February 2026

Opportunities to enhance the accessibility, availability, and affordability of hepatitis C virus (HCV) test-to-treat models

In the United States (U.S.), only one in three people with hepatitis C (HCV) receive timely treatment, defined as HCV treatment within 12 months following diagnosis, despite cure rates in the range of 95% for treatment with direct-acting antivirals (DAAs). People with diagnosed but untreated HCV are at risk of morbidity and disease progression, transmission, and loss to follow up. Further progress towards eliminating HCV as a public health threat in the U.S. requires expanding testing and reducing gaps between diagnosis and treatment. The availability of point-of-care (POC) diagnostics, along with consideration to policy opportunities to address barriers to timely treatment initiation, hold promise for shortening the window between diagnosis and treatment, reducing loss to follow up, and achieving long-term health benefits and cost savings from curing a greater proportion of the 2.4 million people in the U.S. with chronic HCV.

RAPID HCV TESTING & TREATMENT

Understanding the HCV cure cascade

Factors driving the ongoing prevalence of undiagnosed and untreated HCV can be broken down along the HCV cure cascade, also known as a continuum of care. The cascade is a representation of an individual's progression from HCV infection to cure, demonstrating the actions needed to move along the cascade: diagnosis, linkage to care, treatment initiation, and cure.

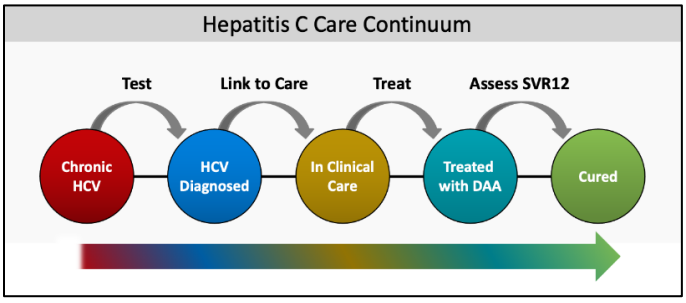

Figure 1: *Hepatitis C Online (UW) – Addressing Structural Barriers to HCV Treatment*

HCV cure cascades using domestic data show that far too many individuals have not progressed through the cascade to achieve cure. Systemic and structural barriers contribute to this, such as stigma and misconceptions, limited access to care, and challenges with affordability and coverage. An analysis of domestic 2017-2020 data found that approximately one-third of people with chronic HCV were unaware of their status, while a 2018 analysis showed that about 30%

of people diagnosed had not yet been cured. A later analysis showed a similar drop-off in those moving from testing to treatment, highlighting linkage to care as a key step in the pathway to cure.

Emerging opportunities for test-to-treat models

Rapid treatment models, also known as "test-to-treat" or "test-to-cure" models, have been shown to simplify and accelerate treatment initiation following diagnosis, potentially smoothing the pathway from test to cure. These models aim to initiate individuals on DAAs for HCV treatment as quickly as possible, and with as few additional visits as necessary, upon receiving an HCV diagnosis.

In 2024, the U.S. Food and Drug Administration (FDA) issued market authorization for a POC nucleic acid test for HCV ribonucleic (RNA) testing called Xpert® HCV, which is manufactured by Cepheid and run on the GeneXpert® testing platform. By using fingerstick blood to confirm the presence of HCV RNA, Xpert® HCV provides an option for testing with shorter turnaround times for receiving results compared to laboratory-based testing, enabling diagnosis and treatment initiation to occur in the same visit.

POC HCV RNA testing (POCT)[1] is advantageous for settings with limited or no on-site access to laboratory testing or phlebotomy blood draws. Recent reviews and reports suggest that settings with higher HCV prevalence and brief or one-off patient interactions may see the greatest benefit from POCT, such as syringe services programs (SSPs), opioid treatment programs (OTPs), large jails, and mobile units serving high-risk communities.

> **"To reduce barriers and cure hepatitis C in as few visits as possible, treatment should be offered where people with hepatitis C already access services"**
> Lewis et al. (2023)

Crucially, these types of settings tend to serve populations for whom it may be more difficult to initiate and complete HCV treatment, as they may have limited routine engagement with health care; experience homelessness, incarceration, or drug use; face transportation barriers; or have limited or no health insurance coverage.

