

BIG IDEAS

ADVANCING SOLUTIONS TO MOVE CLOSER TO ELIMINATING HEPATITIS C
IN THE UNITED STATES

CORRECTIONAL INSTITUTIONS ARE A CRITICAL INTERVENTION POINT FOR HEPATITIS C ELIMINATION

HEPATITIS C (HCV) ELIMINATION is an achievable goal and should be an important national priority.¹ Elimination means reducing the epidemic rate of new HCV infections in the U.S. to near zero, curing existing cases, and ultimately removing HCV as a public health threat.² If left untreated, chronic HCV infection can cause severe liver damage, liver cancer, and ultimately be fatal.³ Given the dispersion of HCV in key populations throughout the country and the complex patchwork of health care financing systems, many policymakers believe that HCV elimination in the United States can only be achieved through broad population-based screenings combined with focused efforts within specific populations and health systems. Indeed, the Veteran's Health System has led the way by testing 85% of its most at-risk cohort and treating over 121,000 veterans thus far.⁴ Other programs such as End HEP C San Francisco and C Change in Philadelphia have established comprehensive elimination efforts.⁵

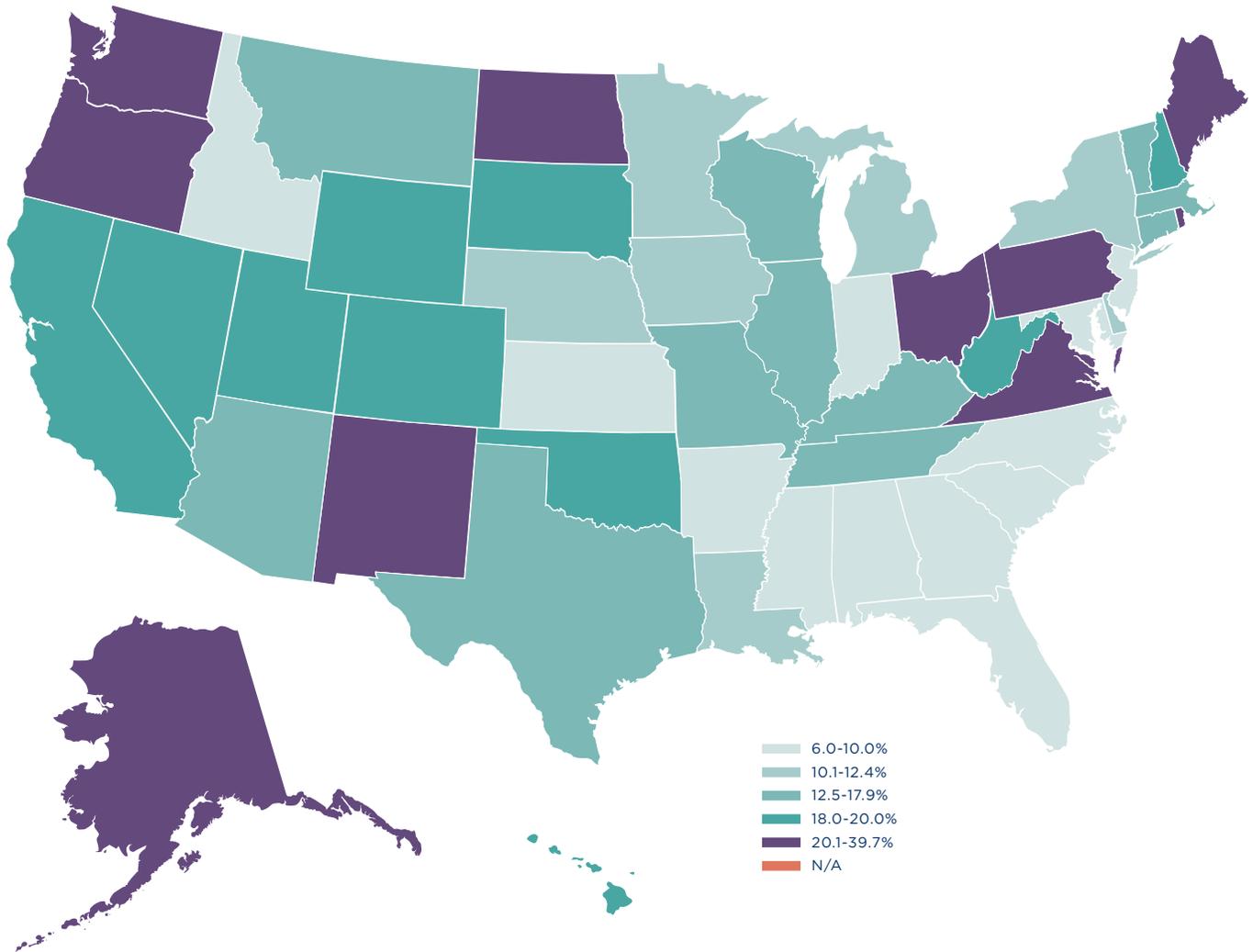
Federal, state, and local correctional facilities are viewed as a critical linchpin of efforts to identify and treat HCV. An estimated 1 in 3 people with HCV in the U.S. has spent time in a jail or prison in a given year.⁶ People who inject drugs—a prominent risk factor for HCV transmission—are also more likely to be incarcerated at some point.⁷ The high prevalence of HCV in corrections makes it an important setting for screening and treatment. This is both to reduce cases within these facilities and to reduce prevalence of HCV in the community, since the majority of persons held in correctional facilities are released at some point.⁸ Despite the opportunity presented by prisons and jails to screen and treat for HCV, such screening and treatment is rare in correctional settings. Cost burdens on correction systems are significant, with

