Integrating Hepatitis Services into HIV Programs

Setting the Federal Policy Stage

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Agenda – Setting the Stage

- Questions to consider in this session
- Brief overview of hepatitis and HIV co-infection
- Opportunities to respond in Ryan White programs
- What ADAPs are doing – focus on HCV treatment
- Health care funding source: Reimbursement for hepatitis testing under health care reform
Questions to Consider

How are HIV programs in your state supporting hepatitis care?
- Curative HCV treatments on ADAP formularies
- Wrap around coverage to help with cost-sharing for insured clients
- Promising steps to improve your state’s response to HIV-Hepatitis co-infection

How are Ryan White and CDC grantees addressing co-infection?
- Testing, counseling, vaccination, treatment
- Tracking and reporting of incidence and treatment data on co-infection
- Stakeholder collaboration – behavioral health, justice system
Viral Hepatitis Overview

• Chronic infectious disease that if untreated can lead to serious liver conditions including cancer and cirrhosis

• Estimated 3.5 million in U.S. with HCV
  – 3 out of 4 people unaware of infection
  – 15,000 deaths annually
  – Curable with new direct-acting agents (DAAs)

• 1.5 million in U.S. with HBV
  – Can be avoided with vaccination

• 25% or more of people living with HIV have HCV

• 5-10% of people living with HIV have HBV
Hepatitis Treatment is HIV Care

• Institute of Medicine 2010 Recommendations
  – HRSA and CDC should “provide resources and guidance to integrate comprehensive viral hepatitis services” into HIV care settings

• Viral Hepatitis Action Plan
  – Promote screening
  – Monitor rates of testing for hepatitis in HIV population
  – Support safety net providers to care for people with hepatitis

• HIV Guidelines
  – Test for and treat viral hepatitis
  – Counsel regarding risk of acquiring and transmitting
  – Vaccinate for HBV
Ryan White Provisions

• Ryan White authorities currently extend resources for hepatitis care only for co-infected HIV clients
  – Ryan White law does not require ADAPs to cover treatment for viral hepatitis

• Provisions in 2006 reauthorization clarify intent to address co-infection
  – Through client representation Part A Planning Councils
  – Use of Part B funds for co-infection service coordination
  – Part C providers must provide hepatitis counseling
Ryan White Provisions

• During 2009 reauthorization process, Congress acknowledged resource needs for co-infection
  – “Unfortunately, coverage for diagnostics, monitoring, treatment and vaccination against viral hepatitis is not uniformly available through state AIDS Drug Assistance Programs (ADAPs), due to funding shortfalls.” (Committee Report)

• Legislatively, 2009 law retained status quo for co-infection care
Ryan White Today

- Current provisions on hepatitis are outdated and limited
  - Curative HCV treatments, approved since last 2009 reauthorization, are now standard of care
  - Risk of co-infection growing in emerging IDU populations
  - Health care reform brings enhanced resources and flexibility for grantees to improve responses to co-infection
HRSA Letter to ADAPs
February 13, 2015

- Benefits of new HCV treatments
- HIV clients should be screened, counseled, and vaccinated as appropriate.
- “AIDS Drug Assistance Programs (ADAPs) have an important role in providing access to medications for people living with HIV, including those with HCV co-infection. When feasible, ADAPs are encouraged to add hepatitis C medications to their formularies.”
ADAP Formularies

- NASTAD ADAP Monitoring – Online database
  - TAI Analysis August 2015
  - 16 states have no HBV treatment on formulary
  - 26 states do not cover HBV vaccine
  - 22 states have no HCV treatment on formulary
  - 19 states cover older non-DAA treatments

- CANN Monthly Report - Co-Infection Watch
  - August 2015 report (tiicann.org/co-infection watch)
  - 36 states not covering DAAs
  - 17 states have no HCV treatment on formularies
ADAP Trends

• Coverage for HCV treatment varies by state
  – ADAP formularies can fluctuate over time
  – States with rural populations and no ADAP coverage, including KY, TN, GA, FL, TX
  – 19 states cover older therapies only
  – 5 states cover Sovaldi, Olysio, Harvoni, VieKira: HI, MA, MN, NJ, WA
  – 4 states cover Sovaldi, Harvoni, VieKira: AZ, CO, IA, VA

Source: CANN Co-Infection Watch, August 2015
ADAP Trends

• More information needed about coverage when ADAP-purchased insurance plans do not cover DAA
  – Colorado will, with prior authorization, if funds available (July 2015 Co-Infection Watch)

• Support and Coordination
  – Co-Infection Watch asks ADAPs if they refer co-infected clients to patient assistance programs (PAPs) for help with HCV
    • As of July 2015 report, only 14 report doing so
    • AR, CT, DE and PR report they do NOT refer to PAPs for HCV

Source: CANN Co-Infection Watch, July 2015
Summary – Ryan White Programs

• Limited federal requirements for Ryan White grantees
• Clear direction that hepatitis testing, counseling, vaccinating and treatment are standard HIV care
• Significant potential with new HCV treatments to improve HIV outcomes
• Grantees should be encouraged to respond to new opportunities to full extent
• Health care reform brings additional resources
Health Care Reimbursement

Preventive Services Benefits

• ACA requires most public and private payers to cover, without cost-sharing, preventive services graded “A” or “B” by the U.S. Preventive Services Task Force (USPSTF).

• USPSTF recommendations for hepatitis testing:
  – One-time screening for Hepatitis C in persons born between 1945 and 1965 (“Baby Boomers”)
  – Screening for Hepatitis C in persons at high risk
  – Screening for Hepatitis B in persons at high risk

• “B” grades – high certainty of moderate or substantial benefit
Health Care Reimbursement

Private plans must cover hepatitis screening

– Required since 2010 to cover USPSTF-recommended services without cost-sharing
– Applies to plans inside and outside Marketplace (unless grandfathered)

Expanded Medicaid plans must cover hepatitis screening

– Required since 2014 to cover USPSTF-recommended services without cost-sharing
– 30 states have opted to expand
Health Care Reimbursement

Traditional Medicaid

• Hepatitis testing covered if medically-necessary as mandatory lab service

• In addition, under ACA, 1% increase in federal match to states that agree to cover all USPSTF-recommended preventive services, without cost-sharing
  – 11 states have been approved: CA, CO, DE, HI, KY, NH, NJ, NV, NY, OH, WI
  – Routine and risk-based hepatitis screening covered without cost-sharing
Health Care Reimbursement

Medicare

• Covers A & B preventive services after national coverage determination (Medicare Improvements for Patients and Providers Act of 2008)
• Without cost-sharing (ACA)
• For HCV Testing, Medicare finalized National Coverage Determination (NCD) in June 2014
  – Medicare now covers one-time HCV testing for boomers and risk-based testing annually without cost-sharing
• Advocates currently seeking NCD for risk-based HBV screening consistent with USPSTF
Conclusion – Moving Forward

• Legislative and administrative initiatives needed to increase capacity to address HIV/Hepatitis co-infection

• Without Ryan White reauthorization
  – Report language in appropriations
  – HRSA activities to identify and promote best practices
  – State-level advocacy for ADAP formulary coverage

• Reauthorization – incentives and strategies to address co-infection through all Parts

• Opportunities for Ryan White and CDC grantees to integrate HIV and hepatitis responses
  – Local collaboration
  – Billing capacity
THANK YOU

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