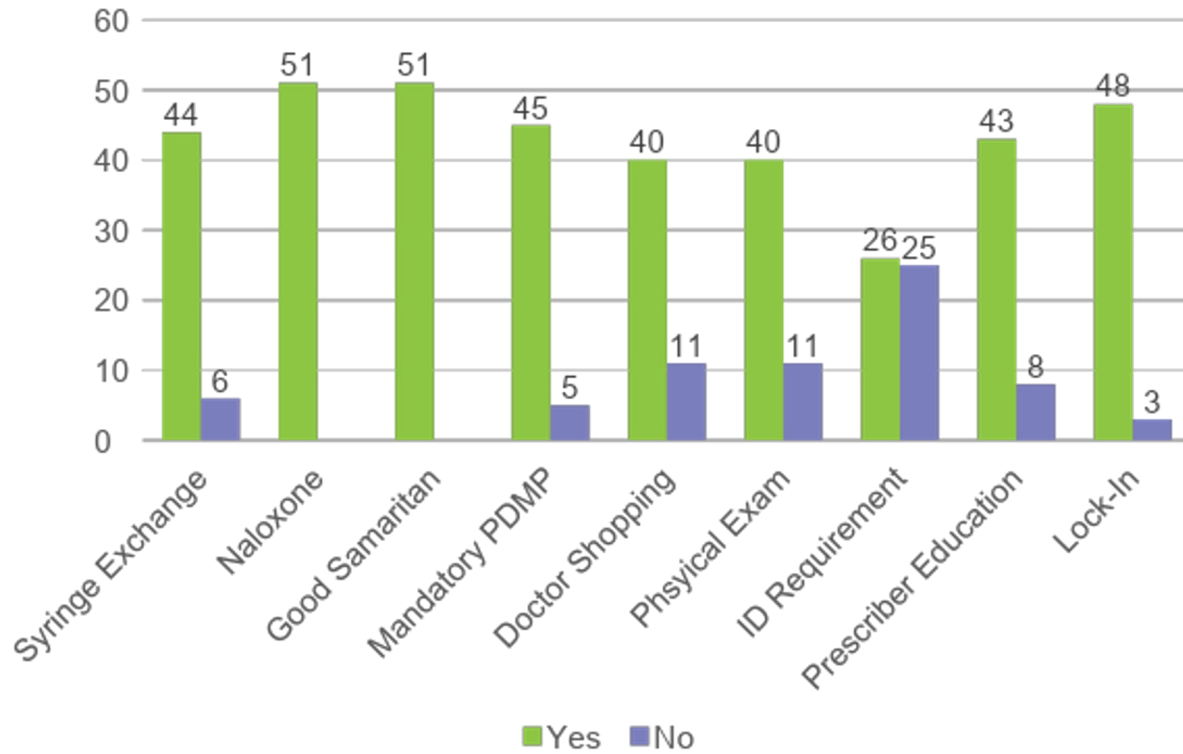
Harm Reduction Trends (Con't.)

Primary barriers to Harm Reduction Measures:

