



June 22, 2015

The Honorable Orrin Hatch, Ron Wyden, Johnny Isakson and Mark R. Warner  
Chronic Care Working Group  
Committee on Finance  
United States Senate  
Washington, DC 20510-6200

*Submitted via e-mail to [chronic\\_care@finance.senate.gov](mailto:chronic_care@finance.senate.gov)*

Dear Chairman Hatch, Ranking Member Wyden and Senators Isakson and Warner:

The National Viral Hepatitis Roundtable (NVHR) appreciates the opportunity to comment on strategies for improving the quality and coordination of Medicare beneficiaries' chronic care services. NVHR is a broad coalition of over 250 organizations working to fight, and ultimately end, the hepatitis B and hepatitis C epidemics.

### **Hepatitis C:**

The Centers for Disease Control and Prevention (CDC) estimates that 2.7 - 3.9 million individuals in the United States are living with chronic hepatitis C, the majority of whom – approximately 75% – do not know they are infected. This estimate is likely to be much higher, as impacted communities such as the homeless and the incarcerated are undercounted. Undiagnosed hepatitis C is the leading cause of catastrophic liver damage, liver transplants, and liver cancer, which is the fastest-rising cause of cancer-related deaths. Underscoring the need for improved screening and linkage to care, hepatitis C has been responsible for more annual deaths in the United States than HIV since 2007 – a number that is expected to double or triple in the next 20 years if current trends are sustained.

With baby boomers (those born during 1945-1965) comprising three-quarters of Americans living with hepatitis C and facing five-fold higher odds of infection, the Medicare population increasingly will be affected, necessitating immediate and proactive steps to detect and treat this chronic condition. Patients with hepatitis C average five times more hospitalizations and triple the emergency room visits as patients without the virus, and generate \$25,296 – five-fold more – in annual excess health costs per patient. Hepatitis C leads to end-stage liver disease and increases patients' risk of liver cancer. Both conditions are precursors that can lead to a liver transplant, which is highly invasive and costly.<sup>1</sup> Among those needing liver transplants, all-cause costs can reach \$264,756 annually in addition to the costs directly associated with the transplant. Studies have found that without access to treatment, including newly

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<sup>1</sup> Centers for Disease Control and Prevention (CDC): <http://www.cdc.gov/hepatitis/C/cFAQ.htm#statistics>

available direct-acting antivirals with high cure rates, the lifetime costs of care for those currently living with hepatitis C is projected to be \$360 billion.

To advance the Committee's goal of identifying bipartisan policy opportunities to strengthen chronic care management in Medicare, we suggest:

- **Adding Hepatitis C Screening Education to the “Welcome to Medicare” Visit** – As baby boomers enter Medicare in increasing numbers, the “Welcome to Medicare” visit<sup>2</sup> provides a key opportunity for preventive care and identification of chronic care coordination opportunities. We recommend that in light of hepatitis C's disproportionate prevalence among baby boomers, the Committee's Chronic Care Working Group explore having the Centers for Medicare and Medicaid Services (CMS) include hepatitis C-related educational information in the Welcome Visit as well as in beneficiaries' ensuing Annual Wellness Visits. This would help prevent missed opportunities to provide a recommended preventive service and enable providers to coordinate any identified need for hepatitis C treatment with beneficiaries' broader care needs. It would also help newly enrolled beneficiaries utilize their HCV screening benefit. Awareness is the first critical step to preventing transmission to others as well as helping ensure the patient is connected to appropriate follow up care.
- **Enabling More Providers to Perform Medicare-Covered Screening** – CMS' National Coverage Determination (NCD) for hepatitis C screening<sup>3</sup> enables primary care providers to perform U.S. Preventive Services Task Force (USPSTF) and CDC-recommended screening for hepatitis C. However, broadening the NCD to enable specialists – such as infectious disease practitioners, hepatologists, gastroenterologists, and emergency physicians – as well as hospital emergency departments (EDs) and Medicare-participating substance abuse providers to receive payment for these critical screenings would facilitate access among additional high-need beneficiaries. These include patients who lack an ongoing relationship with a primary care provider but – in the case of low income beneficiaries, or a high-risk person co-infected with HIV/AIDS or with a history of injection drug use, for instance – may see an infectious disease practitioner or other provider for ongoing care. The ability of ED physicians and hepatitis specialists to perform screenings is critical for successfully identifying and treating a disease in which the overwhelming majority of patients go undiagnosed. For example, a CDC-led pilot initiative in Birmingham, AL, found a 12.3% rate of the disease among a cohort of ED patients who had not been tested.<sup>4</sup> Limiting screening solely to primary care providers undermines other important priorities for CMS, such as care coordination and patient-centered care.
- **Pursuing a Demonstration Program to Improve Hepatitis C Care** – In February 2014, CMS' Center for Medicare and Medicaid Innovation (CMMI) issued a [Request for Information](#) on developing specialty and disease-specific delivery reform initiatives and has since developed an

