



ASAM American Society *of*
Addiction Medicine



ASAM, founded in 1954, is a professional medical society representing over 7,000 physicians, clinicians and associated professionals in the field of addiction medicine. ASAM is dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction.



Hepatitis C Virus, Substance Use, and Addiction

Adoption Date: July 28, 2022



AGENDA

01 - Background

02 - Recommendations



Higher rates of Hepatitis C virus (HCV) are associated with increased injection drug use



HCV is the most prevalent bloodborne infection associated with drug use; HCV is predominantly transmitted through injection drug use.

Estimates show that 3.5 million people are living with HCV.

4x

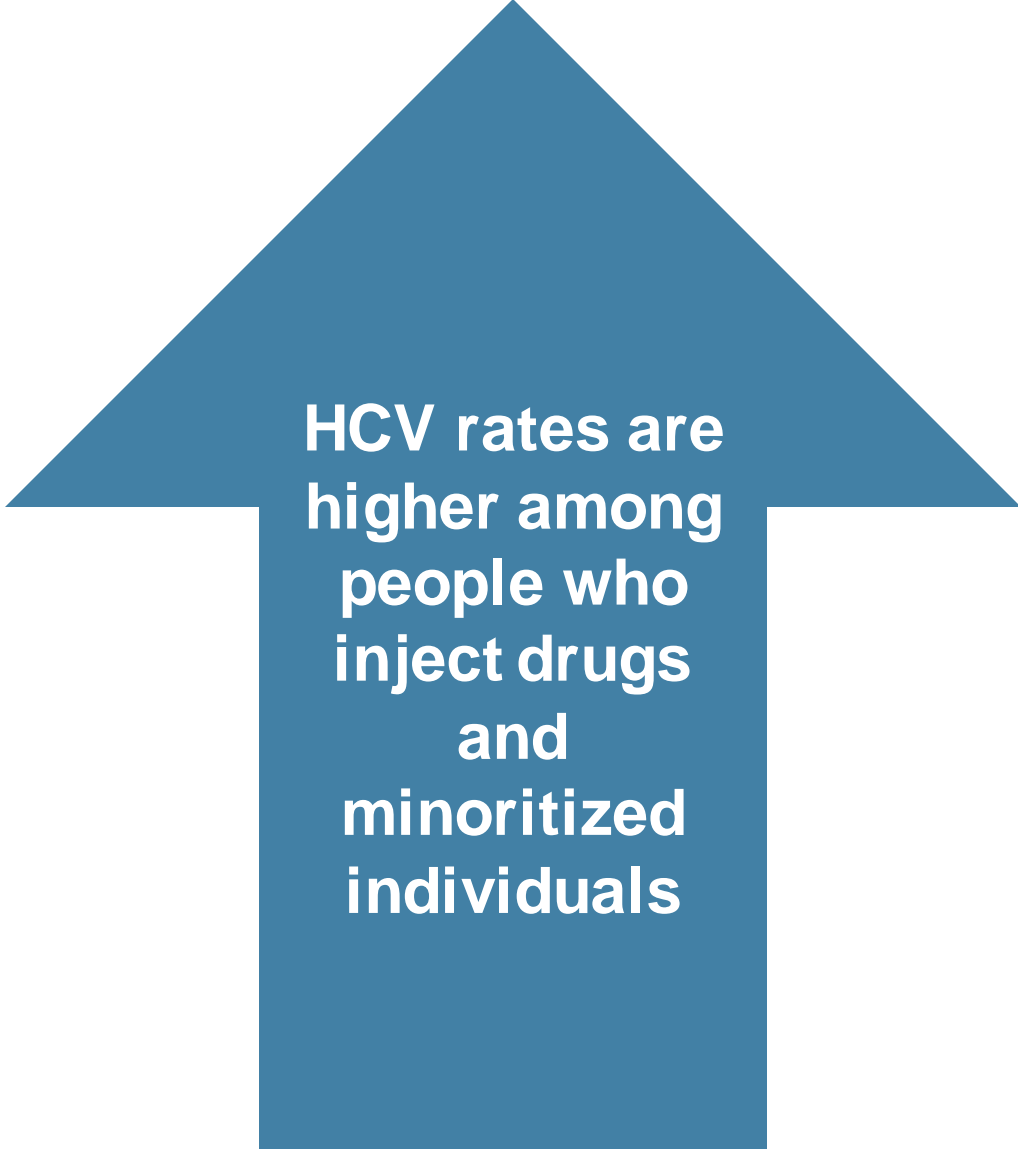
The incidence of HCV has quadrupled from 2010 to 2017.