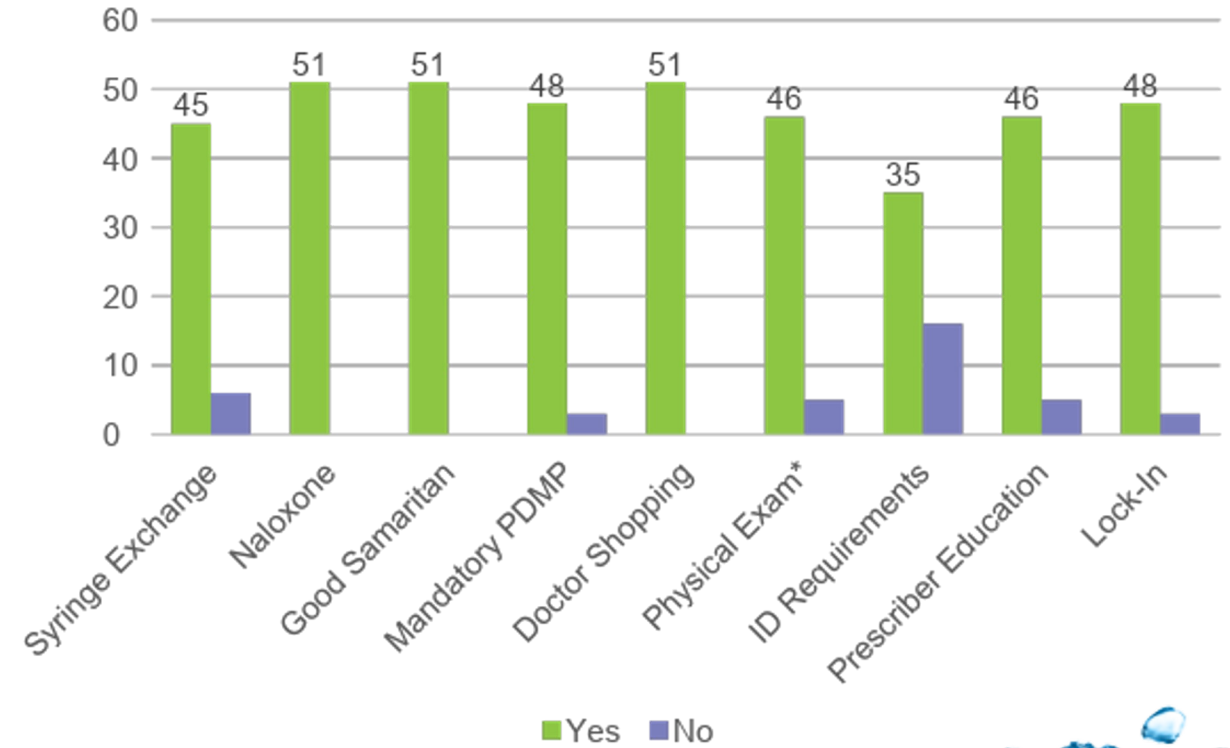
- Stigma - Social stigma, particularly among legislators and providers. Especially true in more rural areas. May constitute illegal discrimination, pending the specific issue.
- Doctor Shopping:
 - Federal blanket statute
 - Reporting/Checking hassle, sometimes determined by payer
 - Often captured under "fraud statutes"
- Physical Exam Requirement*:
 - Physician/Pain Advocate opposition
 - "Too time consuming"
 - "Too onerous"
 - Patient mobility/barriers to accessing care/treatment
- * *Temporarily "on hold" at federal level due to COVID-19 public health emergency since March 2020, telehealth as a pathway to accessing care. However telehealth presents challenges especially in poorer and more rural communities lacking reliable broadband service. Several states already "unwinding" telehealth and federal answers remain absent.*
- ID Requirement for Purchase of Prescription Opioid Drugs:
 - Pain Advocate opposition
 - "Burden on poor/minority patients"
 - Hardware update costs for scanning
 - "Government tracking"
- Prescriber Education:
 - Physician opposition
 - "Time consuming"
- Pharmacy Lock-In Programs:
 - Outdated/User unfriendly software/interface
 - Often determined by payer, sometimes required by statute or waiver (see FL and HI)
 - Paid Advocate opposition
- "Barrier to accessing care/treatment"

Harm Reduction Measures 2019-2022

Harm Reduction August 2019



Harm reduction – July 2022



2022 News

- [Declaration of Public Health Emergency Renewed](#) - On July 15, 2022, the U.S. Department of Health and Human Services (HHS) Secretary Xavier Becerra renewed the existing declaration of a public health emergency (PHE) due to COVID-19. The previous declaration was set to expire in October 2022.
- [As Biden fights Overdoses, Harm Reduction Groups Face Local Opposition](#) - Despite the American Rescue Plan's inclusion of \$30 million to support harm reduction programs, local organizations are struggling to find support in state legislatures, often operating in a legal grey area or outright working against the laws of their state.
- [Disasters Can Interrupt Access to Medications for the Treatment of Opioid Use Disorder](#) - With a spike in overdose deaths occurring during the first years of the COVID-19 pandemic, researchers sought to assess how vulnerable communities lose access to medication assisted treatment during disasters, including hurricanes, tornadoes, flooding, and, yes, pandemics. Researchers found often community vulnerability is not matched with resources and access, leading to and exacerbating disparities.

