Timely Treatment Translates: A Vision for Eradicating HCV

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July 10, 2023

The United States has set the ambitious goal of eliminating hepatitis C (HCV) as a public health threat by 2030, a commitment that was reaffirmed at a recent White House summit (Raman, 2022). Central to this effort is broad access to timely and effective treatment with direct-acting antivirals (DAAs). While the efficacy of such treatment is not in question, with “real world” cure (sustained virologic response, or SVR) rates well over 90%, our ability to get this treatment to those who need it in a timely manner is and has been hampered by exorbitant drug costs, insurer-mandated restrictions on treatment, and a limited pool of treating providers (Mangia et al., 2020). Efforts to expand treatment access are essential to this initiative, as highlighted in the recently proposed HCV elimination program (Fleurence and Collins, 2023).

A recent study in the Morbidity and Mortality Weekly Report (MMWR) sheds some light on the limited extent of HCV treatment access in the U.S. (Thompson et al., 2022). Using insurance claims data from a central database, the authors identified nearly 50,000 people aged 18–69 years with a positive HCV RNA result between January 2019 and October 2020. Of these, fewer than a third initiated treatment within one year. Treatment rates were lowest for people using Medicare or Medicaid compared to private insurance, and additional inequities in treatment initiation were observed based on age, race, and geography, with those who were younger, Black, or living in a state with treatment restrictions less likely to receive treatment.

The solution to the access problem will not be simple, as it is driven by a multitude of patient-, provider-, and system-level issues. At a minimum, however, the authors believe that there are four key strategies for success: first, the cost of HCV treatment must be lowered. While the current average retail cost of a typical course of HCV treatment is just over $20,000 USD, the actual cost may be much higher and is difficult to calculate given the vast array of stakeholders involved in medication distribution and the time and effort costs associated with the medication approval process. Innovative strategies, such as the subscription model implemented in Louisiana, to address rising costs of treatment have had some success at increasing medication access at the local level, but these must be replicated on a national scale to have true impact (Raman, 2022).

Second, insurer-driven treatment restrictions must be eliminated. Although tremendous progress has been made, with many states loosening eligibility rules and 21 states removing the prior authorization requirement for most patients, 31 states (including Puerto Rico) still require prior authorization of HCV medication, 14 states have ongoing restrictions for people with HCV and substance use disorder, and 20 states restrict HCV retreatment based on adherence, substance use, or SVR12 documentation (CHLPI-NVHR, 2023).

Third, health care providers must work toward treating those with HCV as soon as possible after diagnosis. In the pre-DAA era, there were many reasons to carefully select patients who were likely to achieve an SVR. With current SVR rates, however, the only people for whom treatment is not recommended are those with limited life expectancy, and guidelines now support treatment of all people with acute HCV, as well (AASLD-IDA, 2022). When eradication by 2030 is the goal, the authors advocate that a “treatment as prevention” approach with rapid treatment that starts upon diagnosis, as is now standard practice with HIV, will translate into saved lives, reduced costs, and prevention of HCV transmission.

Fourth, the diagnosis and treatment of HCV must expand in the primary care setting. The U.S. Preventive Services Task Force now recommends universal HCV screening of all adults, and the U.S. Centers for Disease Control and Prevention and the American College of Obstetricians and Gynecologists recommend HCV screening for pregnant individuals during each pregnancy (ACOG, 2021; Schillie et al., 2020; USPSTF, 2020). Still, it is estimated that 40%–50% of the over two million HCV-infected individuals in the United States do not know their status, and the majority remain untreated (Thomas, 2020). Primary care providers (PCPs) can play a critical role in meeting this need. Importantly, PCPs can desegnitize the disease and improve access to care for historically vulnerable and undertreated populations, including racial, ethnic, and gender minorities and people...
who use drugs. PCPs are often the only point of contact for such people with the medical system. Data support this approach, with outcomes of people treated in a primary care setting similar to those treated by specialists; such treatment can be expanded through outreach efforts such as the DeLIVER Care program at the University of California, San Francisco (https://viralhep.ucsf.edu/deliver-care/about), which reaches those who lack access to primary care (Kattakuzhy et al., 2017).

Until more PCPs are comfortable treating HCV, however, there will remain a significant bottleneck in the care cascade, and timely treatment will remain out of reach for most people with HCV. Shifting the burden of HCV treatment onto an already overstretched primary care workforce without risking even greater burnout will require both provider-level education and support as well as substantial systemic changes to streamline the process from diagnosis to cure, such as the aforementioned insurance reforms, improved access to point-of-care diagnostic tests, and more widespread availability of training and support for providers.

The authors believe that treating HCV is extremely satisfying: with a finite duration of well-tolerated drugs, almost every treated person can be cured. Nevertheless, expanding the pool of treating clinicians will require education and support for those who have never treated HCV before. Simplified treatment algorithms developed by the American Association for the Study of Liver Diseases and the Infectious Diseases Society of America go a long way to demystifying HCV treatment (AASLD-IDSA, 2022). Moreover, comprehensive resources like Hepatitis C Online, Project ECHO, and the National Clinician Consultation Center’s Hepatitis C Warmline provide clinicians with educational materials and access to highly experienced treating clinicians to help them navigate the challenging clinical scenarios they may encounter in practice (NCCC, 2023; University of New Mexico Health Sciences, 2023; University of Washington IDEA, 2023).

Ultimately, the current administration’s renewed commitment to achieving the 2030 HCV elimination goal will require a multipronged approach to be successful, and the authors laud their recently proposed elimination program for tackling these issues (Fleurence and Collins, 2023). The MMWR analysis highlights how much work remains to be done. Removing existing barriers to treatment, promoting timely treatment as soon as possible after diagnosis, and expanding treatment efforts in the primary care setting will bolster the entire HCV care cascade. In this way, we will mitigate inequities and more rapidly make HCV and its sequelae obsolete.

References


DOI
https://doi.org/10.31478/202307b

Suggested Citation

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Acknowledgments
Ronald Goldschmidt, MD, Professor of Family and Community Medicine at UCSF and former principal investigator for the NCCC provided invaluable insight and support for this work. Marliese Warren, MS; Cristina Gruta, PharmD; Betty Dong, PharmD; Astha Kanani, MD; Cara McAnaney, MD; Jason Tokumoto, MD; Lealah Pollock, MD; and Carolyn Chu, MD, MSc, all provided valuable feedback as well.

Conflict-of-Interest Disclosures
None to disclose.

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