The Affordable Care Act and the Silent Epidemic: Increasing the Viral Hepatitis Response Through Health Reform

ACKNOWLEDGEMENTS

The National Alliance of State & Territorial AIDS Directors (NASTAD) represents the nation's chief state health agency staff who have programmatic responsibility for administering HIV/AIDS and viral hepatitis health care, prevention, education and support service programs funded by state and federal governments. NASTAD represents the Viral Hepatitis Prevention Coordinators (VHPCs) as part of our membership.

NASTAD strengthens state and territory-based leadership, expertise and advocacy, and brings them to bear in reducing the incidence of HIV and viral hepatitis infections and on providing care and support to all who live with HIV/AIDS and viral hepatitis. NASTAD's vision is a world free of HIV/AIDS and viral hepatitis.

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For more information on NASTAD's work on Affordable Care Act implementation, viral hepatitis policy and programs, and a listing of Viral Hepatitis Prevention Coordinators, go to www.NASTAD.org.

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INTRODUCTION

A national commitment to improving prevention, care and treatment of viral hepatitis is essential. The Patient Protection and Affordable Care Act (ACA) has the potential to not only improve access to essential care and treatment for people living with viral hepatitis, but to diagnose viral hepatitis earlier and prevent new infections. The ACA can improve access through expansion of public and private insurance, reforms that eliminate discriminatory insurance practices and make insurance coverage more affordable, and significant investments in prevention, care coordination, and health workforce and infrastructure. This issue brief provides an overview of ACA implementation and opportunities for increasing access to prevention, care and treatment services for persons living with or at risk for viral hepatitis infection.

The Centers for Disease Control and Prevention (CDC) estimate that up to 5.3 million people are living with hepatitis B (HBV) and/or hepatitis C (HCV) in the United States and as many as 75 percent are not aware of their infection. However, these figures are based on National Health and Nutrition Examination Survey (NHANES) data, which does not include homeless individuals, those with unstable housing, or the incarcerated – populations disproportionately affected by viral hepatitis.

In 2010 alone, the CDC estimated that 35,000 Americans were newly infected with HBV and 17,000 with HCV. Unfortunately, due to the lack of an adequate surveillance system, these estimates are likely only the tip of the iceberg. In fact, there is currently no categorical federal funding dedicated specifically to national programs for viral hepatitis screening, surveillance, care or treatment. Without the necessary access to care and/or treatment, viral hepatitis can lead to chronic liver disease, cirrhosis, liver cancer and liver failure and complications from these chronic infections claim 15,000 lives annually. Analyses of viral hepatitis-related morbidity and mortality have found that the mortality rate attributed to viral hepatitis has increased over the last several years. These statistics come at a time when research advances have changed the public health response to ensure that HBV is preventable with a vaccine and HCV treatment is improving with new reports from clinical trials of successful, sustained virologic responses (SVR) to all oral, interferon-free treatments. Still, high-risk adults account for more than 75 percent of all new cases of HBV infection each year and annually result in an estimated $658 million in medical costs and lost wages.

Additionally, viral hepatitis disproportionately impacts several communities, particularly people who inject drugs (PWID), men who have sex with men (MSM), African Americans, Asian Americans and residents of rural and remote areas with limited access to medical treatment, and people living with HIV/AIDS (PLWHA)[1]. Persons born between 1945 and 1965 have the greatest risk for HCV-related morbidity and mortality and CDC released new HCV screening guidelines in 2012 recommending that providers offer the screening to anyone born in this birth.

Furthermore, thanks to government and community leadership and initiative, the *Action Plan for the Prevention, Care and Treatment of Viral Hepatitis,* provides a road map for improving viral hepatitis surveillance, testing, care, and treatment, in line with the goals of Healthy People 2020. The ACA, in turn, provides necessary tools to assist with implementation of this action plan. Perhaps the most significant opportunity presented by the ACA is the potential to leverage existing health systems and infrastructure (e.g., through public and private insurance benefits requirements, expansion of community health center services and health workforce investments) to better equip them to provide necessary prevention, screening, care and treatment for viral hepatitis. This opportunity to integrate viral hepatitis services into broader health systems is particularly important given

[1] All references to the Ryan White Program apply only to PLWHA who are co-infected with HBV and/or HCV or at risk of co-infection.

that there is no separate health infrastructure for those infected with viral hepatitis (e.g., Ryan White Program). Innovative thinking to ensure that these broader systems are responsive to viral hepatitis needs is paramount and will take commitment from health departments, state and federal government stakeholders, providers, advocates, industry and consumers alike.