Contact Information



References available upon request

Community Access National Network (CANN)
1525 Oakwood Drive, Slidell, Louisiana 70458

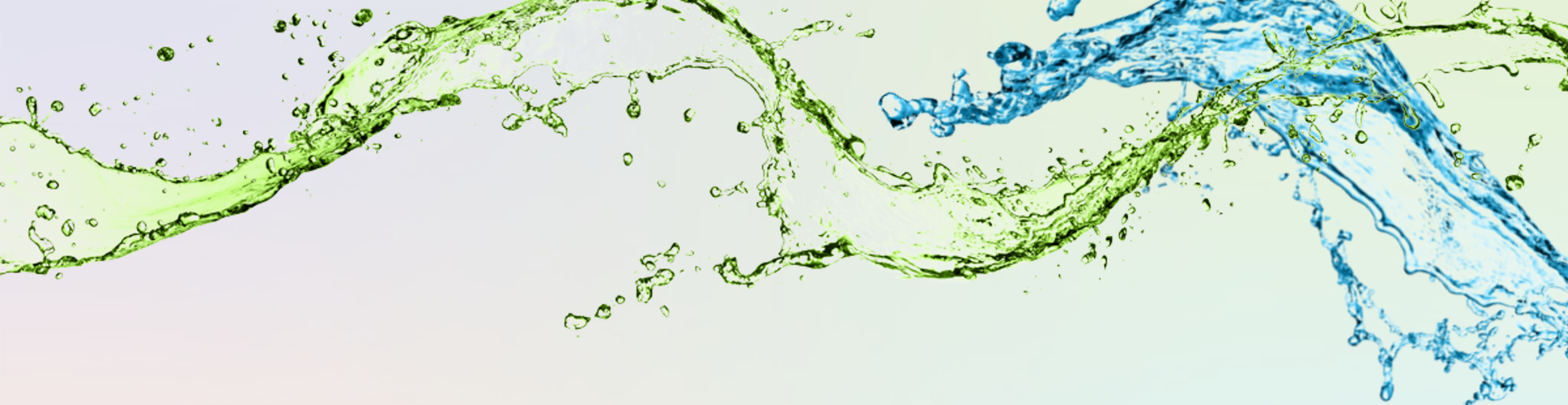
www.tiicann.org

www.hiv-hcv-watch.com

Jen Laws, President & CEO

Jen@tiicann.org





State of Hepatitis C Prevention, Care and Treatment

Marissa Tonelli
Director of HealthHCV

Wednesday, September 21, 2022



DISCLOSURE OF CONFLICT OF INTEREST

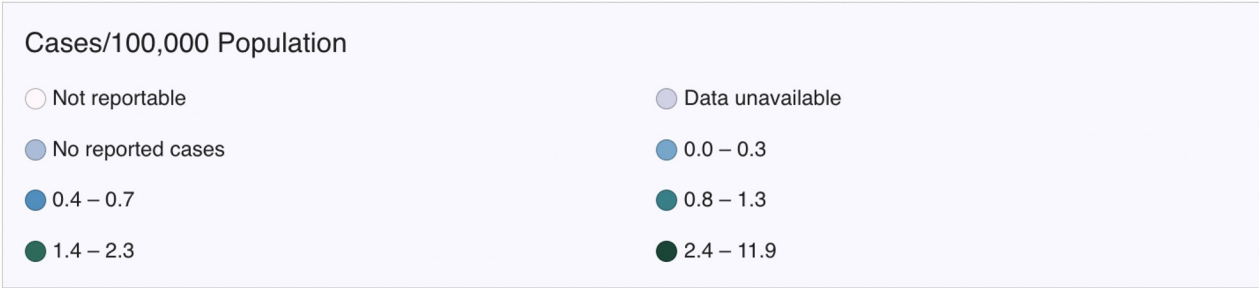
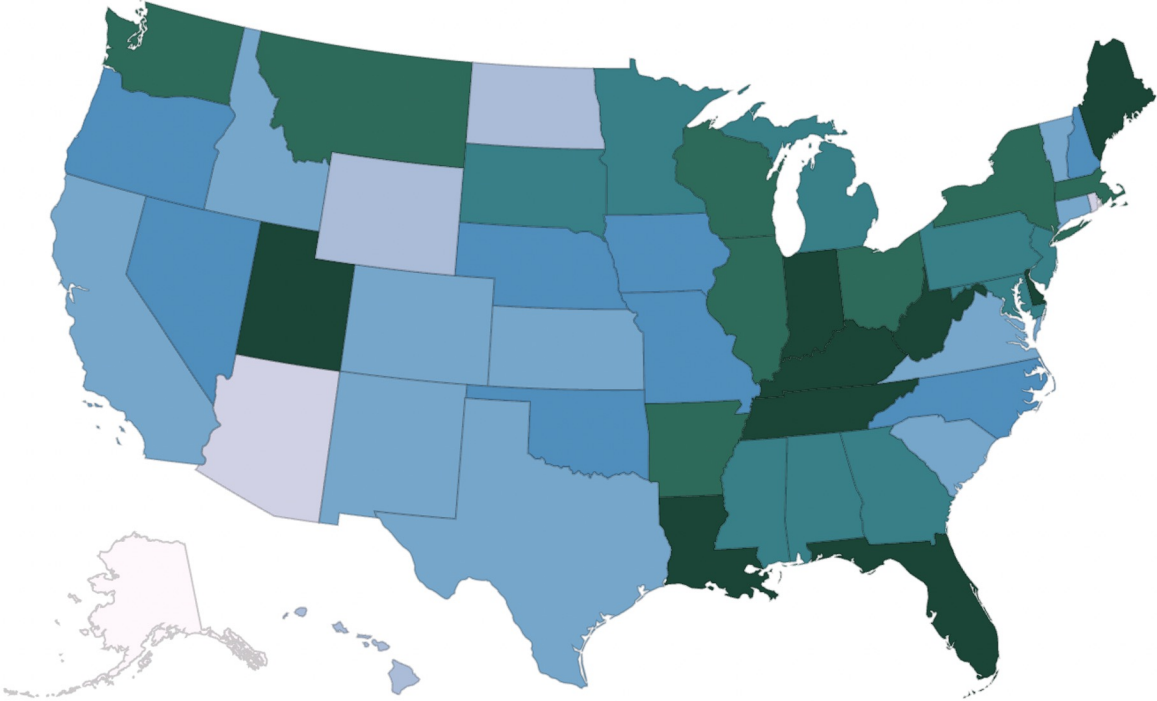
The presenter has no conflicts of interest to disclose.