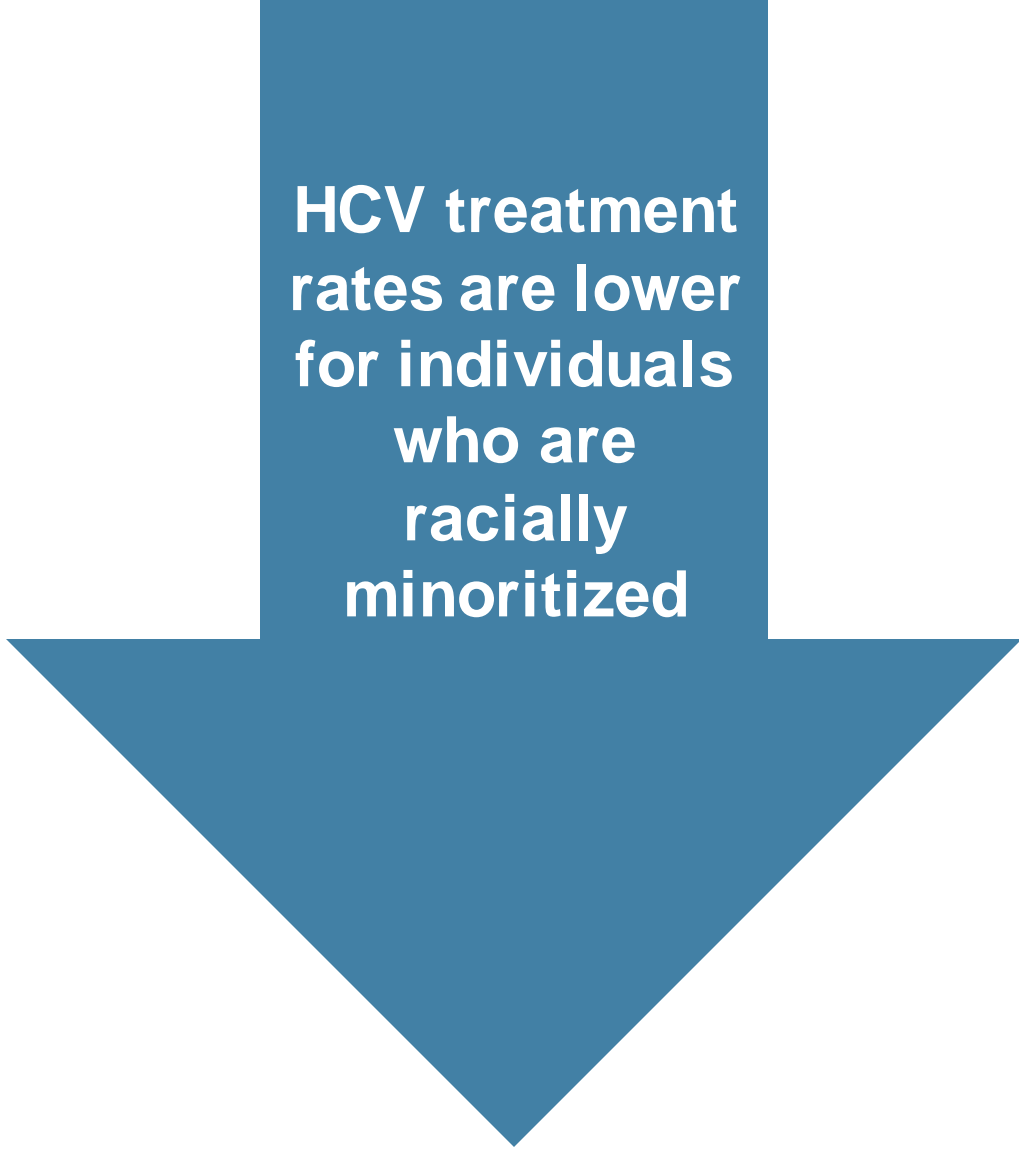
For more information go to <https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2022/07/29/policy-statement-on-the-hepatitis-c-virus-substance-use-and-addiction>



Disparities in HCV rates, treatment, and quality of care



HCV rates are higher among people who inject drugs and minoritized individuals



HCV treatment rates are lower for individuals who are racially minoritized

There are disparities in the quality of HCV care for individuals who are racially minoritized, in rural areas, and with lower socioeconomic status.



