

Hepatitis C Virus Elimination in California

White Paper from the Hepatitis C Working Group (Members Listed in Appendix)

California Medical Leadership Forum for Public Health and Preventive Medicine

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SUMMARY

Hepatitis C virus infection is a major cause of morbidity, mortality and health system cost in California. Its diagnosis and treatment have moved forward considerably over the past 12 years, leading organizations from the World Health Organization to local health departments and healthcare organizations to call for its elimination. Given that the State's current strategic plan for hepatitis C control expires in 2026, we recommend that the California Department of Public Health reconvene a hepatitis C elimination planning group or task force to prepare a new plan for the next five years, the end of which will overlap with the international and national targets for elimination by 2030. Actual elimination may not be a feasible goal within such a short timeline, but continual reduction in incidence and prevalence can be achieved by effective control and prevention. We propose that the issues we have identified in this document, and specific recommendations for some of them, be considered in the development of the new plan.

INTRODUCTION

Hepatitis C virus (HCV) was first described as non-A non-B hepatitis in the 1960s [1,2] in blood transfusion recipients and identified as a flavivirus disease in 1989 [3]. It causes chronic asymptomatic infection, hepatitis, progressive fibrosis that leads to cirrhosis (20-20% [4]), hepatocellular carcinoma (1-13% of those with cirrhosis [5]), liver failure requiring transplantation, and death [6]. Historically it was primarily transmitted parenterally through injection drug use, blood transfusion, organ transplantation, and other unsafe needle practices, although it has been removed from the blood and organ donation systems since screening was initiated. Parenteral transmission from injection drug use is the most common mode of transmission, but it is also readily spread by other unsterile needle use, such as unregulated tattooing and in other countries through medical and dental procedures. Less commonly, it can also be transmitted perinatally from an infected mother to her baby and sexually, particularly among men who have sex with men. It can spread rapidly. For instance, in a cohort of young injection drug users in

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1. Feinstone S, Kapikian AZ, Purcell RH, et al. Transfusion-associated hepatitis not due to viral hepatitis type A or B. *N Engl J Med*. 1975;292:767–70.
 2. Alter J, Purcell RH, Holland PV, et al. Transmissible agent in non-A, non-B hepatitis. *Lancet*. 1978; 1:459–63.
 3. Choo QL, Kuo G, Weiner AJ, et al. Isolation of a cDNA clone derived from a blood-borne non-A, non-B viral hepatitis genome. *Science*. 1989; 244:359–62.
 4. Lingala S, Ghany MG. Natural history of hepatitis C. *Gastroenterol Clin N Am* 2015; 44:717–34.
 5. Spearman CW, Dusheiko GM, Hellard M, Sonderup M. Hepatitis C. *Lancet* 2019; 394:1451–66.
 6. Lee M-H, Yang H-I, Yuan Y, L'Italien G, Chen C-J. Epidemiology and natural history of hepatitis C virus infection. *World J Gastroenterol* 2014; 20:9270-80.

San Francisco, the incidence of infection was 25.1 per 100 person years [7]. Between 50-80% of individuals newly infected with hepatitis C virus will go on to develop chronic infection depending on age and immune status [5]. It is the sequelae of chronic infection that lead to the morbidity and mortality associated with hepatitis C. With an estimated 2.2 million prevalent infections [8], 64,700 incident infections annually [9], and 14,863 annual deaths from hepatitis C nationally [10], it represents a major public health burden. Moreover, beyond liver-related complications, chronic hepatitis C is associated with increased risk for type 2 diabetes mellitus, renal disease, and lymphomas, among other disease; all these sequelae can be mitigated by HCV treatment and cure. In the most recent prevalence estimates from the Centers for Disease Control and Prevention (CDC), there was surprisingly no change in the prevalence of hepatitis C in the United States from 2017-2020 despite the availability of curative therapies, reflecting continued new cases, which have largely been driven by drug use, that are approximately equal to the number who have been cured by treatment [11]. In California, there were 8,431 newly confirmed cases reported in 2024 [12,13], 714,737 cumulative cases reported from 1994 to 2018 [9], and 1,544 deaths in 2023 [8,14]. The rate of acute hepatitis C remained stable between 2015 (0.5 cases per 100,000 population) and 2023 (0.6 per 100,000 population). Rates of acute hepatitis C in 2023 were highest among persons 30-39 years of age (0.5 per 100,000 population) and those 20-29 years of age (0.27 per 100,000 population), which suggests ongoing transmission in younger age groups. Among those with confirmed acute hepatitis C infection, the leading risk factors were injection drug use, healthcare associated exposures, and cosmetic exposures, such as unlicensed tattooing in correctional facilities [15].

