A Path Towards Eliminating Hepatitis C in Arkansas

Arkansas Department of Health
2024

Contents

Summary

What is hepatitis C?
Hepatitis C is a virus that affects the liver. It is the most common bloodborne illness in the United States. The early stages of hepatitis C often have no symptoms, but if left untreated, the infection can persist for decades, potentially leading to liver scarring, cancer, cirrhosis, or death.

Who is affected?
Over two million Americans are living with hepatitis C. This includes at least 20,000 Arkansans. Although anyone can get hepatitis C if they are exposed to another person's blood, some groups are at higher risk. Hepatitis C disproportionately affects people who have low incomes or poor access to healthcare. There are higher rates among men, middle-aged people, and those who have been in prison. Hepatitis C is very common among people who inject drugs because sharing needles can transmit the virus.

What can be done?
Hepatitis C is preventable and curable. Most new hepatitis C infections result from sharing needles or other equipment during injection drug use. To prevent transmitting the virus, everyone should have access to hepatitis C testing, so they know their status. Access to resources that will prevent injection drug use or prevent the sharing of needles can limit spreading the virus. There must also be access to curative treatment for everyone who has a current hepatitis C infection. This requires removing financial, logistical, and administrative barriers in the healthcare and insurance systems.

What does this plan do?
This document was prepared by the Arkansas Department of Health with input from other state agencies, medical providers, and community organizations. It outlines steps we can take together to reduce illness and death from hepatitis C. The federal government has articulated a commitment to end hepatitis C as a major public health problem, and the State of Arkansas shares this commitment. This plan does not represent all stakeholder viewpoints or all possible strategies. The document articulates our overall goals rather than enumerating specific actions for stakeholders to take. We hope this plan provides a starting point for individuals and organizations across our state who are ready to take action against hepatitis C.

How does this fit into the national viral hepatitis strategy?
The U.S. Department of Health and Human Services defines the goal of hepatitis elimination as: "The United States will be a place where new viral hepatitis infections are prevented, every person knows their status, and every person with viral hepatitis has high-quality health care and treatment and lives free from stigma and discrimination." This plan summarizes our thinking about strategies to bring Arkansas closer to this goal. The planning process is a forum for stakeholders to propose new ideas, coordinate efforts, and evaluate outcomes.

The *Viral Hepatitis National Strategic Plan (2021-2025)*

The *Viral Hepatitis National Strategic Plan (2021-2025)*, developed by the U.S. Department of Health and Human Services (HHS), provides a framework aimed at eliminating viral hepatitis as a public health threat by 2030.[1] The plan is designed to guide national, state, and local efforts in addressing the viral hepatitis epidemic, and it serves as a foundation for states to develop their own elimination strategies. The plan emphasizes the importance of partnerships across federal, state, and local governments, as well as community-based organizations and healthcare providers. States play a critical role in implementing the national plan's vision and tracking progress toward elimination. This plan provides a roadmap to eliminate viral hepatitis, guiding policies that enhance healthcare access and prioritize high-risk populations. It highlights the importance of tailoring strategies to fit local needs while aligning with national objectives to achieve elimination by 2030. A summary of the plan pertaining to hepatitis C follows.

Vision
The elimination of hepatitis C as a public health threat in the U.S.

Overarching Goals

- Prevent new hepatitis C infections.
- Improve health outcomes for individuals living with hepatitis C.
- Reduce hepatitis C-related disparities.
- Strengthen public health infrastructure to eliminate hepatitis C.

Core Strategies
States can use the plan's strategies as a foundation for developing or enhancing their own hepatitis C elimination plans.

- Testing and Diagnosis: Expanding hepatitis C screening to ensure more people are tested, diagnosed, and linked to care, with an emphasis on high-risk populations.
- Linkage to Care and Treatment: Ensuring access to effective hepatitis C treatments, removing barriers like prior authorization for medications, and improving linkage to care for newly diagnosed individuals.
- Surveillance and Reporting: Strengthening hepatitis C surveillance systems, improving data collection, and ensuring timely and accurate reporting to better track and respond to trends.

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[1] U.S. Department of Health and Human Services. 2020. Viral hepatitis national strategic plan for the United States: a roadmap to elimination (2021-2025). https://www.hhs.gov/hepatitis/viral-hepatitis-national-strategic-plan/index.html.

- Education and Awareness: Promoting education for healthcare providers, public health officials, and priority communities to increase awareness of hepatitis C risks, testing, and treatment.

- Eliminating and Reducing Barriers: Reducing barriers in hepatitis C care by focusing on vulnerable populations, including racial and ethnic minorities, people in rural areas, people who use drugs, and people in correctional settings.

Priority Populations

The *Viral Hepatitis National Strategic Plan (2021-2025)* identifies four groups of people who are at increased risk of hepatitis C. To reduce the burden of illness, it is especially important for prevention and treatment efforts to reach people in these groups:

- People who inject drugs.
- People who are incarcerated.
- People who were born between 1945 and 1965.
- People who are living with HIV.

Impact on State Hepatitis C Elimination Plans

The *Viral Hepatitis National Strategic Plan (2021-2025)* is a blueprint for states to develop their own elimination strategies. The plan highlights the importance of addressing state-level barriers to care for underserved populations. States can align their own elimination goals with national goals. To increase effectiveness, state public health departments are encouraged to collaborate with healthcare systems, correctional facilities, local governments, and community-based organizations.

Mission of the Arkansas Hepatitis C Program

Ending the hepatitis C epidemic in Arkansas.

Goals of the Arkansas Hepatitis C Program

- Eliminating Hepatitis C: No one in Arkansas should suffer from hepatitis C.

- Coordinated Care: Hepatitis C cannot be addressed in isolation from other health problems. There should be no "wrong door" for Arkansans who are seeking care for hepatitis C or related problems such as substance use disorder, HIV, or sexually transmitted infections (STI).

- Collaboration: Hepatitis C elimination will require a collaborative effort from many stakeholders, including people who are directly affected by hepatitis C. This plan will evolve based on feedback from providers and the public.

- Clear Communication: Clear and concise communication on best practices for hepatitis C prevention, testing, and treatment should be available to the public and providers.

- Evidence-Based Approach: Interventions targeted to reduce hepatitis C must be cost-effective and supported by sound scientific evidence to ensure that resources are used efficiently.

This document has been revised to reflect stakeholder feedback and current state and federal administrative guidelines.

Hepatitis C in Arkansas

The hepatitis C virus was isolated in 1989[2] and hepatitis C has been a nationally reported disease since 2003.[3] Although there has recently been a small decline in new hepatitis C infections nationwide, the federal government estimates that over 60,000 people were newly infected each year from 2020 to 2022.[4] Today, over 1% of the U.S. adult population is living with hepatitis C,[5] including more than 20,000 Arkansans.[6]

There are two major sources of current hepatitis C infections in Arkansas and nationwide. First, a large group of people were exposed by blood transfusions and organ transplants during the 1980s because the blood and organ supply could not be screened for hepatitis C at that time.[7] Many people who were infected this way are still living with chronic hepatitis C. More recently, most new infections are the result of injection drug use with non-sterile needles or other equipment.[8] **Figure 1** shows the age distribution of the 20,424 Arkansas hepatitis C case reports from 2019 to 2022.[9] Reported substance use was most common among younger persons. Because some patients who have a history of substance use cannot be contacted, or deny substance use at interview, this figure underestimates substance use among people with hepatitis C. Many Arkansans with hepatitis C report using methamphetamine, and a somewhat smaller number report using opioids.[10,11] This is consistent with survey data showing that Arkansas has a high rate of methamphetamine use (approximately 1.9% of adults in 2021-22, compared to 1.0% nationally).[12]

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[2] Choo QL, Kuo G, Weiner AJ, Overby LR, Bradley DW, Houghton M. 1989. Isolation of a cDNA clone derived from a blood-borne non-A, non-B viral hepatitis genome. *Science*. 244(4902):359-362. https://doi.org/10.1126/science.2523562.

[3] Hopkins RS, Jajosky RA, Hall PA, Adams DA, Connor FJ, Sharp P, Anderson WJ, Fagan RF, Aponte JJ, Nitschke DA, et al. 2005. Summary of notifiable diseases – United States, 2003. *MMWR Morb Mortal Wkly Rep*. 52(54):1-85. https://pubmed.ncbi.nlm.nih.gov/15889005/.

[4] Centers for Disease Control and Prevention. 2024. 2024 national viral hepatitis progress report. https://www.cdc.gov/hepatitis/php/npr-2024/.

[5] Hall EW, Bradley H, Barker LK, Lewis KC, Shealey J, Valverde E, Sullivan P, Gupta N, Hofmeister MG. 2024. Estimating hepatitis C prevalence in the United States, 2017-2020. *Hepatology*. 81(2):625-636. https://doi.org/10.1097/hep.0000000000000927.

[6] Arkansas Department of Health. 2023. Hepatitis C in Arkansas, 2023. https://healthy.arkansas.gov/wp-content/uploads/hcv_report_final_nov_23.pdf.

[7] Klevens RM, Hu DJ, Jiles R, Holmberg SD. 2012. Evolving epidemiology of hepatitis C virus in the United States. *Clin Infect Dis*. 55(Suppl 1):S3-S9. https://doi.org/10.1093/cid/cis393.

[8] Trickey A, Fraser H, Lim AG, Peacock A, Colledge S, Walker JG, Leung J, Grebely J, Larney S, Martin NK, et al. 2019. The contribution of injection drug use to hepatitis C virus transmission globally, regionally, and at country level: a modelling study. *Lancet Gastroenterol Hepatol*. 4(6):435-444. https://doi.org/10.1016/s2468-1253(19)30085-8.

[9] These cases were identified and counted by the Department of Health in 2019-22, but many patients in this group were initially infected or diagnosed in earlier years. Because hepatitis C is a chronic illness, there can be long delays before a case is diagnosed, and additional delays before the case is reported and counted in the Department of Health data.

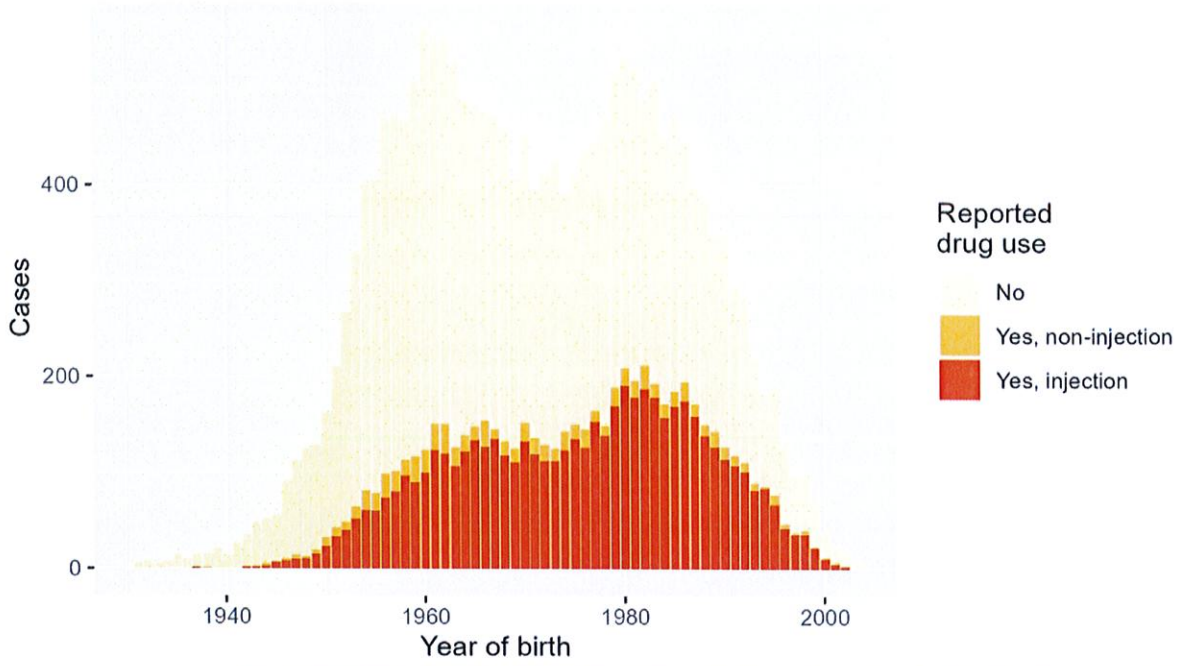
[10] Arkansas Department of Health. 2014. Hepatitis C epidemiologic profile: 2014. https://healthy.arkansas.gov/wp-content/uploads/HCVEpidemiologicProfile.pdf.

[11] Pro G, Hayes C, Bona J, Gu M, Richoux C, Zaller N. 2024. HCV medication receipt among individuals with methamphetamine, opioid, and alcohol use disorders in Arkansas, 2018-2022: a long road ahead for HCV elimination in the US South. *J Drug Issues*. 55(3):434-449. https://doi.org/10.1177/00220426241231720.

[12] Substance Abuse and Mental Health Services Administration. 2024. 2021-2022 NSDUH: model-based estimated prevalence for states. https://www.samhsa.gov/data/report/2021-2022-nsduh-state-prevalence-estimates.

1. New hepatitis C case reports

By year of birth and reported drug use – Arkansas, 2019-22



Provisional and subject to correction. Source: Arkansas Department of Health disease registry. Years with <5 cases are excluded. Cases without drug use information are reported as "No."

Although hepatitis C affects Arkansans from all demographic groups, some people are at higher risk. From 2019 to 2022, men had a higher rate of new hepatitis C case reports than women; American Indians or Alaska Natives and whites had a higher rate of new case reports than other race and ethnicity groups; and people in the Fort Smith and Hot Springs metropolitan areas had a higher rate of new case reports than people in other metropolitan areas or rural parts of the state. **Table 2** shows the rates of new case reports during 2019-22 by demographic group, and **Figure 3** shows the rates of new case reports during 2019-22 by county.[13] Several counties with prisons, including Lee, Lincoln, and Miller, have the highest rates of hepatitis C case reports statewide, even after excluding cases from Department of Corrections intake facilities, since it is not unusual for hepatitis C cases to be reported from other facilities in the Department of Corrections system. However, other counties in the northeastern and western part of the state also have high rates of reported hepatitis C cases.

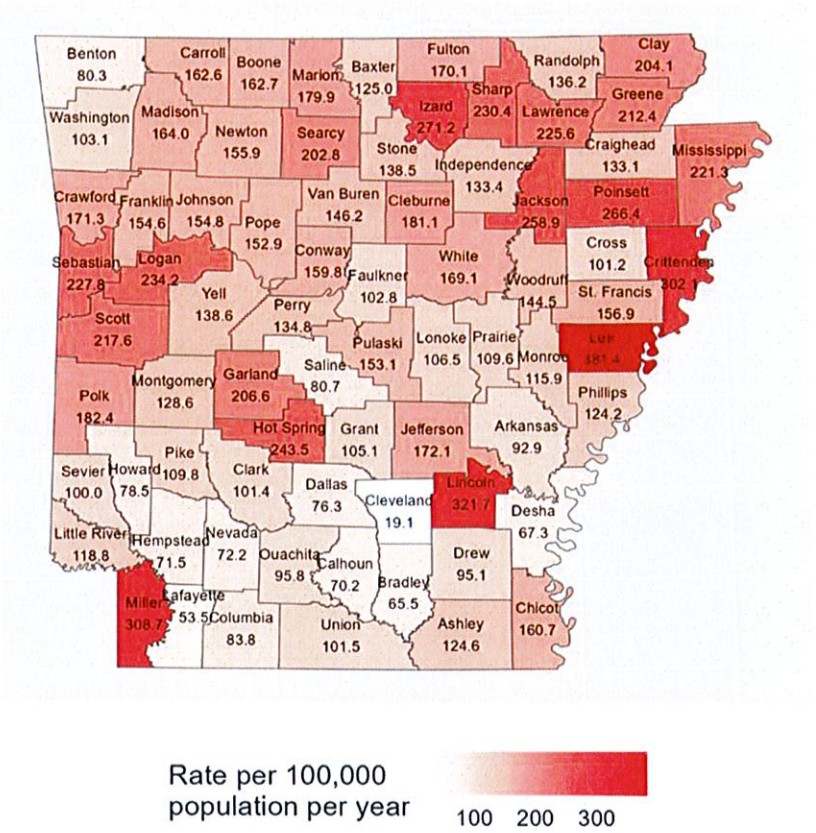
[13] Cases with missing information for each field are excluded. People reporting "Two or more races" are counted in the "Other" group. Cases that are reported with an address at a Department of Corrections statewide intake facility or the Federal Correctional Complex Forrest City are not included in the table of cases by region or the map of cases by county. Cases that are reported with an address at a different prison, or a county jail, are counted in the county of the reported address.

2. New hepatitis C case reports: by demographic group – Arkansas, 2019-22

Field	*Group*	*Case reports*	*Rate per 100,000 population per year*
Sex	Female	7,994	130.8
	Male	12,361	208.6
Race and ethnicity	American Indian or Alaska Native	119	201.4
	Asian	77	42.2
	Black or African American	2,227	122.2
	Hispanic or Latino	405	43.4
	Native Hawaiian or Pacific Islander	20	49.6
	Other	157	35.4
	White	16,254	190.0
Region	Fayetteville-Bentonville-Rogers	1,983	93.1
	Fort Smith	1,588	209.4
	Hot Springs	821	206.9
	Jonesboro	832	156.6
	Little Rock-North Little Rock-Conway	3,770	126.8
	Rest of state	8,761	166.9
Total		20,424	169.7

3. New hepatitis C case reports

By county – Arkansas, 2019-22



Provisional and subject to correction. Source: Arkansas Department of Health disease registry.

Many Arkansans with hepatitis C have a history of incarceration. People who pass through the correctional system have a high risk of hepatitis C infection,[14] and Arkansas state prisons provide opt-out screening for hepatitis C at intake,[15] which increases the rate of cases identified there. From 2019 to 2022, 5,870 (28.7%) of Arkansas hepatitis C case reports indicated some history of incarceration. In 2023, the Department of Corrections estimated that there were 1,361 inmates in the state prisons with hepatitis C (out of a total inmate population of 17,022).[16] This rate is much higher than in the general population. In addition, many people who are living with hepatitis C likely pass through the county jails each year, but this is difficult to measure.

