Department of Health and Human Services
Office of Inspector General
Office of Evaluation and Inspections

DATA BRIEF

October 2026 | OEI-BL-24-00450

# Less Than 25 Percent of Medicaid Beneficiaries With Hepatitis C Received Treatment Within 6 Months

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## Why OIG Did This Review

- More than 2 million Americans have hepatitis C. Thousands die from the disease each year despite the availability of oral medications that can cure hepatitis C with a simple, short course of treatment.
- Hepatitis C treatment is crucial to reducing morbidity and mortality and to achieving HHS's goal of eliminating hepatitis C as a public health threat in the United States by 2030.[1]
- Timely treatment can also generate significant savings for Federal health care programs by preventing costly complications from untreated infection.[2]
- Medicaid is one of the largest insurers of people with hepatitis C, underscoring the program's key role in ensuring access to treatment.[3] Dual-eligible beneficiaries (i.e., those enrolled in both Medicaid and Medicare) would primarily receive treatment for hepatitis C through Medicare rather than Medicaid.

## What OIG Found



### Fewer than 1 in 4 treated

Only 23 percent of Medicaid beneficiaries with hepatitis C received treatment within 6 months of testing



### 7 weeks until treatment

For those treated within 6 months, treatment typically took 7 weeks to start—despite recommendations to treat immediately



### State rates ranged from 7% to 41%

Among individual States, the rate of beneficiaries treated within 6 months ranged from 7 percent to 41 percent



### Rates varied by population

Treatment rates were lower among newly infected beneficiaries, dual-eligible beneficiaries, older adults, and children

## What OIG Recommends

OIG recommends that CMS:

- Take additional steps to increase hepatitis C treatment rates in Medicaid, building on data collected through the Medicaid hepatitis C quality measure starting in 2027.
- Take targeted steps to increase hepatitis C treatment rates among dual-eligible beneficiaries who receive treatment primarily through Medicare.

CMS concurred with our recommendations.

# BACKGROUND

Hepatitis C is a liver disease caused by the hepatitis C virus that affects more than 2 million Americans.[4] Unlike with hepatitis A and B, no vaccine for hepatitis C exists. Fueled in part by the opioid crisis, the number of estimated new hepatitis C infections nearly doubled in the United States between 2015 and 2023, with more than 11,000 hepatitis C-related deaths reported in 2023.[5] However, for more than a decade, drugs that can cure more than 95 percent of hepatitis C cases through a simple, short course of oral treatment have been available for patients. Throughout this data brief, the term "treatment" specifically refers to the use of these curative hepatitis C drugs.

Medicaid is one of the largest insurers of people who have hepatitis C, underscoring the program's key role in ensuring access to treatment and thereby reducing associated morbidity, mortality, and downstream spending on hepatitis-related complications.[6] The Centers for Medicare & Medicaid Services (CMS) has estimated that Medicaid spends almost three times more, on average, for beneficiaries diagnosed with the disease compared to those without it.[7] A Congressional Budget Office analysis determined that a 10-percent increase in hepatitis C treatment rates in Medicaid would generate $700 million in Federal savings over 10 years.[8, 9] Because Medicaid is jointly funded by States and the Federal Government, increased hepatitis C treatment rates may reduce long-term State Medicaid spending as well.

## Hepatitis C Diagnosis and Treatment

Hepatitis C is primarily diagnosed through blood tests; it is considered acute when a person is newly (i.e., recently) infected. Although some people clear acute hepatitis C without treatment, most infected people develop a long-term infection, known as chronic hepatitis C.[10] Hepatitis C is considered chronic if the infection lasts longer than 6 months.[11] Left untreated, chronic hepatitis C can lead to liver damage, cancer, and death.