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7. Hahn JA, Page-Shafter K, Lum PJ, et al. Hepatitis C virus seroconversion in injection drug uses: relationships and risks. *J Infect Dis* 2022; 186:1558-64.
 8. Barker LK, Doshani M, Jiles RB, Teshale E. Hepatitis C surveillance in the United States: past, present, and future. *Public Health Rep* 2025 Aug 28; 333549251351880,
 9. CDC. Viral hepatitis. Number of reported cases* of acute hepatitis C virus infection and estimated infections† — United States, 2013-2020. Available at: <https://www.cdc.gov/hepatitis/statistics/2020surveillance/hepatitis-c/figure-3.1.htm>. Accessed 23 May 2026.
 10. CDC. Viral hepatitis. Numbers and rates* of deaths with hepatitis C listed as a cause of death† among residents, by state or jurisdiction — United States, 2016-2020. Available at: <https://www.cdc.gov/hepatitis/statistics/2020surveillance/hepatitis-c/table-3.7.htm>. Accessed 23 May 2026.
 11. Hall EW, Bradley H, Barker LK, et al. Estimating hepatitis C prevalence in the United States, 2017-2020. *Hepatology* 2025; 81:625-36.
 12. CDC. HepTracker: viral hepatitis surveillance dashboard. Available at: <https://www.cdc.gov/hepatitis/php/data-research/heptracker/index.html>.
 13. California Department of Public Health. Chronic hepatitis C in California, 2018 Executive Summary. Available at: <https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/2018-Chronic-HCV-Surveillance-Report-Exec-Summary.pdf>. Accessed 23 May 2026.
 14. CDC. 2023 viral hepatitis surveillance report. Table 3.7 – hepatitis C: death rates by jurisdiction. Available at: <https://www.cdc.gov/hepatitis/php/data-research/heptracker/index.html>. Accessed 15 August 2026.
 15. California Department of Public Health. Hepatitis C treatment indicated for people with acute infection, using drugs or alcohol, or experiencing homelessness, 2025 Feb 25. Available at: <https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/HCV-Tx-PWID-Brief.pdf>. Accessed 25 May 2026

The advent of direct-acting antiviral agents in 2014 made it possible to treat and cure HCV infection in eight to 12 weeks in 95% of infected individuals [16,17]. This has been a major advance and is what makes elimination possible. Fewer than 5% of individuals who have completed therapy will become reinfected [18]. The potential to cure HCV infection has led the U.S. Preventive Services Task Force to recommend universal one-time screening for all adults living in the United States [19,20]. Screening using both antibody and nucleic acid amplification tests [21] combined with rapid initiation of highly effective antiviral therapy [14] raises the possibility of being able to achieve large population-wide decreases in HCV and even eventual elimination. Screening and treatment both of hepatitis C infection and reduction in the associated sequelae have been modeled and shown to be cost effective over a 10-year timeline horizon in the United States [22].

This white paper outlines the current state of HCV control in the United States in general and California in particular and suggests certain steps the California Department of Public Health, local health agencies, health care organizations, and others could undertake as part of an expanded HCV elimination program.

HCV CONTROL: CURRENT STATE

In 2016 the World Health Organization published goals to eliminate hepatitis C as a public health threat by 2030, operationalized as a 90% reduction in the incidence of infection and a 65% reduction in mortality [23]. Additional WHO programmatic targets included the diagnosis of $\geq 90\%$ of those infected with HCV and treatment of $\geq 80\%$ of those infected who were treatment eligible. Hepatitis C fulfills WHO's criteria for elimination; it has no intermediate animal host, and it does not survive long in the environment. Substantial progress is being made in several countries, including

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16. Falade-Nwulia O, Suarez-Cuervo C, Nelson DR, et al. 2017. Oral direct-acting agent therapy for hepatitis C virus infection: a systematic review. *Ann. Intern. Med.* 166:637–48
 17. American Association for the Study of Liver Diseases, Infectious Diseases Society of America. Hepatitis C guidance 2023 update: recommendations for testing, managing, and treating hepatitis C virus infection. Available at: <https://www.aasld.org/practice-guidelines/hepatitis-c>. Accessed 25 May 2026.
 18. Hajarizadeh B, Cunningham EB, Valerio H, et al. Hepatitis C reinfection after successful antiviral treatment among people who inject drugs: a meta-analysis. *J Hepatol* 2020; 72:643-57.
 19. CDC. Hepatitis C. Clinical Screening and Diagnosis for Hepatitis C, 2025. Available at: <https://www.cdc.gov/hepatitis-c/hcp/diagnosis-testing/index.html>. Accessed 24 May 2026.
 20. US Preventive Services Task Force. Screening for hepatitis C virus infection in adolescents and adults: US Preventive Services Task Force recommendation statement. *JAMA*. 2020; 323:970-75.
 21. Association of Public Health Laboratories. Infectious Diseases. Interpretation of Hepatitis C Virus Test Results: Guidance for Laboratories, Jan 2019. Available at: <https://www.aphl.org/aboutAPHL/publications/Documents/ID-2019Jan-HCV-Test-Result-Interpretation-Guide.pdf>. Accessed 24 May 2026.
 22. Chhatwal J, Aaron A, Zhong H, et al. 2023. Projected health benefits and health care savings from the United States national hepatitis C elimination initiative. Working Paper 31139. Cambridge, Massachusetts: National Bureau of Economic Research, 2023. Available at: <https://www.nber.org/papers/w31139>. Accessed 3 July 2026.
 23. WHO. *Global health sector strategies on viral hepatitis 2016–2021. Towards ending viral hepatitis, 2016*. Available at: <https://iris.who.int/bitstream/handle/10665/246177/WHO-HIV-2016.06-eng.pdf>. Accessed 23 May 2025.