Even though hepatitis C is preventable and curable, it continues to cause illness and death for many Arkansans. Between 2016 and 2022, 30,621 inpatient stays at Arkansas hospitals cited hepatitis C

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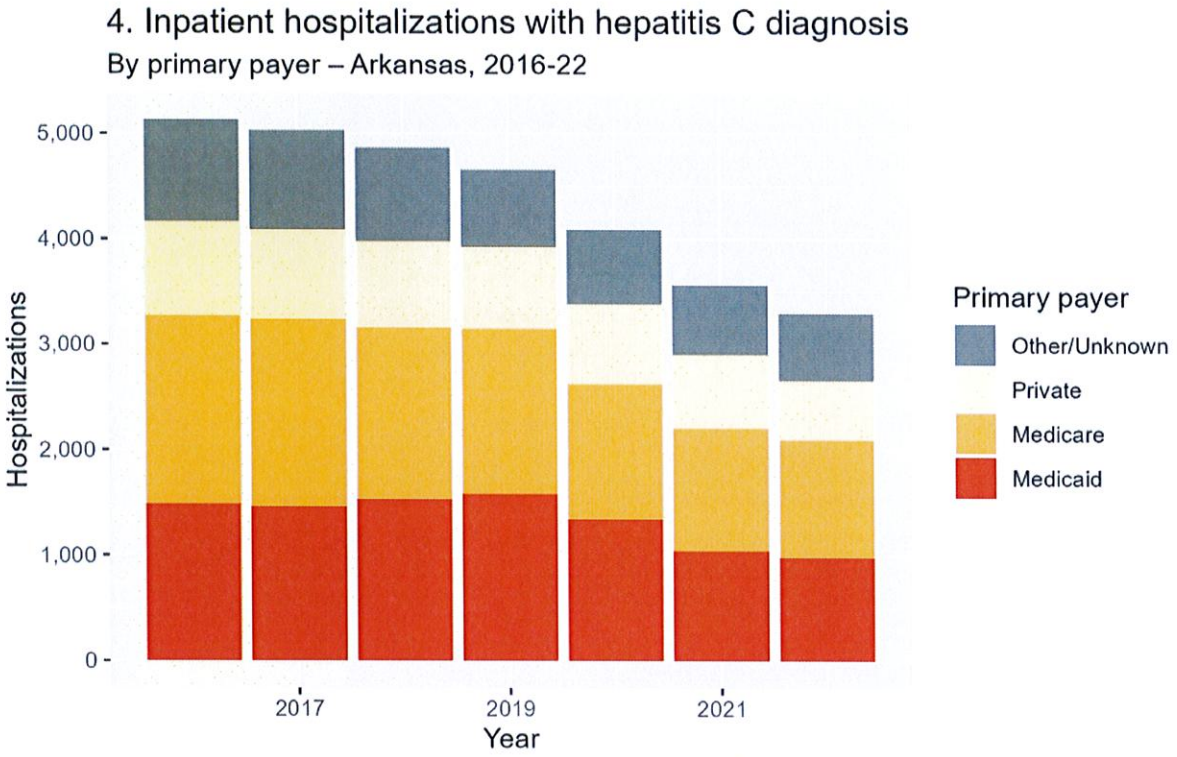
[14] Spaulding AC, Kennedy SS, Osei J, Sidibeh E, Batina IV, Chhatwal J, Akiyama MJ, Strick LB. 2023. Estimates of hepatitis C seroprevalence and viremia in state prison populations in the United States. *J Infect Dis*. 228(Suppl 3):S160-S167. https://doi.org/10.1093/infdis/jiad227.

[15] Arkansas Department of Corrections. 2024. Request for proposal DOC-24-004: comprehensive medical services. https://arbuy.arkansas.gov/bso/external/bidDetail.sdo?docId=S000000285.

[16] Spaulding et al. 2023.

as the primary diagnosis or a contributing diagnosis. The annual number of these hospitalizations fell from 5,126 in 2016 to 3,294 in 2022. This decline may be due to a reduction in illness from hepatitis C because more people were treated with direct-acting antivirals (DAA). However, overall hospital utilization also decreased due to the COVID-19 pandemic, so this trend should be interpreted cautiously.

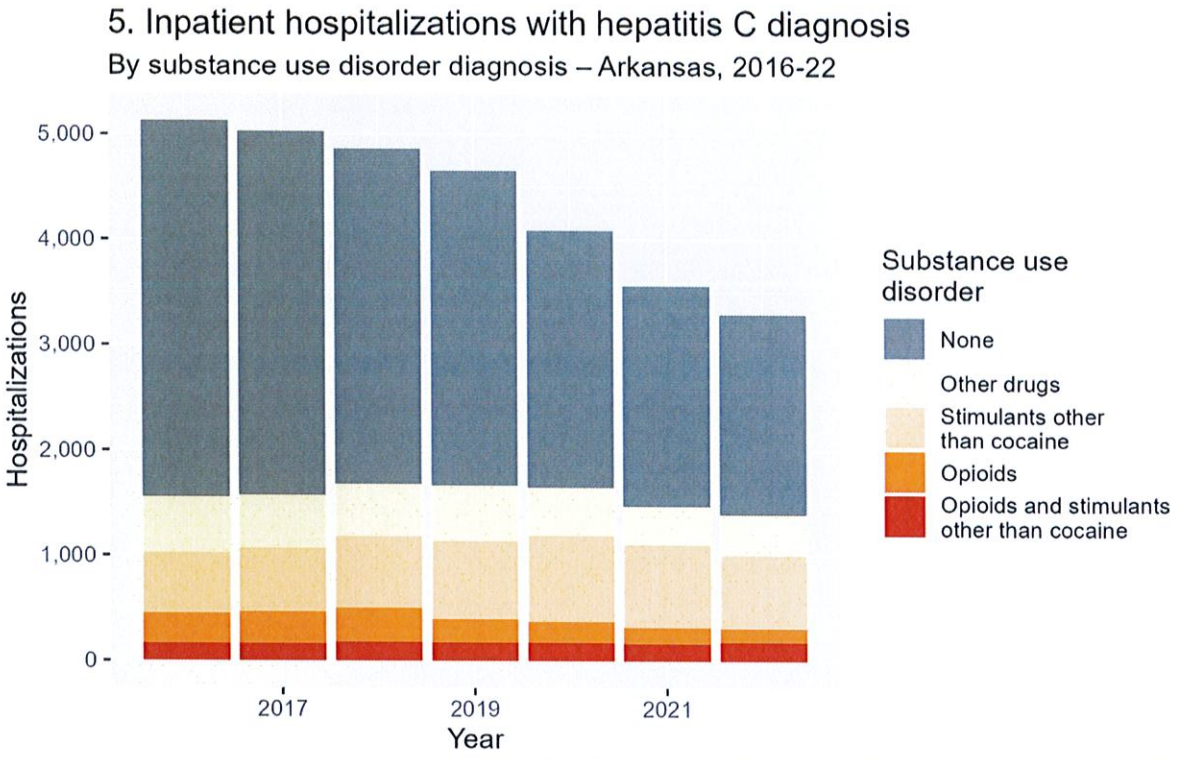
A majority of these hospitalizations were primarily paid for by public insurance programs such as Medicare (10,300, 33.6%) and Medicaid (9,434, 30.8%). This is consistent with national survey findings that people on public insurance plans, without any insurance, or living below the poverty line are more likely to have current hepatitis C infection.[17] Complications of hepatitis C are especially common in Medicare because it covers older people who are more likely to have chronic infections that have progressed to severe liver disease. **Figure 4** shows the distribution of hospitalizations by primary payer each year from 2016 to 2022.



From 2016 to 2022, 10,963 (35.8%) of the hospitalizations had a co-occurring diagnosis of a substance use disorder (other than alcohol or nicotine use). Most hospitalizations with a substance use disorder diagnosis reported stimulants other than cocaine (primarily methamphetamine, 4,890, 16.0%); opioids (1,618, 5.3%); or both (1,200, 3.9%). Another 3,255 hospitalizations had a

[17] Lewis KC, Barker LK, Jiles RB, Gupta N. 2023. Estimated prevalence and awareness of hepatitis C virus infection among US adults: National Health and Nutrition Examination Survey, January 2017-March 2020. *Clin Infect Dis*. 77(10):1413-1415. https://doi.org/10.1093/cid/ciad411.

diagnosis of another substance use disorder not in any of these categories.[18] Furthermore, although overall hospitalizations with hepatitis C decreased between 2016 and 2022, the decrease was slower among hospitalizations citing a substance use disorder, indicating that hepatitis C continues to cause substantial illness among people who are using drugs. **Figure 5** shows the number of hepatitis C-related hospitalizations with and without substance use disorder diagnoses each year from 2016 to 2022.



From 2018 to 2022, each year over 100 Arkansans died with hepatitis C cited as an underlying or contributing cause (total during 2018-22: 677 deaths).[19] Although the number of deaths fell from 150 in 2018 to 114 in 2022, this suggests that many patients still may not be reached by DAA treatment, which reduces deaths from complications of hepatitis C. Hepatitis C is frequently not

[18] Hepatitis C was identified using ICD-10-CM codes B17.1 (Acute hepatitis C), B18.2 (Chronic viral hepatitis C), B19.2 (Unspecified viral hepatitis C), and Z22.52 (Carrier of viral hepatitis C [deprecated]). Opioid use disorder was identified using ICD-10-CM code F11 (Opioid related disorders); stimulant use disorder other than cocaine was identified using F15 (Other stimulant related disorders); and other substance use disorders were identified using F12 (Cannabis related disorders), F13 (Sedative, hypnotic, or anxiolytic related disorders), F14 (Cocaine related disorders), F16 (Hallucinogen related disorders), F18 (Inhalant related disorders), and F19 (Other psychoactive substance related disorders).

[19] Centers for Disease Control and Prevention. 2024. CDC WONDER: multiple cause of death, 2018-2022, single race. https://wonder.cdc.gov/mcd-icd10-expanded.html. Hepatitis C was identified using ICD-10 codes B17.1 (Acute hepatitis C) and B18.2 (Chronic viral hepatitis C).

ascertained on death certificates, so the actual number of hepatitis C-related deaths is likely higher.[20]

Pregnancy is not a risk factor for hepatitis C infection, but hepatitis C is a threat to maternal and child health. Managing hepatitis C infection in pregnant women and newborns requires special attention from providers. Between 2019 and 2022, there were 139,384 births in Arkansas; 673 (0.5%) of birth certificates reported that the mother had hepatitis C,[21] in comparison to 11 perinatal hepatitis C infections ascertained from case reports sent to the Department of Health. National data suggests a similar proportion of pregnancies occurring among women with hepatitis C (0.5% in 2019, increased from 0.05% in 2000).[22] Since an estimated 6%-9% of births to HIV-negative women with hepatitis C result in a perinatal infection (1%-4% perinatal infections, net of clearance),[23] it is likely that some perinatal hepatitis C infections in Arkansas are not being diagnosed or are not being ascertained by public health case reports, even though Arkansas law requires that hepatitis C testing must be offered to all pregnant women.[24]

Patient Feedback on Linkage to Care

To better understand patients' experience with linkage to care for hepatitis C, the ADH hepatitis C team gathered qualitative information about the challenges patients face while seeking treatment. During surveillance interviews, patients reported that delays due to prior authorization were common, sometimes taking weeks or over a month. High co-pays deterred some patients, with others relying on grant funding that caused additional delays. Access to clinics with an insurance-approved specialist also posed problems; many rural towns do not have approved specialty clinicians, forcing patients to deal with transportation barriers. Coordination of care emerged as a key concern, with patients struggling to schedule or attend specialist appointments due to illness, long travel times, or the loss of a primary care provider. Patients often waited for referrals or for their medications to be sent, underscoring the need for improved coordination among providers to ensure timely and accessible hepatitis C care.

These interview findings are consistent with statewide data suggesting that many Arkansans have difficulty receiving timely hepatitis C care after diagnosis. In 2022, 165 hepatitis C patients who had an ADH case report investigated between 2018 and 2021 were re-interviewed as part of a University of Arkansas for Medical Sciences (UAMS) research project.[25] At the time of the second interview, 67 (41%) reported that they had not yet received hepatitis C treatment, often due to problems attending a specialist appointment or other conditions (e.g., COVID-19) being more

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[20] Spradling PR, Zhong Y, Moorman AC, Rupp LB, Lu M, Teshale EH, Schmidt MA, Daida YG, Boscarino JA, Gordon SC, CHeCS Investigators. 2021. The persistence of underreporting of hepatitis C as an underlying or contributing cause of death, 2011-2017. *Clin Infect Dis*. 73(5):891-894. https://doi.org/10.1093/cid/ciab108.

[21] Arkansas Department of Health. 2024. ERAVE. https://healthy.arkansas.gov/programs-services/certificates-records/erave/.

[22] Arditi B, Emont J, Friedman AM, D'Alton ME, Wen T. 2023. Deliveries among patients with maternal hepatitis C virus infection in the United States, 2000-2019. *Obstet Gynecol*. 141(4):828-836. https://doi.org/10.1097/aog.0000000000005119.

[23] Ades AE, Gordon F, Scott K, Collins IJ, Claire T, Pembrey L, Chappell E, Mariné-Barjoan E, Butler K, Indolfi G, et al. 2023. Overall vertical transmission of hepatitis C virus, transmission net of clearance, and timing of transmission. *Clin Infect Dis*. 76(5):905-912. https://doi.org/10.1093/cid/ciac270.

[24] Ark. Code Ann. § 20-15-101.

[25] Canter C. 2022. An assessment of barriers to treatment for persons with hepatitis C virus in Arkansas 2022. University of Arkansas for Medical Sciences. Copy on file with Department of Health.

urgent priorities than hepatitis C. Many patients reported that they had not yet discussed barriers to treatment with a provider. Similarly, in statewide insurance claims data analyzed by the Arkansas Center for Health Improvement, only 36% of Arkansas patients who had a first diagnosis of chronic hepatitis C during 2019 had documentation of receiving DAA treatment within two years.[26] Although these measures should be interpreted with caution, due to limited data sources and the effects of COVID-19 on healthcare utilization, they suggest that the barriers reported by patients at interview may be widespread.

Injection Drug Use

In recent years, most people are infected with hepatitis C by sharing needles, syringes, or other paraphernalia for injection drug use. In 2021-22, the National Survey on Drug Use and Health estimated that 15.8% of Arkansas adults had a substance use disorder compared to the national average of 17.8%, and 8.8% of Arkansas youth aged 12-17 had a substance use disorder compared to the national average of 9.0%.[27] The Gulf Coast High Intensity Drug Trafficking Area, which is sponsored by the Drug Enforcement Administration and includes parts of Alabama, Arkansas, Florida, Louisiana, Mississippi, and Tennessee, estimates that fentanyl is the most important drug threat in the Gulf Coast region, followed by methamphetamine.[28]

People who inject drugs are at a higher risk of hepatitis C. There are several unique challenges that impede good health outcomes for people who inject drugs, including in Arkansas:

- Many people who inject drugs have limited access to healthcare.[29]
- Areas across the United States, including areas where many people are at risk for hepatitis C,[30] have limited harm reduction services.[31,32]

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[26] Arkansas Center for Health Improvement. 2025. Arkansas All-Payer Claims Database analysis of hepatitis C. https://achi.net/publications/arkansas-all-payer-claims-database-analysis-of-hepatitis-c/.

[27] Substance Abuse and Mental Health Services Administration. 2024. 2021-2022 NSDUH: model-based estimated prevalence for states. https://www.samhsa.gov/data/report/2021-2022-nsduh-state-prevalence-estimates.

[28] Office of National Drug Control Policy. 2024. High Intensity Drug Trafficking Areas Program: 2024 report to Congress. https://bidenwhitehouse.archives.gov/wp-content/uploads/2024/02/2024-HIDTA-Annual-Report-to-Congress.pdf.

[29] Heidari O, Tormohlen K, Dangerfield DT, Tobin KE, Faley JE, Aronowitz SV. 2023. Barriers and facilitators to primary care engagement for people who inject drugs: a systematic review. *J Nurs Scholarsh.* 55(3):605-622. https://doi.org/10.1111/jnu.12863.

[30] Canary L, Hariri S, Campbell C, Young R, Whitcomb J, Kaufman H, Vellozzi C. 2017. Geographic disparities in access to syringe services programs among young persons with hepatitis C virus infection in the United States. *Clin Infect Dis.* 65(3):514-517. https://doi.org/10.1093/cid/cix333.

[31] Des Jarlais DC, Nugent A, Solberg A, Feelemyer J, Mermin J, Holtzman D. 2015. Syringe service programs for persons who inject drugs in urban, suburban, and rural areas – United States, 2013. *MMWR Morb Mortal Wkly Rep.* 64(48):1337-1341. https://doi.org/10.15585/mmwr.mm6448a3.

[32] Whiteman A, Burnett J, Handanagic S, Wejnert C, Broz D, NHBS Study Group. 2020. Distance matters: the association of proximity to syringe services programs with sharing of syringes and injecting equipment – 17 U.S. cities, 2015. *Int J Drug Policy.* 85:102923. https://doi.org/10.1016/j.drugpo.2020.102923.

- There is a large gap between need for substance use treatment and current capacity of the substance use treatment system, leaving many people with no access to effective care for addiction.[33,34]

Reducing the risk of hepatitis C and other infectious diseases among people who inject drugs requires a combination of interventions.[35] Everyone who is at risk should be able to access effective substance use treatment, such as medication for opioid use disorder (MOUD), which helps them get into recovery. If they cannot discontinue drug use, they should receive help and counseling about the risks of shared equipment. If they are already living with hepatitis C, they should be offered prompt DAA treatment.[36,37,38]

Access to this evidence-based preventive care is limited in Arkansas:

- Many Arkansas counties have few or no prescribers who offer MOUD to Medicare and Medicaid patients with opioid use disorder,[39] and many Arkansas Medicaid enrollees with opioid use disorder do not receive MOUD.[40,41] Although it is difficult to measure availability of treatment for methamphetamine use disorder, access to recommended

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[33] Krawczyk N, Rivera BD, Jent V, Keyes KM, Jones CM, Cerdá M. 2022. Has the treatment gap for opioid use disorder narrowed in the U.S.? A yearly assessment from 2010 to 2019. *Int J Drug Policy*. 110:103786. https://doi.org/10.1016/j.drugpo.2022.103786.

[34] Substance Abuse and Mental Health Services Administration. 2024. 2023 NSDUH detailed tables. https://www.samhsa.gov/data/report/2023-nsduh-detailed-tables.

[35] Palmateer N, Hamill V, Bergenstrom A, Bloomfield H, Gordon L, Stone J, Fraser H, Seyler T, Duan Y, Tran R, et al. 2022. Interventions to prevent HIV and hepatitis C among people who inject drugs: latest evidence of effectiveness from a systematic review (2011 to 2020). *Int J Drug Policy*. 109:103872. https://doi.org/10.1016/j.drugpo.2022.103872.

[36] Rich KM, Bia J, Altice FL, Feinberg J. 2018. Integrated models of care for individuals with opioid use disorder: how do we prevent HIV and HCV? *Curr HIV/AIDS Rep*. 15(3):266-275. https://doi.org/10.1007/s11904-018-0396-x.

[37] Schwetz TA, Calder T, Rosenthal E, Kattakuzhy S, Fauci AS. 2019. Opioids and infectious diseases: a converging public health crisis. *J Infect Dis*. 220(3):346-349. https://doi.org/10.1093/infdis/jiz133.

[38] Springer SA, Barocas JA, Wurcel A, Nijhawan A, Thakarar K, Lynfield R, Hurley H, Snowden J, Thornton A, Del Rio C. 2020. Federal and state action needed to end the infectious complications of illicit drug use in the United States: IDSA and HIVMA's advocacy agenda. *J Infect Dis*. 222(Suppl 5):S230-S238. https://doi.org/10.1093/infdis/jiz673.

[39] U.S. Department of Health and Human Services Office of Inspector General. 2024. Medicare and Medicaid enrollees in many high-need areas may lack access to medications for opioid use disorder. https://oig.hhs.gov/reports/all/2024/medicare-and-medicaid-enrollees-in-many-high-need-areas-may-lack-access-to-medications-for-opioid-use-disorder/.