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Screening for and diagnosis of HCV infection is important; many do not know they have HCV

50% More than 50% of persons with HCV are unaware they have the virus

- Screening for and diagnosis of HCV infection is low for patients with opioid use disorder (OUD), even at OTPs.

30% About 30% of all individuals living with HCV have spent time in jails or prisons

- Screening rates are low in jails and prisons, and many do not have universal “opt-out” screening policies.
- “Opt-out” is a standardized protocol that screens everyone, except those who opt-out.



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DAA therapies offer promise in reducing HCV disease burden and transmission



HCV infection is a leading cause of liver-related morbidity, including hepatocellular carcinoma (HCC) and liver transplantation, and mortality.

90%

DAAs have replaced older interferon-based treatments because they are better tolerated and vastly more effective, with a cure rate of over 90%.



DAAs are expensive, but the treatment course usually only lasts 8-12 weeks.



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Treatment is recommended for all persons regardless of substance use and upheld by law

All persons with HCV infection are candidates for available, curative treatment

- Professional society guidelines recommend treatment for all persons with acute and chronic HCV, including those with active drug and alcohol use; available [here](#).



The U.S. Constitution requires adequate medical care for incarcerated individuals

- **The Americans with Disabilities Act (ADA) does not allow medical care to be withheld based on illegal use of drugs, if the individual is otherwise entitled to such services.**
- **States must provide Medicaid enrollees with medically necessary treatment in a non-discriminatory manner.**



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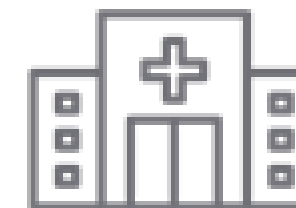
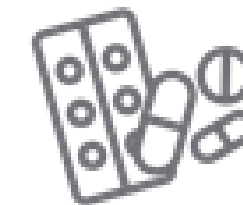
Integrated SUD and HCV care from multiple settings

- Integrated treatment of substance use disorder (SUD) and HCV produces the best outcomes.
- Co-administration of addiction medication and DAA treatment increases uptake of DAA.



HCV treatment can be safely delivered from addiction treatment, primary care, and jail and prison settings

- Syringe services programs play a critical role in reducing transmission of HCV.



HCV-related liver disease has an enormous economic burden; challenges exist to DAA affordability

\$10B The direct economic burden of HCV-related liver disease may exceed \$10 billion

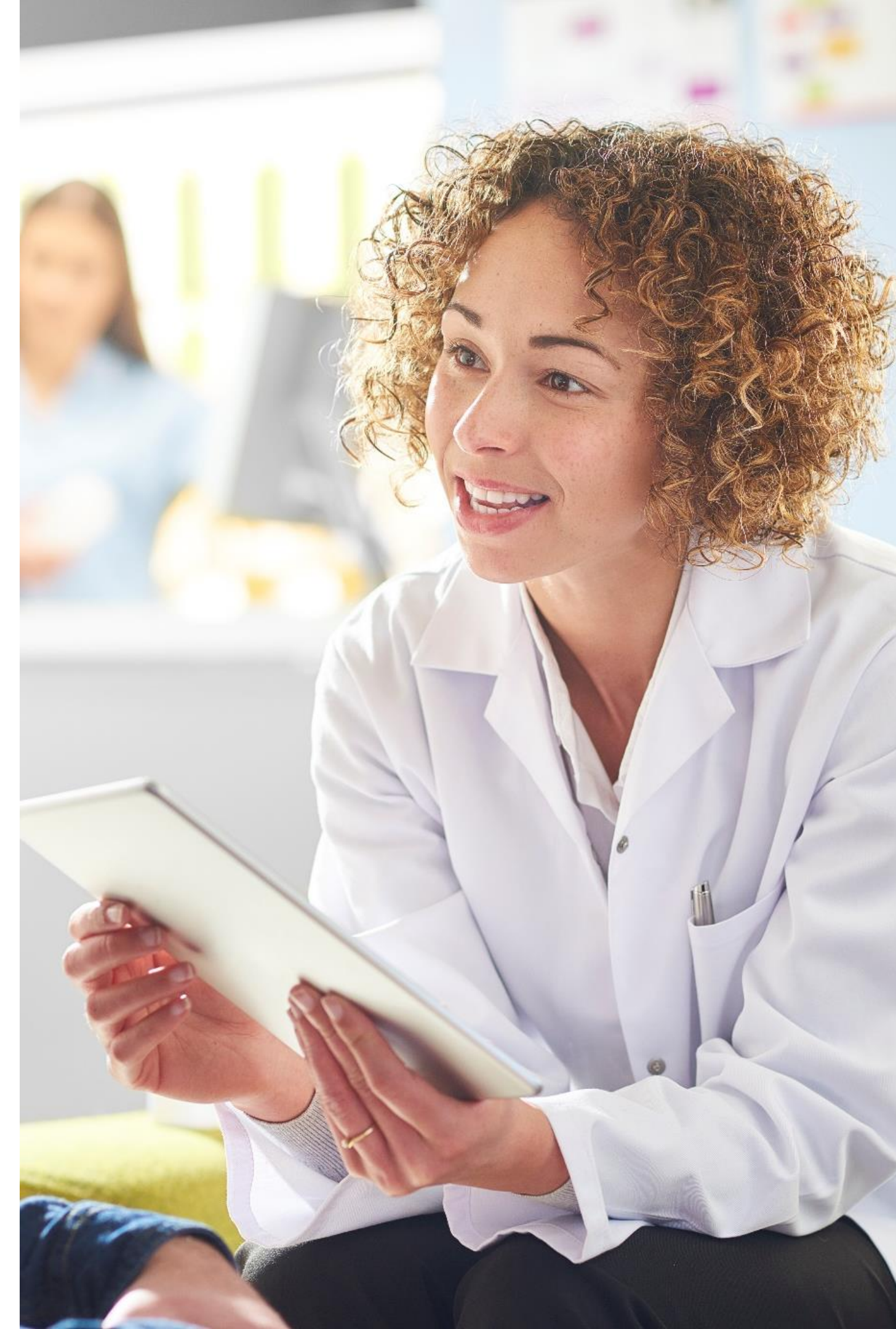
- Institutions like jails and prisons' health care financing structures create difficulties for them to afford DAAs.