Australia, Egypt, Georgia, and Rwanda [24]. In 2023 the United States issued a plan to eliminate hepatitis C infection by 2030. It had three main priorities: (1) accelerating “the availability of point-of-care diagnostic tests”; (2) “providing broad access to curative medications”; and (3) developing “a comprehensive public health effort to engage, inform, identify, and treat people with hepatitis C” [25]. Senate bill 1941, the Cure Hepatitis C Act of 2025, was introduced by Senators Cassidy and Van Hollen but did not advance beyond committee [26]. It called for establishment of a national hepatitis C elimination program and provision of hepatitis C treatments to Medicaid and State Children’s Health Insurance Program recipients (Medi-Cal and Health Families in California), incarcerated individuals, Indian Health Service beneficiaries, and those without minimal essential coverage. The National Bureau of Economic Research estimated that the hepatitis C elimination plan would reduce deaths from hepatitis C infection by 24,000 and add 220,000 life years with a savings of \$18.1 billion direct healthcare spending in total and \$13.3 billion in savings to the federal government [22]. Newer estimates from CDC suggest average lifetime savings of \$65,841 per person in medical costs for treated versus untreated individuals, leading to a conservative estimate of \$147 billion in savings from hepatitis C elimination in the United States in direct medical costs alone [27]. However, at this time, it appears that federal leadership in hepatitis C elimination has stalled although certain agencies, such as the Department of Veterans Affairs and the federal Bureau of Prison along with the Cherokee Nation and the states of Louisiana and Washington have made considerable progress [24].

The California Department of Public Health also called for expanded HCV control and provides extensive resources for hepatitis control [28]. It has published a plan for the five-year period 2022-2026 that addresses syndemic control for HIV, HCV, and sexually transmitted diseases in California [29]. The plan focuses on factors that underlie the three epidemics: racial inequities, lack of housing, lack of universal health access, drug use, and economic inequities. It sets a goal of zero new HCV infections. Additional legislation has addressed hepatitis C control. The 2019 Budget Act provided a one-time allocation of \$4.5 million to the Department of Public Health for local health department-based hepatitis C control activities. This was annualized in the 2020 Budget Act. The 2023 Budget Act allocated an additional \$9 million in one-time funds for local

24. Fleurence JL, Alter JH, Collins FS, Ward JW. Global elimination of hepatitis C virus. *Annu Rev Med* 2025; 76:29-41.

25. Fleurence JL, Collins FS. A national hepatitis C elimination program in the United States: a historic opportunity. *JAMA* 2023; 329:1251-52.

26. United States Senate. S.1941, 2025. Available at: <https://www.congress.gov/119/bills/s1941/BILLS-119s1941is.pdf>. Accessed 24 May 2026.

27. Abimbola TO, Symum H, van Handel M, Teshale E, Thompson W. Lifetime medical costs of chronic hepatitis C in the United States. *BMC Health Serv Res* 2026; 26:609.

28. California Department of Public Health, Office of Sexually Transmitted Infections and Hepatitis C Virus. Viral hepatitis, 2026 Mar 10. Available at: <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/ViralHepatitis-ClinicalGuidelines.aspx>. Access 25 May 2026.

29. California Department of Public Health. Ending the epidemics: addressing human immunodeficiency virus (HIV), hepatitis C virus (HCV), and sexually transmitted infections (STIs) in California. Integrated statewide strategic plan overview 2022-2026. Available at: https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/CDPH_StratPlan2021_FINAL_ADA.pdf. Accessed 25 May 2026.

hepatitis C control activities, which are required to be spent by June 30, 2028 [30]. Additional expenditure guidance is provided by law:

“No less than 50 percent of the funds allocated to local health jurisdictions shall be provided to, or used to support activities in partnership with, community-based organizations for purposes consistent with this section, provided that there are community-based organizations in the jurisdiction that are able to provide these activities and demonstrate expertise, history, and credibility working successfully in engaging the most vulnerable and underserved individuals living with, or at high risk for, HCV infection” [31].

The following jurisdictions divided the \$4.5 million allocation: Alameda, Humboldt, Kern, Long Beach, Los Angeles, Marin, Monterey, Orange, Riverside, Sacramento, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sonoma, and Ventura. The counties of Contra Costa, El Dorado, Fresno, Imperial, Lassen, Mendocino, Merced, San Bernardino, Solano, and Stanislaus, were included along with the original 18 jurisdictions in the \$9 million allocation on a formula basis, which, as noted above, ends in 2028 [28]. The median award was approximately \$200,000 per year per jurisdiction.

Additionally, the 2021 budget act included \$15 million for routine screening of HCV, HIV, and syphilis in emergency departments and that the 2026 budget act included an additional \$30 million for 2026-2029 and another \$30 million for 2029- 2032.