The following provides an overview of some of the most significant pieces of reform for viral hepatitis prevention, screening, linkage and retention to care, and, when necessary, treatment. This document has been separated into three different sections to include Medicaid and Medicare reforms, private insurance reforms and health infrastructure reforms.

PUBLIC INSURANCE REFORM

Medicaid

The Medicaid reforms included in the ACA provide perhaps the most significant opportunity to date to transform what is a "disability system" in most states to a health care system and to increase access to regular insurance for millions of low-income people. The most significant provisions for people living with and at risk for viral hepatitis are discussed below.

Expansion of eligibility

The ACA expands Medicaid eligibility to most people with income up to 133 percent of the federal poverty level (FPL) in 2014 and, because of new income counting rules, there is an additional five percent disregard of income, effectively bumping the income threshold to 138 percent FPL. This is a significant departure from current Medicaid rules in most states, which require people to have both very low income and fall into a qualifying category (e.g., disability) before being eligible for the program. The number of people living with viral hepatitis who will be eligible for Medicaid in 2014 will vary by state. However, the Supreme Court's decision in June of 2012 greatly limited the ability of the federal government to enforce the ACA's Medicaid expansion, creating a question of whether and when every state will comply with the coverage expansion. In states that do not opt to expand Medicaid in 2014, the status quo continues for people living with viral hepatitis. Traditional Medicaid rules will continue to apply, and as is the case today, many people living with viral hepatitis will not be able to qualify. Insurance coverage through exchanges, where people can access subsidies to purchase private health insurance, will be available for those with income between 100 percent and 400 percent FPL.

➢ Action Step: Find out if your state will expand Medicaid and be prepared to point to the impact that the expansion will have on people living with and at risk for viral hepatitis.

Essential Health Benefits requirements

The essential health benefits are mandated benefits that must be included in Medicaid packages for newly-eligible beneficiaries in 2014 (those ineligible under current Medicaid law and moving into the program in 2014) as well as in private insurance plans sold in the state's individual and small group markets.

The ACA included ten categories of benefits as essential health benefits:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management, and
- Pediatric services, including oral and vision care

Even with the essential health benefits requirements, states will have a great deal of flexibility in designing a Medicaid package for newly eligible beneficiaries. This is because the law gives states the flexibility to provide the expansion population with what is called an "Alternative Benefits Plan." The proposed rule indicates that states will have a great deal of flexibility in designing Medicaid benefits packages for the expansion population – states may opt to make this package very similar to its traditional Medicaid package or opt to more closely align it with private insurance plans.

Protections for vulnerable populations to ensure that they are able to access the care and treatment they need to stay healthy already exist in federal Medicaid law, including protections that prohibit Medicaid programs from automatically placing "medically frail" populations in an Alternative Benefit Plan. Providers,

advocates and consumers are urging states to adhere to these protections and provide plans for newly eligible beneficiaries that include hepatitis A (HAV) and HBV vaccinations and viral hepatitis screening, care and treatment.

➢ Action Step: Find out if your state will expand Medicaid and be prepared to point to the impact that the expansion will have on people living with and at risk for viral hepatitis.

Prevention services without cost sharing

The ACA includes an incentive for states to provide prevention services without cost-sharing through their Medicaid programs starting in January 2013.

States will receive a one percent increase in federal matching funds for provision of services with a grade of "A" or "B" from the United States Preventive Services Task Force (USPSTF) or vaccines recommended by the CDC's Advisory Committee on Immunization Practice (ACIP). In the context of viral hepatitis, this provision offers an incentive for state Medicaid programs to provide HBV screening (which currently receive a USPSTF "A" rating) and vaccines for pregnant women. In November 2012, the USPSTF released its draft HCV screening recommendations. The USPSTF's draft gave a "B" grade recommendation for testing high-risk adults, such as those who inject drugs or who received a blood transfusion before 1992; however, the USPSTF's draft has given only a "C" grade recommendation for a one-time test to all individuals born between 1945 and 1965 ("baby boomers"), regardless of risk factors.