This resource will review emerging opportunities to enhance the accessibility, availability, and affordability of rapid HCV treatment, particularly in the context of growing adoption of POCT. Since HCV test-to-treat models are still in the early stages of implementation in

[1] This document uses POCT specifically in reference to HCV RNA point-of-care testing.

the U.S., it is expected that additional opportunities and barriers will become more clearly defined as these models become more prevalent across settings and populations.

ACCESSIBILTY

Test-to-treat models benefit from mechanisms that quickly move an individual from HCV diagnosis to treatment initiation, but some current drug utilization management practices may limit or slow access to treatment.

Prior authorization (PA) restrictions: When DAAs for HCV treatment were first introduced in 2013, their significant prices and large potential patient population led many insurers to limit access through PA restrictions, a form of utilization management that require prescribers to obtain formal insurer approval for an individual's treatment before the insurer covers the medication costs. These restrictions typically specify clinical criteria and documentation requirements as conditions for approving reimbursement for medications.

Although some information required in a PA form may be relevant to the treatment of more complex HCV cases, common PA requirements, such as documentation of HCV genotype, are not clinically indicated in simplified HCV treatment guidance. Compiling information for PA forms can be time-intensive and demanding for both patients and providers. Additionally, delays caused by PA processes can result in those with the most limited healthcare access failing to get care and may hinder attempts to implement test-to-treat models by introducing delays to receiving medications.

Treatment access barriers in state Medicaid programs: In a recent Centers for Disease Control and Prevention (CDC) report on HCV treatment, DAA treatment was found to be lower than average among Medicaid recipients in comparison to individuals with other forms of insurance. CDC also found that Medicaid recipients living in states with Medicaid HCV treatment barriers were 23% less likely to receive timely HCV treatment than those living in states without barriers. This is particularly salient, as a recent analysis of 2017-2020 data found that people with public insurance were 4.7 times as likely to have a current HCV infection as people with private insurance.

As of January 2026, 34 state Medicaid programs have removed PA requirements for HCV treatment for most patients. A national snapshot report from the Hepatitis C: State of Medicaid Access initiative describes state Medicaid HCV treatment policies, offers a cross-jurisdictional overview of current approaches, and provides additional resources.

Sobriety, substance use, and prescriber restrictions: A further analysis of Medicaid documents and claims data found that sobriety restrictions were associated with lower HCV treatment rates. State Medicaid programs vary in the application of substance use–related requirements for accessing DAAs, which may affect treatment access among people actively using substances who may be more vulnerable to acute infection, reinfection, or onward transmission of HCV.

Other barriers include restrictions on the specialty type or training required for prescribers and requirements for documentation outside the scope of simplified treatment guidelines. Therefore, state Medicaid programs who maintain PA requirements for HCV treatment may consider assessing if their coverage policies are aligned with current simplified treatment guidelines.

Retreatment restrictions: In some scenarios, an individual may be reinfected with HCV and require retreatment, for which both insurance coverage and treatment guidance may impose additional restrictions. Current simplified treatment guidance does not apply to individuals with a history of prior HCV treatment. Further, guidance for and restrictions related to retreatment may differ between individuals who failed treatment due to lack of adherence, those who become re-infected with HCV, or those that experience treatment failure despite adherence.

As of January 2026, 12 state Medicaid programs continue to maintain retreatment restrictions that exceed current clinical guidance, or prohibit retreatment entirely. These restrictions may deny authorization based on adherence to past medications or current substance use, prerequisites which are not aligned with current guidance or evidence.

State Medicaid programs may explore resources and report cards to assess opportunities for aligning retreatment restrictions with published treatment guidelines. This may be particularly salient for programs serving people who use drugs who can experience ongoing risk for reinfection. Despite data suggesting that reinfection is rare among people who use drugs, it is important to acknowledge that HCV reinfection can occur, necessitating that strategies be put in place to maximize prevention opportunities and education, provide ongoing testing opportunities, and offer retreatment.

Managed care organization (MCO) parity: An additional facet of Medicaid coverage for HCV treatment relates to MCOs, which the majority of state Medicaid programs contract to administer and deliver care to their enrollees. A 2025 review found that in seven of the 43 jurisdictions contracting with MCOs, the MCO either imposed additional restrictions on or lacked transparency in their coverage of HCV treatment or their PA forms and requirements. Assessing MCO alignment with state fee-for-services (FFS) policies can

help state Medicaid programs to evaluate if their MCOs are in parity with FFS, and identify opportunities to adjust MCO policies and procedures for HCV treatment.