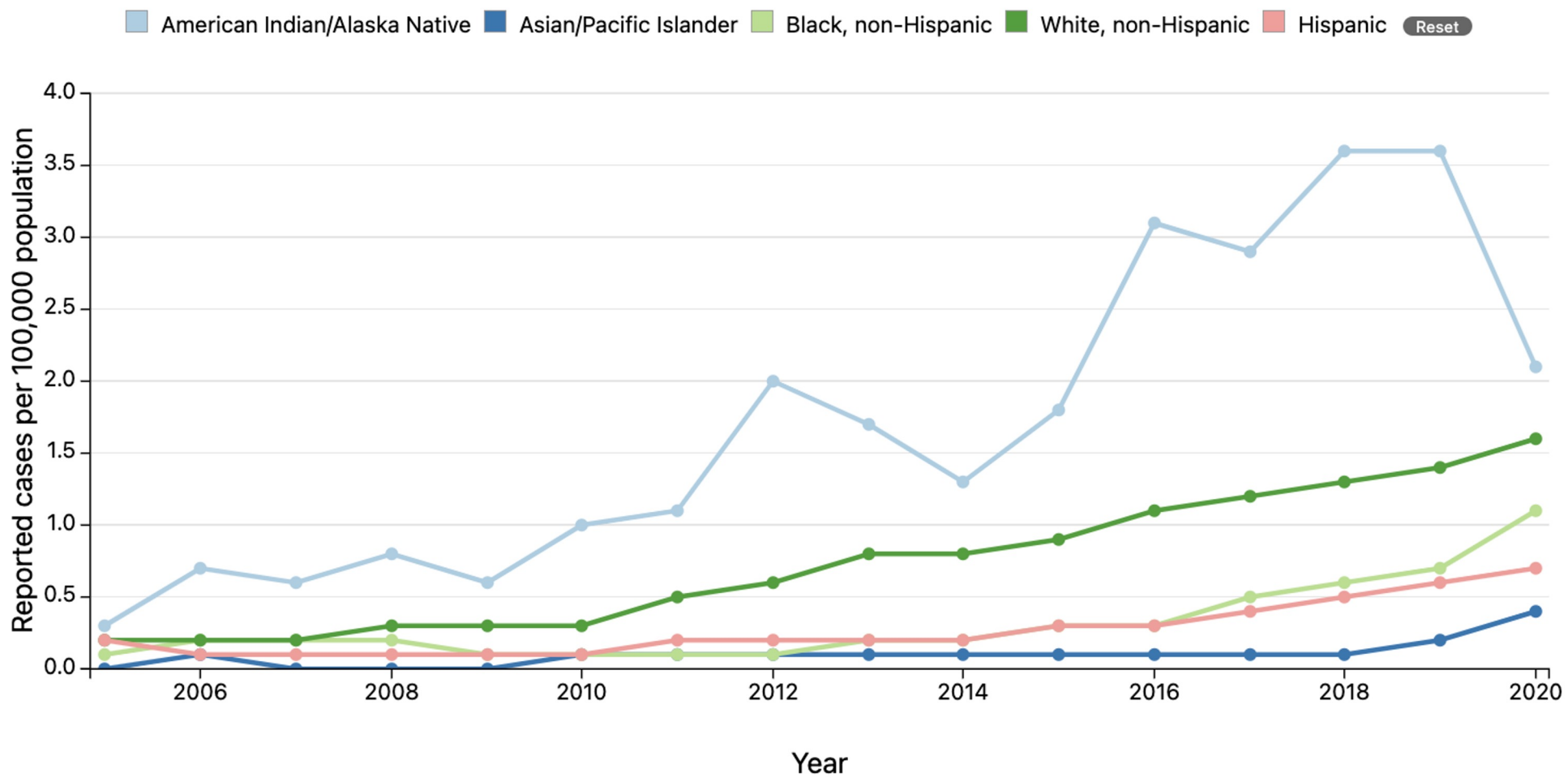
Rates of Acute HCV (2020)