[40] U.S. Department of Health and Human Services Office of Inspector General. 2023. Many Medicaid enrollees with opioid use disorder were treated with medication; however, disparities present concerns. https://oig.hhs.gov/reports/all/2023/many-medicaid-enrollees-with-opioid-use-disorder-were-treated-with-medication-however-disparities-present-concerns/.

[41] Centers for Medicare and Medicaid Services. 2024. 2023 measure performance tables on the Adult Core Set measures. https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html.

services, such as contingency management, is limited[42] and many people with methamphetamine addiction do not receive treatment.[43]

- Most Arkansans who have hepatitis C and a history of substance use disorder likely have not received DAA treatment.[44]

There is an ongoing risk of infectious diseases related to injection drug use in Arkansas.[45] If these gaps in care persist, the state will continue to see transmission of hepatitis C through injection drug use.

Incarceration

Hepatitis C disproportionately impacts people who are currently or formerly incarcerated. Nationwide, an estimated 8.7% of people in state prisons have hepatitis C, which is almost nine times the rate of the general population. In Arkansas, 1,361 of 17,022 inmates in state prison facilities (8.0%) were living with hepatitis C in 2022.[46] Many people in prisons and jails have past or present addiction or substance use disorders, including injection drug use, the primary route of hepatitis C transmission.

Currently, the Arkansas Department of Corrections uses an "opt-out" method for hepatitis C screening. Patients are tested at intake unless they decline. If a patient declines testing, they can be tested at a later date.[47]

Several challenges that are unique to the correctional healthcare system contribute to increased rates of hepatitis C among current and former inmates.

- Pre-Existing Barriers to Care: People in correctional settings are often from marginalized populations with an increased risk of hepatitis C due to socioeconomic factors, limited or no healthcare access, and higher likelihood to participate in high-risk behaviors. Increased education and vigilance about hepatitis C, testing and treatment recommendations, including how to prevent further spread, is necessary in correctional systems. Education about harm reduction measures, such as the risk of shared needles, blood exposure, and non-sterile tattoos, can help reduce the risk of hepatitis C for people who pass through the correctional system.[48]

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[42] U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation. 2023. Contingency management for the treatment of substance use disorders: enhancing access, quality, and program integrity for an evidence-based intervention. https://aspe.hhs.gov/reports/contingency-management-treatment-suds. Contingency management programs offer incentives for negative drug screens.

[43] Substance Abuse and Mental Health Services Administration. 2024. 2023 NSDUH detailed tables. https://www.samhsa.gov/data/report/2023-nsduh-detailed-tables.

[44] Pro et al. 2024.

[45] Gu M. 2021. Prediction of hepatitis C and injection-related diseases in Arkansas. University of Arkansas for Medical Sciences. https://www.proquest.com/openview/d073fffe3c31ad6d785d61abc6cf7584/.

[46] Spaulding et al. 2023.

[47] Wellpath. 2023. HCV management and treatment in ARDOC. Copy on file with Department of Health.

[48] Thornton KA, Deming PD, Archer GRD, Ceniceros JA, Tomedi LE, Selvage D, Jablonski D, Rowan DH, Paul D, Asonganyi W, Arora S. 2024. Expanding hepatitis C virus treatment in the New Mexico state prison system: using the ECHO model for provider and prison peer education. *J Viral Hepat.* 31(11):720-728. https://doi.org/10.1111/jvh.13997.

- Continuity of Care at Entry: When a hepatitis C patient who is currently receiving treatment enters a jail or prison, their treatment regimen can be interrupted if there is not sufficient coordination between the patient's original healthcare provider and the correctional healthcare system. This can lead to treatment failure.[49]

- Continuity of Care at Release: Many Arkansans have limited healthcare access during the transition out of incarceration,[50] and they are at risk of adverse health outcomes, such as drug overdoses.[51] There is also an increased risk of these patients being lost to follow-up or missing medical appointments.

Additional Populations to Consider

- Pregnant Women and Infants: Hepatitis C infections have increased among people of reproductive age, with reported acute cases among people age 20-39 rising more than three-fold nationally between 2010 and 2021.[52] In recent years, approximately 0.4% to 0.5% of U.S. births are to mothers with history of hepatitis C.[53,54] An estimated 5.8% of infants born to women with active hepatitis C infection are infected by mother-to-child transmission if the mother is HIV-negative (10.8% if HIV-positive).[55] From 2019 to 2022, Arkansas reported 11 known cases of perinatal hepatitis C, although this may not represent all infections that occurred in those years.

- People Living with HIV: Hepatitis C is especially challenging for patients who are also living with HIV.[56] Hepatitis C and HIV coinfection occurs because the viruses have similar routes of transmission, especially through injection drug use. A large multistate study

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[49] American Association for the Study of Liver Diseases / Infectious Diseases Society of America. 2023. HCV guidance: recommendations for testing, managing, and treating hepatitis C: monitoring patients who are starting HCV treatment, are on treatment, or have completed therapy. https://www.hcvguidelines.org/evaluate/monitoring.
[50] Centers for Medicare and Medicaid Services. 2024. Arkansas opportunities to test transition-related strategies to support community reentry from incarceration and institutions for mental disease. https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/160061.
[51] Merrall ELC, Kariminia A, Binswanger IA, Hobbs MS, Farrell M, Marsden J, Hutchinson SJ, Bird SM. 2010. Meta-analysis of drug-related deaths soon after release from prison. *Addiction.* 105(9):1545-1554. https://doi.org/10.1111/j.1360-0443.2010.02990.x.
[52] Panagiotakopoulos L, Sandul AL, Conners EE, Foster MA, Nelson NP, Wester C, Collaborators. 2023. CDC recommendations for hepatitis C testing among perinatally exposed infants and children – United States, 2023. *MMWR Recomm Rep.* 72(4):1-21. https://doi.org/10.15585/mmwr.rr7204a1.
[53] Ely DM, Gregory ECW. 2023. Trends and characteristics in maternal hepatitis C virus infection rates during pregnancy: United States, 2016-2021. *Natl Vital Stat Rep.* 72(3):1-11. https://www.cdc.gov/nchs/data/nvsr/nvsr72/nvsr72-03.pdf.
[54] Chen P-H, Johnson L, Limketkai BN, Jusuf E, Sun J, Kim B, Price JC, Woreta TA. 2023. Trends in the prevalence of hepatitis C infection during pregnancy and maternal-infant outcomes in the US, 1998 to 2018. *JAMA Netw Open.* 6(7):e2324770. https://doi.org/10.1001/jamanetworkopen.2023.24770.
[55] Panagiotakopoulos et al. 2023.
[56] Centers for Disease Control and Prevention. 2024. Viral hepatitis among people with HIV. https://www.cdc.gov/hepatitis/hcp/populations-settings/hiv.html.

estimated that 6.7% of all people living with HIV in the U.S. in 2014 also had hepatitis C,[57] and in HIV outbreaks associated with injection drug use during 2014-21, most patients had hepatitis C.[58] (Although less common, hepatitis C can also be transmitted through unprotected sex.[59]) Coinfection with HIV and hepatitis C increases the progression of liver disease, putting patients at higher risk of liver-related morbidity and mortality.[60]

- Rural Populations: Over 40% of Arkansans live in rural areas of the state,[61] where there is often limited healthcare access. Rural areas face shortages of general practitioners[62] and physicians in many specialties.[63] Current hepatitis C prior authorization requirements in some insurance plans, including fee-for-service Arkansas Medicaid, require a specialist such as a gastroenterologist, hepatologist, or infectious disease physician to write prescriptions for DAA treatment.[64] People in rural areas may have to travel long distances to see a doctor who can treat or monitor hepatitis C, which limits access to care.[65]

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[57] Bosh KA, Coyle JR, Hansen V, Kim EM, Speers S, Comer M, Maddox LM, Khuwaja S, Zhou W, Jatta A, et al. 2018. HIV and viral hepatitis coinfection analysis using surveillance data from 15 US states and two cities. *Epidemiol Infect*. 146(7):920-930. https://doi.org/10.1017/s0950268818000766.

[58] Moorman AC, Bixler D, Teshale EH, Hofmeister M, Roberts H, Chapin-Bardales J, Gupta N. 2023. Hepatitis C virus-HIV coinfection in the United States among people who inject drugs: data needed for ending dual epidemics. *Public Health Rep*. Online ahead of print. https://doi.org/10.1177/00333549231181348.

[59] Chan DPC, Sun H-Y, Wong HTH, Lee S-S, Hung C-C. 2016. Sexually acquired hepatitis C virus infection: a review. *Int J Infect Dis*. 49:47-58. https://doi.org/10.1016/j.ijid.2016.05.030.

[60] Graham CS, Baden LR, Yu E, Mrus JM, Carnie J, Heeren T, Koziel MJ. 2001. Influence of human immunodeficiency virus infection on the course of hepatitis C virus infection: a meta-analysis. *Clin Infect Dis*. 33(4):562-569. https://doi.org/10.1086/321909.

[61] U.S. Census Bureau. 2023. Urban and rural: state-level 2020 and 2010 Census urban and rural information for the U.S., Puerto Rico, and island areas sorted by state FIPS code. https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html.

[62] Arkansas Center for Health Improvement. 2023. Profile of the primary care physician workforce in Arkansas. https://achi.net/arkansas-healthcare-workforce/.

[63] Brock M, Jones S, Al-Mousawi H, Lehing L, Courtney J. 2024. Arkansas health professions manpower statistics 2022. Arkansas Department of Health. https://healthy.arkansas.gov/wp-content/uploads/Manpower-Report-2022.pdf.

[64] Arkansas Medicaid Prescription Drug Program. 2024. Hepatitis C virus (HCV) medication therapy request sheet. https://ar.primetherapeutics.com/documents/268611/269351/Hepatitis%20C%20Virus%20Medication%20Therapy%20Request%20Form/b0b28e2d-f05a-ea1d-16a4-6c0502aa4a8d.

[65] Gordon SC. 2018. Hepatitis C virus detection and treatment in rural communities. *Gastroenterol Hepatol (N Y)*. 14(12):720-722. https://pmc.ncbi.nlm.nih.gov/articles/PMC6383161/.

Change Makers

Arkansas's healthcare providers, insurers, community-based organizations, substance use treatment providers, and correctional facilities are key stakeholders in this effort. They can promote testing and prevention, expand access to treatment, and provide other needed healthcare. Collaboration among all stakeholders will advance progress toward eliminating hepatitis C. These sections outline how each group can contribute to elimination, strategies to reduce the burden of hepatitis C, and how the Department of Health can support elimination efforts.

Public Health

The Infectious Disease Branch at the Arkansas Department of Health has statewide responsibility for promoting hepatitis C screening, testing and prevention efforts as well as collecting data to monitor Arkansas's progress toward hepatitis C elimination. Local Health Units in each county provide hepatitis C testing and education. The Department will continue to share information about hepatitis C testing and treatment, collect and publish reliable data about the hepatitis C epidemic, and maintain the capacity to respond to outbreaks and clusters.

Healthcare Providers

Health systems and individual providers, including primary care doctors, specialists, and advanced practice registered nurses, provide essential healthcare in hospital, outpatient, correctional, substance use treatment, and other clinical settings and can make a critical difference in healthcare quality. Providers should follow guidelines for universal hepatitis C testing and treatment and offer patient-centered care that addresses both viral hepatitis and other related health needs. Along with clinical providers, administrators, laboratorians, and others have important roles in guaranteeing access to appropriate healthcare.

Insurers

Insurance coverage is essential for patients to access hepatitis C treatment. Insurance carriers should ensure that their coverage of hepatitis C testing, treatment, and management guarantees access to medically necessary care. They can evaluate their coverage criteria, benefit design, and provider networks to ensure that patients do not face financial or logistical barriers to hepatitis C treatment. Payers for hepatitis C medicines should negotiate with manufacturers to get the best possible price for DAAs, protecting the financial sustainability of their prescription drug coverage.

Community-Based Organizations

Community-based organizations provide free hepatitis C testing and educate the public on hepatitis C screening, treatment, and prevention. They are important partners in planning elimination efforts for hepatitis C and other diseases such as HIV and STIs. Community-based organizations should seek to expand outreach and support to more Arkansans who need help accessing preventive care and hepatitis C treatment.

Substance Use Treatment Providers

Many people who have hepatitis C are living with current or past substance use disorders, and substance use treatment facilities may be their first or only point of contact with the healthcare system. Substance use treatment providers should identify ways to incorporate low-barrier care for

hepatitis C and other infectious diseases into their practice and offer referrals for any care that cannot be provided on site.

Correctional Facilities

Many people in prisons and jails are living with hepatitis C. Currently, they often pass through the correctional system without being treated, but prisons and jails are well positioned to diagnose and treat hepatitis C, because patients are unlikely to be lost to follow-up and correctional healthcare has access to low prices for DAAs. Correctional facilities should consider scaling up testing and treatment and ensure they follow clinical guidelines, and they can also contribute to hepatitis C prevention and education efforts, with direct benefits for inmates and the broader community.

Elimination Strategies

1. Education

Education is crucial to hepatitis C elimination. Patients and the public need high-quality, accessible information about the hepatitis C virus, how it is spread, the disease it causes, and the benefits of consistent prevention measures, early testing, and early treatment. This information should be available to everyone, especially regarding universal hepatitis C testing recommendations, but it is especially important for people who have an undiagnosed hepatitis C infection. Access to continuing education about hepatitis C testing, management, and treatment is also important for providers so they have the resources needed to address hepatitis C in their clinical practice.

1.1. Offer patient and public education

Hepatitis C education can reduce stigma about the disease and provide factual information that helps people take action to protect their health. There are important messages for the general public, for people who are at increased risk of hepatitis C, and for patients with a current hepatitis C infection.

Education for the general public should begin with the universal adult hepatitis C testing recommendation endorsed by the Centers for Disease Control and Prevention (CDC) and the U.S. Preventive Services Task Force (USPSTF).[66,67] An estimated 32% of U.S. adults living with hepatitis C do not know about their infections,[68] so it is important to make everyone aware of the availability and benefits of early testing. Patients should be also informed that hepatitis C is curable if diagnosed so that they understand the rationale for offering universal testing.

Although it applies to everyone, the testing recommendation is especially important for people who might be at increased risk of hepatitis C, including people who have injected drugs, who received a blood transfusion or organ transplant before 1992, or who are living with HIV. Providers and community organizations can refer to CDC's list of hepatitis C risk factors[69] to determine who might be at increased risk. Reaching people in these groups with the testing recommendation is a priority because many of them have undiagnosed hepatitis C infections. People who have ongoing risk of exposure to hepatitis C, such as injection drug use or kidney dialysis, should be informed about the need for periodic repeated testing.

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[66] Schillie S, Wester C, Osborne M, Wesolowski L, Ryerson AB. 2020. CDC recommendations for hepatitis C screening among adults – United States, 2020. *MMWR Recomm Rep*. 69(2):1-17. https://doi.org/10.15585/mmwr.rr6902a1.

[67] US Preventive Services Task Force, Owens DK, Davidson KW, Krist AH, Barry MJ, Cabana M, Caughey AB, Donahue K, Doubeni CA, Epling JW, et al. 2020. Screening for hepatitis C virus infection in adolescents and adults: US Preventive Services Task Force recommendation statement. *JAMA*. 323(10):970-975. https://doi.org/10.1001/jama.2020.1123.

[68] Lewis KC, Barker LK, Jiles RB, Gupta N. 2023. Estimated prevalence and awareness of hepatitis C virus infection among US adults: National Health and Nutrition Examination Survey, January 2017-March 2020. *Clin Infect Dis*. 77(10):1413-1415. https://doi.org/10.1093/cid/ciad411.

[69] Centers for Disease Control and Prevention. 2023. Testing for hepatitis C. https://www.cdc.gov/hepatitis-c/testing/index.html.

Most new hepatitis C infections are the result of injection drug use, and hepatitis C can be very stigmatized as a result. A primary goal of patient and public education is to reduce this stigma and provide information that helps people protect themselves. Hepatitis C education campaigns should inform people who have ongoing risk of exposure, such as injection drug use, about how the infection is transmitted and how they can protect themselves. Because there is no vaccine, the best way to prevent hepatitis C is to avoid exposures to other people's blood. For those who are injecting drugs, effective substance use treatment, such as MOUD, also reduces the risk of hepatitis C.[70] Patients should be offered help with finding substance use treatment, such as the directories available from the Substance Abuse and Mental Health Services Administration[71] and the Arkansas Department of Human Services.[72] A summary of prevention strategies is available from CDC; another key recommendation is that people who are injecting drugs should always use sterile equipment.[73]

For people who are already living with hepatitis C, the primary goal of education is to help them access DAA treatment. Many patients may be unaware of DAA treatment or uncertain how to access it, even if they are in groups that are frequently targeted by hepatitis C messaging, such as people who inject drugs.[74,75] Some patients may need information about the effectiveness of DAAs; others may need information that will help them navigate the healthcare system, such as signing up for insurance or finding a provider who can prescribe hepatitis C treatment.

Providers, community-based organizations, and others who are carrying out hepatitis C education campaigns may benefit from using existing resources. The Division of Viral Hepatitis at CDC[76] and the National Institute of Diabetes and Digestive and Kidney Diseases at the National Institutes of Health[77] have web pages that address many frequently asked questions about hepatitis C. CDC also provides a number of posters, flyers, and fact sheets that are free to reproduce.[78] The Infectious Disease Branch at the Department of Health provides information about hepatitis C testing,

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[70] Platt L, Minozzi S, Reed J, Vickerman P, Hagan H, French C, Jordan A, Degenhardt L, Hope V, Hutchinson S, et al. 2017. Needle syringe programs and opioid substitution therapy for preventing hepatitis C transmission in people who inject drugs. *Cochrane Database Syst Rev*. 9(9):CD012021. https://doi.org/10.1002/14651858.cd012021.pub2.

[71] Substance Abuse and Mental Health Services Administration. 2024. FindTreatment.gov. https://findtreatment.gov/.

[72] Arkansas Department of Human Services. 2024. DAABHS substance abuse treatment services: catchment areas, funded contractors. https://humanservices.arkansas.gov/divisions-shared-services/shared-services/office-of-substance-abuse-and-mental-health/samh-treatment/; https://humanservices.arkansas.gov/wp-content/uploads/CSAT-8-Funded-Providers-Map-Updated.10.2024.pdf.

[73] Centers for Disease Control and Prevention. 2024. Hepatitis C prevention and control. https://www.cdc.gov/hepatitis-c/prevention/index.html.

[74] Falade-Nwulia O, Irvin R, Merkow A, Sulkowski M, Niculescu A, Olsen Y, Stoller K, Thomas DL, Latkin C, Mehta SH. 2019. Barriers and facilitators of hepatitis C treatment uptake among people who inject drugs enrolled in opioid treatment programs in Baltimore. *J Subst Abuse Treat*. 100:45-51. https://doi.org/10.1016/j.jsat.2019.01.021.

[75] Balsom CR, Farrell A, Kelly DV. 2023. Barriers and enablers to testing for hepatitis C virus infection in people who inject drugs – a scoping review of the qualitative evidence. *BMC Public Health*. 23(1):1038. https://doi.org/10.1186/s12889-023-16017-8.

[76] Centers for Disease Control and Prevention. 2024. Hepatitis C. https://www.cdc.gov/hepatitis-c/index.html.

[77] National Institutes of Health. 2020. Hepatitis C. https://www.niddk.nih.gov/health-information/liver-disease/viral-hepatitis/hepatitis-c.