Should the USPSTF final recommendation stay the same, it means that routine HCV testing of baby boomers would not eligible for the increased federal match. The USPSTF is expected to release their final recommendation for HCV screening later in 2013 and has already begun the review process for their HBV screening recommendations. Finally, HAV and HBV vaccines are eligible services for the enhanced federal match.

➢ Action Step: Find out if your state is adopting these preventive services in its Medicaid program and make sure that providers are aware of potential opportunities for reimbursement.

Primary care Medicaid reimbursement bump

The ACA includes an enhanced Medicaid reimbursement rate for primary care providers in 2013 and 2014.

For those two years, the Medicaid reimbursement rate for specified evaluation and management services will be pegged to the Medicare reimbursement rate. Final federal regulations indicate that the enhanced rate will be available to physicians with a specialty designation of family medicine, general internal medicine, or pediatric medicine or subspecialty (as well as non-physician providers working under the supervision of qualified physicians).

The federal government will cover the cost of the difference between the regular Medicaid rate and the enhanced rate. Whether viral hepatitis providers will be eligible for the enhanced rate will depend on their specialty and/or subspecialty designation as well as the services for which they are billing.

➢ Action Step: Ensure that viral hepatitis providers are aware of this reimbursement bump and the eligibility criteria.

Medicaid Health Home program

The Medicaid Health Home program allows states to amend their Medicaid state plans to provide care coordination services (including care management, patient and family support, referral to community and social support services, and use of health information technology to link services) to high-need Medicaid beneficiaries with chronic conditions.

Oregon's Medicaid Health Home Program

Prior to the ACA, Oregon had initiated the Oregon Patient-Centered Primary Care Home Program, which developed a definition for a primary care medical home, including quality measures and processes for provider certification, and incorporated enhanced Medicaid reimbursement for certified medical home providers. Oregon's State Plan Amendment implementing the ACA's Medicaid Health Home Program builds on this model, identifying individuals living with HCV as eligible for the program.

Oregon's program designates the following as qualified health home providers:

- Physicians (including pediatricians, gynecologists, obstetricians, Certified Nurse Practitioners and Physician Assistants)
- Clinical practices or clinical group practices
- Federally Qualified Health Centers
- Rural Health Clinics
- Tribal clinics
- Community health centers
- Community mental health program
- Drug and alcohol treatment programs with integrated primary care providers

Services eligible for the enhanced match include:

- Comprehensive care management (e.g., development of action plans to better manage chronic conditions)
- Care coordination (e.g., tracking of tests and result notification and referrals and collaboration specialty providers)
- Self-management resources
- Individual and family support services (including peer supports)
- Referrals to community and support services

Under the program, states are eligible for an enhanced federal match (90 percent federal match for the first two years of the program) for providing these care coordination services. The ACA includes a non-exhaustive list of eligible conditions and the Secretary of the Department of Health and Human Services (HHS) has used her authority to expand this list. For instance, states have already been approved for programs that include viral hepatitis.

This program has particular potential to improve viral hepatitis care because of the often multiple needs and coordination among medical and social services providers needed to enable people to adhere to treatment regimens.

➢ Action Step: Find out if your state has proposed a Health Home Program under the new ACA option, and ensure that state Medicaid officials are aware that viral hepatitis is an eligible condition for the program.

Medicare

In addition to major reforms of the Medicaid program, the ACA also introduces a number of provisions aimed at making prescription drug coverage through Medicare Part D more affordable and improving prevention services for Medicare beneficiaries. These provisions are discussed below.

Medicare Part D reforms

The ACA includes significant reforms to make prescription drug coverage under the Medicare Part D program more affordable.[2] Many of these reforms are already helping people living with viral hepatitis more easily afford prescriptions. Most significantly, the ACA phases out the "coverage gap" or "doughnut hole," which occurs after a beneficiary has incurred a certain amount of out-of-pocket spending but before catastrophic coverage applies and during which the beneficiary is responsible for 100 percent of out-of-pocket costs. Starting in 2011, drug manufacturers are required to provide beneficiaries with a 50 percent discount on the price of brand-name drugs for beneficiaries in the coverage gap. In addition, the coverage gap will be incrementally phased out completely by 2020.[3] Also starting in 2011, AIDS Drug Assistance Program (ADAP), which currently allows for payment of viral hepatitis treatments for individuals who are co-infected with HIV and HBV and/or HCV, contributions can count toward the out-of-pocket spending threshold a beneficiary must reach before entering catastrophic coverage and getting out of the coverage gap. For people who are co-infected with HIV and viral hepatitis and for whom ADAPs help with Medicare Part D payments, this provision is already helping to make prescription drug coverage more affordable.