SCREENING AND TREATING HEPATITIS C IN CORRECTIONAL FACILITIES IS INTEGRAL TO ACHIEVING ELIMINATION

An estimated 1 in 3 people with HCV in the U.S. will spend time in a jail or prison in a given year. Therefore, they present important settings for HCV screening and treatment. The diversity of these settings, budget constraints, varying length of stays, and the decentralized nature of these facilities create barriers to HCV screening and treatment. Nonetheless, policy action can have a big impact, and this can produce important improvements in health for the affected individuals and reduce the community prevalence of HCV. Essential actions include:

- **Prioritize funding and resource allocation for evidence-based screening and treatment for opioid use disorder (OUD) and co-occurring infectious diseases in correctional facilities.**
- **Improve enrollment and navigation into Medicaid for people transitioning to release**
- **Foster collaborations between corrections and community health networks to facilitate linkage to care for people reentering the community from correctional facilities**
- **Promote screening for HCV in behavioral health settings, and expand training to increase number of providers with capacity to treat HCV.**

HCV ANTIBODY PREVALENCE IN U.S. STATE PRISON POPULATIONS



SOURCE: HepCorrections, <http://www.hepcorrections.org/map>. Note: State antibody prevalence data are the most current available, sourced from data estimates and state-reported rates with reference years ranging from 2005-2018.

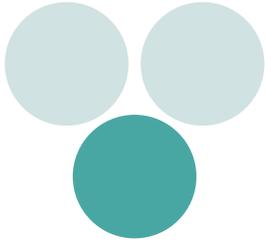
an average manufacturer price of \$49,657 per course of HCV treatment.⁹ These costs are perceived to be an avoidable expense for many prisons and jails. Despite cost and other barriers, correctional facilities remain an important venue for HCV treatment and focused policy action can lead to more incarcerated individuals being screened and treated.

THE RIGHT TO HEALTH CARE IN CORRECTIONAL FACILITIES

The U.S. Constitution guarantees incarcerated individuals certain protections while in confinement. This includes the 8th Amendment protection against cruel and unusual punishment.¹⁰ In the seminal case of *Estelle v. Gamble* in 1976, the Supreme Court ruled that not providing the “community standard of care”

for incarcerated persons amounts to cruel and unusual punishment, and violates their constitutional rights.¹¹ Short-course direct-acting antiviral (DAA) medication has been available since 2013 and is recognized as the standard of treatment to cure HCV.^{12,13} Nonetheless, corrections systems have been slow to adapt their practices to comply with this current community standard. Only 35% of U.S. prisons conduct routine opt-out screening for HCV, and only 3% of persons in prisons have access to HCV treatment medications.^{14,15} Relying on the *Estelle* precedent, lawsuits filed by incarcerated persons in state prisons alleging the denial of treatment for their HCV violated their civil rights have led to successful settlements with states that require HCV testing and treatment be made available to all persons in custody. In 2019, a federal court judge ordered that the state of Florida test and treat all people in state prisons.¹⁶ A January 2020 settlement in South Carolina requires opt-out

HCV AND CORRECTIONS: QUICK FACTS



1 IN 3 PERSONS WITH HCV PASS THROUGH THE CORRECTIONAL SYSTEM IN A GIVEN YEAR



SOME STATE PRISONS HAVE HCV PREVALENCE AS HIGH AS 39%



ONLY 3% OF PEOPLE INCARCERATED IN U.S. PRISONS HAVE ACCESS TO HCV TREATMENT



95% OF PEOPLE IN U.S. PRISONS WILL TRANSITION BACK IN TO THE COMMUNITY

screening of all 19,000 persons currently in custody, of whom 6,000 are projected to test positive for HCV and receive treatment.^{17,18}