Another significant piece of legislation was AB 789, authored by Assembly Member Low and signed by Governor Newsom in 2021. This law requires health facilities delivering primary health care to adults to offer hepatitis B and C screening [32]. Additionally, California regulations require all narcotics treatment programs to test new patients being admitted for opiate substitution treatment [33]. The regulations specify both antibody and, for those found to be antibody-positive, RNA testing with an allowance for opting out. Finally, in FY 2025-26, the California Department of Public Health made \$1 million available to local health jurisdictions and community-based organizations for the newly approved point-of-care HCV RNA test, Xpert HCV, with funds used for purchase of the Cepheid GeneXpert Xpress machines, Xpert HCV RNA rapid test cartridges, and related testing supplies. These funds were on a one-time basis and came from AIDS Drug Assistance Program (ADAP) rebate funds [34].

30. California Department of Public Health. Local health department directors and health officers. Hepatitis C virus (HCV) allocations – fiscal year 2024=25 through fiscal year 2027-28, 2024 Mar 28. Available at: <https://www.cdph.ca.gov/Programs/RPHO/Pages/All-Local-Health-Jurisdiction-Letters-Notices/HCV-Allocations-Fiscal-Year-2024-25-through-Fiscal-Year-2027-28.aspx>. Accessed 25 May 2026.

31. California Health and Safety Code 122440 (a)(1)(C).

32. California Health and Safety Code 1216.7(a) and 1216.7(c).

33. CCR Title 9, Chapter 4, §10270.

34. California Department of Public Health. Local Health Jurisdictions and Community-Based Organizations. In-Kind Opportunity for Hepatitis C Virus (HCV) Ribonucleic Acid (RNA) Point of Care Machines, Test Cartridges, and Supplies, 17 February 2026. Available at: https://www.cdph.ca.gov/Programs/RPHO/Pages/All-Local-Health-Jurisdiction-Letters-Notices/In-Kind-Opportunity-for-HCV-RNA-Point-of-Care-Machines,-Test-Cartridges,-and-Supplies_2-17-26.aspx. Accessed 16 August 2026.

The Department of Health Care Services, for its part, provided updated guidance for hepatitis C diagnosis and treatment in 2021 and updated diagnostic guidance in 2024 [35]. Coupled with the California Department of Public Health's *Viral Hepatitis Guide for Primary Care Providers* [36], the Medi-Cal program will pay for therapy for anyone who is infected with HCV except those with "short life expectancy that cannot be improved with HCV therapy, liver transplantation, or another directed therapy".

In addition to statewide efforts, several counties have developed hepatitis C control programs. Among these are Los Angeles [37,38], San Diego [39], and San Francisco [40], which have common themes of increasing awareness, testing, and access as well as some unique aspects such as an annual summit meeting of Hepatitis C Taskforce in Los Angeles [37], peer navigation in San Francisco [40], and numeric goals and modeling in San Diego [39]. While complicated, local data from Los Angeles [38] and San Diego [39] suggest that local control efforts are not yet on track to reach the World Health Organization's 2030 goals. Another major entity, the Permanente Medical Group, which provides medical care to Kaiser Permanente Health Plan members in Northern California, has emphasized integrated care, dedicated care coordinators, information technology, and reflex testing as key elements of their HCV program, and by mid-2019, had screened 50% of its baby-boomer members and treated 12,000 of them [41]. Further, the Northern California Permanente Medical Group demonstrated sustained virologic responses in over 95% of those treated, affirming the high cure rates with current direct-acting antivirals.

In conclusion, the Working Group agrees that hepatitis C elimination is feasible, laudable, and worth additional investment. At its most basic, HCV elimination will need to include surveillance, harm reduction, screening, treatment, research, and program evaluation. California has taken large steps in making these components happen, but we suggest that an additional push is needed, especially as the 2022-2026 plan is expiring at the end of this year.

RECOMMENDATIONS

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35. California Department of Health Care Services, Medi-Cal Drug Use Review Program. Screening, diagnosis, and treatment of chronic hepatitis C virus infection, 2024 Sep 17. Available at: https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/dur/educational-articles/dured_Screening_Diagnosis_Treatment_of_Chronic_Hepatitis_C_Infection.pdf. Accessed 25, May 2026.
 36. California Department of Public Health. Viral hepatitis guide for primary care providers: screening, vaccination, and billing. Available at: <https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/HepatitisBandCScreeningToolkitforPrimaryCare.pdf>. Accessed 2026 May 25.
 37. County of Los Angeles, Public Health. Join the hepatitis C task force. Available at: <http://ph.lacounty.gov/acd/diseases/hepatitis/HepC-Taskforce.htm>. Accessed 24 May 2026.
 38. Hernandez-Tamayo C, Stafylis C, Klausner JD. Lack of hepatitis C elimination by 2030 in Los Angeles County at current treatment rate. *Open Forum Infect Dis* 2023; 10(4):ofad125.
 39. Cheema JS, Suckow S, Ramers C, et al. Is San Diego California on track to reach HCV elimination? A modeling analysis of combination prevention strategies. *Viruses* 2024; 16:1819.
 40. End Hep C SF. Available at: <https://endhepcsf.org/>. Accessed 25 May 2026.
 41. Permanente Medicine. Progress toward eliminating hepatitis C, 2019 Jul 25. Available at: <https://permanente.org/progress-toward-eliminating-hepatitis-c/>. Accessed 25 May 2026.

