Strategies to Improve Hepatitis C Care in Jails

A tool for advocates seeking to improve availability and uptake of HCV screening and treatment with direct-acting antivirals in jails

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"If you want to touch a lot of people from a public health standpoint, you stand at the doors of a jail… It's going to be orders of magnitude easier to eliminate hepatitis C if jails are an integral part of [the strategy.]"[1]

INTRODUCTION

As plans to eliminate hepatitis C continue to gather steam at the federal and state levels, jails and houses of correction must be part of the planning process. While these institutions present unique challenges given the complex psychosocial needs of carceral populations, the frequency of short stays, and the fact that they are subject to local control, they also provide a critical opportunity to reach more individuals with hepatitis C treatment—particularly as treatment rates among the non-incarcerated population decline.[2] Yet hepatitis C screening and treatment in jails is rare, and they are not always included in state elimination plans. The following resource aims to arm advocates with resources to improve hepatitis C care in jails, including potential policy opportunities and strategies for success.

BACKGROUND

Hepatitis C is a widespread condition that is disproportionately concentrated among people who have experienced incarceration. Researchers estimate that more than 2.7 million people in the United States are living with hepatitis C,[3] and up to 30% of these individuals spend time in a carceral facility in any given year.[4] High rates of incarceration among people who inject drugs, lack of access to comprehensive healthcare for this population, and increased instances of housing instability all contribute to these disparate rates and present significant obstacles to increasing treatment access.[5] Hepatitis C is also a contributor to health care inequity, as hepatitis C disproportionately impacts uninsured people, American Indian and Alaska Native persons, and non-Hispanic Black persons.[6]

Although drugs that can cure hepatitis C for most people in eight to twelve weeks—known as direct-acting antivirals (DAAs)—have been available for a decade, as of 2022, only about a third of people living with hepatitis C in the U.S. had been cured.[7] This must change if the United States is to eliminate hepatitis C.[8] Given the high proportion of people with hepatitis C who experience incarceration, screening and treatment in carceral facilities must be part of this strategy—including screening and treatment in jails. Yet access in jails to routine testing for hepatitis C—let alone treatment with DAAs—is rare.[9]

Unlike prisons, which generally incarcerate people with sentences of one year or longer, jails are administered by local law enforcement authorities and incarcerate people serving short sentences or awaiting trial.[10] These characteristics of jails create both challenges and opportunities when it comes to hepatitis C screening and treatment. Millions of people cycle through jails annually,[11] and while many are incarcerated for too short a time to complete a full course of DAAs,[12] those who can be cured

of hepatitis C will return to their communities healthier and unable to transmit the virus to others. Additionally, local control of jails may make it possible to identify and connect with leaders who view hepatitis C as a significant public health problem to which jails can play a role in responding.

Recognizing the need for increased access to hepatitis C screening and treatment in jails, the Center for Health Law and Policy Innovation undertook a project to assess policy opportunities and strategies to improve access to hepatitis C services in jails. We combined legal, policy, and public health research with interviews with experts working in Massachusetts in the fields of health, public health, county jails and houses of correction,[13] and social services to develop the following resource, which surveys sources of law, policy, and guidelines that may be leveraged to improve access to hepatitis C services. The resource also identifies policy opportunities to address barriers to screening and treatment and broader strategy tips and themes that emerged from our interviews.

Sources of Law, Policy, and Guidance that Can Promote Improved Hepatitis C Care in Jails

A variety of sources of law, policy, and guidance, including clinical guidelines, may be useful for advocates urging corrections officials to adopt policies that improve access to hepatitis C screening and treatment in jails. While the information below is not intended as legal advice, it may help orient advocates to sources that can help them in their advocacy.