[78] Centers for Disease Control and Prevention. 2024. Hepatitis C public resources. https://www.cdc.gov/hepatitis-c/public-resources/index.html.

treatment, and prevention online,[79] with answers to frequently asked questions available in Spanish and Marshallese. ADH offers a resource guide that includes information about Arkansas healthcare providers who can treat hepatitis C and advice for how to cover the costs of DAAs.[80] Anyone who has a question about hepatitis C that is not answered by these existing resources is encouraged to contact the Department of Health for more information.

1.2. Increase education in high-prevalence settings

Education about hepatitis C prevention, testing, and treatment is very important in settings that serve large numbers of people who are at risk of hepatitis C, or already living with hepatitis C, such as correctional facilities and substance use treatment facilities.

Many people in prisons and jails either have hepatitis C[81] or are at risk of hepatitis C because of an ongoing substance use disorder. In 2007-09, an estimated 58% of state prisoners and 63% of sentenced jail inmates nationwide met then-current diagnostic criteria for drug dependence or abuse.[82] Although there are unique considerations for preventing, diagnosing, and treating hepatitis C in prisons and jails, correctional healthcare providers and program planners can offer patient education founded on setting-specific guidance from the American Association for the Study of Liver Diseases and the Infectious Diseases Society of America (AASLD/IDSA),[83] the University of Washington,[84] CDC,[85] and the Federal Bureau of Prisons.[86] Evidence from the New Mexico Corrections Department suggests that a successful hepatitis C education program in the correctional setting should involve peer educators as active participants and broad access to DAA treatment in accordance with clinical guidelines.[87,88]

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[79] Arkansas Department of Health. 2023. Hepatitis C. https://healthy.arkansas.gov/programs-services/diseases-conditions/infectious-disease/hepatitis-c/.

[80] Arkansas Department of Health. 2022. Statewide hepatitis C resources and services. https://healthy.arkansas.gov/wp-content/uploads/Hep_C_Resource_Guide.pdf.

[81] Spaulding AC, Kennedy SS, Osei J, Sidibeh E, Batina IV, Chhatwal J, Akiyama MJ, Strick LB. 2023. Estimates of hepatitis C seroprevalence and viremia in state prison populations in the United States. *J Infect Dis*. 228(Suppl 3):S160-S167. https://doi.org/10.1093/infdis/jiad227.

[82] Bronson J, Stroop J, Zimmer S, Berzofsky M. 2017. Drug use, dependence, and abuse among state prisoners and jail inmates, 2007-2009. Bureau of Justice Statistics. NCJ # 250546. https://bjs.ojp.gov/library/publications/drug-use-dependence-and-abuse-among-state-prisoners-and-jail-inmates-2007-2009.

[83] American Association for the Study of Liver Diseases / Infectious Diseases Society of America. 2023. HCV guidance: recommendations for testing, managing, and treating hepatitis C: HCV testing and treatment in correctional settings. https://www.hcvguidelines.org/unique-populations/correctional.

[84] University of Washington. 2024. Hepatitis C online: treatment of HCV in a correctional setting. https://www.hepatitisc.uw.edu/go/key-populations-situations/treatment-corrections/core-concept/all.

[85] Centers for Disease Control and Prevention. 2024. Summary of CDC recommendations for correctional settings. https://www.cdc.gov/correctional-health/recommendations/index.html.

[86] Federal Bureau of Prisons. 2021. Evaluation and management of hepatitis C virus (HCV) infection: Federal Bureau of Prisons clinical guidance. https://www.bop.gov/resources/pdfs/hcv_guidance.20210513.pdf.

[87] Thornton K, Sedillo ML, Kalishman S, Page K, Arora S. 2018. The New Mexico peer education project: filling a critical gap in HCV prison education. *J Health Care Poor Underserved*. 29(4):1544-1557. https://doi.org/10.1353/hpu.2018.0111.

[88] Thornton KA, Deming PD, Archer GRD, Ceniceros JA, Tomedi LE, Selvage D, Jablonski D, Rowan DH, Paul D, Asonganyi W, Arora S. 2024. Expanding hepatitis C virus treatment in the New Mexico state prison system: using the ECHO model for provider and prison peer education. *J Viral Hepat*. 31(11):720-728. https://doi.org/10.1111/jvh.13997.

Because so many hepatitis C patients are exposed through injection drug use, outreach at substance use treatment facilities is a critical component of education initiatives, and potentially an efficient way to reach many people who are at risk of hepatitis C or living with undiagnosed infections. Substance use treatment programs licensed by the state Department of Human Services are also required to provide "HIV/AIDS, STD, Hepatitis, and TB education per admission" as a condition of licensure.[89] Guidance is available from the Substance Abuse and Mental Health Services Administration.[90] In addition to standard messages about hepatitis C prevention, testing, and treatment, clients at substance use treatment facilities can be informed that successful treatment engagement, such as participation in MOUD treatment, can reduce the risk of bloodborne infections including hepatitis C.[91] Patients who have current hepatitis C should be advised that they can be treated and cured. DAAs are effective in people who have substance use disorders,[92,93,94] recent or current substance use should not prevent DAA treatment,[95] and many insurers, such as Arkansas Medicaid, have ended policies that previously required patients to be abstinent from substance use before receiving DAAs.[96]

Providers, community-based organizations, and others who are interested in providing improved hepatitis C education in high-prevalence settings can contact the Department of Health. The Department offers technical support and Arkansas-relevant data on hepatitis C and, whenever possible, it will assist to help organize new education programs. The Infectious Disease Branch also offers free training on hepatitis C antibody testing and counseling in a course that also covers HIV and STIs.[97]

1.3. Offer provider education

Healthcare providers in many specialties, across all parts of the state, are essential partners in the effort to reduce hepatitis C. Studies have shown that primary care providers are well qualified to

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[89] Arkansas Department of Human Services. 2020. Licensure standards for alcohol and other drug abuse treatment programs. https://humanservices.arkansas.gov/wp-content/uploads/Licensure_Standards_for_Alcohol_and_Other_Drug_Abuse_Treatment_Programs.pdf.

[90] Substance Abuse and Mental Health Services Administration. 2021. Screening and treatment of viral hepatitis in people with substance use disorders. https://store.samhsa.gov/sites/default/files/pep20-06-04-004.pdf.

[91] Platt L, Minozzi S, Reed J, Vickerman P, Hagan H, French C, Jordan A, Degenhardt L, Hope V, Hutchinson S, et al. 2017. Needle syringe programs and opioid substitution therapy for preventing hepatitis C transmission in people who inject drugs. *Cochrane Database Syst Rev*. 9(9):CD012021. https://doi.org/10.1002/14651858.cd012021.pub2.

[92] Norton BL, Akiyama MJ, Agyemang L, Heo M, Pericot-Valverde I, Litwin AH. 2020. Low adherence achieves high HCV cure rates among people who inject drugs treated with direct-acting antiviral agents. *Open Forum Infect Dis*. 7(10):ofaa377. https://doi.org/10.1093/ofid/ofaa377.

[93] Kramer JR, Puenpatom A, Cao Y, Yu X, El-Serag HB, Kanwal F. 2022. Treatment of hepatitis C virus infection in people with opioid use disorder: a real-world study of elbasvir/grazoprevir in a US Department of Veterans Affairs population. *Am J Drug Alcohol Abuse*. 48(4):445-453. https://doi.org/10.1080/00952990.2021.1983821.

[94] Litwin AH, Lum PJ, Taylor LE, Mehta SH, Tsui JI, Feinberg J, Kim AY, Norton BL, Heo M, Arnsten J, et al. 2022. Patient-centred models of hepatitis C treatment for people who inject drugs: a multicentre, pragmatic randomised trial. *Lancet Gastroenterol Hepatol*. 7(12):1112-1127. https://doi.org/10.1016/s2468-1253(22)00275-8.

[95] American Association for the Study of Liver Diseases / Infectious Diseases Society of America. 2023. HCV guidance: recommendations for testing, managing, and treating hepatitis C: key populations: identification and management of HCV in people who inject drugs. https://www.hcvguidelines.org/unique-populations/pwid.

[96] Arkansas Medicaid Prescription Drug Program. 2024. Hepatitis C virus (HCV) medication therapy request sheet. https://ar.primetherapeutics.com/documents/268611/269351/Hepatitis%20C%20Virus%20Medication%20Therapy%20Request%20Form/b0b28e2d-f05a-ea1d-16a4-6c0502aa4a8d.

[97] Arkansas Department of Health. 2023. Hepatitis C prevention. https://healthy.arkansas.gov/programs-services/prevention-healthy-living/hepatitis-c-prevention/.

treat hepatitis C with appropriate training,[98,99] and low-barrier access to hepatitis C care, such as through primary care, increases rates of successful treatment.[100,101] Providers need access to current information about hepatitis C prevention, testing, management, and treatment so they are prepared to address the disease in their clinical practices. Continuing education is available from a variety of state and national sources.

A comprehensive clinical practice guideline for hepatitis C is available from AASLD/IDSA.[102] The AASLD/IDSA recommendations are regularly updated and address many stages of hepatitis C care, with advice for testing, diagnosis, treatment workup and DAA regimen selection, on-treatment monitoring, and management of complications and medication issues. The University of Washington also has a website that summarizes clinical guidelines for hepatitis C, supplemented with case examples and self-study modules that qualify for continuing education credits in several specialties.[103]

These resources can be used to organize a clinic or health system's hepatitis C training, or guide provider self-study. They may also be a useful reference for experienced providers who want to refresh their knowledge about a specific clinical issue. Among the state's Federally Qualified Health Centers, the ARcare network has implemented extensive programs for hepatitis C provider training[104] and linkage to care.[105,106] Providers and health systems who are interested in strengthening their hepatitis C training and care can contact ARcare for additional information.

Individual advice about hepatitis C cases is available for free, five days a week, from the peer-to-peer clinician phone line at the University of California, San Francisco National Clinician Consultation Center (NCCC).[107] NCCC providers are available to help interpret practice guidelines and provide suggestions on more complex issues such as HIV and hepatitis C coinfection or drug-drug interactions.

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[98] Kattakuzhy S, Gross C, Emmanuel B, Teferi G, Jenkins V, Silk R, Akoth E, Thomas A, Ahmed C, Espinosa M, et al. 2017. Expansion of treatment for hepatitis C virus infection by task shifting to community-based nonspecialist providers: a nonrandomized clinical trial. *Ann Intern Med.* 167(5):311-318. https://doi.org/10.7326/m17-0118.

[99] Stanley K, Bowie BH. 2021. Comparison of hepatitis C treatment outcomes between primary care and specialty care. *J Am Assoc Nurse Pract.* 34(2):292-297. https://doi.org/10.1097/jxx.0000000000000621.

[100] Wade AJ, Doyle JS, Gane E, Stedman C, Draper B, Iser D, Roberts SK, Kemp W, Petrie D, Scott N, et al. 2020. Outcomes of treatment for hepatitis C in primary care, compared to hospital-based care: a randomized, controlled trial in people who inject drugs. *Clin Infect Dis.* 70(9):1900-1906. https://doi.org/10.1093/cid/ciz546.

[101] Eckhardt B, Mateu-Gelabert P, Aponte-Melendez Y, Fong C, Kapadia S, Smith M, Edlin BR, Marks KM. 2022. Accessible hepatitis C care for people who inject drugs: a randomized clinical trial. *JAMA Intern Med.* 182(5):494-502. https://doi.org/10.1001/jamainternmed.2022.0170.

[102] American Association for the Study of Liver Diseases / Infectious Diseases Society of America. 2023. HCV guidance: recommendations for testing, managing, and treating hepatitis C. https://www.hcvguidelines.org/.

[103] University of Washington. 2024. Hepatitis C online. https://www.hepatitisc.uw.edu/.

[104] Rhew T. 2022. Assessment of screening, knowledge, self-efficacy, and barriers in hepatitis C: comparison of survey results before and after educating providers. Delta State University. Copy on file with Department of Health.

[105] Blum K. 2023. Pharmacy technician links patients with hepatitis C to care. *ASHP News Center.* American Society of Health-System Pharmacists. https://news.ashp.org/news/feature-stories/2023/08/16/pharmacy-technician-links-patients-with-hepatitis-c-to-care.

[106] Carney K. 2023. Pharmacy technicians as patient navigators in hepatitis C linkage services. American Society of Health-System Pharmacists. https://www.ashp.org/pharmacy-practice/pai/pai-case-studies/arcare.

[107] University of California, San Francisco. 2024. Hepatitis C management. https://nccc.ucsf.edu/clinician-consultation/hepatitis-c-management/.

In Arkansas, educational sessions about hepatitis C are planned as part of the Project ECHO (Extension for Community Healthcare Outcomes) meeting series sponsored by ARcare and the South-Central AIDS Education and Training Center (SCAETC). Project ECHO meetings are free to attend, usually held online during lunch, and open to any interested provider. ARcare anticipates offering sessions on hepatitis C testing and treatment during 2025, and providers can register at the SCAETC website.[108] New Project ECHO agenda items can be added by provider request. Any provider who would like to request Project ECHO sessions on a specific topic should contact ARcare or the Department of Health. The Department of Health also intends to increase the provider information available on its hepatitis C webpages, with a focus on practice guidelines, related treatment information for conditions such as HIV, STIs, and substance use disorders (SUD), and information about hepatitis C drug costs and coverage.

Practice guidance is also available for HIV,[109] STIs,[110] opioid[111] and stimulant[112] use disorders. Because many hepatitis C patients are also at risk for one or more of these conditions, these resources may be helpful for hepatitis C providers. Providers are encouraged to consider opportunities to treat co-occurring conditions simultaneously when treating hepatitis C. Further information is available by contacting the Department of Health's HIV Prevention,[113] STD Prevention,[114] or Substance Misuse and Injury Prevention[115] programs. Arkansas providers who want to offer MOUD in their practice can contact the Psychiatric Research Institute (PRI) at UAMS. Through the Medication-Assisted Treatment Recovery Initiative for Arkansas Rural Communities (MATRIARC), PRI provides free clinician consultations five days a week[116] and weekly Project ECHO conferences[117] on opioid use disorder treatment. PRI also has dedicated grant funding to support providers who offer MOUD, in partnership with the Department of Human Services. Application information is available on the PRI website.[118]

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[108] South Central AIDS Education and Training Center. 2024. Education and training: calendar. https://hsc.unm.edu/scaetc/education-training/calendar.html.
[109] HIV.gov. 2024. Clinical guidelines. https://clinicalinfo.hiv.gov/en/guidelines.
[110] Centers for Disease Control and Prevention. 2023. Sexually transmitted infections treatment guidelines, 2021. https://www.cdc.gov/std/treatment-guidelines/default.htm.
[111] American Society of Addiction Medicine. 2020. The ASAM national practice guideline for the treatment of opioid use disorder: 2020 focused update. *J Addict Med.* 14(2S Suppl 1):1-91. https://doi.org/10.1097/adm.0000000000000633.
[112] American Society of Addiction Medicine / American Academy of Addiction Psychiatry. 2024. The ASAM/AAAP clinical practice guideline on the management of stimulant use disorder. *J Addict Med.* 18(1S Suppl 1):1-56. https://doi.org/10.1097/adm.0000000000001299.
[113] Arkansas Department of Health. 2024. HIV prevention. https://healthy.arkansas.gov/programs-services/prevention-healthy-living/hiv-prevention/.
[114] Arkansas Department of Health. 2024. STD prevention. https://healthy.arkansas.gov/programs-services/diseases-conditions/infectious-disease/std-prevention/.
[115] Arkansas Department of Health. 2024. Substance misuse & injury prevention. https://healthy.arkansas.gov/programs-services/prevention-healthy-living/substance-misuse-injury-prevention/.
[116] University of Arkansas for Medical Sciences. 2024. MATRIARC. https://psychiatry.uams.edu/clinical-care/outpatient-care/cast/matriarc/.
[117] University of Arkansas for Medical Sciences. 2024. MATRIARC: Project ECHO. https://psychiatry.uams.edu/clinical-care/outpatient-care/cast/matriarc/project-echo/.
[118] University of Arkansas for Medical Sciences. 2024. Improving access to treatment for opioid use disorder. https://psychiatry.uams.edu/clinical-care/outpatient-care/cast/improving-access-to-treatment-for-opioid-use-disorder/.

2. Testing

Diagnostic testing is very important to prevent the spread of hepatitis C, so that patients can know their status and take action to avoid new transmission. Complete testing is the first step in linkage to hepatitis C treatment. To reach the broadest possible group of patients, hepatitis C testing should be made available in a wide variety of settings and in accordance with universal testing guidelines. Prompt access to reliable testing is especially necessary for people who are at increased risk of infection, such as by injection drug use.

2.1. Implement universal offer of testing

CDC and USPSTF recommend hepatitis C testing for all adults age 18-79, even if they do not have known risk factors.[119,120] Many patients acquired hepatitis C long ago, such as through blood transfusions and organ transplants in the 1980s, and may not know about their infections today; others may not disclose risk factors such as injection drug use to their healthcare providers. For these reasons, previous risk-based hepatitis C screening guidance did not identify all infections, leaving many people undiagnosed.

Hospitals, primary care providers, and other healthcare providers should offer universal adult hepatitis C testing wherever it is clinically feasible, and they can incentivize testing uptake using internal quality measures or electronic health record (EHR) reminders. Studies have shown that provider- and practice-level interventions, such as default orders for hepatitis C testing if screening guidelines are met, can increase testing uptake.[121,122,123] Providers and health systems can use this growing evidence base to tailor the implementation of these universal screening recommendations for their practices. Providers should also repeat hepatitis C testing periodically for patients who have ongoing risk exposures, such as injection drug use or needlestick injuries. Health systems that are interested in implementing hepatitis C screening as a formal quality measure can refer to

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[119] Schillie S, Wester C, Osborne M, Wesolowski L, Ryerson AB. 2020. CDC recommendations for hepatitis C screening among adults – United States, 2020. *MMWR Recomm Rep*. 69(2):1-17. https://doi.org/10.15585/mmwr.rr6902a1.

[120] US Preventive Services Task Force, Owens DK, Davidson KW, Krist AH, Barry MJ, Cabana M, Caughey AB, Donahue K, Doubeni CA, Epling JW, et al. 2020. Screening for hepatitis C virus infection in adolescents and adults: US Preventive Services Task Force recommendation statement. *JAMA*. 323(10):970-975. https://doi.org/10.1001/jama.2020.1123.

[121] Yartel AK, Rein DB, Brown KA, Krauskopf K, Massoud OI, Jordan C, Kil N, Federman AD, Nerenz DR, Brady JE, et al. 2018. Hepatitis C virus testing for case identification in persons born during 1945-1965: results from three randomized controlled trials. *Hepatology*. 67(2):524-533. https://doi.org/10.1002/hep.29548.

[122] Mehta SJ, Day SC, Norris AH, Sung J, Reitz C, Wollack C, Snider CK, Shaw PA, Asch DA. 2021. Behavioral interventions to improve population health outreach for hepatitis C screening: randomized clinical trial. *BMJ*. 373:n1022. https://doi.org/10.1136/bmj.n1022.