Summary of opportunities – ACCESSIBILITY
• State Medicaid programs may review jurisdictional report cards and available resources for a comparative assessment of HCV treatment access policies to identify potential opportunities for improvement • State Medicaid programs may consider potential benefits of and avenues for removing PA requirements, or options to move existing requirements into alignment with simplified treatment guidelines • State Medicaid programs may explore options to reduce retreatment requirements or move existing retreatment requirements into alignment with retreatment guidelines • State Medicaid programs that contract with MCOs may assess MCO alignment with FFS policies to ensure transparency and parity

AVAILABILITY

Delays in medication access impair test-to-treat programs' ability to rapidly initiate treatment. Exploring opportunities to provide on-demand medication to individuals diagnosed with HCV can support progress along the HCV cascade of care.

Starter packs for immediate treatment initiation: Drawn from the experiences of programs providing HIV testing and treatment navigation, "starter packs" of medications allow for immediate on-site treatment initiation. For individuals who meet simplified HCV treatment guidance, this eliminates the need for an individual to travel to a pharmacy or to coordinate medication delivery. Initiating same-day, on-site treatment with starter packs can benefit individuals facing housing instability, active substance use, and limited access to health care services.

Often, starter packs can represent a heavy financial burden to the programs providing them, as programs may not receive reimbursement from insurers for them. Some programs may look into potential opportunities to receive starter packs from a pharmaceutical company, grantor, or researcher. However, these opportunities may be limited and time-bound, and not available to all types of programs or patients. Recent federal funding to pilot test-to-treat models allows programs to use funds to purchase medications for certain individuals, and assessing the impact of this pilot may help to clarify the potential benefit of starter packs on treatment initiation.

Co-location of services at pharmacies: Offering HCV testing services at or with a pharmacy allows for the co-location of HCV testing and medication dispensing. Currently, only 12 jurisdictions explicitly allow pharmacists to independently perform rapid HCV tests. State health departments and pharmacy licensing bodies can explore the feasibility of adjusting policies to expand pharmacist duties to include performing rapid HCV tests, while still accounting for implementation and workforce sustainability.

Collaborative practice agreements (CPAs): CPAs between primary care providers (PCPs) and pharmacists can expand testing and treatment at pharmacies by allowing pharmacists to practice under a formal relationship that delegates provider functions to the pharmacist, such as being able to conduct HCV screening and then prescribe and manage DAAs for HCV treatment.

Currently, only 34 jurisdictions permit non-patient-specific CPAs, allowing pharmacists to provide services to all community members. Where some CPAs authorize pharmacists to provide drug therapy management, others may be more limited. State bodies that oversee CPAs can review their jurisdictional landscape and consider expanding CPA scopes to allow HCV testing and treatment. Additionally, for CPAs to be well-utilized and adopted, education and awareness-building may be necessary in many states.

Multidisciplinary team models for care: HCV care navigation models that coordinate multidisciplinary teams, such as teams composed of a nurse navigator, pharmacist, and pharmacy technician, may be well-suited to increase HCV treatment initiation, particularly for individuals facing complex social circumstances or comorbid conditions. Exploring multidisciplinary and team-based options for partnering with pharmacies may provide a benefit to navigation programs run by health departments, community-based organizations (CBOs), medical clinics, SSPs, and others.

Dispensation quantity limits: Restrictions on how many doses of medication can be dispensed, which are typically driven by payer rules, may require a return visit to a pharmacy or coordination of an additional delivery for further doses, which can introduce possibilities for delays or gaps in treatment. Existing research demonstrates the efficacy of dispensation of the full treatment course at baseline treatment initiation. State Medicaid programs can consider options for full dispensation of the treatment course, and review examples of states in which this option is currently available and allowable.