In general, prisons and jails have a constitutional obligation under the Eighth Amendment to the U.S. Constitution to provide medical care for those whom they incarcerate.[14] In order to prove that this obligation has been violated, an inmate must prove deliberate indifference to their medical needs, meaning that those needs are objectively "sufficiently serious,"[15] and that a prison official knew of and disregarded an "excessive risk" to health or safety.[16] This is a high bar to meet, made more difficult by the fact that incarcerated individuals must comply with the federal Prison Litigation Reform Act in order to bring an Eighth Amendment lawsuit.[17] In addition, advocates have pointed to the federal Americans with Disabilities Act, which prohibits public entities from discriminating against persons with disabilities in their programs, services, as a source of legal obligations to meet the health needs of incarcerated people.[18] Relying on these standards, inmates across the country have sued to access hepatitis C treatment in prisons and jails; while some of these lawsuits have been successful in achieving increased access to hepatitis C treatment in carceral facilities, others have been unsuccessful.[19]

Other sources of state and local law, policy, and guidance may also be important for determining facility obligations to provide care and policies that impact care. For example, many carceral facilities contract with private companies to provide healthcare to inmates, and these contracts may include policies that impact who receives hepatitis C screening and/or treatment.[20] Individual jails may also have internal policies (written or otherwise) that dictate who receives screening and treatment. And, in Massachusetts, although houses of correction are operated at the county level, many receive pharmacy services through the State Office of Pharmacy Services (SOPS), so SOPS policies can also impact access to medications.[21]

States may also have statutes or regulations that advocates can leverage to demand or urge improvements in care, such as regulations promulgated by state departments of public health that mandate infectious disease screening in carceral facilities.[22] Where carceral facilities and public health departments collaborate to provide certain types of care, these collaborations can provide some insight into carceral facility policies, particularly around hepatitis C screening.[23] State hepatitis C elimination plans—along with the national elimination plan, should one be adopted[24]—can also be both important statements of existing policy and opportunities to influence hepatitis C screening and treatment access, especially as elimination policies are being developed.[25] (For further discussion of eliminations plans, see below)

Finally, several sources have released clinical guidelines and recommendations that reflect current medical standards of care and how these should be applied to carceral settings. These include guidelines and recommendations from the American Association for the Study of Liver Diseases (AASLD) and Infectious Diseases Society of America (IDSA),[26] the Federal Bureau of Prisons (FBOP),[27] and the federal Centers for Disease Control and Prevention (CDC).[28] A 2023 review by the Civil Rights Litigation Clearinghouse ("Clearinghouse") also assessed the landscape of legal settlements that have led to expansions of access to hepatitis C screening and treatment in state correctional systems, and used this review to inform model policies that can guide expansion of hepatitis C care in correctional systems nationwide.[29] All of the above sources recommend universal, opt-out screening and widespread access to treatment with DAAs.[30]

Policy Opportunities to Improve Hepatitis C Screening and Treatment in Jails

Expanding Access to Screening

As noted above, the AASLD/IDSA, the FBOP, and the CDC guidelines all recommend universal, opt-out screening for hepatitis C, yet screening in jails is currently rare.[31] More education of local jail officials regarding the advantages of opt-out screening—for example, to reduce the affect that hepatitis C stigma may have on willingness to request a test[32]—may therefore be necessary as far as moving more jails toward implementation of an opt-out screening policy.

However, opt-out screening policies alone may be insufficient to increase meaningful uptake of screening, as even an opt-out policy must be implemented in a way that takes into consideration the realities of the jail setting. For example, the CDC currently recommends that hepatitis C testing be performed through a two-step process that first tests for the presence of hepatitis C antibodies, then tests for hepatitis C RNA if the antibody test is reactive.[33] While samples for both tests can be taken simultaneously, this process still often results in delays of several days or more between testing and results because jails often rely on external laboratories.[34] Many individuals booked into jails will be released within hours or days,[35] meaning that even if a jail were to adopt opt-out testing for everyone at booking, some individuals would likely be released before they receive their results. The rollout of hepatitis C point-of-care testing, which does away with the need to send samples to an external laboratory, could help alleviate these challenges in the jail, making it critical that jails receive access to the new technology.[36]

Moreover, expanded access to screening must be coupled with increased access to treatment, because screening without treatment access may be viewed by providers and patients as wasteful or pointless.[37] Therefore, it is important to couple expanded screening policies with implementation strategies that account for the often-rapid turnover in jails, and that connect as many people as possible with active hepatitis C to treatment. This could be through linkage to care in the community for people with very short stays, or, preferably, through treatment offered in the jail.