➢ Action Step: Ensure that clients are aware of Medicare Part D reforms and the availability of financial assistance to get through the coverage gap.

Medicare preventive services requirements

Starting in 2011, the ACA requires Medicare to cover a new annual wellness visit, which will include a screening schedule based on USPSTF recommendations. In addition, Medicare must cover the following prevention services without cost sharing: HBV vaccine, HIV screening, mammograms, colorectal screening, cervical cancer screening, cholesterol/cardiovascular screening, diabetes screening, medical nutrition therapy, prostate screening, annual flu, pneumonia vaccine, and bone mass measurement, and abdominal aortic aneurism screening for at-risk individuals.[4] Every day, more and more baby boomers become newly eligible for Medicare. Although the USPSTF draft grade of a "C" for baby boomers does not allow for automatic inclusion of screening to be part of the annual wellness visit or the "Welcome to Medicare" initial preventive exam for new Medicare beneficiaries, the Secretary of HHS does have the discretion to include HCV screening in both visits.[5]

➢ Action Step: Ensure that providers and clients are aware of new Medicare preventive services requirements.

[2] ACA, § 3301.

[3] United States Government Accountability Office, Medicare Part D Coverage Gap Discount Program Effects and Brand-Name Drug Price Trends (September 2012), available at http://www.finance.senate.gov/newsroom/chairman/download/?id=e892854a-706c-4738-b8fb-f441387623f3.

[4] ACA, §§ 4103, 4104; Healthcare.gov, Fact Sheet: Benefits for Seniors of New Affordable Care Act Rules on Expanding Prevention Coverage, http://www.healthcare.gov/news/factsheets/pdf/07-14-10_prevention_seniors_fact_sheet.pdf.

[5] Social Security Act (SSA) §§ 1834(n)(1)(B), SSA 1861(hhh)(2)(G)

PRIVATE INSURANCE REFORMS

Coupled with the significant expansion of Medicaid eligibility, the ACA also makes private insurance more accessible through a number of provisions that eliminate discriminatory insurance underwriting practices, streamline application and enrollment procedures, and make coverage more affordable. These provisions are discussed below.

Exchange establishment and design

Starting in 2014, every state must have an "exchange" – a regulated marketplace where people and small businesses can compare and purchase private insurance. States have the option of setting up their own exchange, letting the federal government run the exchange, or working collaboratively with the federal government to share exchange functions. Regardless of which model a state chooses, all exchanges must have:

- **Consumer outreach programs**
  Every exchange must have a Patient Navigator program that will help provide outreach and information to applicants, including information about what programs people may be eligible for and how to apply and enroll. The program must include at least one community-based non-profit. In addition, states must pursue a range of consumer outreach activities through in-person assisters, websites, and written materials. These programs must be responsive to vulnerable populations, including those who may be living with or at risk for viral hepatitis. In order to ensure that people living with viral hepatitis are directed to the appropriate coverage option, outreach programs must contract with community providers (e.g., community health centers, Ryan White Program providers, and safety net hospital systems).