Medication carve-outs: In a 2022 survey of providers and patients engaged in HCV treatment, half of the respondents indicated that mandatory dispensing of HCV treatment medications through specialty pharmacies can limit treatment access. A majority of state Medicaid programs contract with MCOs, which may require specialty pharmacy dispensing and impose additional requirements or procedures that can limit

access to medications. MCOs and other insurance plans may mandate the completion of intake forms that mimic PA forms, even in states that have removed PA requirements for Medicaid beneficiaries requesting HCV treatment, while others may impose restrictive dispensing limitations.

An opportunity to minimize discrepancies between FFS Medicaid policies and MCO policies is to carve out HCV medications in MCO contracts. Carve outs typically require MCOs to bill for medications through FFS mechanisms, instead of through individual policies or specialty pharmacies. Carve outs can lead to more uniform policies and have been implemented in multiple state Medicaid programs.

Streamlining processes and forms: For states who do not carve out HCV medications from MCO contracts, the differing processes and requirements implemented by each specialty pharmacy, pharmacy benefit manager (PBM), or insurer can cause confusion and administrative burden for providers and patients. Programs can explore engaging directly with specialty pharmacies, PBMs, and insurers to reduce or streamline forms and limit data collection to the minimum necessary information, thereby helping to minimize provider and patient burden, treatment delays, and patients lost to follow up.

Expanding medication dispensing to include retail pharmacies: When navigating a variety of discrepant systems, patients and providers may experience uncertainty about where providers can send prescriptions and where patients can pick them up. In some states, including Louisiana and Virginia, the state Medicaid program permits retail pharmacies to fill and dispense prescriptions for Medicaid beneficiaries to alleviate this barrier. By amending or adjusting MCO contracts, state Medicaid programs may be able to permit DAAs for HCV treatment to be filled by non-specialty pharmacies, allowing for expanded patient choice and access when picking up medications.

Reducing restrictions on medication replacements: After individuals have received their initial medications, restrictions on replacing lost or stolen medication can interrupt treatment, requiring individuals to re-start the entire 8- or 12-week course of medication. Not only do interruptions slow the time to cure, allowing for onward transmission, but they can incur additional medication costs as well as additional costs, time, and administrative efforts for repeat medical visits, laboratory tests, and approval paperwork.

Medication storage: Programs conducting HCV testing, navigation, or treatment can consider implementing medication storage options that allow individuals to store medication in a secure location, either on-site or at a partner location. Providing secure storage for medications can reduce the incidence of lost, stolen, or damaged medications by providing a dry, safe place to store medications, and may increase willingness to initiate treatment among people experiencing homelessness. Further, medication storage lockers

co-located at agencies providing primary care or substance use services may facilitate opportunities to provide additional support and engagement.

Summary of opportunities – AVAILABILITY
• HCV programs may consider options to acquire and dispense "starter packs" for on-site, same-day treatment initiation • State Legislators, Boards of Pharmacy, and other regulatory bodies may consider expanding pharmacist scope of practice to include rapid HCV testing • State health departments and non-clinical HCV programs in jurisdictions with expanded CPAs may consider options to partner with pharmacies to enhance HCV testing and treatment services • State health departments and HCV programs may consider the feasibility of implementing multidisciplinary teams that include pharmacists and/or pharmacy technicians to support HCV testing and treatment • State Medicaid programs may consider options for allowing dispensation of the full HCV treatment course at the initial medication fill • State Medicaid programs may explore carving DAAs out of their MCO contracts • State Medicaid programs and other insurers may consider engaging directly with specialty pharmacies, PBMs, and insurers to reduce the administrative requirements for DAA approvals and dispensing • State Medicaid programs may consider amending MCO contracts to allow DAAs to be filled by non-specialty, retail pharmacies • State Medicaid programs, MCOs, PBMs, insurers, and other payers may consider options to reduce restrictions on replacing lost or stolen medications • HCV programs may consider installing medication storage options on-site or at trusted partner organizations

AFFORDABILITY

As organizations weigh whether to adopt POCT in their programs, the costs to set up and maintain a testing sequence utilizing the Cepheid Xpert® HCV test can be steep. Following an HCV diagnosis, patients, programs, and payers must then address the cost of DAAs.