We recommend that the California Department of Public Health and its statewide and local public health, healthcare, correctional, and non-governmental organization partners convene a planning group or task force to design a plan for the next five years of hepatitis C elimination efforts. A core element of this plan should be expanded screening and rapid or even same-day initiation of antiviral therapy (referred to as a “test-and treat” model of care) by primary care and other front-line providers, as has been recommended by the American Association for the Study of Liver Disease (AASLD) and others. Statewide partners could include, for instance, the California Department of Health Care Services, the California Department of Corrections and Rehabilitation, the California Conference of Local Health Officials, the California STD/HIV Controllers’ Association, representatives of local correctional agencies and harm reduction providers, and representation from the specialties of hepatology, infectious diseases, preventive medicine/public health, primary care, emergency medicine, addiction medicine, street medicine, pharmacy, and laboratory medicine. Consideration should be given to including members of our own Working Group. Local partners could include impacted local health departments, health care organizations such as the Permanente Medical Group, opioid treatment clinics, and non-governmental organizations that are and have been active in hepatitis C control efforts. It would also be worthwhile to have input from potential federal partners such as CDC and the Department of Veterans Affairs, as examples. Since California has already made strides forward to hepatitis C control and eventual elimination, the work of the group will need to focus on what additional efforts need to be made, when they need to be made, how to finance them, and how to evaluate impact and progress toward elimination.

Some key issues and specific measures that our Working Group recommends be considered for inclusion in the new Strategic Plan include:

1. Strategy. We suggest that the Task Force adopt a consensus definition of “elimination” to serve as an evaluation target. The World Health Organization’s definition has evolved since 2016, and the newest definition from 2023 is shown in Box 1 [42]. The Task Force should review this and other definitions and adopt a definition that considers epidemiologic, therapeutic, and programmatic elements along with appropriate programmatic targets (e.g., proportion of persons living with chronic HCV that have been diagnosed and the proportion of those diagnosed that have been treated). Moreover, the Department should provide annual estimates of the incidence of HCV infections, either based on reported data or modeled, to focus the ongoing elimination efforts.

Box 1. WHO criteria for hepatitis C elimination [37].

≤5 new annual HCV infections/100 000 persons
 ≤2 new annual HCV infection/100 people who inject drugs

42. World Health Organization. Guidance for country validation of viral hepatitis elimination and path to elimination. Geneva: World Health Organization, 2023. Available at: <https://iris.who.int/server/api/core/bitstreams/02fc7c1f-ed6e-4bd7-b9c0-7251a9882d50/content>. Accessed 15 August 2026.

Absolute combined hepatitis B- and hepatitis C-related mortality rate of $\leq 6/100\ 000$ per year by 2030

Additionally, we suggest that the Task Force explore a hepatitis C elimination cascade, as suggested by the World Health Organization [43], and consider ways to gather then necessary data.

2. The Task Force should consider how to expand laboratory surveillance to understand better the evolving epidemiology of HCV and the success of screening and treatment. While HCV is already a reportable disease, additional activities to consider could include a state mandate for laboratories to offer reflex testing (in which positive HCV antibody tests would automatically trigger HCV RNA testing) and reporting of negative antibody tests (to assess completeness of screening and prevalence. If not already done, individuals diagnosed with HCV RNA should have all subsequent HCV RNA test results also reported to be able to assess cure.

Incidence screening. Serial screening of certain high-risk populations, such as incarcerated persons, should also be considered to identify incident cases and prevent ongoing transmission in these settings.

3. Expanded screening. While there are recommendations for universal screening, approximately 40% of infected individuals remain undiagnosed. What additional screening would help identify these cases? Automation of electronic medical records to flag previously unscreened individuals could be a feasible approach. Screening of general populations might also, for instance, be encouraged through asking the National Committee for Quality Assurance to create a Health Plan and Data Information Set (HEDIS) indicator, as was done with screening for *Chlamydia*. Alternatively, a similar incentive could be approached at the state level by seeking to engage the Department of Health Care Services about using the Center for Medicare and Medicaid Services' Child and Adult Core Health Care Quality Measurement Sets [44]. For hepatitis C, this could include the percentage of adult enrollees tested for HCV and the percentage of adult enrollees in treatment for chronic HCV infection within six months of diagnosis.

3.1 Screening in primary care. Screening for hepatitis C by primary care providers is one of the keys to hepatitis C elimination, as this is often the only point of healthcare contact. Automated electronic medical record-based reminders for primary care providers may be a relatively low-cost intervention.

43. World Health Organization. Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030. Geneva: World Health Organization, 2022. Available at: <https://iris.who.int/server/api/core/bitstreams/6b18ac34-f56a-466e-9660-b5653cb52ef0/content>. Accessed 15 August 2026.

44. Center for Medicare and Medicaid Services. 2027 core set of adult health care quality measures for Medicaid (adult core set). Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/2027-adult-core-set.pdf>. Accessed 18 August 2026.