JAILS AND PRISONS OFFER DIFFERENT OPPORTUNITIES TO ADDRESS HCV

Jails and prisons face different challenges to expanding HCV testing and treatment in their facilities, yet also offer distinctive opportunities to engage those at greatest risk for HCV in screening and treatment. Universal opt-out screening is the most effective means of screening for HCV in corrections populations and identifying the greatest number of cases, yet only 35% of state prisons and 4% of jails provide routine HCV testing.^{19,20,21,22}

For many, local jails are the initial entry point into the correctional system. Detainment in jails, however, often lasts only a few days or weeks. Thus, these facilities are often challenged in initiating health services for persons detained for an uncertain amount of time, and they are often reluctant to incur the costs of testing for and treating HCV, especially when the person will not be detained long enough to complete

the 8-12-week course of treatment while in custody. The majority of the 10.6 million people admitted to jails annually, however, return to the community within the year, so this is a lost opportunity to identify new cases. Many who acquired HCV through injection drug use (IDU) increase the risk of further transmission if they return to IDU after release. The bulk of the cost lies in the medications to treat HCV, not the cost to administer screenings.²³ Universal screening in jails can be coupled with linkage to community-based services to provide treatment upon release, such as Medicaid enrollment and reinstatement of benefits upon release, linkage to federally qualified health centers (FQHCs), and enrollment in the Ryan White HIV/AIDS Program for those with HCV also living with HIV. Other opportunities in jail settings are increased peer education on harm reduction strategies to prevent infections and transmissions. Expansion of community-based services is needed to meet the demand for care to treat HCV in these populations and prevent HCV transmission once people are released.

Many prisons only test newly incarcerated persons who have risk factors that increase their susceptibility to HCV infections, such as past or current IDU or an HIV diagnosis. Risk-based testing, however, could miss as many as 76% of the HCV cases in a facility.^{24,25}

UNIVERSAL OPT-OUT SCREENING IS THE MOST EFFECTIVE MEANS OF SCREENING FOR HCV IN CORRECTIONS POPULATIONS AND IDENTIFYING THE GREATEST NUMBER OF CASES, YET ONLY 35% OF STATE PRISONS AND 4% OF JAILS PROVIDE ROUTINE HCV TESTING.

Incarceration in prisons is often for several years, which allows sufficient time for a person to complete the DAA treatment regimen while incarcerated. DAA treatment involves taking 1 to 3 daily pills and does not require rigorous clinical monitoring by specialists for most patients, so many prisons can provide treatment with only nominal increases in general practice clinical personnel. Although the cost of DAA medications is cited as the principle barrier to treating, costs for the drugs have decreased in recent years, and court rulings enforcing that state prisons provide HCV treatment should compel states to prioritize funding to meet their legal obligation to provide HCV care.

POLICY ACTION CAN HAVE AN IMPACT

The U.S. likely cannot achieve HCV elimination unless we increase interventions in correctional systems. Pragmatic policy solutions are available that can make a difference:

PRIORITIZE FUNDING AND RESOURCE ALLOCATION FOR EVIDENCE-BASED SCREENING AND TREATMENT FOR OUD AND CO-OCCURRING INFECTIOUS DISEASE IN CORRECTIONAL FACILITIES

More than 200,000 persons actively using heroin pass through the U.S. correctional system every year, and HCV prevalence among adults in state and federal corrections is 10 times higher than the general population.^{26,27} Screening and treatment for OUD and HCV, however, are generally nonexistent or inadequate in most of these facilities. An increase in political will and public support is necessary to provide the needed funding for these services.²⁸ The connection between these correctional health issues suggests the need for integrated OUD and HCV treatment in correctional settings as a yet underutilized opportunity to reach a large number of persons at greatest risk for infection and transmission of HCV.

IMPROVE ENROLLMENT AND NAVIGATION INTO MEDICAID FOR PEOPLE PREPARING FOR RELEASE

Pre-release enrollment for all Medicaid-eligible persons and reinstatement of pre-incarceration Medicaid benefits for persons transitioning out of corrections can provide an uninterrupted means of receiving and continuing health care for those returning to the community from correctional settings. Continuity of care is associated with reduced health care costs, and access to treatment can reduce the risk of post-release transmission of HCV by people returning to the community. Coordination

efforts should be made between state Medicaid administrators and the criminal justice system to ensure that people previously enrolled in Medicaid prior to incarceration are able to have their coverage seamlessly reinstated once they return to the community.