Given the benefits associated with early treatment, clinical and public health guidance recommend immediate treatment with hepatitis C drugs for nearly all patients, regardless of disease stage.[12, 13, 14] Hepatitis C drugs are well-tolerated and can clear the virus from the body in as little as 8 weeks. During our period of review (2023 and 2024), these drugs were approved specifically to treat chronic hepatitis C; however, providers may prescribe "off label" for other purposes, including acute hepatitis C infection.[15, 16] In June 2025, a widely used hepatitis C drug received formal approval from the Food and Drug Administration (FDA) to expand its indication to acute hepatitis C.[17]

## Medicaid Coverage of Hepatitis C Drugs

All State Medicaid programs (including the District of Columbia) covered hepatitis C drugs during our review period.[18] Historically, many States imposed restrictions on coverage of hepatitis C drugs due in part to their high costs. Common restrictions included: (1) requiring prior authorization, (2) requiring patients to maintain or be counseled on sobriety, and (3) only covering treatment when it is prescribed by or in consultation with a specialist.[19] As additional, lower-cost hepatitis C drugs entered the market, some States have reduced or eliminated these restrictions.[20] For example, during our period of review, at least seven States removed prior authorization requirements.[21]

### Coverage for Dual-Eligible Beneficiaries

According to CMS, dual-eligible beneficiaries (i.e., those enrolled in both Medicare and Medicaid) make up more than 15 percent of the Medicaid population.[22] Generally, Medicare is the primary payer for items and services received by dual-eligible beneficiaries. In other words, most dual-eligible beneficiaries who are prescribed hepatitis C drugs would primarily receive their treatment through Medicare Part D rather than Medicaid.

## HHS Efforts to Eliminate Hepatitis C

The Department of Health and Human Services (HHS) has established a goal to eliminate viral hepatitis, including hepatitis C, as a public health threat by 2030. HHS's Viral Hepatitis National Strategic Plan outlines multiple objectives related to preventing new infections, improving health outcomes of people with viral hepatitis, and coordinating related efforts among stakeholders.[23]

To support these objectives, the Centers for Disease Control and Prevention (CDC) issued a strategic plan articulating goals and strategies to reduce viral hepatitis infections. Consistent with this plan, CDC provides funding to State and local health departments to reduce the burden of viral hepatitis.[24, 25] The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) have also provided funding opportunities to State and community-based organizations to support hepatitis C treatment. In 2025, CMS announced a new Medicaid quality measure to evaluate hepatitis B and C testing and treatment rates. Under the measure, State Medicaid programs will begin voluntarily reporting hepatitis C treatment rates for their adult Medicaid populations to CMS in 2027.[26]

## Methodology in Brief

We primarily used 2023 and 2024 Medicaid and Medicare claims data (including encounter records) to determine the extent to which Medicaid beneficiaries with hepatitis C received treatment.[27] We considered a beneficiary to have active

hepatitis C if their 2023 Medicaid claims (or Medicare claims if they were dual-eligible) included a hepatitis C test, followed within 6 months by a claim indicating a hepatitis C diagnosis.[28]

We then used pharmacy claims to determine the proportion of Medicaid beneficiaries who received treatment within 6 months of testing through Medicaid (or Medicare if they were dual-eligible). We included dual-eligible beneficiaries in our national treatment analysis because they represented one-third of the Medicaid beneficiaries we identified with hepatitis C.[29]

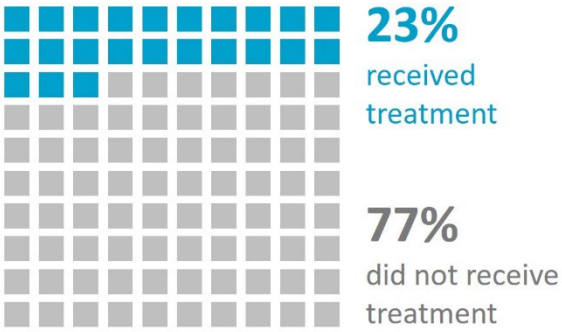
# FINDINGS

## Less than one-quarter of Medicaid beneficiaries with hepatitis C received treatment within 6 months of testing

We identified approximately 230,000 Medicaid beneficiaries with hepatitis C in 2023.[30] Only 23 percent of these beneficiaries received hepatitis C treatment within 6 months of testing through Medicaid (or Medicare if they were dual-eligible), despite recommendations to treat patients as soon as the virus is detected.

**Exhibit 1: Twenty-three percent of beneficiaries with hepatitis C received treatment within 6 months of testing**

Source: OIG analysis of 2023-2024 Medicaid and Medicare claims data.