Many state Medicaid programs have limited coverage of DAAs

- CMS clarified the extent to which states can restrict payer coverage of DAAs in 2015.
- Strategies exist for states to lower the cost of DAAs, such as the “subscription fee” model.



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The American Society of Addiction Medicine recommends



State-of-the-art medical care for HCV should be accessible and available to all persons who need it. **Active alcohol or other drug use should not exclude any person should be excluded from receiving HCV treatment for active alcohol or drug use.**

- All agencies, payers, and professionals should align policy and practice accordingly.
- The patient and practitioner should decide to initiate HCV treatment following a careful risk/benefit analysis.



All healthcare settings, especially addiction treatment programs, should provide or coordinate comprehensive HCV care.

- Payers and policymakers should ensure that medical clinicians at OTPs are reimbursed for HCV treatment.
- HCV care delivery should be integrated at nontraditional locations like harm reduction sites, due to SUD-related stigma that may cause patients to avoid traditional healthcare settings.



Healthcare systems and professionals should adjust policy and practice to address and rectify underlying racial discrimination; research is needed to identify the policies and practices that contribute to racial disparities in HCV treatment eligibility and receipt.



Jails and prisons should improve screening policies to detect HCV infection and communicate the screening results to individuals; universal “opt-out” testing for HCV, Hepatitis B Virus (HBV), and Human Immunodeficiency Virus (HIV) should be provided to all incarcerated individuals.



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Addiction medicine, infectious disease, and primary care clinicians must have increased mutual awareness and collaboration. Infectious disease and addiction medicine partnerships are important and synergistic; government agencies should coordinate collaboration and invest in these fields' evidence-based strategies for reducing HCV infection, including increasing access to addiction medications, DAA treatment, and harm reduction services.



Treating persons with HCV can save future costs and improve health outcomes, therefore, third-party payers should cover comprehensive HCV care consistent with evidenced-based treatment practices and nationally accepted guidelines.

- Payer restrictions to HCV treatment based on chronicity, fibrosis stage, prescriber specialty, or those with substance abstinence requirements may violate federal law and should be removed.



Alternative payment models designed to integrate medical, behavioral, and SUD treatment services should be developed to meet the needs of persons with SUD and co-occurring HCV infection.

- Innovative state-based strategies for expanding access to evidence-based pharmaceutical treatments for HCV infection, such as subscription models, should be considered, their effectiveness should be rigorously evaluated, and successes should be replicated.
- In partnership with community-based organizations, governments should invest in local strategies to expand HCV screening, diagnosis, linkages to care, and treatment.



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