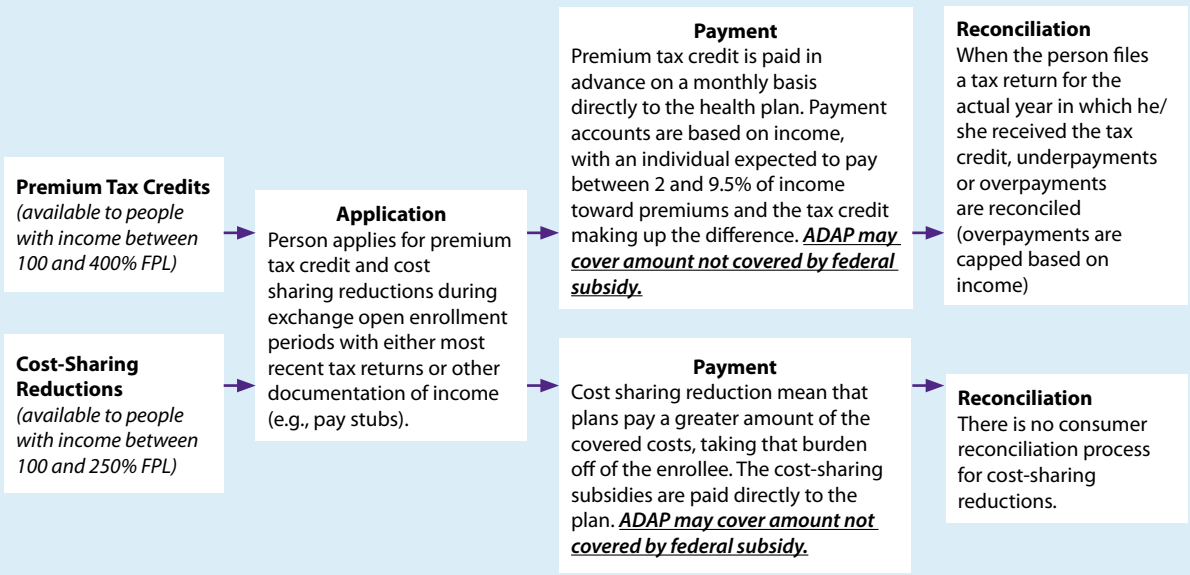
- **Plan certification standards**
  In addition to meeting benefits requirements, plans sold through exchanges will have to meet criteria established by the exchange. These criteria include how many and what types of providers have to be available in plan networks as well as quality measures plans have to use. An adequate provider network will be particularly important for people living with viral hepatitis who will need uninterrupted access to providers that have the skills and experience to treat them. Ensuring meaningful access to liver specialists (e.g. gastroenterologists, hepatologists, etc.), for instance, will be critical to ensuring that provider networks include viral hepatitis providers.

- **Affordability**
  In addition to access and quality standards, the ACA includes a number of provisions aimed at making private insurance more affordable. This is particularly important in the context of viral hepatitis treatment because access to prescription drug coverage is often complicated by plan design features that can greatly increase the out-of-pocket expenses of certain drugs. For instance, many prescription drug formularies place HCV treatment medications on specialty tiers, with up to 30 percent coinsurance. The following are the most significant provisions for people living with viral hepatitis:

  - **Advance premium tax credit**: People with income between 100 and 400 percent FPL who are not eligible for Medicaid, affordable employer-sponsored coverage, or any other public insurance will have access to premium tax credits to help offset the cost of premiums. People will apply for these credits through the exchange and premium payments will be paid in advance directly to plans. The amount of assistance will depend on a person's income.

  - **Cost-sharing reductions**: Cost-sharing reductions, which will limit the amount of money people will have to pay out of pocket for services, are available for people with income between 100 and

How Federal Subsidies to Purchase Private Insurance Work



250 percent FPL. Like the premium tax credit, people will apply for cost-sharing reductions when they apply for coverage through the exchange.

➢ Action Step: Ensure that clients are aware of new ACA provisions that will make private insurance more affordable and how to apply.

Essential Health Benefits requirements

Starting in 2014, plans sold in the individual and small group markets must include the ten categories of "essential health benefits" described earlier. HHS has indicated through a proposed rule that states will have a great deal of flexibility in defining and implementing this standard.[6] States may choose from one of ten private insurance plans already in place in the private insurance market and this plan will become the "benchmark" for essential health benefits requirements. The following provisions will have the greatest impact on access to viral hepatitis prevention, care and treatment:

- **Definitions of benefits categories**
  The following benefits categories are the most significant for people living with and at risk for viral hepatitis:

  ➢ **Prescription drug coverage** requirements require plans to cover the greater of 1) one drug in every category and class *or* 2) the same number of drugs in each category and class as the EHB-benchmark plan. Analysis of prescription drug coverage within benchmark options indicates that most plans go well beyond one drug per class and cover the vast majority of anti-retroviral medications. Each plan is able to cover different drugs than are covered by the benchmark plan, but drugs must be presented using U.S. Pharmacopeia (USP) classification system. Importantly, plans must have procedures in place to ensure that enrollees have access to clinically appropriate drugs

[6] HHS, Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, November 26, 2012, available at, http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf.

that are prescribed by providers but not included on the plan's drug list. A list of state benchmark choices was appended to the proposed rule and a number of state plans appear to offer subpar coverage within the hepatitis antiviral drug class.[7]

- **Mental health and substance use disorder services**, including behavioral health treatment services, must be provided in accordance with the Mental Health Parity and Addiction Equity Act of 2008. This means that mental health and substance use disorder services cannot be subject to more restrictive treatment limits, financial requirements, or scope of coverage than medical/surgical benefits. Access to the range of services effective at treating mental illness and substance use disorders is critical to prevent inpatient hospitalizations and to support people living with viral hepatitis to maintain the care and treatment that they need to stay healthy. However, more details are needed as to how the parity requirements will be measured and enforced.