### Five percent of beneficiaries with an acute-only hepatitis C diagnosis received treatment

Approximately 9,000 Medicaid beneficiaries included in our analysis were specifically diagnosed with acute hepatitis C only. The treatment rate among this acute-only group was 5 percent—much lower than the overall 23-percent treatment rate.

Clinical and public health guidance recommends treatment with hepatitis C drugs at the time of initial diagnosis, regardless of infection stage.[31] Early treatment can prevent the development of serious liver complications (such as fibrosis) and reduce the number of patients who disengage from care.[32] Additionally, acute hepatitis C may be associated with increased risk of transmission—treatment of this group is therefore especially important for reducing further spread of the virus.[33]

During our period of review, hepatitis C drugs were not explicitly FDA-approved for acute hepatitis C, which may have contributed to low rates of treatment for acute infection.[34] In June 2025, a widely used hepatitis C drug received formal FDA approval to expand its indication to include acute hepatitis C.[35, 36] This expanded indication represents an opportunity to increase treatment among newly infected patients.

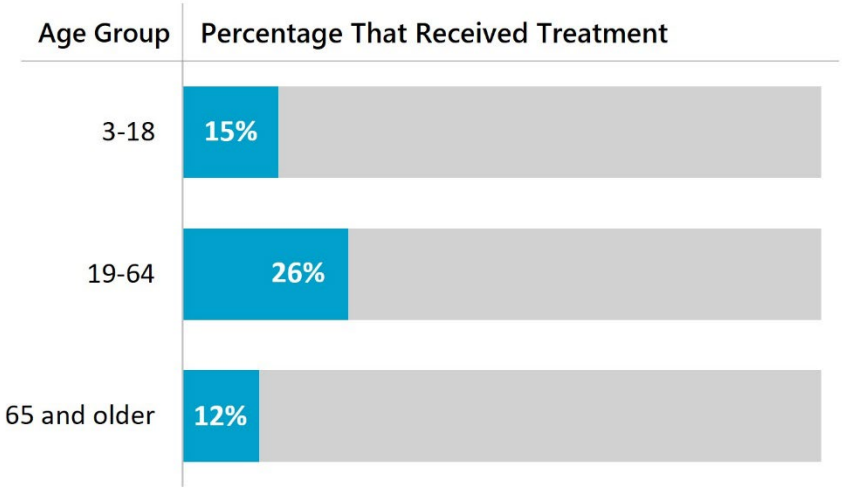
## Dual-eligible beneficiaries were half as likely to receive hepatitis C treatment as Medicaid-only beneficiaries

Just 14 percent of dual-eligible beneficiaries received treatment within 6 months of testing, compared to 28 percent of Medicaid-only beneficiaries.[37] Medicare programmatic factors and/or care coordination gaps between Medicare and Medicaid may contribute to low treatment rates among dual-eligible beneficiaries. For some dual-eligible beneficiaries, age may also impact treatment uptake—58 percent of dual-eligible beneficiaries included in our study population were 65 or older. The remainder likely qualified for Medicare due to disability or another qualifying condition.

## Older adults and children were less likely to receive hepatitis C treatment than non-elderly adults

Twelve percent of Medicaid beneficiaries aged 65 and older (nearly all of whom were dual-eligible) received treatment for their hepatitis C within 6 months of testing. In contrast, more than one-quarter of non-elderly adult beneficiaries (ages 19 to 64) received treatment. According to CDC, the hepatitis C death rate is highest among people aged 65 to 74.[38] Children aged 3 to 18 were also less likely to receive treatment compared to non-elderly adult beneficiaries.[39]

**Exhibit 2: Twelve percent of beneficiaries aged 65 and older with hepatitis C received treatment within 6 months of testing**