- Rates of acute HCV are highest among American Indian / Alaska Native (AI/AN) persons
- Persons aged 20–39 years had the highest incidence of acute HCV
- 66% of cases with risk information reported injection drug use
- Rates of acute HCV were highest among those living in the eastern and southeastern states
- Incidence rate of acute HCV doubled from 2013–2020, a 124% increase

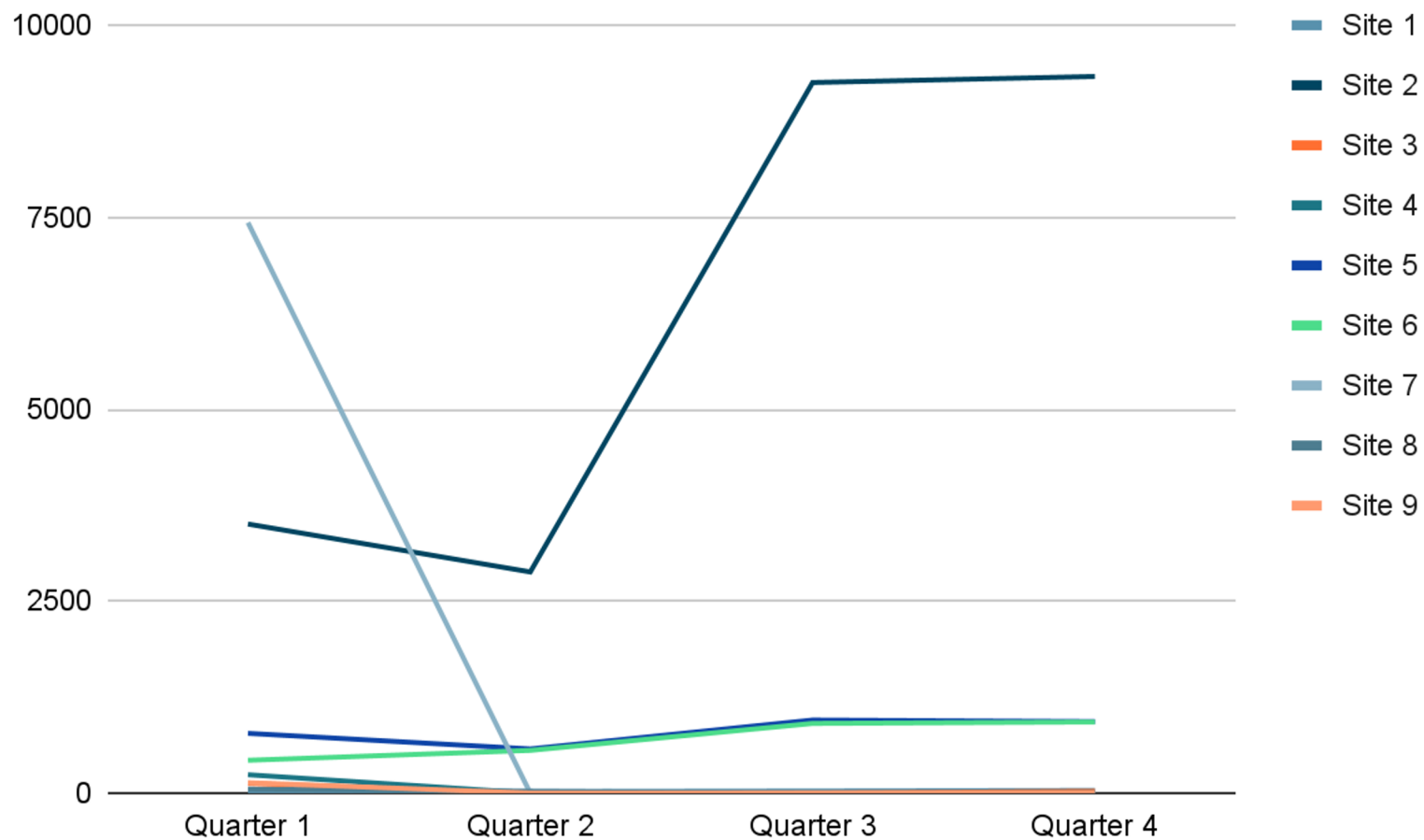
Rates of reported cases of acute HCV infection, by state/jurisdiction – United States, 2005-2020