- **Preventive services** must include all of the preventive services required by section 2713 of the ACA. The EHB definition essentially incorporates the preventive services that all new group or individual non-grandfathered private insurance are required to cover starting in 2010 (and 2012 for women's preventive services). These services include preventive services with a USPSTF Grade A or B rating, ACIP recommended vaccines and immunizations, as well as specified women's preventive services). Importantly, this means that routine HCV screening will not be a required service for baby boomers (though screening for those at high risk will be covered). HBV screening will only be covered for pregnant women. In addition, HAV and HBV vaccines will be required services without cost sharing.

- **Chronic disease management** is a required benefits category under the EHB rule, however there is no federal definition as to what services encompass chronic disease management. Consumer advocates have urged for viral hepatitis to be identified as a condition eligible for chronic disease management and have recommended that HHS define the benefit to include patient-centered care coordination and case management services along with the flexibility to cover services (such as nutrition services and adherence support) as medically indicated. Comprehensive disease management benefits are crucial to support both engagement in care and treatment adherence, both of which will help to reduce complications arising from untreated viral hepatitis such as liver cirrhosis and liver cancer.

- Action Step: Find out here what benchmark plan your state chose for the private insurance market and if this benchmark includes viral hepatitis prevention, care, and treatment services.

- **Non-discrimination and enforcement** The ACA includes protective language to ensure that insurance plans do not discriminate based on health status or disability and to ensure that benefits packages are able to meet the needs of vulnerable populations. HHS has incorporated a non-discrimination mandate into the

[7] CCIIO, Additional Information on Proposed State Essential Health Benefits Benchmark Plans, available at http://cciio.cms.gov/resources/data/ehb.html. Ten state benchmark plans appear to offer limited coverage within the anti-hepatitis drug class (Colorado, the District of Columbia Hawaii, Iowa, Maryland, New Mexico, North Carolina, Pennsylvania, South Dakota, Tennessee, and Utah). In some states, the hepatitis medications may be covered as a "specialty" drug, but is unclear from the regulation how specialty medications will be reflected in the drug coverage standard set by the state benchmark.

definition of EHB, prohibiting an insurance issuer from meeting EHB requirements if its benefit design "discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions." States are charged with monitoring and identifying discriminatory plan designs, and states are encouraged to develop discrimination analyses to identify significant deviation from typical plan offerings, including unusual cost sharing and benefits limits. This provision does not prohibit issuers from using utilization management techniques (e.g., prior authorization); however, issuers cannot use these techniques to discriminate against certain groups of people. In the context of viral hepatitis, there may be an opportunity to use the non-discrimination requirements to ensure that critical medications are not placed out of reach of people who need them through specialty tiers or extremely high cost sharing.

- Action Step: Identify discriminatory plan designs – for instance, exclusions or service limits that prevent people living with viral hepatitis from accessing care and treatment – and report those practices to your state department of insurance.

Pre-existing Condition Insurance Plans (PCIP)
To provide a bridge to 2014, starting in 2010 the ACA required every state to have a PCIP to provide insurance coverage to people with pre-existing conditions (including viral hepatitis) who are not eligible for public insurance and cannot access insurance in the private market. A person must be a U.S. citizen, be uninsured for six months, and provide a letter from an insurance company denying coverage. States have the option of running their own PCIPs or allowing the federal government to run the PCIP. People currently enrolled in PCIPs will transition to coverage through the exchanges in 2014, and ensuring that this transition is smooth for people living with viral hepatitis will be essential to prevent harmful disruptions in care and treatment.

- Action Step: Find out what your state's transition plan is for people currently enrolled in a PCIP (or state high risk pool, many of which are also closing in December of 2013).