Expanding Access to Treatment

Many barriers exist to improving access to DAAs in jails, as reflected in both the literature and the interviews we conducted. These include challenges such as staffing shortages, stigma among jail officials, providers, and patients, and extraordinary health-related social needs (HRSN) that incarcerated people often face upon release. There are also proven evidence-based interventions that do not prioritize or exclusively cater to abstinence, but carceral facilities have not widely adopted these methods.[38] However, a key issue running through many of the interviews we conducted and throughout the literature is the cost of DAAs. Although the cost of DAAs has decreased substantially, from as high as $94,000 per patient to as low as around $20,000,[39] this is still a high cost per patient for jails with limited health budgets to absorb, especially considering the prevalence of hepatitis C. The following policy opportunities therefore focus primarily on strategies to mitigate cost—while acknowledging the importance of coupling these strategies with others such as non-stigmatizing hepatitis C education and training for all stakeholders, adequate staffing, resources and effective supports to address HRSN upon release.

STATE AND NATIONAL ELIMINATION PLANS

A growing number of jurisdictions and entities in the United States are establishing hepatitis C elimination plans.[40] Given the importance of hepatitis C screening and treatment in jails, development of state-level elimination plans can be an opportunity to engage jail administrators in developing elimination strategies and goals for jails.[41] Elimination plans can also be important articulations of state policy commitments that can be leveraged to obtain for funding hepatitis C treatment in jails. For example, Washington's elimination plan includes as a goal its intent to:

> [i]mprove treatment access and continuity of care for people who are institutionalized (e.g., in jail, prison, state hospitals), such as leveraging the purchasing of HCV medications for jails and a centralized place to deliver medications to jails to ease financial and administrative burden (e.g., this could involve pairing opioid treatment and HCV treatment through these channels), and/or including HCV in the Health Care Authority's 1115 waiver proposal… to continue Medicaid coverage for medication to treat opioid use disorder for people while they are in jail.[42]

In June 2025 Senators Bill Cassidy and Chris Van Hollen, calling for the development of a national strategy to expand access to direct-acting antivirals among key populations, introduced the Cure Hepatitis C Act.[43] The bill would require the creation of a voluntary drug subscription program

along with a national strategy for eliminating hepatitis C, and is based upon a Louisiana pilot in which the State crafted a five-year partnership with a drug manufacturer to reduce the long-term cost of expanding treatment access.[44] Moreover, the bill framework includes strategic benefits and requirements for participating states, such as a requirement to remove prior authorization policies for direct-acting antivirals and possibility of funding support for investments in new technologies like point-of-care testing. The bill could dramatically expand treatment access in states that choose to participate, and bipartisan support for the initiative suggests that it is still viable under the new administration. If enacted, it will be especially important for hepatitis C and carceral health care advocates to push for correctional facilities' participation in the program and the appropriate allocation of resources across hepatitis C services.