Government pricing for POCT materials: While POCT cartridges are priced similar or lower to their lab-based counterparts, starting up POCT is typically more expensive for HCV

programs than continuing to utilize lab-based testing, as it requires a testing instrument. When the Xpert® HCV test came on the market in 2024, the 2-module and 4-module testing platforms were priced at $21,000 and $39,000, respectively. Additional costs to programs include staff time to conduct test collection, handling, and transport. Settings with high-volume testing may be able to improve their cost-effectiveness, thereby justifying sequences utilizing POCT.

For testing programs looking for options to improve the affordability of implementing POCT, government pricing for purchasing the testing instrument and test cartridges is available to certain CBOs that receive public health funding. Continuation and expansion of these types of discounts may make upfront costs more manageable for smaller and less-resourced organizations, as well as acting as an incentive for larger organizations to pursue POCT.

Procurement strategies for POCT materials: Additionally, organizations may choose to pursue different procurement strategies for both the test cartridges and the testing instrument. While some organizations may be able to make a capital purchase, others could consider leasing or rentals. Instrument leasing allows a program to lease the testing instrument for a set period, while cartridges are purchased separately. This may allow for a trial or pilot of POCT, lowering the short-term costs of the testing instrument.

In addition to leasing the testing instrument, a program can pursue reagent rentals, in which a minimum volume of cartridge units is included in the agreement. This not only can support a program to conduct a trial or pilot of POCT, but it also allows for the separate purchase of additional cartridges as needed.

Investments in workforce and information technology (IT) for POCT programs: Starting up a POCT program may require substantial staff time for training, development of protocols, and creation of quality assurance mechanisms. Additional efforts to ensure IT connectivity for appropriate tracking and reporting of test results can also increase costs related to training and staffing prior to and during implementation of POCT. Investing in workforce development, quality assurance, and health information systems can help organizations initiate and maintain POCT programs. Targeted training, standardized data systems, and simplified quality assurance tools can reduce staff burden, improve service quality, and streamline reporting and data integration.

DAA cost considerations: A standard course of HCV treatment currently costs approximately $25,000 out-of-pocket, and even after discounts, the costs ranged from $11,000 to $17,000 in early 2023. Although the current cost range is significantly lower than initial prices that neared $100,000 per course in 2014, it is still out of reach for many individuals.

In general, pharmaceutical companies determine the wholesale acquisition cost (WAC), or "sticker price", of the medication. Each health care coverage system then manages its own mechanisms to control costs, such as negotiating through PBMs or directly with pharmaceutical companies or receiving drug rebates. Typically, individuals will incur costs based on their own pharmacy plan, as either a copayment or coinsurance. For some, out-of-pocket costs may be partially or fully covered by a patient assistance program offered by a pharmaceutical company.

For large programs such as state prison systems and state Medicaid programs, the cost of DAAs for all eligible individuals in their system may exceed available budgets and funding. Finding options to reduce the per-course cost of DAAs can expand treatment access within these systems. This is particularly salient for correctional systems, which are usually excluded from rebates. In response, states and treatment programs have been exploring financing models such as 340B pricing and innovative payment models (IPMs) over the past decade since the introduction of DAAs.

340B Drug Pricing Program: Some organizations, such as those receiving viral hepatitis funding from or partnering with state health departments, are able to utilize 340B Drug Pricing Program prices to stretch resources further. As of 2019, state health department viral hepatitis programs funded under Section 318 of the Public Health Service Act are 340B-eligibile, meaning they can apply and register to purchase DAAs for HCV treatment at 340B pricing levels. Under 340B contracts, programs may be allowed to cover medications dispensed at traditional pharmacies, as well as those dispensed via mechanisms such as mobile units, telehealth, and street-based outreach. It can even be an option for some correctional systems, which may drastically lower the per-course cost of DAAs for in-house treatment.

Innovative payment models (IPMs): At a state level, IPMs are drug procurement strategies designed to be a more cost-effective way to pay for large quantities of DAAs. States such as Louisiana and Washington were early adopters of modified subscription models, in which they enter into an agreement with a treatment manufacturer to pay a set price or annual cap for access to HCV medications.

Implementing IPMs may also spur interest and investment in testing and linkage to care efforts by reducing affordability barriers for CBOs, state Medicaid programs, or correctional systems. For example, in Louisiana, adopting an IPM dropped the average cost of covered treatment from over $30,000 per course in 2018 to just $5,645 per course. Over time, more states including Michigan and Missouri have adopted IPMs and entered into agreements with manufacturers to make DAAs more affordable, and there is growing interest in a national IPM as well.