Rates of reported cases of acute HCV infection, by race/ethnicity – United States, 2005-2020



HealthHCV Screening and Linkage to Care Cohort (2020)



Source: HealthHCV's HCV 20x20 national cohort data, 2020-2021.

Rates of Chronic HCV (2020)

- Chronic HCV affects multiple generations with infections highest among two age groups: 20 – 39 and 55 – 70 years
- During 2020, the rate of newly reported chronic HCV cases was highest among AI/AN persons
- During 2020, 64% of newly reported chronic HCV cases occurred among men
- HCV-associated deaths during 2020 increased 4% compared to 2019
- The age-adjusted death rate for HCV during 2020 decreased 22% from 2016
 - The death rates were higher among AI/AN and non-Hispanic Black persons (3.2 times and 1.8 times, respectively) than among non-Hispanic White persons

2022 Viral Hepatitis National Progress Report Overview

	Baseline 2017 data year	2020 Observed (Annual Target*)	2025 Goal 2023 data year	Trend	2020 Status
Hepatitis C					
Reduce estimated[†] new hepatitis C virus infections by $\geq 20\%$	44,700	66,700 (39,850)	35,000		✗
Reduce reported rate[‡] of new hepatitis C virus infections among persons who inject drugs[¶] by $\geq 25\%$	2.3	2.9 (2.0)	1.7		✗
Reduce reported rate[‡] of hepatitis C-related deaths by $\geq 20\%$	4.13	3.45 (3.57)	3.00		✓
Reduce reported rate[‡] of hepatitis C-related deaths among American Indian and Alaska Native persons by $\geq 30\%$	10.24	10.17 (8.71)	7.17		✗
Reduce reported rate[‡] of hepatitis C-related deaths among non-Hispanic Black persons by $\geq 30\%$	7.03	5.63 (5.98)	4.92		✓

* Annual targets assume a constant (linear) rate of change from the observed baseline (2017) to the 2025 goal (2023 data year).
[†] The number of estimated viral hepatitis infections was determined by multiplying the number of reported cases by a factor that adjusted for underascertainment and underreporting (CDC 2020 Viral Hepatitis Surveillance Report and Klevens, et al, 2014).
[‡] Per 100,000 population.
[¶] Persons aged 18–40 years were used as a proxy for persons who inject drugs.



Met or exceeded current annual target



Moving *toward* annual target, but annual target was not fully met



Annual target was not met and has not changed or moved *away* from annual target

Source: Division of Viral Hepatitis, National Center for HIV, Viral Hepatitis, STD, and TB Prevention.