FOSTER COLLABORATIONS BETWEEN CORRECTIONS AND COMMUNITY HEALTH NETWORKS TO FACILITATE LINKAGE TO CARE FOR PEOPLE REENTERING THE COMMUNITY FROM CORRECTIONAL FACILITIES

Improving health outcomes of those recently released from corrections is often overlooked, but is a critical part of reducing recidivism, drug overdose deaths, and rates of infectious diseases such as HCV.²⁹ Coordinated efforts between corrections and community programs that utilize evidence-based reentry programs can provide linkage to care for opioid use disorder, infectious disease prevention and treatment, and promote use of harm reduction practices.³⁰

PROMOTE SCREENING FOR HCV IN BEHAVIORAL HEALTH SETTINGS, AND EXPAND TRAINING TO INCREASE THE NUMBER OF PROVIDERS WITH CAPACITY TO TREAT HCV

The availability of screening and treatment in a variety of settings will increase access to these services for more people and improve engagement and maintenance in care. Appropriately treated behavioral health has shown to reduce risk of recidivism and improve overall health outcomes.³¹ Comprehensive opt-out infectious disease screening of persons engaged in behavioral health treatment will help to identify new cases and connect people to care. This will require increased training of behavioral health personnel on how to test and counsel clients on prevention and successfully seeking treatment. Training also ensures a quality standard for screening and treatment implementation.

THE TIME IS NOW

The extremely disparate rates of HCV in corrections requires decisive action to screen and treat this population in order to successfully achieve elimination in the U.S. As litigation mandates more jurisdictions to provide screening and treatment, all correctional facilities should take the necessary steps to expand screening and treatment of HCV in their facilities.

LEARNING FROM THE FIELD

Some correctional facilities have made strides in addressing high rates of HCV by expanding testing, treatment, and community care navigation. Strategies to reduce correctional HCV rates require comprehensive collaboration between correctional, community, and public health stakeholders to provide the support services needed to provide testing and treatment. Notable examples:

PHILADELPHIA JAILS

Philadelphia is faced with some of the highest rates of opioid use disorder (OUD) and HCV infections in the nation. As a proactive response to a 2018 legal settlement that required Pennsylvania state prisons to provide HCV treatment, the city of Philadelphia implemented universal opt-out testing and treatment for all within its jails. The initiative, which began in 2019, aims to cure 700 people within the first year at a cost of approximately \$9 million.ⁱ

LOUISIANA HCV MEDICATION PAYMENT MODEL

In June 2019, Louisiana brokered an agreement with Asegua Therapeutics, a subsidiary of Gilead Sciences, Inc., to pay one price to cover the total cost of medication to treat all people with HCV in state correctional facilities and who receive Medicaid. This innovative payment model helps the state control treatment costs while ensuring it can meet the demands for medication. Washington state is implementing a similar model to provide broader coverage.

As a Medicaid expansion state, Louisiana also has increased efforts to enroll eligible people into Medicaid to improve treatment access to reduce incidence. Because benefit interruptions can be a major barrier to care as persons are released from prison, Louisiana also has a Justice-Involved Pre-Release Enrollment Program that facilitates initial enrollment and reinstatement of Medicaid benefits for persons approaching their release date from state corrections. Case managers assist to locate care facilities, schedule appointments, and provide

an adequate supply of all necessary medications upon release to ensure a seamless continuation of medical care after release.ⁱⁱ

WASHINGTON HCV EDUCATION IN CORRECTIONS PROJECT

The Hepatitis Education Project (HEP) collaborated with the Washington State Department of Corrections and the King County Jail System to implement a hepatitis education initiative for persons held in adult and juvenile facilities. The project was part of a multifaceted effort to manage hepatitis C in correctional settings. The educational sessions are delivered through a mix of in-person and web-based formats, and cover general information on viral hepatitis and HIV, risk reduction, and communication skills. HEP also offers peer educator training to serve as a resource and promote continued dissemination of accurate information within the facilities.ⁱⁱⁱ

NEW YORK STATE APPLIES FOR MEDICAID 1115 WAIVER TO BEGIN MEDICAID COVERAGE 30 DAYS PRIOR TO RELEASE FROM CORRECTIONS

In 2019, NY State Department of Health applied for an 1115 Medicaid Demonstration Project Waiver for federal approval to provide Medicaid coverage for incarcerated persons 30 days prior to their release.^{iv} If approved, this first-in-the-nation program would allow persons to be covered under Medicaid prior to reentry, and create plans to move seamlessly into care upon return to the community.^v

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