Summary of opportunities – AFFORDABILITY
• Health departments, hospitals, CBOs, SSPs, and others may explore options for lower-cost pricing of POCT instruments and materials, such as negotiating government and non-profit rates or discounts • Programs implementing POCT may consider alternative procurement strategies for the testing instrument and test cartridges, such as instrument lease and reagent rental • Federal and state agencies, in collaboration with HCV testing programs and national organizations and associations may consider developing protocols, training aids, and quality assurance guides to support POCT start-up, implementation, and evaluation • Health care coverage systems may consider negotiating through PBMs or directly with pharmaceutical companies to reduce the price of DAAs • State health departments may consider DAA purchase and dispensation through the 340B Drug Pricing Program for their programs and partners, including correctional systems • States may consider IPMs as an alternative method to finance large quantities of DAAs for HCV treatment

CONCLUSION

Test-to-treat approaches represent an innovative opportunity to maximize the impact of both new and existing diagnostic and treatment tools, and address persistent frictions that may impede progress along the HCV cure cascade. Deliberate planning, coordination, and investment to ensure that rapid HCV treatment is highly accessible, available, and affordable to those receiving POCT may help to more effectively achieve the promise of test-to-treat models.

> **"The success of any nationwide elimination initiative will rest on going beyond removing obstacles and toward retrofitting our systems to facilitate low-barrier, comprehensive care for all."**
> Hepatitis C: State of Medicaid Access (2023)

At the federal level, recently proposed legislation and enacted awards could play a role in the expansion of test-to-treat approaches in the future. In June 2025, the Cure HCV Act of 2025 was introduced into the U.S. Senate, which if enacted, would authorize expanded federal funding for HCV testing and outreach, public health infrastructure investments, and DAAs for HCV treatment. Additionally, HHS awarded $98 million in September 2025 to 19 state and community-based organizations to

develop best practices and successful models for preventing, testing, treating, and curing HCV, with an emphasis on POCT for people with substance use disorder or serious mental illness. Alongside these opportunities, HCV programs may also consider leveraging funding such as opioid settlement funds or rural health transformation grants to scale-up test-to-treat models.

If HCV diagnosis and treatment rates remain stagnant, only marginal improvements may be expected to occur by 2030, the year targeted by the HHS Viral Hepatitis National Strategic Plan to achieve elimination of HCV as a public health threat. The plateau in the number of people treated annually for HCV may indicate that current strategies are yielding diminishing returns and new approaches are needed. The innovative implementation of POCT and rapid treatment through test-to-treat models offers the possibility of moving the nation closer toward its achievable goal of HCV elimination.

For more information, please visit www.nvhr.org or contact info@nvhr.org

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SUMMARY OF OPPORTUNITIES

ACCESSIBILITY	• State Medicaid programs may review jurisdictional report cards and available resources for a comparative assessment of HCV treatment access policies to identify potential opportunities for improvement • State Medicaid programs may consider potential benefits of and avenues for removing PA requirements, or options to move existing requirements into alignment with simplified treatment guidelines • State Medicaid programs may explore options to reduce retreatment requirements or move existing retreatment requirements into alignment with retreatment guidelines • State Medicaid programs that contract with MCOs may assess MCO alignment with FFS policies to ensure transparency and parity
AVAILABILITY	• HCV programs may consider options to acquire and dispense "starter packs" for on-site, same-day treatment initiation • State Legislators, Boards of Pharmacy, and other regulatory bodies may consider expanding pharmacist scope of practice to include rapid HCV testing • State health departments and non-clinical HCV programs in jurisdictions with expanded CPAs may consider options to partner with pharmacies to enhance HCV testing and treatment services • State health departments and HCV programs may consider the feasibility of implementing multidisciplinary teams that include pharmacists and/or pharmacy technicians to support HCV testing and treatment • State Medicaid programs may consider options for allowing dispensation of the full HCV treatment course at the initial medication fill • State Medicaid programs may explore carving DAAs out of their MCO contracts • State Medicaid programs and other insurers may consider engaging directly with specialty pharmacies, PBMs, and insurers to reduce the administrative requirements for DAA approvals and dispensing • State Medicaid programs may consider amending MCO contracts to allow DAAs to be filled by non-specialty, retail pharmacies • State Medicaid programs, MCOs, PBMs, insurers, and other payers may consider options to reduce restrictions on replacing lost or stolen medications • HCV programs may consider installing medication storage options on-site or at trusted partner organizations
AFFORDABILITY	• Health departments, hospitals, CBOs, SSPs, and others may explore options for lower-cost pricing of POCT instruments and materials, such as negotiating government and non-profit rates or discounts • Programs implementing POCT may consider alternative procurement strategies for the testing instrument and test cartridges, such as instrument lease and reagent rental • Federal and state agencies, in collaboration with HCV testing programs and national organizations and associations may consider developing protocols, training aids, and quality assurance guides to support POCT start-up, implementation, and evaluation • Health care coverage systems may consider negotiating through PBMs or directly with pharmaceutical companies to reduce the price of DAAs • State health departments may consider DAA purchase and dispensation through the 340B Drug Pricing Program for their programs and partners, including correctional systems • States may consider IPMs as an alternative method to finance large quantities of DAAs for HCV treatment