HEALTH INFRASTRUCTURE INVESTMENTS

In addition to improving access to insurance coverage and developing standards for the content of that coverage, the ACA includes a number of investments and programs aimed at improving the ability of the nation's public health infrastructure and workforce to adapt to and innovate with those public and private insurance expansions. The following provisions will have the greatest impact on access to viral hepatitis prevention, care and treatment:

- **Community health center investments**
  The ACA includes a significant investment in community health centers, which currently act as a vital safety net for millions of low-income people and will become an even more important source of care in 2014 as more people enter the health care system. The ACA includes $11 billion in new funding for community health centers, to fund the creation of new health centers and to allow existing health centers to expand their capacity.[8] This investment will improve access to viral hepatitis prevention and care in several ways. First, many community health centers also provide viral hepatitis care and additional money will help them either initiate or expand these services. Second, viral hepatitis providers may take advantage of new opportunities to apply to become a federally qualified health center (FQHC). And third, because of the community health center expansion, there may be increased opportunities for viral hepatitis providers to create affiliation agreements or other relationships with community health centers to ensure that people living with viral hepatitis have access to the range of services they need to stay healthy.

- **Prevention and Public Health Fund**
  The most significant investment in prevention and wellness included in the ACA is establishment of the Prevention and Public Health Fund. The Fund allocates billions of dollars for prevention initiatives and programs each year, including viral hepatitis prevention activities overseen by the Centers for Disease Control and Prevention (CDC).[9] In FY2012, the Division of Viral Hepatitis (DVH) received $10 million for a viral hepatitis screening initiative. This is an unprecedented investment in the identification of the millions of people who do not know their HBV or HCV status. These additional testing dollars have been dispersed to prioritize early identification of foreign-born persons living with HBV, HCV testing and linkage to care in settings that provide services to PWID, and HCV services in community health centers and other settings. The Fund also includes a "Community Transformation Grant" program, which supports state and local governments as well as community-based organizations to implement comprehensive prevention plan programs in their communities.[10] The Fund provides an opportunity to continue to leverage new funding streams for viral hepatitis prevention going forward.

- **Health information technology**
  A key goal of the ACA is to improve and modernize the nation's health information technology (IT) systems.[11] To further this goal, the ACA includes a number of programs and incentives to support states in building and implementing data systems to operate exchanges, support

[8] ACA, § 10503.

[9] ACA, § 4002.

[10] CDC, Community Transformation Grants, available at http://www.cdc.gov/communitytransformation/index.htm.

[11] Emma Hoo, et al., Commonwealth Fund, Health Plan Quality Improvement Strategy Reporting Under the Affordable Care Act: Implementation Considerations (April 2012), http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Apr/1592_Hoo_hlt_plan_qual_improve_strategy_report_v2.pdf.

Medicaid reforms, and improve states' ability to measure and monitor health quality indicators. This investment in health IT systems provides an opportunity to create and improve viral hepatitis surveillance systems, for instance, by including upgrades to surveillance information technology in state public health initiatives and programs (e.g., through "Community Transformation Grants" discussed earlier). There may also be opportunities to improve the collection of health quality indicator information in state Medicaid programs as states upgrade their Medicaid Management Information Systems (MMIS). Finally, on the private insurance side, the ACA requires plan reporting and data collection to improve health care quality. HHS is collecting stakeholder input on quality measures that should be reported with a goal of publishing national standards and templates to support this kind of data collection.[12] These efforts complement the Health Information Technology for Economic and Clinical Health (HITECH) Act, which creates incentives for the adoption of health information technology that will improve quality of care, including electronic health records (EHRs) and private and secure electronic health information exchange. Eligible health care professionals and hospitals can qualify for Medicare and Medicaid incentive payments when they adopt certified EHR technology and use it to advance specific quality goals. These provisions and investments provide an opportunity to better integrate both viral hepatitis surveillance and quality measures into a range of public health and private and public health insurance systems.

➢ Action Step: Find out if your local community health center is currently providing viral hepatitis screening or treatment and explore opportunities to partner with community health centers and other safety net providers that may be increasing the scope of their services as a result of ACA investments.