[123] Mehta SJ, Torgersen J, Small DS, Mallozzi CP, McGreevey JD, Rareshide CAL, Evans CN, Epps M, Stabile D, Snider CK, Patel MS. 2022. Effect of a default order vs an alert in the electronic health record on hepatitis C virus screening among hospitalized patients: a stepped-wedge randomized clinical trial. *JAMA Netw Open*. 5(3):e222427. https://doi.org/10.1001/jamanetworkopen.2022.2427.

guidance from the Centers for Medicare and Medicaid Services (CMS) on universal adult screening[124] and annual screening for people who inject drugs.[125]

The Department of Health offers hepatitis C testing at all Local Health Units.[126] In accordance with the universal screening recommendation, patients at most types of Local Health Unit visits are offered hepatitis C testing by default; testing is also available by appointment. The Department also sponsors community organizations that offer hepatitis C testing[127] and, in some cases, it is able to accept hepatitis C samples from outside submitters at the Public Health Laboratory. Providers who need help making hepatitis C testing available to their patients and/or submitting samples to the Public Health Laboratory can contact the Department of Health for assistance.

2.2. Use a one-visit testing strategy

Hepatitis C testing is usually a two-step process. A test for hepatitis C antibodies shows whether the patient has ever been exposed to hepatitis C; if the antibody result is positive, the patient is tested for hepatitis C RNA, which shows whether they are currently infected. Only people who have positive hepatitis C RNA are capable of transmitting the virus, or in need of treatment. If the initial antibody testing and the subsequent RNA testing are offered at different appointments, patients may be lost to follow-up before receiving an RNA test, which means they will not know whether they are currently infected.

Every patient with positive hepatitis C antibody should have access to an RNA test to complete diagnosis, without needing to return for a second visit. Testing approaches that require patients with positive hepatitis C antibody to return for a second clinic visit should be avoided, because this can cause loss to follow-up. Providers, community organizations, and others who are providing or sponsoring hepatitis C testing should ensure this by using one-visit testing approaches. Guidance is available from CDC outlining ways to implement this recommendation.[128] One common approach is reflex testing, where if the hepatitis C antibody result is positive, blood from the same sample is used to complete RNA testing. Reflex testing should usually be the default hepatitis C test order in laboratory catalogs and electronic health records; it is already implemented in some health systems, such as the Department of Veterans Affairs,[129] and at the state Public Health Laboratory.[130] In some settings, especially outside traditional medical facilities, providers

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[124] Centers for Medicare and Medicaid Services. 2023. Quality ID #400: one-time screening for hepatitis C virus (HCV) and treatment initiation [version 8.0]. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2024_Measure_400_MIPSCQM.pdf.

[125] Centers for Medicare and Medicaid Services. 2023. Quality ID #387: annual hepatitis C virus (HCV) screening for patients who are active injection drug users [version 8.0]. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2024_Measure_387_MIPSCQM.pdf.

[126] Arkansas Department of Health. 2024. Health Units. https://healthy.arkansas.gov/health-units/.

[127] Arkansas Department of Health. 2023. Hepatitis C prevention. https://healthy.arkansas.gov/programs-services/prevention-healthy-living/hepatitis-c-prevention/.

[128] Cartwright EJ, Patel P, Kamili S, Wester C. 2023. Updated operational guidance for implementing CDC's recommendations on testing for hepatitis C virus infection. *MMWR Morb Mortal Wkly Rep.* 72(28):766-768. https://doi.org/10.15585/mmwr.mm7228a2.

[129] U.S. Department of Veterans Affairs. 2018. Laboratory tests: hepatitis C. https://www.hepatitis.va.gov/hcv/screening-diagnosis/laboratory-tests.asp.

[130] Arkansas Department of Health. 2024. Glen F. Baker Public Health Laboratory: directory of service. https://healthy.arkansas.gov/wp-content/uploads/DOS_for_Public.pdf.

may also consider using newly approved point-of-care tests for hepatitis C RNA, which prevent the need for a two-step testing process by offering patients a hepatitis C RNA result at the initial testing visit. CDC has published guidance that can help providers identify situations where point-of-care hepatitis C RNA testing may be appropriate.[131]

2.3. Increase testing in high-prevalence settings

Although hepatitis C testing should be made available to everyone age 18-79, per CDC/USPSTF guidance, the value of testing is especially high in settings where patients at high risk of hepatitis C frequently receive healthcare, such as substance use disorder clinics and correctional facilities. Providers in these settings should place special emphasis on making universal, opt-out hepatitis C testing available. The Department of Corrections offers universal hepatitis C testing at intake,[132] and the Department of Human Services licensure standards for drug and alcohol rehabilitation facilities require them to offer testing for HIV, viral hepatitis, STIs, and tuberculosis, either on-site or by referral.[133] Many people starting treatment for opioid use disorder do not receive hepatitis C testing,[134,135] and many substance use treatment facilities report that they have little or no ability to provide hepatitis C tests.[136] Although hepatitis C testing may be offered less often in county jails than in state prisons, because they tend to have fewer healthcare resources, they may also be a suitable setting to test for hepatitis C, since the prevalence of hepatitis C infections among people who pass through jails is high.[137,138]

Providers in correctional or substance use clinics should strive to make hepatitis C testing universally available, even if they are not currently covered by a policy or licensure standard that requires it, and to simplify the testing process so that patients do not need to complete a referral from one facility to another to receive testing. The Department of Health is available to provide technical assistance to providers implementing hepatitis C testing and, in some cases, may be able to accept samples for testing at the Public Health Laboratory.

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[131] Centers for Disease Control and Prevention. 2024. Considerations for the implementation of point-of-care testing for the diagnosis of hepatitis C virus infection. https://stacks.cdc.gov/view/cdc/164804.

[132] Arkansas Department of Corrections. 2024. Request for proposal DOC-24-004: comprehensive medical services. https://arbuy.arkansas.gov/bso/external/bidDetail.sdo?docId=S000000285.

[133] Arkansas Department of Human Services. 2020. Licensure standards for alcohol and other drug abuse treatment programs. https://humanservices.arkansas.gov/wp-content/uploads/Licensure_Standards_for_Alcohol_and_Other_Drug_Abuse_Treatment_Programs.pdf.

[134] Ahrens K, Sharbaugh M, Jarlenski MP, Tang L, Allen L, Austin AE, Barnes AJ, Burns ME, Clark S, Zivin K, et al. 2023. Prevalence of testing for human immunodeficiency virus, hepatitis B virus, and hepatitis C virus among Medicaid enrollees treated with medications for opioid use disorder in 11 states, 2016-2019. *Clin Infect Dis.* 76(10):1793-1801. https://doi.org/10.1093/cid/ciac981.

[135] Ivasiy R, Madden LM, DiDomizio E, Johnson KA, Machavariani E, Ahmad B, Oliveros D, Ram A, Kil N, Altice FL. 2024. The cascade of care for commercially-insured persons with opioid use disorder and comorbid HIV and HCV infections. *Drug Alcohol Depend.* 263:112410. https://doi.org/10.1016/j.drugalcdep.2024.112410.

[136] Pro G, Tompkins DA, Azari S, Zaller N. 2021. National trends in testing for hepatitis C virus in licensed opioid treatment programs: differences by facility ownership and state Medicaid expansion status. *Drug Alcohol Depend.* 228:109092. https://doi.org/10.1016/j.drugalcdep.2021.109092.

[137] Schoenbachler BT, Smith BD, Seña AC, Hilton A, Bachman S, Lunda M, Spaulding AC. 2016. Hepatitis C virus testing and linkage to care in North Carolina and South Carolina jails, 2012-2014. *Public Health Rep.* 131(Suppl 2):98-104. https://doi.org/10.1177/00333549161310s215.

[138] Hoff E, Warden A, Taylor R, Nijhawan AE. 2023. Hepatitis C epidemiology in a large urban jail: a changing demographic. *Public Health Rep.* 138(2):248-258. https://doi.org/10.1177/00333549221076546.

2.4. Offer testing during every pregnancy

CDC recommends that every pregnant woman should be offered hepatitis C testing during pregnancy.[139] Arkansas law requires this testing to be offered to all pregnant women, per Act 598 of 2021.[140] A national study of women who gave birth during 2015-19 (before the CDC recommendation and Act 598) indicated that approximately 75% in both Medicaid and commercial insurance did not receive hepatitis C testing in those years,[141] indicating the need for an ongoing commitment to make sure the new screening requirement in Act 598 is fully implemented.

Obstetricians-gynecologists, delivery hospitals, and other providers of care for pregnant women should always offer hepatitis C testing, along with other testing that is required to be offered during pregnancy per Arkansas law, such as for syphilis, hepatitis B, and HIV.[142] This testing should be provided as early as possible during prenatal care, but if that opportunity is missed, it should be offered at the delivery hospitalization. Women who are diagnosed with hepatitis C during pregnancy cannot usually be treated immediately because DAAs are not well studied for use in pregnant women,[143] but they can be linked to care and treated after delivery. Providers should also be aware that if hepatitis C infection is confirmed during pregnancy, clinical guidance is available for offering testing[144] and treatment[145] to children who were perinatally exposed.

2.5. Pay for testing according to guidelines

Universal adult testing (age 18-79) for hepatitis C is required to be covered by most private insurers, at no out-of-pocket cost, because it is recommended by USPSTF and therefore covered by the federal preventive services mandate.[146] Screening for hepatitis C is also available with no out-of-pocket cost in Medicare[147] and Arkansas Medicaid.[148] However, some insurance plans are not subject to this requirement. Because universal hepatitis C testing is cost-effective and is a key

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[139] Schillie S, Wester C, Osborne M, Wesolowski L, Ryerson AB. 2020. CDC recommendations for hepatitis C screening among adults – United States, 2020. *MMWR Recomm Rep*. 69(2):1-17. https://doi.org/10.15585/mmwr.rr6902a1.

[140] Ark. Code Ann. § 20-15-101.

[141] Khan MA, Thompson WW, Osinubi A, Meyer WA, Kaufman HW, Armstrong PA, Foster MA, Nelson NP, Wester C. 2023. Testing for hepatitis C during pregnancy among persons with Medicaid and commercial insurance: cohort study. *JMIR Public Health Surveill*. 9:e40783. https://doi.org/10.2196/40783.

[142] Ark. Code Ann. § 20-16-507.

[143] American Association for the Study of Liver Diseases / Infectious Diseases Society of America. 2022. HCV guidance: recommendations for testing, managing, and treating hepatitis C: HCV in children. https://www.hcvguidelines.org/unique-populations/children.

[144] Panagiotakopoulos L, Sandul AL, Conners EE, Foster MA, Nelson NP, Wester C, Collaborators. 2023. CDC recommendations for hepatitis C testing among perinatally exposed infants and children – United States, 2023. *MMWR Recomm Rep*. 72(4):1-21. https://doi.org/10.15585/mmwr.rr7204a1.

[145] American Association for the Study of Liver Diseases / Infectious Diseases Society of America 2022.

[146] KFF. 2024. Preventive services covered by private health plans under the Affordable Care Act. https://www.kff.org/womens-health-policy/fact-sheet/preventive-services-covered-by-private-health-plans/.

[147] Centers for Medicare and Medicaid Services. 2024. Hepatitis C virus infection screenings. https://www.medicare.gov/coverage/hepatitis-c-virus-infection-screenings.

[148] Arkansas Department of Human Services. 2024. Provider manuals: section I – general Medicaid policy. https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/manuals/all-prov/. See § 134.000, *Exclusions from cost sharing policy*.

intervention to stop viral transmission and link patients to treatment,[149] payers should cover it with no out-of-pocket costs, even in plans that are not subject to the preventive services mandate. This is expected to improve screening uptake, because patients tend to reduce their use of needed preventive services when they face out-of-pocket costs.[150]

[149] Schillie S, Wester C, Osborne M, Wesolowski L, Ryerson AB. 2020. CDC recommendations for hepatitis C screening among adults – United States, 2020. *MMWR Recomm Rep*. 69(2):1-17. https://doi.org/10.15585/mmwr.rr6902a1.

[150] Agarwal R, Mazurenko O, Menachemi N. 2017. High-deductible health plans reduce health care cost and utilization, including use of needed preventive services. *Health Aff (Millwood)*. 36(10):1762-1768. https://doi.org/10.1377/hlthaff.2017.0610.

3. Surveillance

The Department of Health is responsible for collecting and publishing data about hepatitis C to measure progress toward elimination, ensure patients are linked to care, and maintain readiness to respond to clusters and outbreaks. Together, these data collection efforts make up the statewide surveillance effort for hepatitis C. Healthcare facilities report hepatitis C to the Department of Health according to rules issued by the State Board of Health. The Department of Health also uses other data sources, such as hospital discharge records and insurance claims, to identify who is affected by hepatitis C and whether they are receiving appropriate care.

3.1. Collect and disseminate statewide hepatitis C data

Hepatitis C is a reportable condition in Arkansas, as defined by the State Board of Health's *Rules Pertaining to Reportable Diseases*.[151] Healthcare providers and facilities are required to report a clinical diagnosis of hepatitis C, or laboratory findings that indicate hepatitis C infection, to the Department of Health. The Infectious Disease Branch carries out an investigation of each reported hepatitis C case, which may include interviewing the patient, contacting the reporting provider, or requesting medical records. The investigation collects standard information about each case of hepatitis C, including the patient's demographic information, any symptoms of illness, and if applicable, reported risk factors such as injection drug use. Cases are counted and reported using standard case definitions published by the Council of State and Territorial Epidemiologists.[152,153] This information helps the Department of Health identify trends in newly identified hepatitis C cases, such as an increased rate of cases in a certain county or demographic group, enabling stakeholders in hepatitis C elimination to understand the scope of the epidemic in Arkansas and who is most affected by the burden of illness.[154] During case surveillance interviews, Infectious Disease Branch staff provide initial education to patients about hepatitis C, how it is spread, the availability of treatment, and how to find a provider who can prescribe DAAs.

The Department of Health compiles and disseminates the information collected from routine hepatitis C surveillance. Surveillance data is made available on a public web page[155] and in statewide surveillance reports,[156,157] both of which are frequently updated. Along with other state and territorial health departments, the Department of Health forwards viral hepatitis data to CDC.

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[151] Arkansas State Board of Health. 2023. Rules pertaining to reportable diseases. https://healthy.arkansas.gov/wp-content/uploads/ReportableDiseaseList.pdf.

[152] Church DR, Coyle J, Kuncio D. 2017. Public health reporting and national notification of perinatal hepatitis C virus infection [17-ID-08]. Council of State and Territorial Epidemiologists. https://cdn.ymaws.com/www.cste.org/resource/resmgr/2017PS/2017PSFinal/17-ID-08.pdf.

[153] Church D, Bocour A, Coyle J. 2019. Revision of the case definition for hepatitis C [19-ID-06]. Council of State and Territorial Epidemiologists. https://cdn.ymaws.com/www.cste.org/resource/resmgr/2019ps/final/19-ID-06_HepatitisC_final_7..pdf.

[154] HepVu / National Alliance of State and Territorial AIDS Directors. 2023. 2022 viral hepatitis surveillance status report. https://hepvu.org/viral-hepatitis-surveillance-status-report22/.

[155] Arkansas Department of Health. 2024. Hepatitis C information. https://experience.arcgis.com/experience/73cafc1e9f0d43da87726c3c0470c123/.

[156] Arkansas Department of Health. 2014. Hepatitis C epidemiologic profile: 2014. https://healthy.arkansas.gov/wp-content/uploads/HCVEpidemiologicProfile.pdf.

[157] Arkansas Department of Health. 2023. Hepatitis C in Arkansas, 2023. https://healthy.arkansas.gov/wp-content/uploads/hcv_report_final_nov_23.pdf.

CDC uses this and other data sources to produce annual summaries of viral hepatitis surveillance data[158] and updates on progress toward national hepatitis elimination goals.[159]

Effective surveillance requires collaboration from all stakeholders, including community and healthcare partners, epidemiologists, and surveillance case investigators. Healthcare providers can contribute by promptly submitting case reports with complete information as required in the *Rules Pertaining to Reportable Diseases*. The Department of Health will work to strengthen its surveillance capacity for hepatitis C, for example by supporting implementation of electronic laboratory reports to replace paper or faxed reporting, which can increase the timeliness and reliability of hepatitis C case report data.[160,161] Providers who are interested in submitting electronic data for hepatitis C can contact the Interoperability Branch.[162] The Infectious Disease and Epidemiology branches at the Department of Health will also work together to provide additional public data releases summarizing information about hepatitis C in Arkansas from case surveillance and other sources. Any member of the public who has a data request about hepatitis C or would like to request the creation of a new hepatitis C-related report can contact the Epidemiology Branch and the Office of the Chief Science Officer.[163,164]

3.2. Use alternative data sources as appropriate

Although case reporting is the foundation of hepatitis C surveillance, there are limitations to case report data. For example, CDC notes that some information such as illegal drug use may not be well captured by case reports due to stigma, and identifying the time that an infection occurred is challenging for chronic infections such as hepatitis B and C. Additionally, because of the nature of disease reporting requirements, patients cannot always be followed over time to measure outcomes such as receipt of hepatitis C treatment, deaths or hospitalizations related to hepatitis C.[165]

To address these limitations, the Department of Health uses additional data sources, such as hospital discharges,[166] death certificates,[167] and insurance claims in the Arkansas All-Payer Claims

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[158] Centers for Disease Control and Prevention. 2024. 2022 viral hepatitis surveillance report. https://www.cdc.gov/hepatitis-surveillance-2022/about/ .

[159] Centers for Disease Control and Prevention. 2024. 2024 viral hepatitis national progress report. https://www.cdc.gov/hepatitis/php/npr-2024/.

[160] Heisey-Grove DM, Church DR, Haney GA, DeMaria A. 2011. Enhancing surveillance for hepatitis C through public health informatics. *Public Health Rep.* 126(1):13-18. https://doi.org/10.1177/003335491112600105.

[161] Tsang CA, Khan MA, Brady SM, Erhart LM, Komatsu KK. 2020. Utilizing electronic laboratory reporting data to assess the burden of hepatitis C in Arizona. *J Public Health Manag Pract.* 26(6):562-569. https://doi.org/10.1097/phh.0000000000001011.

[162] Arkansas Department of Health. 2024. Promoting Interoperability (PI) program. https://healthy.arkansas.gov/programs-services/data-statistics-registries/promoting-interoperability-pi-program/.

[163] Arkansas Department of Health. 2024. Epidemiology. https://healthy.arkansas.gov/programs-services/diseases-conditions/epidemiology/.

[164] Arkansas Department of Health. 2025. Office of the Chief Science Officer. https://healthy.arkansas.gov/resources/about-adh/office-of-the-chief-science-officer/.

[165] Centers for Disease Control and Prevention. 2024. Viral hepatitis: general surveillance. https://web.archive.org/web/20250131132830/https://www.cdc.gov/hepatitis/statistics/surveillanceguidance/GeneralSurveillance.htm.

[166] Arkansas Department of Health. 2024. Hospital Discharge Data System. https://healthy.arkansas.gov/programs-services/data-statistics-registries/hospital-discharge-data-system/.

[167] Arkansas Department of Health. 2024. ERAVE. https://healthy.arkansas.gov/programs-services/certificates-records/erave/.