- 3.2 Screening in urgent care facilities, emergency departments, and county hospital outpatient clinics. All of these are important because many infected persons do not have access to other sources of primary care. We encourage the Task Force to consider ways to incentivize urgent care facilities, emergency departments, and county hospital outpatient clinics to screen for hepatitis C along with HIV and syphilis. As noted above, funding for HCV, HIV, and syphilis screening in emergency departments has been included in recent budget bills, but should be renewed and expanded to all counties. Since some of these facilities may not include laboratories and may have only limited point of care testing capabilities (see below), such testing should include arrangements for promptly informing individuals of results and offering referral to treatment or referral to local health departments for follow up when results are positive. Additionally, this could include funding for screening (and treatment initiation) for uninsured patients presenting to such clinical settings.
- 3.3 Screening in incarcerated populations. For special populations, such as individuals incarcerated in jails, opt-out testing, as the California Department of Corrections and Rehabilitation has already been successfully doing in prisons [45], may be an option. We suggest that the Task Force consider a recommendation to expand this screening to county jail facilities, using opt-out testing in a manner analogous to that used in the prison system.
- 3.4 Alcohol and drug treatment programs. While opt-out screening is required by regulation in California for individuals entering narcotic treatment programs [33], the requirement is limited to those entering opiate substitution therapy. We suggest that this requirement be extended to other types of drug and alcohol rehabilitation services and that compliance with the existing regulation be assured. As with any screening program, providers at these sites should be able to start antiviral therapy at the time of diagnosis or have a rapid referral system in place.
- 3.5 Other special populations. Outreach to populations experiencing homelessness is another avenue to be considered. This could involve street medicine providers and point-of-care testing.
4. Point-of-care testing. Point-of-care testing should be promoted, especially in facilities where the availability of results during a visit is especially important and in high-prevalence populations. The 2023 U.S. plan included a recommendation for development of point-of-care testing. In 2024, the Food and Drug Administration granted marketing authorization for an HCV RNA point-of-care test, the Xpert HCV test, which is used with the GeneXpert Xpress System

45. Lucas KD, Krawiec A, Wada J, Kanan RJ. The hepatitis C care cascade in California state prisons: screening and treatment scale-up and progress toward elimination, 2016-2023. Clin Liver Dis (Hoboken) 2024; 23:e0117.

(Cepheid, Sunnyvale, California) [46]. It can be used at any site with a Clinical Laboratory Improvement Act Certificate of Waiver, such as substance use disorder treatment clinics and correctional facilities and opens the possibility for rapid or same day “test-and- treat”. Also, there may be additional opportunities for testing in the field through, for instance, street medicine. The Department of Public Health may also consider development of simpler and faster alternatives.

5. Financial support for local health jurisdictions. In order to build a truly statewide system, financial support (as allowed by the state budget and any additional sources of funding) should be expanded from the selected local health jurisdictions and emergency departments currently receiving aid to all local health jurisdictions and emergency departments. If more funding cannot be achieved in the state budget, existing funding may need to be spread more widely, but that would achieve suboptimal results.
6. Organization of hepatitis C activities in local health departments. We encourage the Task Force to recommend that every local health jurisdiction have a focal point designated to be in charge of public health activities for hepatitis C. This should not detract from the Department’s laudable efforts to approach control of HIV, sexually transmitted infections, hepatitis B and hepatitis C syndemically, but we believe that in the short to medium term, a vertical approach will be necessary for hepatitis C. This may be added to other duties, but the designated staff should be provided with sufficient training to fulfill these tasks. In small jurisdictions, this responsibility could potentially be shared across counties. Training for these individuals may be provided by state, local, academic, and private sources, but all training should be approved by the Department.

We also suggest that the Task Force consider recommendations to local health jurisdictions to organize their public health functions for hepatitis C similar to those for sexually transmitted diseases, HIV, and tuberculosis. These activities should include surveillance, linkage to care, case management as indicated, promotion of screening, assuring provider awareness of screening tests and of curative treatment, and partner services (including contact tracing) when appropriate, for instance, for needle-sharing partners. Linkage to care should be defined in detail in the plan but should include outreach to all patients testing RNA-positive to assure they know their diagnosis and availability of curative treatment (a project at the University of Southern California for Los Angeles County has shown the value of this) and that they will have a source of treatment.

7. Expanded treatment. The advent of direct-acting antiviral therapy has revolutionized the control of hepatitis C with cure possible for the vast majority of infected individuals with eight to 12 weeks of therapy, as noted above. Three things will require additional consideration. First, how should access to antiviral

46. Food and Drug Administration. FDA permits marketing of first point-of-care hepatitis C RNA test., 2024 Jul 27. Available at: <https://www.fda.gov/news-events/press-announcements/fda-permits-marketing-first-point-care-hepatitis-c-rna-test>. Accessed 25 May 2026.

therapy be expanded in particular for underinsured populations? Secondly, how can treatment be encouraged among primary care physicians, since this is the level where much of the screening takes place. Thirdly, how should completion of treatment be assured? Our strong suggestion is that treatment be initiated by the diagnosing provider and that referral be minimized except for certain complex patients.