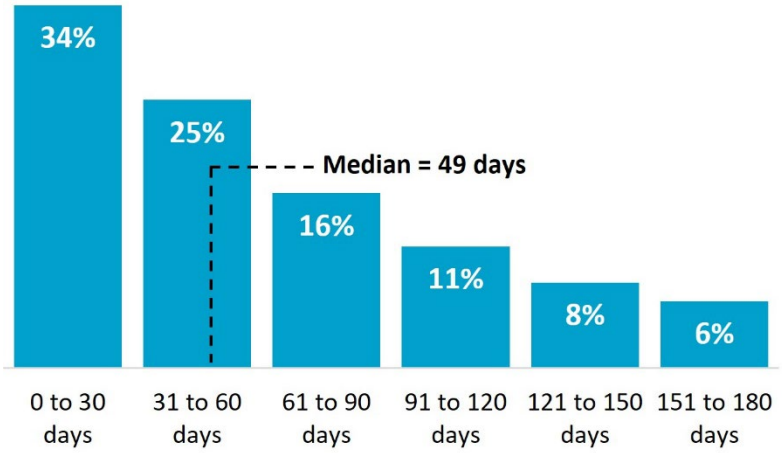



Source: OIG analysis of 2023-2024 Medicaid and Medicare claims data.
Note: We excluded beneficiaries under the age of 3 because treatment is not recommended for this age group.

## Beneficiaries who were treated with hepatitis C drugs typically began treatment 7 weeks after testing

Of beneficiaries who received treatment within 6 months, the median time from test to treatment was 49 days. One-third of these beneficiaries received their treatment in 30 days or less, while one-quarter began treatment more than 90 days after testing.[40] Experts recommend treating patients early in the course of hepatitis C, as delayed treatment can worsen the disease's progression and allow the virus to spread.[41]

**Exhibit 3: Thirty-four percent of beneficiaries who were treated received their prescription within 30 days**



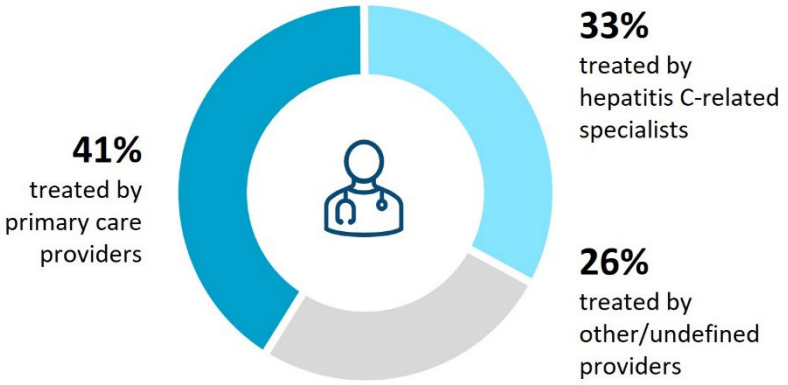

Source: OIG analysis of 2023-2024 Medicaid and Medicare claims data.

The median length of time before treatment was 4 days longer (53 days) among beneficiaries diagnosed with acute hepatitis C only.

## Forty-one percent of treated beneficiaries received their hepatitis C drug prescription from a primary care provider

Forty-one percent of beneficiaries who were treated within 6 months received their initial prescription from a primary care provider. Thirty-three percent received their prescription from providers in specialty fields traditionally associated with treating hepatitis C, including gastroenterology, hepatology, and infectious disease.[42]

**Exhibit 4: Forty-one percent of beneficiaries who were treated received their first prescription from a primary care provider**




Source: OIG analysis of provider taxonomy/specialty data and 2023-2024 Medicaid/Medicare claims data. See Methodology section for details on how we defined "primary care provider."