Clinical Provider Practices in HCV – 2021-2022

- HealthHCV's Fourth Annual State of HCV Care National Survey
 - 389 individuals providing HCV services and/or working at organizations that provide HCV services completed a national survey
 - Represented 35 states, Washington DC, and Puerto Rico



HCV Screening Practices

- ▶ Many HCV service providers are not implementing CDC HCV screening recommendations.
 - ▷ Fewer than two-thirds implement one-time screening for *all* adult patients
- ▶ Over one-third (39%) do not screen all baby boomers
- ▶ Nearly one half (44%) do not screen patients with HIV
- ▶ Only 14% screen patients pregnant in the third trimester

Increasing HCV Diagnosis

- ▶ Respondents report the following settings to be most effective for increasing HCV screening to improve diagnosis:



**HIV care and
treatment programs**



**Substance use
centers**



**Needle exchange
centers**



**Private practice
centers**

HCV Service Delivery Models

The data shows that respondents provide different HCV service delivery models.



Co-located Onsite Model



Distributed Onsite and Referral Model



Telehealth-based Collaborative Management Model

Linkage to HCV care after diagnosis is key to expanding access to HCV cure therapy and is often where most patients with HCV drop out of care.

Reported Re-infection

- ▶ Nearly a quarter (24%) of respondents reported HCV reinfection amongst their patient populations in the past 12 months
- ▶ Populations reported to experience reinfection:



95%

are injection drug users



39%

are experiencing homelessness



34%

are co-infected with HIV and HCV



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Impact of COVID-19 on HCV Care

- ▶ 28% experienced an increase in patients diagnosed with HCV in last year
- ▶ 48% predict they will scale up care within two years



39%
reported
services
remained the
same



32%
incorporated
telemedicine



21%
halted HCV
services



31%
re-prioritized
away from HCV
services

Reported Barriers to HCV Care

▶ Provider-level barriers:

- ▶ Limited infrastructure for providing services (32%)
- ▶ Administrative time for processing prior authorizations/pre-approvals (28%)
- ▶ Treatment utilization policies impacting payer coverage (26%)
- ▶ Lack of consensus about care guidelines (23%)

▶ Client-level barriers:

- ▶ Social barriers (66%)
- ▶ Lack of knowledge of HCV (34%)
- ▶ Costs (31%) and insurance restrictions (27%)
- ▶ Lack of symptoms (28%)
- ▶ Substance use-associated comorbid conditions (22%)

Reported Facilitators to HCV Care

- ▶ Provider-level facilitators:
 - ▶ Co-location of wraparound services (53%) and HCV care services (46%)
 - ▶ HCV training and resources (46%)
 - ▶ Simplicity of Direct-Acting Antivirals (44%)
- ▶ Client-level facilitators:
 - ▶ Accessing a trustworthy provider (57%)
 - ▶ Receiving culturally competent care (49%) and wraparound services (38%)
 - ▶ Accessing care via a co-located model (36%)
 - ▶ Receiving insurance/payment navigation (31%)
 - ▶ Ability to pay for HCV services (31%)

Funding Structure

- ▶ 35% of respondents do not use patient assistance programs to assist with HCV service costs
- ▶ Primary Sources of HCV Funding:



Addressing Payer Barriers

- ▶ 29% respondents reported that they were unable to treat a patient with HCV due to payer/insurance restrictions.
- ▶ Addressing barriers:



54%
used insurance
navigation
services



53%
use prior
authorization or
pre-approval
processing



46%
used info
on patient
assistance
programs



46%
work with
pharmacies
for prior
authorization

Training Needs

- ▶ The top five training needs identified by respondents:
 - ▷ Current HCV screening guidelines
 - ▷ Current HCV treatment guidelines
 - ▷ Simplifying HCV care and treatment in practice
 - ▷ Enhancing HCV linkage to care strategies to increase HCV clients on treatment
 - ▷ Discussing substance use with patients with HCV



Survey Implications

- ▶ More HCV patients are expected to enter care
- ▶ Capacities needed to scale up program and accommodate demand:
 - ▷ Increased linkage and navigation services
 - ▷ Increased administrative capacity
 - ▷ Integration of harm reduction services with HCV care
 - ▷ Comprehensive wraparound services
 - ▷ Implementation of simplified treatment algorithms
 - ▷ Collaborative HCV care management
 - ▷ Decreases in payer restrictions and authorizations

HealthHCV's Fourth Annual State of HCV Care National Survey™ Report

Download the full report at:
<https://healthhcv.org/>

Contact Marissa Tonelli for more
information at
Marissa@HealthHCV.org





Q & A

Thank you for joining this session!

Please submit your questions via the chat function.