Database (APCD).[168] The Department incorporates hospital discharge and death data into surveillance reports to measure the burden of hepatitis C. The Infectious Disease Branch has also procured a contract with the Arkansas Center for Health Improvement, which maintains the APCD, to analyze healthcare utilization in Arkansas related to hepatitis B and C.[169] Results from this analysis are expected to be available during 2025. The Department of Health will continue to identify additional ways to measure hepatitis C outcomes using existing data sources. Researchers have also published information on patients receiving hepatitis C care in Arkansas,[170] vulnerability to hepatitis C in Arkansas counties,[171] and DAA treatment among Arkansans who have hepatitis C with a substance use disorder.[172] Researchers who are interested in obtaining data about hepatitis C in Arkansas can contact the Department of Health, the Arkansas Center for Health Improvement, and other organizations to request data files.

3.3. Practice infection control

Although most hepatitis C infections today result from injection drug use, there is also a risk of hepatitis C transmission from other sources, including healthcare-associated infections. In particular, the risk of hepatitis C in the healthcare setting might be increased by invasive procedures[173] or by care that requires repeated contact with patients' blood such as kidney dialysis.[174] Although infection control lapses in healthcare can result in clusters and outbreaks of hepatitis B or C,[175] stakeholders can take evidence-based action to reduce the risk.

Healthcare providers should exercise caution when performing procedures that could result in bloodborne pathogen exposures for patients or staff. Providers should always follow applicable infection control guidance, including the *Bloodborne pathogens* standard from the Occupational Safety and Health Administration[176] and the Arkansas *Rules and Regulations Pertaining to the Management of Medical Waste from Generators and Health Care Related Facilities*.[177] General

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[168] Arkansas Center for Health Improvement. 2024. Arkansas All-Payer Claims Database. https://www.arkansasapcd.net/Home/.

[169] Arkansas Department of Finance and Administration. 2023. Contract no. 4600052982.https://www.ark.org/dfa/transparency_2024/contracts.php.

[170] George N, Harrell SM, Rhodes KD, Duarte-Rojo A. 2018. Recreational drug and psychosocial profile in chronic hepatitis C patients seeking antiviral therapy. *Ann Hepatol*. 17(1):76-84. https://doi.org/10.5604/01.3001.0010.7537.

[171] Gu M. 2021. Prediction of hepatitis C and injection-related diseases in Arkansas. University of Arkansas for Medical Sciences. https://www.proquest.com/openview/d073fffe3c31ad6d785d61abc6cf7584/.

[172] Pro G, Hayes C, Bona J, Gu M, Richoux C, Zaller N. 2024. HCV medication receipt among individuals with methamphetamine, opioid, and alcohol use disorders in Arkansas, 2018-2022: a long road ahead for HCV elimination in the US South. *J Drug Issues*. 55(3):434-449. https://doi.org/10.1177/00220426241231720.

[173] Henriot P, Castry M, Luong Nguyen LB, Shimakawa Y, Jean K, Temime L. 2022. Meta-analysis: risk of hepatitis C virus infection associated with hospital-based invasive procedures. *Aliment Pharmacol Ther*. 56(4):558-569. https://doi.org/10.1111/apt.17106.

[174] Nguyen DB, Bixler D, Patel PR. 2019. Transmission of hepatitis C virus in the dialysis setting and strategies for its prevention. *Semin Dial*. 32(2):127-134. https://doi.org/10.1111/sdi.12761.

[175] Centers for Disease Control and Prevention. 2023. Health care-associated hepatitis B and C outbreaks (≥ 2 cases) reported to CDC 2008-2019. https://archive.cdc.gov/#/details?url=https://www.cdc.gov/hepatitis/outbreaks/healthcarehepoutbreaktable.htm.

[176] Occupational Safety and Health Administration. 2019. Bloodborne pathogens and needlestick prevention. https://www.osha.gov/bloodborne-pathogens/standards.

[177] Arkansas State Board of Health. 2016. Rules and regulations pertaining to the management of medical waste from generators and health care related facilities. https://healthy.arkansas.gov/wp-content/uploads/Medical_Waste_Regs_2016_FINAL.pdf.

guidance that outlines best practices for response to suspected healthcare-associated hepatitis B or C is available from CDC.[178] This will be used to guide outbreak response at the Department of Health, and it may also be of use to healthcare providers. CDC has published best practices that are specific to kidney dialysis clinics,[179] and dialysis providers should consult the CMS *Conditions for Coverage*, which includes applicable infection control requirements.[180] Providers should also ensure that hepatitis C patients under their care are linked to treatment as soon as possible, which benefits the patients but also prevents further transmission of the hepatitis C virus after successful treatment. Clinical guidance about hepatitis C care for patients with kidney disease is available from AASLD/IDSA[181] and Kidney Disease Improving Global Outcomes.[182]

The Department of Health's Healthcare-Associated Infections program is available to provide free, non-regulatory infection control consultations to all Arkansas healthcare providers. Providers who are interested in scheduling an infection control discussion or consultation with the Department of Health can contact the Healthcare-Associated Infections program.[183] Kidney dialysis providers can also receive infection control support from the End Stage Renal Disease Network 13, which conducts dialysis quality improvement activities in Arkansas, Louisiana, and Oklahoma.[184]

3.4. Maintain outbreak response plan

Currently, HIV outbreaks associated with injection drug use often also have concurrent transmission of hepatitis C.[185] The Department of Health maintains an outbreak response plan for communicable diseases, as well as specific guidance relating to viral hepatitis. This addresses the possibility of injection drug use-associated hepatitis C clusters as well as other topics such as healthcare-associated infections and outbreaks of hepatitis A or B. This documentation is periodically reviewed and updated; it covers testing, outbreak investigation, linkage to care, communications, partnerships with healthcare providers, and additional measures to prevent the spread of bloodborne infections. Additional guidance is available from CDC on healthcare-associated hepatitis C outbreaks[186] and addressing infectious disease outbreaks among people who inject drugs.[187] The Department will continue to revise its outbreak response plan as appropriate.

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[178] Centers for Disease Control and Prevention. 2024. Viral hepatitis: health care-associated outbreak investigation toolkit. https://www.cdc.gov/hepatitis/php/health-care-outbreak-toolkit/.

[179] Centers for Disease Control and Prevention. 2024. Dialysis – preventing infections. https://www.cdc.gov/infection-control/hcp/dialysis-infections/index.html.

[180] Centers for Medicare and Medicaid services. 2008. Medicare and Medicaid programs: conditions for coverage for end-stage renal disease facilities. 73(73):20370-20484. https://www.federalregister.gov/d/08-1102.

[181] American Association for the Study of Liver Diseases / Infectious Diseases Society of America. 2022. HCV guidance: recommendations for testing, managing, and treating hepatitis C: patients with renal impairment. https://www.hcvguidelines.org/unique-populations/renal-impairment.

[182] Kidney Disease Improving Global Outcomes. 2022. Hepatitis C in CKD. https://kdigo.org/guidelines/hepatitis-c-in-ckd/.

[183] Arkansas Department of Health. 2024. Healthcare-associated infections. https://healthy.arkansas.gov/programs-services/diseases-conditions/healthcare-associated-infections/.

[184] Health Services Advisory Group. 2024. ESRD Network 13. https://www.hsag.com/ESRDNetwork13.

[185] Moorman AC, Bixler D, Teshale EH, Hofmeister M, Roberts H, Chapin-Bardales J, Gupta N. 2023. Hepatitis C virus-HIV coinfection in the United States among people who inject drugs: data needed for ending dual epidemics. *Public Health Rep*. Online ahead of print. https://doi.org/10.1177/00333549231181348.

[186] Centers for Disease Control and Prevention. 2024. Viral hepatitis: health care-associated outbreak investigation toolkit. https://www.cdc.gov/hepatitis/php/health-care-outbreak-toolkit/.

[187] Centers for Disease Control and Prevention. 2018. Managing HIV and hepatitis C outbreaks among people who inject drugs: a guide for state and local health departments. https://stacks.cdc.gov/view/cdc/53008.

3.5. Notify if an outbreak is suspected

Outbreaks of viral hepatitis are often first identified by clinicians. Although healthcare providers do not need to implement a formal surveillance program for hepatitis C outbreaks, they may be the first to notice the signs of a cluster, such as an unusual number of new hepatitis C diagnoses. This is true for both healthcare-associated outbreaks (due to an infection control problem) and community outbreaks (usually due to injection drug use). In both cases, providers are requested to contact the Infectious Disease and Epidemiology branches at the Department of Health if they suspect an outbreak.

4. Treatment

DAA treatment for hepatitis C is safe and effective in clearing the virus. It reduces liver cancer and liver-related deaths and is recommended for almost everyone with limited exceptions. However, patients may face financial, logistical, or other challenges in receiving hepatitis C treatment, and providers may face challenges in prescribing it. A comprehensive response to the burden of hepatitis C in Arkansas requires action to ensure that every patient can access DAA treatment as per clinical guidelines.

4.1. Offer treatment on site or by referral

When a patient tests positive for hepatitis C RNA, it is preferable to initiate treatment early. Prompt treatment improves patient outcomes by preventing the progression of liver disease.[188] Improved linkage to treatment is important because many Arkansans with hepatitis C still have not received DAAs and have not cleared their infections.[189,190] In some cases, providers may want to initiate treatment immediately after diagnosis; this is especially desirable for patients who might be at high risk of loss to follow-up if treatment is delayed. Rapid initiation of treatment after diagnosis is feasible,[191] but it requires advance planning, because providers must still be able to complete pre-treatment lab workup and assessment, which includes hepatitis B surface antigen testing, pregnancy screening, checking for drug-drug interactions, etc. Providers who want to consider rapid initiation of DAA treatment may find the AASLD/IDSA guidance helpful.

However, some providers may not be able to start DAA treatment on site, due to staffing limitations, inability to obtain insurance coverage for the prescription, or other challenges. If unable to offer treatment, providers are encouraged to consider providing a "warm handoff" to a prescriber who can evaluate patients for treatment and prescribe DAAs. This can be a formal (for example, hiring a social worker or nurse to coordinate referrals) or informal process (for example, a primary care provider reaching out to nearby liver specialists). In either case, the focus should be on simplifying the process for patients, so that they can start treatment promptly, without loss to follow-up. Studies have shown that reducing the number of steps for patients to access treatment makes it more likely they will successfully complete it.[192,193] If there are issues with coordinating

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[188] American Association for the Study of Liver Diseases / Infectious Diseases Society of America. 2022. HCV guidance: recommendations for testing, managing, and treating hepatitis C: when and in whom to initiate HCV therapy. https://www.hcvguidelines.org/evaluate/when-whom.

[189] Pro G, Hayes C, Bona J, Gu M, Richoux C, Zaller N. 2024. HCV medication receipt among individuals with methamphetamine, opioid, and alcohol use disorders in Arkansas, 2018-2022: a long road ahead for HCV elimination in the US South. *J Drug Issues*. 55(3):434-449. https://doi.org/10.1177/00220426241231720.

[190] Tsang CA, Tonzel J, Symum H, Kaufman HW, Meyer WA, Osinubi A, Thompson WW, Wester C. 2024. State-specific hepatitis C virus clearance cascades – United States, 2013-2022. *MMWR Morb Mortal Wkly Rep*. 73(21):495-500. https://doi.org/10.15585/mmwr.mm7321a4.

[191] Morris MD, McDonell C, Luetkemeyer AF, Thawley R, McKinney J, Price JC. 2023. Community-based point-of-diagnosis hepatitis C treatment for marginalized populations: a nonrandomized clinical trial. *JAMA Netw Open*. 6(10):e2338792. https://doi.org/10.1001/jamanetworkopen.2023.38792.

[192] Wade AJ, Doyle JS, Gane E, Stedman C, Draper B, Iser D, Roberts SK, Kemp W, Petrie D, Scott N, et al. 2020. Outcomes of treatment for hepatitis C in primary care, compared to hospital-based care: a randomized, controlled trial in people who inject drugs. *Clin Infect Dis*. 70(9):1900-1906. https://doi.org/10.1093/cid/ciz546.

[193] Eckhardt B, Mateu-Gelabert P, Aponte-Melendez Y, Fong C, Kapadia S, Smith M, Edlin BR, Marks KM. 2022. Accessible hepatitis C care for people who inject drugs: a randomized clinical trial. *JAMA Intern Med*. 182(5):494-502. https://doi.org/10.1001/jamainternmed.2022.0170.

a referral or obtaining reimbursement, providers can refer to the Department of Health's list of liver and infectious disease clinics and payment assistance programs for hepatitis C,[194] or contact the Department directly for assistance.

Providers offering hepatitis C testing should consider implementing a quality measure or review process to measure the proportion of hepatitis C patients who are linked to care. This can be accomplished through follow-up interviews with patients, review of medical records, reports from EHR data, or other sources, depending on the type of clinic and the data available. For patients who are not linked to treatment, providers should evaluate the sources of loss to follow-up and repeat attempts to complete the referral process. The Department of Health will conduct an assessment of this type to evaluate whether there are gaps in the referral process for patients who receive a hepatitis C diagnosis at a Local Health Unit. Providers who are interested in evaluating hepatitis C outcomes in their clinics can benefit from existing resources such as the published study findings[195] and implementation guide[196] from a recent project to improve DAA treatment rates among people coinfected with HIV and hepatitis C and receiving care at Ryan White Program clinics. In Arkansas, the ARcare Federally Qualified Health Centers have developed experience with simplifying hepatitis C referrals;[197,198] providers who want to learn about ARcare's referral process can contact the Department of Health or contact ARcare directly.

Many people who have hepatitis C are also living with, or at risk for, other serious illnesses such as substance use disorders, HIV, STIs, and hepatitis A and B; hepatitis C may also increase the risk of chronic conditions such as diabetes and kidney disease.[199] Providers who see hepatitis C patients

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[194] Arkansas Department of Health. 2022. Statewide hepatitis C resources and services. https://healthy.arkansas.gov/wp-content/uploads/Hep_C_Resource_Guide.pdf.

[195] Brooks R, Wegener M, Speers S, Nichols L, Sideleau R, Valeriano T, Buchelli M, Villanueva M. 2023. Creating a longitudinal HCV care cascade for persons with HIV/HCV coinfection in selected HIV clinics using data to care methods. *Health Promot Pract*. 24(5):1039-1049. https://doi.org/10.1177/15248399231169792.

[196] TargetHIV. 2022. Leveraging a data to care approach to cure hepatitis C within the RWHAP. https://targethiv.org/spns/hiv-hcv-dtc.

[197] Blum K. 2023. Pharmacy technician links patients with hepatitis C to care. *ASHP News Center*. American Society of Health-System Pharmacists. https://news.ashp.org/news/feature-stories/2023/08/16/pharmacy-technician-links-patients-with-hepatitis-c-to-care.

[198] Carney K. 2023. Pharmacy technicians as patient navigators in hepatitis C linkage services. American Society of Health-System Pharmacists. https://www.ashp.org/pharmacy-practice/pai/pai-case-studies/arcare.

[199] Centers for Disease Control and Prevention. 2025. Clinical overview of hepatitis C. https://www.cdc.gov/hepatitis-c/hcp/clinical-overview/index.html.

should be prepared to screen for these conditions as appropriate,[200,201,202,203,204] keeping in mind that there are additional screening recommendations for some populations such as pregnant women, and to treat them according to clinical practice guidelines. If these co-occurring conditions cannot be treated on site, providers should have a plan to make needed referrals. For example, patients with substance use disorders can be connected with nearby drug treatment facilities or (for opioid use disorder) buprenorphine prescribers; directories are available from the Substance Abuse and Mental Health Services Administration[205] and the Arkansas Department of Human Services.[206] Patients with HIV can be referred to the Ryan White Program, which helps pay for medications, including HIV and hepatitis C drugs, and provides care coordination and social services.[207] Patients with STIs can be treated at a Local Health Unit.[208] In some cases, depending on the provider's assessment, these other conditions may need to be addressed before patients are ready to start hepatitis C treatment.

Some patients may also need referrals to social services, such as homeless shelters or food pantries; hepatitis C prevalence is very high among people who are homeless or unstably housed.[209] Wherever possible, clinics that see hepatitis C patients should be knowledgeable about how to connect patients to these services. Guides to housing and social service resources are available for

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[200] US Preventive Services Task Force, Krist AH, Davidson KW, Mangione CM, Barry MJ, Cabana M, Caughey AB, Curry SJ, Donahue K, Doubeni CA, et al. 2020. Screening for unhealthy drug use: US Preventive Services Task Force recommendation statement. *JAMA*. 323(22):2301-2309. https://doi.org/10.1001/jama.2020.8020.

[201] US Preventive Services Task Force, Owens DK, Davidson KW, Krist AH, Barry MJ, Cabana M, Caughey AB, Curry SJ, Doubeni CA, Epling JW, et al. 2019. Screening for HIV infection: US Preventive Services Task Force recommendation statement. *JAMA*. 321(23):2326-2336. https://doi.org/10.1001/jama.2019.6587.

[202] US Preventive Services Task Force, Davidson KW, Barry MJ, Mangione CM, Cabana M, Caughey AB, Davis EM, Donahue KE, Doubeni CA, Krist AH, et al. 2021. Screening for chlamydia and gonorrhea: US Preventive Services Task Force recommendation statement. *JAMA*. 326(10):949-956. https://doi.org/10.1001/jama.2021.14081.

[203] US Preventive Services Task Force, Mangione C, Barry MJ, Nicholson WK, Cabana M, Chelmow D, Coker TR, Davis EM, Donahue KE, Jaén CR, et al. 2022. Screening for syphilis infection in nonpregnant adolescents and adults: US Preventive Services Task Force reaffirmation recommendation statement. *JAMA*. 328(12):1243-1249. https://doi.org/10.1001/jama.2022.15322.

[204] US Preventive Services Task Force, Krist AH, Davidson KW, Mangione CM, Barry MJ, Cabana M, Caughey AB, Donahue K, Doubeni CA, Epling JW, et al. 2020. Screening for hepatitis B virus infection in adolescents and adults: US Preventive Services Task Force recommendation statement. *JAMA*. 324(23):2415-2422. https://doi.org/10.1001/jama.2020.22980.

[205] Substance Abuse and Mental Health Services Administration. 2024. FindTreatment.gov. https://findtreatment.gov/.

[206] Arkansas Department of Human Services. 2024. DAABHS substance abuse treatment services: catchment areas, funded contractors. https://humanservices.arkansas.gov/divisions-shared-services/shared-services/office-of-substance-abuse-and-mental-health/samh-treatment/; https://humanservices.arkansas.gov/wp-content/uploads/CSAT-8-Funded-Providers-Map-Updated.10.2024.pdf.

[207] Arkansas Department of Health. 2024. Ryan White FAQs. https://healthy.arkansas.gov/programs-services/diseases-conditions/infectious-disease/ryan-white-program/ryan-white-faqs/.

[208] Arkansas Department of Health. 2024. Health Units. https://healthy.arkansas.gov/health-units/.

[209] Edlin BR, Eckhardt BJ, Shu MA, Holmberg SD, Swan T. 2015. Toward a more accurate estimate of the prevalence of hepatitis C in the United States. *Hepatology*. 62(5):1353-1363. https://doi.org/10.1002/hep.27978.