- 7.1 Expanded access to antiviral therapy. The Task Force should explore ways to expand access to antiviral therapy once a diagnosis is made. An example of this is AB 1843 (Elhawary), which would prohibit a health care service plan or health insurer from requiring prior authorization for treatment with direct-acting antiviral drugs that are medical necessary for the treatment of hepatitis C [47].
- 7.2 Treatment by primary care physicians and advanced clinical providers. Treatment of HCV infection at the primary care level should be expanded and encouraged as a central strategy for hepatitis C elimination. This can allow expanded opportunities for treatment, especially in rural areas, and not risk losing patients through referrals. In many cases, the primary care provider has identified the infection and has the most immediate access to getting the patient into treatment without the need for referral and is best positioned to provide after case (e.g. surveillance for liver cancer in those with cirrhosis at time of HCV cure). Primary care providers have been shown in multiple practice situations to provide effective treatment, often more cost-effective, closer, and more conveniently and rapidly available than centers with specialty clinics. Such expanded opportunities could also include pharmacy-led programs, which have also been successful in primary care-based HIV treatment. However, these settings have been scattered, and more statewide availability would be beneficial. See below for two additional recommendations regarding criteria for specialty consultation or referral and training for primary care physicians. If an infected person identified by screening does not had access to a personal primary care provider, referral by the local public health department to such a provider can achieve the dual benefit of convenient treatment of the hepatitis C and introduction to a medical home for ongoing care.

To supplement national treatment guidelines [48], state guidelines should be developed on the treatment of uncomplicated cases by primary care physicians, including the amount of training needed, and on criteria for consults or referral of cases to hepatologists (for instance, for advanced liver disease with complications) or infectious disease specialists (for instance, for co-infections,

47. Assembly bill 1843, introduced by Assembly Member Elwahary, February 11, 2026. Available at: https://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB1843. Accessed 18 August 2026.

48. Bhattacharya D, Aronsohn A, Price J, Lo Re V 3rd, AASLD-IDSA HCV Guidance Panel. Hepatitis C guidance 2023 update: American Association for the Study of Liver Diseases- Infectious Diseases Society of America recommendation for testing, managing, and treating hepatitis C virus infection. Clin Infect Dis 2023; ciad319

drug resistance, or drug interactions). The Department of Public Health has already developed an algorithm for emergency departments on appropriate referrals of patients testing positive, which could be expanded and generally applied in all medical settings. That issue is not dealt with in the current national guidelines and can be considered as state policy. Additionally, the Task Force may wish to consider how responsible, human-centered artificial intelligence can be utilized to support clinical decision making for clinicians.

- 7.3 Test and treat. As a cornerstone of HCV control, same-day or rapid initiation of treatment for patients with detectable HCV RNA as soon as HCV RNA levels are available should be encouraged as the optimal standard of care. The AASLD and the Infectious Diseases Society of America's (IDSA) guidelines [48] advocate test and treat as a preferred clinical approach for uncomplicated patients. Such test and treat models were transformative for controlling the HIV epidemic. State guidelines for treatment should be consistent with the 2023 guidelines for the use of available medications for all six genotypes from AASLD and IDSA and updates to these guidelines [48].
- 7.4 Explore greater use of 340B funding. Certain clinics are eligible for the Health Resources and Services Administration's 340B Drug Pricing Program, which requires drug manufacturers to provide deep outpatient drug discounts to safety net providers, including community health centers, sexually transmitted disease clinics and federally qualified health centers [49,50]. Treatment expansion should include maximizing 340B participation. There are currently a number of bills before the Congress about reforming the 340B program, which the Department should follow [51].
- 7.5 Assuring completion of therapy. Peer navigators, nurse navigators, and care coordinators have all been successfully used to help patients complete therapy. As noted below, San Francisco's End Hep C SF coalition has had experience with peer navigators. Repeat HCV RNA after treatment should also be encouraged to assure sustained virologic response. This is analogous in many ways to tuberculosis therapy where outreach and directly observed therapy have been important in disease control. This is another area in which artificial intelligence could be used to support medication adherence and follow up testing for sustained virologic response.

49. Health Resources and Services Administration. 340B Drug Pricing Program. Available at: <https://www.hrsa.gov/opa>. Accessed 18 August 2026.

50. National Association of State and Territorial AIDS Directors. 340B drug pricing program guidance for viral hepatitis programs, November 2021. Available at: <https://nastad.org/sites/default/files/2021-11/PDF-340B-Viral-Hepatitis.pdf>. Accessed 18 August 2026.

51. 340B Tracker. Congressional 340B bill tracker. Available at: <https://340breport.com/340b-congressional-tracker/>. Accessed 18 August 2026.