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<sup>2</sup> <http://www.medicare.gov/people-like-me/new-to-medicare/welcome-to-medicare-visit.html>

<sup>3</sup> [http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=272&NcaName=Screening+for+Hepatitis+C+Virus+\(HCV\)+in+Adults&bc=AIAAAAAACAEAAA%3d%3d&](http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=272&NcaName=Screening+for+Hepatitis+C+Virus+(HCV)+in+Adults&bc=AIAAAAAACAEAAA%3d%3d&)

<sup>4</sup> <http://www.cdc.gov/nchhstp/docs/SuccessStory/HCV-in-ER-AL.pdf>

Oncology Care Model to test an accountable care organization (ACO)-type arrangement for cancer care. In this spirit, we recommend that the Working Group explore having CMMI pursue a similar demonstration – including delivery and payment reform dimensions – for Medicare and Medicaid beneficiaries with hepatitis C, including those who are also living with HIV. Such an initiative has the potential to benefit a high-need population while promoting care coordination and reducing total costs.

To assure that policy changes are data driven, we recommend that the policy recommendations above be accompanied by a mandatory Department of Health and Human Services report to Congress within two years of any legislation's passage assessing hepatitis C prevalence, disease progression, screening, diagnosis, and linkage to care rates in the Medicare population. The report would provide valuable insight into the aggregate impact of policy changes on hepatitis C's toll, as well as specific indicators that drive Medicare costs, such as related hospital admissions, readmissions, and opportunities to address those costs.

### **Hepatitis B:**

CDC estimates that there are 700,000 – 1.4 million individuals in the United States living with chronic hepatitis B. As with hepatitis C, this figure is likely much higher. An estimated 67% are not aware of their chronic hepatitis B infection, placing them at risk for advanced liver disease, liver cancer, and/or need for a liver transplant. Asian Americans and Pacific Islanders (AAPI) are disproportionately impacted by hepatitis B, as they comprise over 50% of hepatitis B cases in the United States and 1 in 12 AAPIs is living with hepatitis B.

Under the authority granted by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), CMS has the authority to cover preventive services that have received an "A" or "B" grade from the U.S. Preventive Services Task Force after a service undergoes a National Coverage Determination process. In May 2014, the USPSTF updated its hepatitis B screening recommendations and issued a "B" grade for testing those at risk for hepatitis B infection.

These revised recommendations are a significant advance in efforts to identify those with chronic hepatitis B and link them to care. However, Medicare coverage of hepatitis B screening has not been updated to reflect these recommendations. Adoption of USPSTF's revised grade would allow Medicare to play a crucial role in helping to identify those who are unaware they are hepatitis B positive. Of the identified and reported cases of hepatitis B in the U.S. between 2007 and 2012, 15.6% were over the age of 65 and part of the Medicare covered population. Seniors who are Medicare beneficiaries and are unaware of their hepatitis B infection are likely to have been living with the disease for a very long time and it is vital to ensure they are linked to care and treatment before they develop advanced liver disease or liver cancer. Additionally, those with end stage renal disease are at higher risk for hepatitis B infection and are less likely to respond to the hepatitis B vaccine, and would benefit greatly from screening and subsequent linkage to care.

On May 28, 2015, a formal request was submitted to CMS asking for the initiation of a NCD process. To date, a process has not been initiated. **We urge the Committee to convey its support to CMS for this request and to emphasize the importance of identifying people living with chronic hepatitis B and linking them to care and treatment.**

Thank you again for the opportunity to provide our recommendations on strengthening chronic care for Medicare beneficiaries. Should you have any questions, please contact me at [rclary@nvhr.org](mailto:rclary@nvhr.org) or (202) 408-4848 x 221.

Sincerely,

A handwritten signature in cursive script that reads "Ryan Clary".

Ryan Clary  
Executive Director