Little Rock,[210] Northwest Arkansas,[211] Fort Smith,[212] Jonesboro,[213] Pine Bluff,[214] and other cities. Help is often available from community organizations or city governments, and providers can also contact their local homelessness Continuum of Care, sponsored by the U.S. Department of Housing and Urban Development (HUD),[215,216,217] or use the Arkansas resource directory on the HUD website.[218] Stakeholders who have questions about social services for Arkansans who are homeless or unstably housed can also contact the Department of Health's Homeless Shelter and Encampment Outreach program.[219]

4.2. Consider use of simplified treatment guidance

The medical complexity of hepatitis C cases varies widely. Some patients who do not have coinfections or severe complications of liver disease require relatively less intensive care to complete successful treatment. Other patients who have conditions such as HIV, hepatitis B, or late-stage liver disease may need extensive specialty care for treatment side effects, drug-drug interactions, or additional monitoring for liver injuries. Providers are encouraged to consider use of a tool such as the AASLD/IDSA simplified hepatitis C treatment guidance to determine which cases are most likely to be complex.[220,221] Non-specialist providers may consider treating uncomplicated cases on-site but providing a specialist referral with a "warm handoff" for cases requiring a higher level of care. Providers should also consider taking advantage of the University of California, San Francisco National Clinician Consultation Center, which provides consultations on hepatitis C treatment free of charge.[222]

4.3. Use telehealth where appropriate

Many hepatitis C patients in Arkansas live in rural areas where travel to a provider who can treat hepatitis C is difficult. A recent clinical trial found that offering DAAs through telehealth can

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[210] Our House. 2024. Resources. https://ourhouseshelter.org/resources/.
[211] NWA Continuum of Care. 2022. Regional access points. https://nwacoc.com/wp-content/uploads/2022/07/Regional-Access-Points-JUL-2022.png.
[212] City of Fort Smith. 2024. Social & support services. https://www.fortsmithar.gov/resident-services/community-resources/social-support-services.
[213] City of Jonesboro. 2024. HUB (Helping Underserved Belong). https://www.jonesboro.org/476/HUB-Helping-Underserved-Belong.
[214] Pine Bluff/Jefferson County Library System. 2024. Homeless hub. https://www.pinebluffllibrary.org/library-services/homeless-hub/.
[215] Central Arkansas Team Care for the Homeless. 2024. https://catcharkansas.org/.
[216] Northwest Arkansas Continuum of Care. 2024. https://nwacoc.com/.
[217] Arkansas Balance of State Continuum of Care. 2021. https://www.arboscoc.org/.
[218] U.S. Department of Housing and Urban Development. 2025. Arkansas homepage: homelessness. https://www.hud.gov/states/arkansas#Homelessness.
[219] Arkansas Department of Health. 2024. Homeless shelter and encampment outreach. https://healthy.arkansas.gov/wp-content/uploads/ADH_Homeless_Shelter_Flyer.pdf.
[220] American Association for the Study of Liver Diseases / Infectious Diseases Society of America. 2023. HCV guidance: recommendations for testing, managing, and treating hepatitis C: simplified HCV treatment for treatment-naive adults without cirrhosis. https://www.hcvguidelines.org/treatment-naive/simplified-treatment.
[221] American Association for the Study of Liver Diseases / Infectious Diseases Society of America. 2023. HCV guidance: recommendations for testing, managing, and treating hepatitis C: simplified HCV treatment algorithm for treatment-naive adults with compensated cirrhosis. https://www.hcvguidelines.org/treatment-naive/simplified-treatment-compensated-cirrhosis.
[222] University of California, San Francisco. 2024. Hepatitis C management. https://nccc.ucsf.edu/clinician-consultation/hepatitis-c-management/.

improve treatment completion rates for patients with opioid use disorder.[223] Several telehealth initiatives for hepatitis C treatment have published results suggesting that telehealth is a viable pathway to offer hepatitis C care in some circumstances.[224,225]

Wherever possible, health systems that serve populations with access challenges should consider making some steps of hepatitis C treatment available through telehealth.[226] Although some steps of the process will always require an in-person visit, patient access can be increased simply by reducing the number of visits that require travel. Providers might also consider implementing practice agreements between a specialty provider in an urban area and a primary care provider in a rural area, so that hepatitis C patients can receive a specialty consultation via telehealth during a visit to a primary care provider's office closer to their homes. In addition to journal articles, implementation guidance has been published for DAA treatment via telemedicine in substance use treatment programs.[227]

4.4. Link pregnant women to care

Women cannot usually be treated for hepatitis C during pregnancy,[228] but they should be offered treatment after delivery. If an infant is born to a woman with a hepatitis C infection, pediatricians should use CDC screening guidelines for perinatal exposures.[229] Children with hepatitis C infection can be treated beginning at age 3.[230] Providers should also be aware that resources are available to help pregnant women who have common co-occurring conditions as well as hepatitis C. For example, pregnant and parenting women who have a substance use disorder can be referred to the Specialized Women's Services at the Department of Human Services, which offer prioritized access to substance use treatment.[231] Providers who are caring for pregnant women with hepatitis B can receive additional support from the Arkansas Perinatal Hepatitis B Prevention Program at

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[223] Talal AH, Markatou M, Liu A, Perumalswami PV, Dinani AM, Tobin JN, Brown LS. 2024. Integrated hepatitis C-opioid use disorder care through facilitated telemedicine: a randomized trial. *JAMA*. 331(16):1369-1378. https://doi.org/10.1001/jama.2024.2452.

[224] Gormley MA, Moschella P, Cordero-Romero S, Wampler WR, Allison M, Kitzmiller K, Estes L, Heo M, Litwin AH, Roth P. 2024. No patient left behind: a novel paradigm to fulfill hepatitis C virus treatment for rural patients. *Open Forum Infect Dis*. 11(5):ofae206. https://doi.org/10.1093/ofid/ofae206.

[225] Spencer H, Leichtling G, Babiarz J, Fox CB, Herink M, Cooper J, Jones K, Gailey T, Leahy J, Cook R, et al. 2024. Peer-assisted telemedicine for hepatitis C (PATHS): process evaluation results from a State Opioid Response-funded program. *J Subst Use Addict Treat*. 167:209510. https://doi.org/10.1016/j.josat.2024.209510.

[226] Khoja A, Akber NA, Feroz A. 2021. Telehealth as an important player in the management of hepatitis C virus. *Gastroenterol Insights*. 12(2):183-195. https://doi.org/10.3390/gastroent12020016.

[227] New York City Department of Health and Mental Hygiene / State University of New York Research Foundation. 2020. Integration of hepatitis C telemedicine at substance use treatment programs: an implementation guide. https://nastad.org/sites/default/files/2021-12/Microsite_hepc_telemedicineguide.pdf.

[228] American Association for the Study of Liver Diseases / Infectious Diseases Society of America. 2022. HCV guidance: recommendations for testing, managing, and treating hepatitis C: HCV in children. https://www.hcvguidelines.org/unique-populations/children.

[229] Panagiotakopoulos L, Sandul AL, Conners EE, Foster MA, Nelson NP, Wester C, Collaborators. 2023. CDC recommendations for hepatitis C testing among perinatally exposed infants and children – United States, 2023. *MMWR Recomm Rep*. 72(4):1-21. https://doi.org/10.15585/mmwr.rr7204a1.

[230] American Association for the Study of Liver Diseases / Infectious Diseases Society of America. 2022. HCV guidance: recommendations for testing, managing, and treating hepatitis C: HCV in children. https://www.hcvguidelines.org/unique-populations/children.

[231] Arkansas Department of Human Services. 2024. Specialized Women Services (SWS). https://humanservices.arkansas.gov/divisions-shared-services/shared-services/office-of-substance-abuse-and-mental-health/specialized-women-services-sws/.

the Department of Health,[232] and providers who need help finding syphilis treatment for any patient, including a pregnant woman, can contact their Local Health Unit.[233]

4.5. Pay for treatment according to guidelines

AASLD/IDSA guidance recommends treatment for everyone with hepatitis C, with a small number of exceptions where DAAs are not well studied or have low value, such as pregnant women, children under age 3, or people who have an irremediably short life expectancy. Insurance carriers should cover DAAs for all hepatitis C patients who are recommended to receive treatment per AASLD/IDSA guidance. In particular, current practice guidelines do not support denying treatment to patients on account of their stage of liver fibrosis or denying treatment to patients with current substance use disorders.[234] For patients with ongoing injection drug use, insurance carriers can encourage or incentivize appropriate counseling to facilitate receipt of substance use treatment and prevent hepatitis C reinfection, but should not deny treatment coverage. Comprehensive coverage of hepatitis C treatment is cost-effective and possibly cost saving,[235,236] and can prevent illness and death from liver disease progression,[237] as well as improve uptake of DAAs.[238]

Many Arkansas payers have already aligned their coverage policies for DAAs to match these clinical practice guidelines. The Department of Human Services has updated the Medicaid DAA coverage criteria to allow treatment regardless of liver fibrosis stage or substance use disorder,[239] and the Department of Health follows AASLD/IDSA guidance when approving hepatitis C treatments for HIV-coinfected patients in the Ryan White program.[240]

4.6. Allow non-specialist providers to prescribe DAAs

Historically, many insurers have required hepatitis C treatment prescriptions to be written by, or in consultation with, specialist providers such as gastroenterologists, hepatologists, and infectious disease physicians. However, recent evidence suggests that primary care providers are able to

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[232] Centers for Disease Control and Prevention. 2024. Perinatal hepatitis B coordinator list.https://www.cdc.gov/vaccines/php/perinatal-hep-b-prevention/coordinators-list.html.

[233] Arkansas Department of Health. 2024. Health units. https://healthy.arkansas.gov/health-units/.

[234] American Association for the Study of Liver Diseases / Infectious Diseases Society of America. 2022. HCV guidance: recommendations for testing, managing, and treating hepatitis C: when and in whom to initiate HCV therapy. https://www.hcvguidelines.org/evaluate/when-whom.

[235] Kaplan DE, Serper M, Kaushik A, Durkin C, Raad A, El-Moustaid F, Smith N, Yehoshua A. 2022. Cost-effectiveness of direct-acting antivirals for chronic hepatitis C virus in the United States from a payer perspective. *J Manag Care Spec Pharm*. 28(10):1138-1148. https://doi.org/10.18553/jmcp.2022.28.10.1138.

[236] Chhatwal J, Aaron A, Zhong H, Sood N, Irvin R, Alter HJ, Zhuo Y, Sharfstein JM, Ward JW. 2023. Projected health benefits and health care savings from the United States national hepatitis C elimination initiative [working paper 31139]. National Bureau of Economic Research. https://doi.org/10.3386/w31139.

[237] Sahakyan Y, Lee-Kim V, Bremner KE, Bielecki JM, Krahn MD. 2021. Impact of direct-acting antiviral regimens on mortality and morbidity outcomes in patients with chronic hepatitis C: systematic review and meta-analysis. *J Viral Hepat*. 28(5):739-754. https://doi.org/10.1111/jvh.13482.

[238] Furukawa NW, Ingber SZ, Symum H, Rapposelli KK, Teshale EH, Thompson WW, Zhu W, Roberts HW, Gupta N. 2024. Medicaid expansion and restriction policies for hepatitis C treatment. *JAMA Netw Open*. 7(7):e2422406. https://doi.org/10.1001/jamanetworkopen.2024.22406.

[239] Arkansas Department of Human Services / Prime Therapeutics. 2024. Arkansas Medicaid Pharmacy Program: announcements: hepatitis C update. https://ar.primetherapeutics.com/web/arkansas/announcements.

[240] Arkansas Department of Health. 2022. Ryan White Part B ADAP formulary. https://healthy.arkansas.gov/wp-content/uploads/AR-ADAP-Formulary-10-24-2023.pdf.

provide acceptable hepatitis C care.[241,242] If the process to receive hepatitis C treatment is simplified, such as by authorizing primary care providers to offer it, patients are more likely to complete treatment successfully.[243,244,245] Expanding prescriber specialty lists can prevent the difficult search for a specialist and allow more local providers to offer continuity of care for hepatitis C patients. 47 of 50 state Medicaid programs have expanded DAA prescribing eligibility to non-specialist providers, although Arkansas is not yet among them.[246] Expanding the provider workforce that is able to treat hepatitis C is especially important for people in rural areas, since there are provider shortages in many rural counties in Arkansas,[247] and rural healthcare facilities may lack funding for medical equipment and lab testing required for follow-up appointments prior to medication, creating the need to travel to larger medical facilities.

Insurers can address this barrier to care by considering ways to broaden the provider workforce that is allowed to prescribe hepatitis C treatment. In addition to relaxing specialist prescriber requirements, this might include initiatives such as sponsoring provider education or directing providers to existing training resources for hepatitis C treatment. Insurers who are interested in broadening the provider workforce for DAA treatment in their plans can contact the Department of Health for technical assistance. In some cases, it may be possible to meet training needs with existing programs sponsored by Federally Qualified Health Centers and AIDS Education and Training Centers.[248]

4.7. Simplify prior authorization

Many insurance carriers cover DAAs with a requirement for prescribers to submit a formal request for coverage – prior authorization (PA) – before claims can be paid out. Insurers who require a PA for these drugs should ensure that the PA process functions to improve quality of care, not to delay needed care. If a PA is imposed, the requirements should not be any more complicated than medically necessary. Insurers should consider discontinuing PA requirements that are more burdensome than AASLD/IDSA treatment guidelines. For example, in patients whose treatment is

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[241] Kattakuzhy S, Gross C, Emmanuel B, Teferi G, Jenkins V, Silk R, Akoth E, Thomas A, Ahmed C, Espinosa M, et al. 2017. Expansion of treatment for hepatitis C virus infection by task shifting to community-based nonspecialist providers: a nonrandomized clinical trial. *Ann Intern Med.* 167(5):311-318. https://doi.org/10.7326/m17-0118.

[242] Stanley K, Bowie BH. 2021. Comparison of hepatitis C treatment outcomes between primary care and specialty care. *J Am Assoc Nurse Pract.* 34(2):292-297. https://doi.org/10.1097/jxx.0000000000000621.

[243] Radley A, Robinson E, Aspinall EJ, Angus K, Tan L, Dillon JF. 2019. A systematic review and meta-analysis of community and primary-care-based hepatitis C testing and treatment services that employ direct acting antiviral drug treatments. *BMC Health Serv Res.* 19(1):765. https://doi.org/10.1186/s12913-019-4635-7.

[244] Wade AJ, Doyle JS, Gane E, Stedman C, Draper B, Iser D, Roberts SK, Kemp W, Petrie D, Scott N, et al. 2020. Outcomes of treatment for hepatitis C in primary care, compared to hospital-based care: a randomized, controlled trial in people who inject drugs. *Clin Infect Dis.* 70(9):1900-1906. https://doi.org/10.1093/cid/ciz546.

[245] Eckhardt B, Mateu-Gelabert P, Aponte-Melendez Y, Fong C, Kapadia S, Smith M, Edlin BR, Marks KM. 2022. Accessible hepatitis C care for people who inject drugs: a randomized clinical trial. *JAMA Intern Med.* 182(5):494-502. https://doi.org/10.1001/jamainternmed.2022.0170.

[246] Harvard Law School Center for Health Law and Policy Innovation / National Viral Hepatitis Roundtable. 2024. Hepatitis C: state of Medicaid access: 2024 national snapshot report. https://stateofhepc.org/2024-national-snapshot-report/.

[247] Brock M, Jones S, Al-Mousawi H, Lehing L, Courtney J. 2024. Arkansas health professions manpower statistics 2022. Arkansas Department of Health. https://healthy.arkansas.gov/wp-content/uploads/Manpower-Report-2022.pdf.

[248] South Central AIDS Education and Training Center. 2024. Education and training: calendar. https://hsc.unm.edu/scaetc/education-training/calendar.html.

"simplified" per AASLD/IDSA and who do not have cirrhosis, testing for hepatitis C genotype may not be needed, and insurers can consider not requiring it.[249]

Some PA requirements may have a particularly negative impact on completion of treatment. For example, increasing the complexity of pre-treatment laboratory workup beyond what is required in clinical guidance may mean that patients have to travel a long distance, since advanced laboratory services are not always available in rural areas. Requiring drug screening to be submitted to an insurer if it is not medically necessary may deter some from being evaluated for treatment at all. Insurers should regularly consult with their Pharmacy and Therapeutics committees to identify how the PA process can be simplified without compromising quality of care. In some cases, this may also include administrative changes, such as making an electronic form available to submit PA requests. Reducing the paperwork burden on patients and providers has the potential to improve DAA uptake and free up additional healthcare system resources for clinical care.

4.8. Strengthen DAA coverage outside traditional insurance

Hepatitis C disproportionately affects people who are socioeconomically marginalized; some hepatitis C patients do not have health insurance, but they should still receive the same standard of care as insured patients. Patients should be assisted to enroll in insurance if they are willing and eligible. However, if this is not possible, providers should seek alternate ways to cover the cost of treatment. For example, the Department of Corrections, through its medical contractor, has obtained discounted prescription drugs, including DAAs, through the federal 340B Drug Pricing Program.[250] Other correctional facilities, as well as federally qualified health centers and certain hospitals and specialized clinics, are also eligible for the 340B Program, and should consider participating.[251]

Providers who are already participating in the 340B Program should make every effort to expand coverage of hepatitis C drugs, especially for patients who could not otherwise afford them, so that everyone under their care can receive treatment in accordance with AASLD/IDSA guidelines. Drug manufacturers also offer discount programs that may cover DAA costs fully or partially. The Infectious Disease Branch at the Department of Health provides information about manufacturer discount programs,[252] and providers who are interested in enrolling in 340B to cover hepatitis C medications can contact the Department of Health for assistance. Information about 340B coverage of hepatitis C treatment is available from the National Alliance of State and Territorial AIDS Directors.[253]

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[249] American Association for the Study of Liver Diseases / Infectious Diseases Society of America. 2023. HCV guidance: recommendations for testing, managing, and treating hepatitis C: simplified HCV treatment for treatment-naïve adults without cirrhosis. https://www.hcvguidelines.org/treatment-naive/simplified-treatment.

[250] Arkansas Department of Corrections. 2024. Bid solicitation S000000285: comprehensive medical services [DOC-24-004 QA 3.29.2024.Final.pdf]. https://arbuy.arkansas.gov/bso/external/bidDetail.sdo?docId=S000000285.

[251] Health Resources & Services Administration. 2024. 340B eligibility. https://www.hrsa.gov/opa/eligibility-and-registration.

[252] Arkansas Department of Health. 2022. Statewide hepatitis C resources and services. https://healthy.arkansas.gov/wp-content/uploads/Hep_C_Resource_Guide.pdf.

[253] National Alliance of State and Territorial AIDS Directors. 2024. 340B for viral hepatitis programs: 340B drug pricing program guidance & webinar series. https://nastad.org/resources/340b-viral-hepatitis-programs-340b-drug-pricing-program-guidance-webinar-series.

Treatment of hepatitis C in correctional facilities is especially important for elimination efforts because so many hepatitis C patients receive care there.[254] Hepatitis C treatment guidance for the correctional setting is available from the Federal Bureau of Prisons[255] and AASLD/IDSA.[256] Correctional facilities should attempt to provide access to DAA treatment as broadly as possible, including, for example, finishing the course of treatment for any inmates who are receiving DAAs at intake to avoid medication interruptions. The Department of Human Services has applied for a federal waiver to allow inmates to enroll in Arkansas Medicaid 90 days before they are released.[257] If approved, this waiver will offer continuous healthcare access for many inmates at release, reducing the risk that care for hepatitis C or other medical conditions will be interrupted.