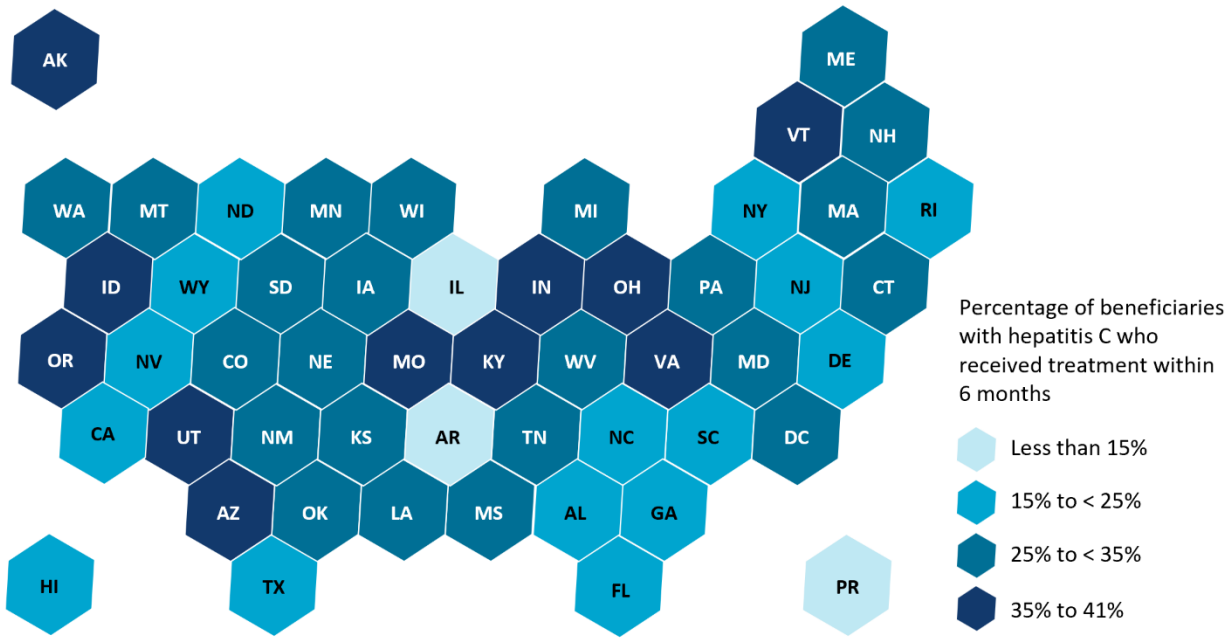
Prior to the introduction of modern hepatitis C drugs, treating hepatitis C involved complex regimens and intense patient monitoring that often required specialty training to manage.[43] As a result, many State Medicaid programs initially required prescriptions to be written by specialists, such as gastroenterologists, as a condition of coverage.[44]

In recent years, increasingly simplified treatment protocols have allowed hepatitis C drugs to be safely and effectively provided by a wide range of health care professionals, including primary care providers.[45] This expanded provider capacity to treat hepatitis C can improve patient access to treatment, especially in areas that lack specialty providers. Consequently, many States have eliminated or eased prescriber restrictions.[46]

## Among individual States, the hepatitis C treatment rate ranged from 7 percent to 41 percent

State-level hepatitis C treatment rates for Medicaid-only beneficiaries were consistently low.[47] Even in the highest-performing States, only 4 in 10 beneficiaries with hepatitis C received treatment within 6 months of testing. In States at the lower end of the range, fewer than 1 in 10 beneficiaries with hepatitis C received treatment within 6 months of testing. (We excluded dual-eligible beneficiaries from our State treatment rate calculations because Medicare, rather than State Medicaid programs, is generally responsible for paying for services and treatments related to hepatitis C for dual-eligible beneficiaries.)

**Exhibit 5: State treatment rates among Medicaid-only beneficiaries with hepatitis C ranged from 7 percent to 41 percent**




Source: OIG analysis of 2023-2024 Medicaid claims data.

State coverage restrictions may play a role in differing treatment rates, but we are unable to distinguish the effects of State policies from other factors that may impact treatment.[48] This is due, in part, to changes in State policies that occurred during our period of review. Additionally, we cannot measure and control for factors like prescriber availability, provider familiarity with hepatitis C treatment, and care coordination gaps, which may vary among States. Similarly, population characteristics (e.g., comorbidities) and stigma surrounding viral hepatitis may also differ among States.[49]

# CONCLUSION AND RECOMMENDATIONS

Hepatitis C treatment is crucial to preventing serious health complications caused by untreated infection and to reducing further spread of the virus. However, despite the availability of highly effective drugs that can cure hepatitis C within weeks, we found that less than 25 percent of Medicaid beneficiaries with hepatitis C received treatment within 6 months of testing. Treatment rates were even lower among newly infected beneficiaries, dual-eligible beneficiaries, older adults, and children, and in certain States.