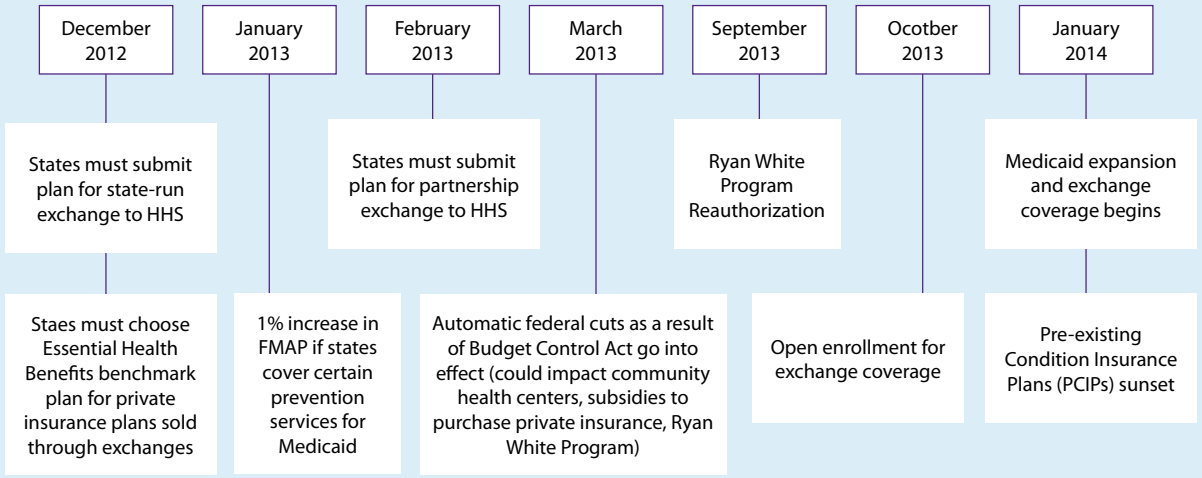
[12] ACA, § 2717; HHS, Request for Information Regarding Health Care Quality for Exchanges, 77 Federal Register 70786 (Nov. 27, 2012), available at http://www.gpo.gov/fdsys/pkg/FR-2012-11-27/pdf/2012-28473.pdf.

BEYOND THE ACA: ONGOING CHALLENGES AND OPPORTUNITIES

While the ACA provides a number of tools to help improve prevention, care and treatment of viral hepatitis, there will continue to be gaps in services and populations covered that must be addressed. First, though the EHB requirements discussed earlier will undoubtedly improve access to substance use services, injection drug users (a very high risk group for viral hepatitis) still face many barriers to care and treatment. Lifting the federal ban on syringe-exchange programs, for instance, is essential to enabling community-based harm reduction programs to continue to make headway against HCV transmission. In addition to gaps in covered services, there will also be significant gaps in populations covered. The ACA did not change current federal laws around coverage of undocumented immigrants, and this population will not be eligible for Medicaid under the 2014 expansion or for private insurance available through exchanges.[13] The ACA also leaves in place the five-year ban before legal immigrants are eligible for Medicaid. However, legal immigrants within the five-year Medicaid ban may enroll in coverage through exchanges and are eligible for federal subsidies to purchase insurance. These exclusions will have a particular impact on foreign-born, undocumented individuals from countries with a higher than 2 percent prevalence of HBV. The gaps in services and populations covered through the ACA underscore the importance that safety net health systems and providers will play to ensure that people living with and at risk for viral hepatitis have access to lifesaving prevention, care and treatment.

[13] ACA, § 1312(f).

ACA Implementation Timeline: Key Dates



CONCLUSION

The ACA offers an unprecedented opportunity to improve early identification and linkage to comprehensive care and treatment for viral hepatitis. However, realizing this opportunity will require leadership and vision from providers, advocates and federal, state, and local government. Many of the ACA's provisions are broad and require federal and state regulatory decisions. For instance, whether and when states will expand Medicaid, whether exchanges are designed in ways that are responsive to vulnerable populations, and whether benefits requirements meet the prevention, care, and treatment needs are decisions that are playing out in states in the coming months. Viral hepatitis advocates and providers – and particularly state health departments – have a role to play to ensure that these new ACA systems are responsive to these needs. For instance, the CDC-funded Viral Hepatitis Prevention Coordinators (VHPCs) in 48 states and four cities will be crucial in helping to ensure that these broader systems and reforms are implemented in ways that meet viral hepatitis prevention, screening, and treatment needs.

Health Reform Resources:

- NASTAD Health Reform Resources
- HIV Health Reform
- State Refo(ru)m
- Center for Consumer Information and Insurance Oversight (CCIIO)
- CMS Medicaid Health Home Resources
- Healthcare.gov