# State Policies Limiting Progress Towards HCV Elimination in the U.S.

Phillip Waters, JD[1], Robert Greenwald, JD[1], Michael Ninburg, MPA[2,3], Adrienne Simmons, PharmD, MS[2,3]

[1] Center for Health Law and Policy Innovation, [2] Hepatitis Education Project, [3] National Viral Hepatitis Roundtable

## 1 BACKGROUND

Hepatitis C virus (HCV) infection rates continue to rise in the U.S. with injection drug use being the driving factor.[1] The elimination of HCV is possible given the availability of highly curative direct-acting antiviral (DAA) therapy. The World Health Organization (WHO) has set a goal to eliminate viral hepatitis by 2030.[2] However, this goal remains out of reach in the U.S. due to various barriers, including state policies that limit access to curative therapy. A widespread barrier to HCV treatment access is restrictions related to alcohol and/or substance use. Many Medicaid programs require individuals to abstain from use for a specified timeframe prior to treatment initiation. Others require individuals to submit to screening or attest to maintaining abstinence during treatment, or require providers to counsel patients on substance use and in some cases, refer active users for treatment.[3] These restrictions persist despite current research showing that people who inject drugs achieve similar sustained virologic response (SVR) as compared to patients who do not use drugs.[4] They also undermine the AASLD/IDSA HCV guidelines that are widely recognized as the standard of care.[5] While litigation under the Eighth Amendment and the Medicaid Act has been a successful tool to address other HCV treatment access restrictions, its success for sobriety restrictions is uncertain.[6]

Other state policies further impede the ability to eliminate viral hepatitis in the U.S. In 12 states (AL, AZ, IA, KS, MO, MS, NE, OK, PA, SD, TX, WY), there are no laws explicitly authorizing syringe service program (SSP) operation, nor are there other general state laws that are consistent with operating an SSP.[7] Additionally, there are 13 states that criminalize the transmission of hepatitis (GA, ID, IN, IA, NE, MO, MS, NC, OH, PA, TN, UT, VA).[8] This study characterizes state Medicaid sobriety restrictions across the U.S. and discusses the intersection of those restrictions with SSP and criminalization laws.

## 2 METHODS

Between 2017 and 2020, Medicaid treatment criteria was analyzed to determine whether drug or alcohol screening or a period of abstinence from drugs and/or alcohol was required prior to treatment initiation. This included reviews of prior authorization forms, clinical criteria, pharmacy & therapeutics committee notes, provider notices and memos, and other publicly-available materials published on Medicaid websites. Policies were categorized as the following: no restrictions; screening and counseling only; or abstinence from drugs and alcohol for a specified time period: 1, 3, 6, or 12 months.

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## 4 RESULTS

**Figure 1. 2017 State Medicaid Sobriety Restrictions[3]**

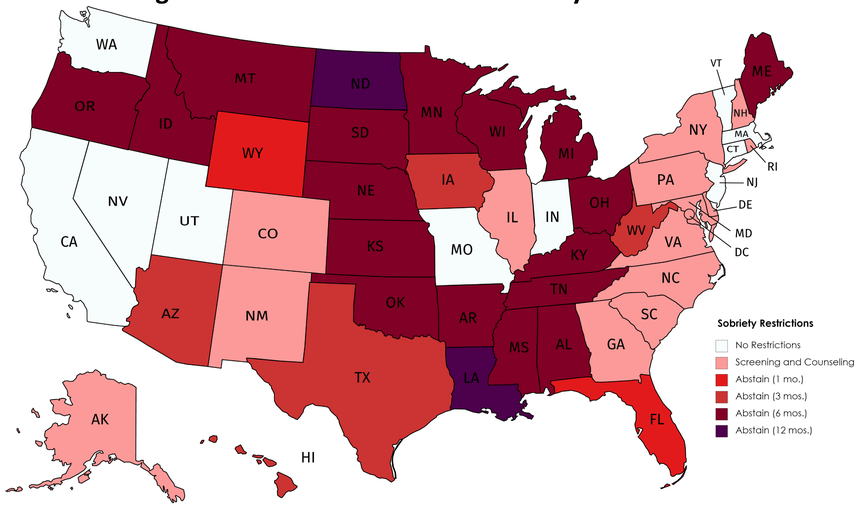
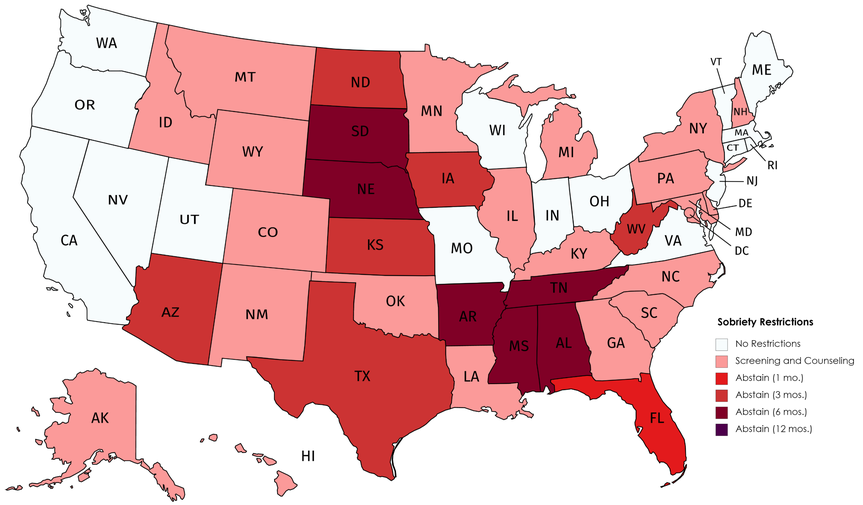



**Figure 2. 2020 State Medicaid Sobriety Restrictions[9]**




## 5 DISCUSSION

Overall, from 2017 to 2020, the number of states requiring documented periods of abstinence has decreased. Currently, 74% of Medicaid programs impose no documented minimum time period of sobriety prior to authorizing HCV treatment, up from just 41% of programs in 2017. Similarly, states that have persisted in requiring sobriety have shortened the requisite time period: no state requires a full year of sobriety any longer, and the majority of states with restrictions require six months or less.

Of the 12 states that do not have laws explicitly authorizing SSP operation or general laws that are consistent with operating an SSP, all but one (Missouri) also include a sobriety-related restriction to access HCV treatment in Medicaid. Of the 13 states that criminalize hepatitis transmission, all but four (Ohio, Missouri, Utah, and Virginia) also include a sobriety-related restriction to access HCV treatment in Medicaid. The legal and policy environment in these states is thus the most unfavorable for people who use drugs who may be HCV positive. The inability to access SSPs and curative therapy undermine the ability to prevent the progression of liver disease and to reduce or eliminate the risk of HCV transmission.

It's important to note that stigma and discrimination are additional factors that hinder HCV prevention and treatment efforts among people who use drugs.[10] While stigma was not assessed in this study, we acknowledge the role that stigma and discrimination – including discrimination by clinicians – play in efforts to eliminate hepatitis in the U.S.

## 6 CONCLUSION

Policymakers in all jurisdictions must acknowledge the lack of medical and scientific evidence to support sobriety requirements and take the necessary steps to remove harm reduction barriers. These discriminatory restrictions reflect and amplify the stigma surrounding alcohol and drug use, which can often discourage people who use drugs or alcohol from seeking HCV testing and treatment. Delaying and restricting access to care for people who use substances not only allows the health of these individuals to deteriorate, but also undermines public health efforts to end the HCV epidemic.

## 7 DISCLOSURES

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