ALTERNATIVE PRICING STRATEGIES

Some jurisdictions have pursued alternative pricing strategies to reduce the cost of hepatitis DAAs for incarcerated people. These strategies include contracting with entities who are eligible for the 340B Drug Pricing Program. For this approach, carceral systems enter into contracts with entities who are eligible to purchase drugs at reduced prices under the Program, and those entities (which include disproportionate share hospitals and federally qualified health centers) provide hepatitis C treatment to inmates.[45] This strategy has been used to generate moderate savings on DAAs for incarcerated people.[46]

Louisiana and Washington have each leveraged a strategy known as the "Netflix" or modified subscription model, whereby they contracted directly with a manufacturer to access an unlimited amount of a specific drug for a set period of time at a capped annual cost.[47] However, these states have struggled to treat as many patients under the contracts as they had hoped—in part because jails were not included in the programs.[48] Building off the work of these states and other jurisdictions, the proposed national hepatitis C elimination plan envisions a subscription model on a national scale to help facilitate cost-effective purchasing of DAAs for currently underserved populations, including incarcerated people.[49]

DEDICATED STATE OR MUNICIPAL BUDGET FUNDS FOR HEPATITIS C TREATMENT

A number of jurisdictions have set aside funds specifically to enable testing and treatment for hepatitis C—including people without advanced liver disease—in carceral facilities. Although these circumstances have often involved state departments of corrections who entered into settlement agreements to resolve litigation,[50] some exceptions exist. After the Philadelphia Department of Corrections settled a lawsuit by agreeing to provide hepatitis C treatment to inmates, the Philadelphia jail system was threatened with similar litigation, but was "eager to comply with the new standard of care."[51] Recognizing the public health value of hepatitis C treatment, the city of Philadelphia allocated $14 million to the jails for one year to treat inmates with hepatitis C.[52] Since people incarcerated in jails may leave unexpectedly, the jail system partners with community health nonprofit Philadelphia FIGHT, whose case managers visit the jails to provide education about

hepatitis C and information on where to go for follow-up care in the community.[53] New York City's Health + Hospitals/Correctional Health Services (CHS) has also scaled up treatment of hepatitis C in New York City's jails with municipal budget support and a preferred pricing agreement with pharmaceutical partners.[54] At the statewide level, the Michigan Department of Corrections budget includes a line item for hepatitis C treatment.[55]

MEDICAID 1115 WAIVERS FOR PRERELEASE COVERAGE

Although federal law generally prohibits federal Medicaid funds from paying for carceral healthcare, the Centers for Medicare and Medicaid Services (CMS) has begun approving state waiver requests under section 1115 of the Social Security Act to enable people nearing release from incarceration to enroll in Medicaid for a defined period prior to release.[56] These waivers are intended to improve health care transitions for people leaving incarceration, and must include, at minimum, Medicaid coverage of case management services to assess the need for and linkage to health-related social needs services, Medication Assisted Therapy and counseling for substance use, and a 30 days' supply of prescription medications post-release.[57] Consistent with the purpose of improving health outcomes after reentry, states may request authority to include prerelease coverage of other services, and CMS has highlighted "treatment for hepatitis C" as a specific example.[58] Many states have proposed and received approval for waivers that could increase access to hepatitis C treatment before release,[59] and CHLPI is maintaining an online tracker that assesses these waivers.[60]

These waivers do have important limitations. First, CMS has only approved waivers for up to 90 days prior to an inmate's release, so Medicaid funds remain unavailable to cover treatment before that point.[61] Given that a course of DAAs can be completed in 8-12 weeks,[62] 90 days of prerelease coverage plus 30 days of post-release medication may be long enough to complete a full regimen—but the existence of the waiver should not operate as an excuse to delay treatment for a person whose sentence exceeds 90 days.[63] States also retain considerable discretion in how they design and implement the waivers, with substantial variation in key program components such as the length of time prior to release when a person will be eligible; whether people held in jails will be eligible, or only those in state prison; and whether services will be provided by carceral health providers or by community providers offering in-reach services, which facilitates building trust with medical providers who can continue care after release.[64]