4.9. Negotiate DAA prices

Hepatitis C treatment is expensive, with list prices initially over $70,000 per patient and falling to approximately $20,000-$25,000 in recent years as new regimens have been released on the market.[258] Many payers negotiate rebates and discounts off these list prices. Although these rebates are confidential for most payers, they are estimated to reduce the net costs substantially below list prices (national average net cost $11,500-$17,000 in 2020).[259] This is roughly consistent with publicly reported cost information from Louisiana's 2019-24 state contract for hepatitis C treatment in Medicaid and correctional facilities (16,723 patients treated[260] at an estimated cost of $35,000,000 per year for five years[261]). Especially at these lower prices, the major issue for many payers appears not to be the cost-effectiveness of DAA treatment, but the overall budgetary impact of covering DAA regimens for the possibly over 1% of their members who have hepatitis C.[262]

Public and private payers should make all possible efforts to hold down the unit cost of DAAs. This is crucial for long-term financial stability in tax-funded programs such as Medicaid, Ryan

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[254] Akiyama MJ, Kronfli N, Cabezas J, Sheehan Y, Thurairajah PH, Lines R, Lloyd AR, International Network on Health and Hepatitis in Substance Users – Prisons Network. 2021. Hepatitis C elimination among people incarcerated in prisons: challenges and recommendations for action within a health systems framework. *Lancet Gastroenterol Hepatol*. 6(5):391-400. https://doi.org/10.1016/s2468-1253(20)30365-4.

[255] Federal Bureau of Prisons. 2021. Evaluation and management of hepatitis C virus (HCV) infection: Federal Bureau of Prisons clinical guidance. https://www.bop.gov/resources/pdfs/hcv_guidance.20210513.pdf.

[256] American Association for the Study of Liver Diseases / Infectious Diseases Society of America. 2023. HCV guidance: recommendations for testing, managing, and treating hepatitis C: HCV testing and treatment in correctional settings. https://www.hcvguidelines.org/unique-populations/correctional.

[257] Centers for Medicare and Medicaid Services 2024.

[258] U.S. Department of Health and Human Services Office of Inspector General. 2022. Part D plan preference for higher-cost hepatitis C drugs led to higher Medicare and beneficiary spending [OEI-BL-00200]. https://oig.hhs.gov/reports/all/2022/part-d-plan-preference-for-higher-cost-hepatitis-c-drugs-led-to-higher-medicare-and-beneficiary-spending/.

[259] Silseth S, Shaw H. 2021. Analysis of prescription drugs for the treatment of hepatitis C in the United States. Milliman. https://www.milliman.com/en/insight/analysis-of-prescription-drugs-for-the-treatment-of-hepatitis-c-in-the-united-states.

[260] Louisiana Department of Health. 2024. Hepatitis C treatment: Medicaid and state corrections. https://ldh.la.gov/assets/hepc/prod/.

[261] Georgetown Law School O'Neill Institute for National & Global Health Law. 2021. Innovative payment models: an analysis of the promise and practice of novel hepatitis C procurement strategies in the U.S. https://oneill.law.georgetown.edu/wp-content/uploads/2021/07/Innovative-Payment-Models.pdf.

[262] Linas BP, Nolen S. 2018. A guide to the economics of hepatitis C virus cure in 2017. *Infect Dis Clin North Am*. 32(2):447-459. https://doi.org/10.1016/j.idc.2018.02.013.

White, or the Department of Corrections managed care contract; in plans with copays, it also reduces the costs that must be passed on to patients. Payers may consider strategies such as joining prescription drug purchasing pools,[263] offering preferred drug list placement in exchange for rebates, or negotiating "subscription pricing" agreements where an unlimited volume of prescriptions is available for a flat yearly fee.[264] These approaches are often legally, financially, or administratively complex, but they can generate substantial savings, which reduces financial strain and improves patient access.[265] In turn, insurance plans should ensure that cost-sharing provisions in their plans are not preventing patients from accessing DAAs when needed.

[263] National Council of State Legislatures. 2023. Bulk purchasing of prescription drugs. https://www.ncsl.org/health/bulk-purchasing-of-prescription-drugs.
[264] Georgetown Law School O'Neill Institute for National & Global Health Law 2021.
[265] U.S. Department of Health and Human Services. 2024. Financing integrated viral hepatitis services: recommendations for state and federal entities. https://www.hhs.gov/sites/default/files/financing-integrated-viral-hepatitis-services-report.pdf.

5. Prevention

Most new hepatitis C infections today are the result of sharing needles and other equipment during injection drug use. To prevent these infections, people who are using drugs need access to services that will help them stop injecting or reduce the risks of bloodborne infections from sharing needles and make progress toward recovery. Many stakeholders have the opportunity to improve these services, guided by a growing evidence base about hepatitis C prevention. Stakeholders are encouraged to consider additional steps to prevent the harms associated with injection drug use and non-sterile needles and other drug injection equipment.

5.1. Offer MOUD

Every Arkansan who is living with drug addiction should have access to compassionate, evidence-based treatment. For people with opioid use disorder, the gold standard is MOUD with methadone, buprenorphine, or naltrexone, which suppress cravings for opioids or block their psychological effects.[266] In addition to reducing addiction and overdoses, MOUD helps people stop injecting opioids and reduces the incidence of hepatitis C.[267]

UAMS offers technical and financial assistance to providers who prescribe buprenorphine,[268] and providers in areas where patients have low access to MOUD should consider participating in this program. Since 2023, any prescriber with a valid Drug Enforcement Administration registration can prescribe buprenorphine.[269]

Providers in all settings who encounter patients with opioid use disorder should have a plan to offer MOUD or refer to an MOUD provider with a "warm handoff." Any provider who cannot offer substance use treatment on site can use the directories available from the Substance Abuse and Mental Health Services Administration[270] and the Arkansas Department of Human Services[271] to locate nearby facilities. The Department of Corrections has instituted a program to offer naltrexone to certain inmates,[272] and every effort should be made to continue and expand this initiative.

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[266] American Society of Addiction Medicine. 2020. The ASAM national practice guideline for the treatment of opioid use disorder: 2020 focused update. *J Addict Med.* 14(2S Suppl 1):1-91. https://doi.org/10.1097/adm.0000000000000633.

[267] Platt L, Minozzi S, Reed J, Vickerman P, Hagan H, French C, Jordan A, Degenhardt L, Hope V, Hutchinson S, et al. 2017. Needle syringe programs and opioid substitution therapy for preventing hepatitis C transmission in people who inject drugs. *Cochrane Database Syst Rev.* 9(9):CD012021. https://doi.org/10.1002/14651858.cd012021.pub2.

[268] University of Arkansas for Medical Sciences. 2024. Improving access to treatment for opioid use disorder. https://psychiatry.uams.edu/clinical-care/outpatient-care/cast/improving-access-to-treatment-for-opioid-use-disorder/.

[269] Substance Abuse and Mental Health Services Administration. 2024. Waiver elimination (MAT Act). https://www.samhsa.gov/medications-substance-use-disorders/waiver-elimination-mat-act.

[270] Substance Abuse and Mental Health Services Administration. 2024. FindTreatment.gov. https://findtreatment.gov/.

[271] Arkansas Department of Human Services. 2024. DAABHS substance abuse treatment services: catchment areas, funded contractors. https://humanservices.arkansas.gov/divisions-shared-services/shared-services/office-of-substance-abuse-and-mental-health/samh-treatment/; https://humanservices.arkansas.gov/wp-content/uploads/CSAT-8-Funded-Providers-Map-Updated.10.2024.pdf.

[272] Arkansas Department of Corrections. 2018. Arkansas Community Correction administrative directive: 18-35 medication assisted treatment. https://doc.arkansas.gov/wp-content/uploads/2020/09/AD_18-35_Medication_Assisted_Treatment_AD.pdf.

5.2. Offer behavioral treatment for stimulant use disorder

For some substance use disorders, especially disorders involving stimulants such as methamphetamine and cocaine, medication is not available and the standard of care is behavioral treatment.[273] Contingency management, where patients are rewarded for negative drug screens, has the strongest evidence base for stimulant use;[274] it has been widely adopted within the Veterans Affairs health system[275] but is generally underused in other settings.[276,277] There is also some evidence of effectiveness for other behavioral treatment approaches such as community reinforcement and cognitive behavioral therapy.[278,279]

Providers should have plans to offer in-house behavioral treatment or offer a "warm handoff" when necessary. Substance use treatment programs should prioritize evidence-based behavioral interventions, such as contingency management for the treatment of stimulant use disorders. The need for effective stimulant use disorder treatment is especially urgent for the many Arkansans who are living with a methamphetamine addiction. Methamphetamine is likely among the most commonly injected drugs in the state, so helping more people get into recovery from methamphetamine use disorder will help prevent hepatitis C transmission from sharing needles.

5.3. Use evidence-based strategies to prevent overdoses

Healthcare providers who routinely see patients with a substance use disorder should be prepared to discuss substance use and overdose prevention. Although the goal is to help everyone achieve recovery, some patients are not ready to enter treatment immediately or may relapse once they have started treatment. Overdose prevention is not only important for these patients overall, since they are at ongoing risk, but also a key part of care for hepatitis C, since patients need to avoid fatal overdoses in order to engage in hepatitis C treatment. Opioid overdose prevention interventions are appropriate for patients who report many kinds of drug use, not only opioid use,

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[273] American Society of Addiction Medicine and American Academy of Addiction Psychiatry. 2024. The ASAM/AAAP clinical practice guideline on the management of stimulant use disorder. *J Addict Med.* 18(1S Suppl 1):1-56. https://doi.org/10.1097/adm.0000000000001299.

[274] Brown HD, DeFulio A. 2020. Contingency management for the treatment of methamphetamine use disorder: a systematic review. *Drug Alcohol Depend.* 216:108307. https://doi.org/10.1016/j.drugalcdep.2020.108307.

[275] DePhilippis D, Khazanov G, Christofferson DE, Wesley CW, Burden JL, Liberto J, McKay JR. 2023. History and current status of contingency management programs in the Department of Veterans Affairs. *Prev Med.* 176:107704. https://doi.org/10.1016/j.ypmed.2023.107704.

[276] Rawson RA, Erath TG, Chalk M, Clark HW, McDaid C, Wattenberg SA, Roll JM, McDonell MG, Parent S, Freese TE. 2023. Contingency management for stimulant use disorder: progress, challenges, and recommendations. *J Ambul Care Manage.* 46(2):152-159. https://doi.org/10.1097/jac.0000000000000450.

[277] U.S. Department of Health and Human Services. 2023. Contingency management for the treatment of substance use disorders: enhancing access, quality, and program integrity for an evidence-based intervention. https://aspe.hhs.gov/reports/contingency-management-treatment-suds.

[278] De Crescenzo F, Ciabattini M, D'Alò GL, De Giorgi R, Del Giovane C, Cassar C, Janiri L, Clark N, Ostacher MJ, Cipriani A. 2018. Comparative efficacy and acceptability of psychosocial interventions for individuals with cocaine and amphetamine addiction: a systematic review and network meta-analysis. *PLoS Med.* 15(12):e1002715. https://doi.org/10.1371/journal.pmed.1002715.

[279] De Giorgi R, Cassar C, D'Alò GL, Ciabattini M, Minozzi S, Economou A, Tambelli R, Lucchese F, Saulle R, Amato L, et al. 2018. Psychosocial interventions in stimulant use disorders: a systematic review and qualitative synthesis of randomized controlled trials. *Riv Psichiatr.* 53(5):233-255. https://doi.org/10.1708/3000.30003.

since fentanyl and fentanyl analogs may be present in the supply of other drugs such as methamphetamine.[280]

Providers should offer counseling and services that will help reduce drug overdoses, such as naloxone and fentanyl test strips. Naloxone, an opioid antagonist that can reverse opioid overdoses,[281] is available to any Arkansan under a statewide standing order,[282] and fentanyl test strips are exempt from Arkansas's drug paraphernalia laws.[283] If funding is needed for naloxone, fentanyl test strips, or other overdose prevention interventions, healthcare providers and community organizations can apply for grants from the Arkansas Opioid Recovery Partnership.[284] Some community organizations, such as the Central Arkansas Harm Reduction Project, already distribute naloxone and have reported a number of successful overdose reversals.[285]

5.4. Pay for substance use treatment according to guidelines

Arkansas law requires insurers to cover MOUD with minimal restrictions,[286] and most insurance plans are also subject to a federal requirement to provide behavioral health and substance use coverage at "parity" with physical healthcare.[287] Insurance carriers should strive to meet these objectives even in plans that may be exempt from such mandates and should continuously evaluate the adequacy of their networks to provide substance use treatment. Wherever possible, reimbursement policies should incentivize substance use treatments that are known to be effective, such as MOUD, or contingency management for stimulant use disorder.

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[280] U.S. Drug Enforcement Administration. 2024. Facts about fentanyl. https://www.dea.gov/resources/facts-about-fentanyl.

[281] Chimbar L, Moleta Y. 2018. Naloxone effectiveness: a systematic review. *J Addict Nurs*. 29(3):167-171. https://doi.org/10.1097/jan.0000000000000230.

[282] Arkansas Department of Health. 2024. Arkansas opioid antagonist protocol. https://healthy.arkansas.gov/wp-content/uploads/Naloxone_Standing_Order_Dr_Bala.pdf.

[283] Ark. Code Ann. § 5-64-101.

[284] Arkansas Opioid Recovery Partnership. 2024. Funding opportunities. https://www.arorp.org/funding-opportunities/.

[285] Pro G, Richoux C, Bolt M, Kincade A, White R, Kasper C, Zaller N. 2024. Factors associated with self-reported overdose reversals using naloxone in Little Rock, Arkansas: implications for harm reduction service delivery in the US South. *J Drug Issues*. Online ahead of print. https://doi.org/10.1177/00220426241236686.

[286] Ark. Code Ann. § 23-99-1119.

[287] Centers for Medicare and Medicaid Services. 2024. The Mental Health Parity and Addiction Equity Act (MHPAEA). https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity.

Application of Strategies

Although we hope all parts of this document are useful for stakeholders, some segments are more relevant than others for each stakeholder group. The following table summarizes strategies that are of interest to specific types of stakeholders as identified above.

Stakeholders	Key Strategies
Public Health	1.1, Offer patient and public education 2.1, Implement universal offer of testing 2.2, Use a one-visit testing strategy 2.4, Offer testing during every pregnancy 3.1, Collect and disseminate statewide hepatitis C data 3.2, Use alternative data sources as appropriate 3.3, Practice infection control 3.4, Maintain outbreak response plan 4.1, Offer treatment on site or by referral 4.4, Link pregnant women to care
Healthcare Providers	1.1, Offer patient and public education 1.3, Offer provider education 2.1, Implement universal offer of testing 2.2, Use a one-visit testing strategy 2.4, Offer testing during every pregnancy 3.3, Practice infection control 3.5, Notify if an outbreak is suspected 4.1, Offer treatment on site or by referral 4.2, Consider use of simplified treatment guidance 4.3, Use telehealth where appropriate 4.4, Link pregnant women to care 5.1, Offer MOUD 5.2, Offer behavioral treatment for stimulant use disorder 5.3, Use evidence-based strategies to prevent overdoses
Insurers	2.5, Pay for testing according to guidelines 4.5, Pay for treatment according to guidelines 4.6, Allow non-specialist providers to prescribe DAAs 4.7, Simplify prior authorization 4.9, Negotiate DAA prices 5.4, Pay for substance use treatment according to guidelines
Community-Based Organizations	1.1, Offer patient and public education 2.1, Implement universal offer of testing 2.2, Use a one-visit testing strategy 2.3, Increase testing in high-prevalence settings 4.8, Strengthen DAA coverage outside traditional insurance 5.3, Use evidence-based strategies to prevent overdoses

Substance Use Treatment Providers	1.2, Increase education in high-prevalence settings 2.1, Implement universal offer of testing 2.2, Use a one-visit testing strategy 2.3, Increase testing in high-prevalence settings 4.8, Strengthen DAA coverage outside traditional insurance 5.1, Offer MOUD 5.2, Offer behavioral treatment for stimulant use disorder
Correctional Facilities	1.2, Strengthen education in high-prevalence settings 2.1, Implement universal offer of testing 2.2, Use a one-visit testing strategy 2.3, Increase testing in high-prevalence settings 4.8, Strengthen DAA coverage outside traditional insurance

Future of Elimination

The Arkansas Department of Health prioritizes clear, concise, and timely communication with community-based organizations, healthcare providers, and the public about hepatitis C testing, treatment, and prevention best practices. The agency offers several resources on our website including a data hub dashboard with real time updates of hepatitis C data in Arkansas. Data will continue to be updated and available for accurate infection numbers. The agency will work to ensure that when there are updates to state policy or Medicaid policy relating to hepatitis C, stakeholders are aware.

The Arkansas Department of Health highly values our community-based partnerships and the essential role they play in hepatitis C testing and diagnosis. Our goal is to ensure a comprehensive and thorough approach to hepatitis C care through complete testing protocols including antibody and reflex testing, timely follow-up and continuity of care that extends through sustained treatment. We can assist in complete testing by offering support for reflex testing if community-based organizations lack the trained staff or testing equipment.

In the future, the Department of Health would like to work toward the goal of transitioning all of our community-based organizations to a point of care model for hepatitis C testing, which will greatly improve diagnosis and treatment outcomes. Compared to traditional laboratory-based testing that requires a phlebotomist, point of care testing can be done using a fingerstick which can be resulted faster and encourages more efficient continuity of care and less opportunity for patients to be lost to follow-up. This model is especially important in high prevalence settings.

Arkansas's current hepatitis C Medicaid policy has made some positive changes recently that will increase access to treatment. As of November 2023, Arkansas Medicaid does not impose fibrosis restrictions, or any substance use restrictions. There are several steps that can be taken for continued improvement, such as simplifying the prior authorization process by allowing general practitioners to submit requests enhancing access to medication. Reducing the documentation requirements for genotyping, adherence and mental health will streamline treatment start times. Targeting outreach and educational programs within Medicaid programs can raise awareness of hepatitis C and encourage adherence.

A syndemic approach to hepatitis C addresses the interconnected factors that drive spread of the virus, including substance use and limited access to healthcare. By encouraging a collaborative approach between healthcare, state and community organizations can offer more hepatitis C testing, treatment and education. This approach will ultimately improve health outcomes and may reduce hepatitis C infections. The Department of Health can take the steps toward a syndemic approach by partnering with departments within our organization that share similar goals, such as the HIV Planning Group. By including hepatitis C on the planning meeting agenda, we can gather feedback, discuss further partnership and collaboration, and share best practices for testing and education.

This evolving elimination plan is designed to be continually updated, refined and adapted based on ongoing feedback from stakeholders and community partners. Our goal is to create a plan that is both informative and genuinely reflective of the communities we serve. The objectives outlined

here will be more impactful if our state, healthcare and community-based organizations share ownership of this plan, fostering a collaborative commitment to the success of our shared hepatitis C elimination goals. We can gather feedback by conducting listening sessions and interviews with members of these groups as well as circulating a survey to obtain a better understanding of the barriers and successes these groups face when testing, treating and educating for hepatitis C. We would like to grow existing partnerships and foster new collaboration efforts because we believe if the community takes an ownership in the elimination efforts of hepatitis C we will enhance our success.

Resources

ADH Data Hub - Hepatitis (arcgis.com)
Hepatitis C - Arkansas Department of Health