GLOSSARY

CBO	Community-based organization
CDC	Centers for Disease Control and Prevention
CPA	Collaborative practice agreement
DAA	Direct-acting antiviral
FDA	Food and Drug Administration
FFS	Fee-for-service
HCV	Hepatitis C virus
HHS	Department of Health and Human Services
HIV	Human immunodeficiency virus
IPM	Innovative payment model
IT	Information technology
MCO	Managed care organization
OTP	Opioid treatment program
PA	Prior authorization
PBM	Pharmacy benefit manager
PCP	Primary care provider
POC	Point-of-care
POCT	Point-of-care HCV RNA testing
RNA	Ribonucleic acid
SSP	Syringe services program
U.S.	United States
WAC	Wholesale acquisition cost

RESOURCES

For more information or resources, please visit www.pix-ta.org or contact info@nvhr.org

Rapid HCV treatment and the HCV cure cascade

- Hepatitis C Online – The Path to HCV Cure: HCV Care Continuum
- CDC MMWR – Hepatitis C Virus Clearance Cascade – United States, 2013-2022
- AASLD/IDSA – HCVGuidelines.org
- AASLD/IDSA – Simplified HCV Treatment for Treatment-Naive Adults Without Cirrhosis
- AASLD/IDSA – Key Populations: Identification and Management of HCV in People Who Inject Drugs

Implementing the point-of-care HCV RNA Xpert® HCV test

- Cepheid – Xpert® HCV
- CMS – Clinical Laboratory Improvement Amendments (CLIA)
- CDC – Considerations for the Implementation of Point-of-Care Testing for the Diagnosis of Hepatitis C Virus Infection
- HepNET – Unlocking HCV Care in Key Settings
- INHSU – Barriers and solutions to increasing point-of-care HCV testing
- NVHR – From Fingerstick to Cure
- Finbraten et al., *Gastroenterology & Hepatology* (2022) – Rapid Treatment Initiation for Hepatitis C Infection: Potential Benefits, Current Limitations, and Real-World Examples

Medicaid treatment access

- NVHR/CHLPI – Hepatitis C: State of Medicaid Access and Report Cards
- CDC MMWR – Vital Signs: Hepatitis C Treatment Among Insured Adults – United States, 2019-2020
- CDC MMWR – Too Few People Treated for Hepatitis C

Innovative delivery and payment models

- CDC – Collaborative Practice Agreements and Pharmacists' Patient Care Services
- NASTAD – Pharmacist Authority to Provide Viral Hepatitis Prevention, Testing, and Treatment Services
- Morris et al., *JAMA Open Network* (2023) – Community-Based Point-of-Diagnosis Hepatitis C Treatment for Marginalized Populations: A Nonrandomized Controlled Trial
- O'Neill Institute – Innovative Payment Models: An analysis of the promise and practice of novel hepatitis C medication procurement strategies in the U.S.
- NASTAD – 340B Drug Pricing Program Guidance for Viral Hepatitis Programs

For additional information

- The Policy Innovation Exchange (PIX) – www.pix-ta.org
- NVHR – www.nvhr.org
- NNPHI – www.nnphi.org