PARTNERSHIPS WITH COMMUNITY HEALTH CENTERS TO PROVIDE CARE

Nationwide, there are more than 1,400 federally supported community health centers (CHCs), which provide access to primary care and related services for underserved patients and communities without regard to their ability to pay.[65] Some CHCs contract with jails and prisons to provide medical services to incarcerated individuals, which can help promote continuity of care once an individual is released.[66] The federal Health Resources and Services Administration (HRSA), which funds CHCs, released final guidance in December 2024 for CHCs outlining the conditions under which they may provide services to incarcerated or detained individuals within their established CHC scope of project.[67] The guidance makes clear that CHCs may provide health services to

incarcerated individuals who are expected to or scheduled to be released within 90 days.[68] HRSA also made grants in 2024 to 54 CHCs to support transitions in care for people being released from incarceration.[69] These grants are to support services focused on "managing chronic conditions," "[p]reventing, screening, diagnosing, and treating diseases," reducing the risk of overdose, and managing mental health and substance use.[70] While this funding opportunity has closed, given the growing awareness of the health needs of people leaving incarceration, additional funding opportunities for CHCs to provide in-reach medical services may arise.

Many of the above policy opportunities and strategies can be used in combination—for example, alternative pricing strategies can lower treatment costs, making dedicated funding streams potentially more feasible, and Medicaid 1115 waivers can be used to compensate CHCs for some or all in-reach services provided to people with hepatitis C who are incarcerated in jails. State and local policy makers thus have a broad menu of policy options to expand access to hepatitis C treatment in jails.

Advocacy Strategies and Interview Themes

In addition to the opportunities and issues discussed above, our research highlighted the following strategies and themes that hepatitis C advocates and others should keep in mind as they consider approaches to improving access to screening and treatment in jails.

- **"Correctional health is community health."**[71] People who are incarcerated are members of communities before, during, and after incarceration, and helping these individuals achieve better health while they are incarcerated can positively impact public health in their communities.[72] Jail administrators are increasingly recognizing this, and those who do may be particularly amenable to improving access to hepatitis C screening and treatment.[73]

Suffolk County Infectious Diseases Coordinator

Suffolk County (where Boston is located) is a priority jurisdiction for the federal Ending the HIV Epidemic initiative. Through the EHE, the Massachusetts Department of Public Health (DPH) obtained funding for an infectious diseases coordinator located at the Suffolk County House of Correction. The infectious diseases coordinator performs many important functions that help to improve care and monitoring of HIV, hepatitis C, and other infectious diseases within the facility, including overseeing screening; offering education to inmates around HIV, hepatitis C, and harm reduction strategies; linking people who test positive to infectious disease care within the facility and in the community; and providing helpful to data to DPH around, for example, numbers of individuals screened and treated for hepatitis C. Multiple interviewees spoke highly of the infectious disease coordinator role and its impact on access to hepatitis C screening, treatment, and education at the House of Correction.

- **Identify a champion.** Since jails are run at the local level, one or two well-positioned administrators within the system may have substantial influence over treatment policies. In addition, many jails are run by sheriffs,[74] who are usually elected,[75] so county sheriff elections can be an opportunity to elevate hepatitis C screening and treatment access as a priority for local jails.

- **Embrace a syndemic approach.** The hepatitis C epidemic is deeply intertwined with the substance use, HIV, and other epidemics nationwide. Therefore, a successful hepatitis C response must be combined with education (including for carceral health care providers) and resources to address these other epidemics, especially access to quality, evidence-based interventions that improve the health of people who use drugs. Additionally, combining resources to address syndemics can help enable effective interventions to combat multiple epidemics at once, as the Suffolk County infectious diseases coordinator demonstrates. (See above.)