- 7.6 Telehealth. Telehealth may also be a solution both for patient follow up and warm-line consulting, especially in remote communities. Follow-up treatment visits and specialty consultations could be conducted in this manner, avoiding the time and expense of travel.
8. Referral system for local health jurisdictions. While we strongly encourage treatment by primary care providers who make the diagnosis, we recognize that some local health departments may not have this capacity. In this care, these departments that are not providing treatment themselves should have a referral system providing rapid access to willing providers. For many rural jurisdictions, referral to a local primary care provider with interest and experience may be the most practical option. Primary care providers interested in treating uncomplicated cases, but not previously experienced, may be referred to training projects such as Project Echo [52,53], academic consultants, and/or virtual training resources. In some group practice situations, practice colleagues have been available to provide the needed training.
 9. Harm reduction should be major aspect of the plan consistent with the 2021 guidelines, including availability of clean needles and syringes. pharmacies should be encouraged to serve as access points for harm reduction, by selling syringes, needles, and sharps disposal containers over the counter, as permitted by California law [54], and needle exchange programs should be encouraged to inform patients of this available service when and where the programs are not available (these programs do not exist at all in about 20 counties and are only available at a few locations for a few hours a week or month in others). Referrals to treatment for drug use should be coordinated with existing efforts by public health and other agencies for substance use disorder, including prevention of opioid overdose prevention. Additionally, while commercial tattooing is regulated by the Department of Consumer Affairs, informal tattooing, particularly in correctional institutions may represent a significant risk for HCV transmission. Ways to make this practice safer should also be considered.
 10. Understanding barriers to hepatitis C elimination. We suggest that a study be conducted to elucidate what barriers currently exist to prevention and treatment of hepatitis C in California, e.g., prior authorization, stigma, lack of provider education, lack of transportation, conflicts with work or dependent care, etc. Measures to mitigate any such barriers, that are not included in the Strategic Plan, should be built into a mid-period update.
 11. Evaluation. Not only will the success of screening need to be evaluated but also the frequency of and completion of treatment, again analogous to completion rates in tuberculosis control programs. The World Health Organization, for instance, has programmatic goals of diagnosing $\geq 90\%$ of those infected and

52. UCSF Project ECHO Liver Care. Available at: <https://viralhep.ucsf.edu/echo>. Accessed 25 May 2026.

53. USC Project ECHO. Available at: <https://sites.usc.edu/echo/>. Accessed 25, May 2026.

54. Calmatters. Digital Democracy. AB 309: hypodermic needles and syringes. Available at: https://calmatters.digitaldemocracy.org/bills/ca_202520260ab309. Accessed 18 August 2026.

treating $\geq 80\%$ of those eligible. As rate of cure with a single course of therapy is high ($>95\%$), treatment goal of having 80% of infected individuals diagnosed. Those who have failed to achieve sustained virologic response after therapy will need to be evaluated, for instance, for antiviral resistance, inadequate treatment course, or reinfection. Understanding who fails therapy and why may be important to improving the elimination effort going forward. Finally, the overall success will need to be evaluated by setting a target for elimination, whether the World Health Organization's, CDC's, or others', both in terms of incidence, prevalence, mortality, and liver transplantation, as well as treatment indicators such as the proportion of a population that has been screened and completion rates for therapy. We recommend that the Task Force, in conjunction with its work on the epidemiology of hepatitis C, review and adopt specific clear metrics that can be followed to determine the success of the elimination effort both at the statewide and local levels. Examples of this have been published by the Coalition for Global Hepatitis Elimination [55].

12. Education and health literacy. Improving the general public's knowledge of hepatitis C as well as liver health and disease in general may also be a goal of an expanded effort. Professional education may be necessary to assure that providers understand the importance of screening and the recommendations that acute infection, recent substance use, homelessness, and concerns for reinfections are not contraindications of treatment [56,57]. Additional professional education may be needed for primary care providers to feel comfortable overseeing a treatment course and not referring patients for specialty care [31]. Online consultation for physicians managing patients with hepatitis C, such as Project ECHO [40,41], is also an important adjunct to broadening the base of hepatitis C care beyond specialty clinics.
13. Research issues. The Task Force may also wish to consider areas of research that may add value to hepatitis C elimination. Supporting hepatitis C vaccine research is an example of where the state may wish to make an investment. Another area is updated cost-effectiveness analyses. As a final example, post-exposure prophylaxis, or even in some circumstances pre-exposure prophylaxis, may be an issue worthy of formal study.

55. Coalition for Global Hepatitis Elimination. National hepatitis elimination profiles. Available at: <https://www.globalhep.org/tools-resources/view-national-hepatitis-elimination-profiles>. Accessed 18 August 2026.

56. American Association for the Study of Liver Diseases, Infectious Diseases Society of America. Management of unique & key populations with HCV infection, 2020 Aug 30. Available at: <https://www.hcvguidelines.org/guidance/management-of-unique-key-populations-with-hcv-infection/>. Accessed 25 May 2026.

57. California Department of Public Health. Hepatitis C treatment indicated for people with acute infection, using drugs or alcohol, or experiencing homelessness, 2025 Feb 25. Available at: <https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/HCV-Tx-PWID-Brief.pdf>. Accessed 25 May 2026

14. Other issues. Other things to consider are population movements across California's international border and immigration from other states and countries, which may complicate screening, therapy, and contact tracing.

This list of recommended issues and measures is incomplete, but represents a starting point for consideration in an updated hepatitis C elimination plan. New federal programs, technological advances in diagnostics and therapeutics, and improved surveillance and health education techniques will need to be considered as the field moves forward. The State's current plan advocates for a syndemic approach for the HIV, hepatitis C, and sexually transmitted diseases epidemics and the social and economic factors that underlie them. Since the current plan is expiring in 2026, the next generation hepatitis C elimination plan, while not losing sight of the complex drivers of infection, should harness new approaches that can help California achieve a goal of substantially reducing the burden undiagnosed and untreated hepatitis C by 2030, ideally on a trajectory for elimination.

APPENDIX

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