- **Protect patient privacy and be aware of stigma.** While difficult in a jail setting, efforts to protect patient privacy can help more people access screening and treatment given ongoing stigma around hepatitis C and risk factors such as injection drug use. This is a strong argument for opt-out testing, as it does not require people to implicitly or explicitly admit that they might be at risk for hepatitis C.[76] Jail officials can also consider policies and practices around how people are pulled out for healthcare, as people who are incarcerated have expressed fear around being singled out for treatment, especially if they are being treated for a stigmatized condition such as hepatitis C or HIV.[77]

- For people who will be linked to treatment after release, **interventions to address the social determinants of health and case managers with lived experience of incarceration can be critical to successful treatment.** Many of the experts we interviewed discussed the many competing priorities of people leaving incarceration that can interfere with or delay health care, such as the urgent needs to find housing, transportation, income, and food. Boston Healthcare for the Homeless, for example, meets people who are being released from jail and provides a backpack that includes a cell phone, which can be critical for connecting with patients regarding appointments.[78] The Transitions Clinic Network has developed an evidence-based model of primary care for people leaving incarceration that hires and trains community health workers with lived experience of incarceration, who provide care navigation that has been shown to improve health outcomes at reentry.[79] Similar models and programs could help improve hepatitis C linkage to treatment for those who cannot be treated while incarcerated.

Conclusion

Increasing access to hepatitis C screening and treatment in jails is both possible and necessary. While there is no one-size-fits-all solution to meet this challenge, the federal government, states, localities, and advocates have charted numerous paths that can be pursued individually or in combination in response to local conditions and needs.

Endnotes

1 Nicholas Florko, *With a promising new plan to pay for pricey cures, two states set out to eliminate hepatitis C. But cost hasn't been the biggest problem*, STAT (Sept. 13, 2022) (quoting Marc Stern, professor at the University of Washington School of Public Health), https://perma.cc/XB38-N92S.

2 *See* Justin Chan, Matthew Akiyama et al, *Treating Hepatitis C Virus Infection in Jails as an Offset to Declines in Treatment Activity in the Community, New York City, NY, 2014–2020*, AJPM Focus, Apr. 2024, at 1, 3, https://perma.cc/UJ9E-59RF, ("Scale up of jail-based hepatitis C virus treatment is an important strategy to offset declines observed in the community.").

3 *See* Nat'l Inst. of Diabetes and Digestive and Kidney Diseases, Hepatitis C, https://perma.cc/7PZ4-Q6GU.

4 *See* Tessa Bialek & Matthew J. Akiyama, *Policies for Expanding Hepatitis C Testing and Treatment in United States Prisons and Jails*, 57 U. Mich. J. L. Reform 1 (2023), https://repository.law.umich.edu/cgi/viewcontent.cgi?article=2587&context=mjlr.

5 Stacey Trooskin, et al., *We Must Do Better: Addressing HCV Treatment Barriers in Persons Who Inject Drugs in the United States*, 222 J. Infectious Diseases 773, 774 (2020), https://perma.cc/4LK5-W36N.

6 Rachael L. Fleurence & Francis S. Collins, *A National Hepatitis C Elimination Program in the United States*, 329 JAMA Viewpoint 1251 (2023), https://jamanetwork.com/journals/jama/fullarticle/2802533 ("National Elimination Program").

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8 National Elimination Program, *supra* note 6.

9 *See* Morgan Maner et al., *Infectious disease surveillance in U.S. jails: Findings from a national survey*, Plos One 4-10, Aug. 25, 2022, https://perma.cc/NV25-G8PB, Wurcel et al., *"I'm not gonna be able to do anything about it, then what's the point?": A broad group of stakeholders identify barriers and facilitators to HCV testing in a Massachusetts jail*, Plos One, May 26, 2021, https://perma.cc/S2G7-HRWS, ("Barriers to HCV testing").

10 Nat'l Inst. of Just., *Correctional Facilities*, https://perma.cc/74Q2-P7DS (last visited Mar. 10, 2025).

11 *See* Chan & Akiyama *supra* note 2, Emily Widra, *New data and visualizations spotlight states' reliance on excessive jailing*, Prison Policy Initiative, Apr. 15, 2024, https://perma.cc/V4Y9-9WDS.

12 Zhen Zeng, Bureau of Justice Statistics, US. Dep't of Justice, Jail Inmates in 2021 – Statistical Tables, 2022, Annual Survey of Jails (2022), at 3, ("The average length of time in jails in 2021 was 33 days.") https://perma.cc/2JZN-U9WD, while a full course of DAAs currently requires eight to twelve weeks of treatment, *Clinical Care of Hepatitis C*, Ctrs. for Disease Control (Jan. 21, 2025), https://perma.cc/53KU-3VHJ.

13 In Massachusetts, "jails" and "houses of correction" serve different purposes, but both are operated by the county government and incarcerate those who are pretrial or serving sentences shorter than two and a half years. *See* Mass. G.L.c. 126, §§ 4, 8; Mass. G.L.c. 279, §§ 19, 23. For simplicity, this resource uses the term "jails" to refer to both except when describing a specific institution.

14 *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

15 *Wilson v. Seiter*, 501 U.S. 294, 298 (1991).

16 *Farmer v. Brennan*, 511 U.S. 825, 837 (1994).

17 *See* Prison Litigation Reform Act of 1995, 42 U.S.C. § 1997(e) (2013). For further discussion of inmates' constitutional rights and ability to litigate for access to health care in prisons and jails, *see* Columbia Human Rights Law Review, *A Jailhouse Lawyer's Manual*, 12th Ed., Chapter 14: The Prison Litigation Reform Act, Chapter 23: Your Right to Adequate Medical Care, and Chapter 26: Infectious Diseases: AIDS, Hepatitis, Tuberculosis, and MRSA in Prison https://perma.cc/U4L8-4ZQA. *See also* Marcella Alsan, et al., *Health Care in U.S. Correctional Facilities—A Limited and Threatened Constitutional Right*, New Eng. J. Med., Mar. 1, 2023, https://www.nejm.org/doi/full/10.1056/NEJMms2211252.

18 *See* Alsan, *supra* note 17.

19 *See* Bialek & Akiyama *supra* note 4, at 10-11, *see also, e.g., Barfield v. Semple*, No. 3:18-CV-1198 (MPS), 2019 WL 3680331 (D. Conn. Aug. 6, 2019) (denying motion to dismiss claim for relief under the Eighth Amendment); *but see Atkins v. Parker*, 972 F.3d 734 (6th Cir. 2020), cert. denied, *Atkins v. Williams*, 209 L. Ed. 2d 547, 141 S. Ct. 2512 (2021) (denying relief); *Hoffer v. Sec'y, Fla. Dep't of Corr.*, 973 F.3d 1263 (11th Cir. 2020) (denying relief).

20 *See* Jason Szep et al., *Special Report: U.S. jails are outsourcing medical care — and the death toll is rising*, Reuters (Oct. 26, 2020), https://www.reuters.com/article/world/special-report-us-jails-are-outsourcing-medical-care-and-the-death-toll-is-idUSKBN27B1D6/.

21 *See* Mass.gov, *State Office for Pharmacy Services (SOPS) Facilities*, https://www.mass.gov/info-details/state-office-for-pharmacy-services-sops-facilities (last visited Mar. 10, 2025). One interviewee lamented challenges related to SOPS policies, including that facilities cannot split one 30-day bottle of DAAs between multiple patients (which is costly for the facility if the patient leaves before the bottle is used up) and that SOPS has negotiated with pharmaceutical manufacturers for cheaper access to a twelve-week course of DAAs, rather than an eight-week course (the latter of which would allow for treatment of more individuals before they are released). Interview with Alysse Wurcel, at 8:04-27 and 11:15-12:00 (on file with authors).

22 For example, Massachusetts law requires superintendents of correctional institutions, jails, and houses of correction to ensure that people incarcerated for a term of 30 days or more receive a physical examination. *See* M.G.L.c. 127 § 16; 105 Code Mass. Regs. § 205.101. This examination is to include "[c]ounseling about hepatitis C and voluntary testing for hepatitis C virus infection according to risk assessment and age-based recommendations of the USPSTF and the Centers for Disease Control and Prevention," 105 Code Mass. Regs. 2 205.200(D)(9).

23 In Massachusetts, the Department of Public Health Bureau of Infectious Disease and Laboratory Sciences supports hepatitis C testing at all but of one of the state's 13 county houses of correction through outposted services and utilization of the state lab. Mass. Dep't of Pub. Health, *Massachusetts HCV Elimination Plan*, https://www.mass.gov/info-details/massachusetts-hcv-elimination-plan#partners:-internal,-external,-cross-governmental-and-future-.

[24] *See* National Elimination Plan, *supra* note 6.

[25] For example, Louisiana's hepatitis C elimination plan included making DAAs available to people incarcerated by the state Department of Corrections (though not local jails). *See* Louisiana Dep't of Health, *Louisiana launches hepatitis C innovative payment model with Asegua Therapeutics, aiming to eliminate the disease* (June 26, 2019, https://perma.cc/QAU4-2ZL3. For an overview of state elimination plans as of August 2023, *see* O'Neill Institute, Hepatitis Policy Project, https://perma.cc/JR89-B48F..

[26] *See* AASLD/IDSA, *HCV Testing and Treatment in Correctional Settings*, https://perma.cc/R8QQ-9TUJ.

[27] *See* Fed. Bureau of Prisons, Evaluation and Management of Hepatitis C Virus (HCV) Infection (Mar. 2021), https://perma.cc/Y86D-GZVH. ("FBOP").

[28] Nat'l Ctr. for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, *At-a-glance : CDC recommendations for correctional and detention settings testing, vaccination, and treatment for HIV, viral hepatitis, TB, and STIs* (Aug. 10, 2022), https://stacks.cdc.gov/view/cdc/120256.

[29] *See* Bialek & Akiyama *supra* note 4.

[30] *Id* at 15, 20; AASLD/IDSA, *supra* note 26; FBOP *supra* note 27, p. 6, 12-14.

[31] *See* Chan & Akiyama, *supra* note 2.

[32] *See* Wurcel et al., *supra* note 9, *see also* Bialek & Akiyama, *supra* note 2 at 17.

[33] Ctrs. for Disease Control and Prevention, Clinical Screening and Diagnosis for Hepatitis C (Dec. 19, 2023), https://www.cdc.gov/hepatitis-c/hcp/diagnosis-testing/index.html.

[34] Adam Tricky et al., *Impact of hepatitis C virus point-of-care RNA viral load testing compared with laboratory-based testing on uptake of RNA testing and treatment, and turnaround time: a systematic review and meta-analysis*, 8 Lancet Gastroenterol Hepatol 352-70 (2023), https://www.thelancet.com/journals/langas/article/PIIS2468-1253(22)00346-6/fulltext

[35] *See* Widra *supra* note 11.

[36] *See* National Elimination Program, supra note 6 (describing accelerating the availability of point-of-care (POC) testing as a priority and indicating that making POC testing available will be "game-changing for hepatitis C single-visit programs, particularly in high-impact settings such as … correctional facilities[.]).

[37] *See* Wurcel *supra* note 9.

[38] Nora D. Volkow & Tisha Wiley, *Everyone deserves addiction treatment that works—including those in jail*, July 9, 2024, https://perma.cc/DWD3-RSU8.

[39] Liz Highleyman, *Many People on Medicaid and Prisoners Still Lack Access to Hepatitis C Treatment*, Hep Mag (September 22, 2020), https://www.hepmag.com/article/many-people-medicaid-prisoners-still-lack-access-hepatitis-c-treatment.

[40] U.S. Dep't of Health and Human Serv., Mapping Hepatitis Elimination in Action, https://perma.cc/87GD-GVRL.

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