Our findings reveal missed opportunities to reduce mortality, prevent further spread of disease, and realize savings in Federal health care programs. Because Medicaid is one of the largest insurers of people with hepatitis C, increasing treatment rates among Medicaid beneficiaries is vital to eliminating hepatitis C and reducing health care burden and costs. To address our findings, we recommend that CMS:

## Take additional steps to increase hepatitis C treatment rates in Medicaid

CMS should further build on its work with States to increase hepatitis C treatment rates and thereby reduce morbidity, mortality, and health care costs associated with long-term infection. In 2027, State Medicaid programs will begin calculating and reporting hepatitis C treatment rates to CMS as part of a new, voluntary quality measure. This quality measure represents an opportunity for CMS to engage with States regarding strategies to improve treatment rates. CMS could also facilitate information-sharing between States regarding hepatitis C elimination strategies.

In addition to supporting States, CMS could take direct steps to increase hepatitis C treatment rates in Medicaid. Examples of actions CMS could take include:

- Developing and testing alternative payment models with potential to increase access to treatment while reducing health care costs and administrative burden. CMS has taken this approach in other contexts, such as its implementation of the Cell and Gene Therapy Access Model for treating sickle cell disease and other rare illnesses.[50]

- Working with Federal partners, such as CDC, SAMHSA, and HRSA, to educate States and providers about the benefits of immediate treatment for nearly all hepatitis C patients. For example, outreach could highlight low treatment rates among older adults and newly infected beneficiaries, as well as a recently expanded FDA indication that includes acute infection. Outreach could also include toolkits to assist Medicaid providers with integrating hepatitis C treatment into primary care practice.

CMS may identify additional or alternative actions as it receives new information through the hepatitis C quality measure.

## Take targeted steps to increase hepatitis C treatment rates among dual-eligible beneficiaries

We found that dual-eligible beneficiaries were half as likely to receive hepatitis C treatment within 6 months compared to Medicaid-only beneficiaries. CMS should therefore take targeted steps to increase hepatitis C treatment rates among dual-eligible beneficiaries. Because Medicare is the primary payer for dual-eligible beneficiaries, CMS may be better positioned than State Medicaid programs to identify and address barriers to treatment among this group. These steps could include assessing potential hepatitis C care coordination gaps for dual-eligible beneficiaries.

Our analysis did not include the full Medicare population, meaning we were unable to determine whether treatment rates were lower among Medicare as a whole or just among dual-eligible beneficiaries. To investigate this further, CMS should consider analyzing hepatitis C treatment rates among all Medicare beneficiaries (including those who are not dual-eligible).

# AGENCY COMMENTS AND OIG RESPONSE

CMS concurred with our recommendations.

In response to our first recommendation, CMS stated that it will build on its partnership with States to help them increase hepatitis C treatment rates in Medicaid. CMS also stated that it will support States in reporting on the new hepatitis C quality measure.

In response to our second recommendation, CMS stated that it will take steps to increase hepatitis C treatment rates among dual-eligible beneficiaries. Specifically, CMS stated that it will review existing data and work with partners to identify and implement options for increasing treatment rates.

We appreciate CMS's planned actions to support increased hepatitis C treatment rates, and we look forward to receiving additional details in CMS's Final Management Decision.

For the full text of CMS's comments, see Appendix B.

# METHODOLOGY

## Data Analysis

States, certain Territories, and the District of Columbia submit Medicaid and Children's Health Insurance Program (hereinafter collectively referred to as "Medicaid") data to CMS through the Transformed Medicaid Statistical Information System (T-MSIS). Our analysis was primarily based on T-MSIS claims data (including encounter records) accessed through CMS's Integrated Data Repository Cloud. Our analysis also included beneficiary enrollment and eligibility information, provider data, and Medicare claims data (including encounter records).

### Identifying the hepatitis C study population

Hepatitis C is primarily diagnosed through blood tests, the results of which are not included in Medicaid and Medicare administrative data. We instead relied on a combination of hepatitis C testing and diagnosis claims to identify the beneficiaries included in our study population.[51]

First, we identified beneficiaries whose 2023 Medicaid claims (or Medicare claims if they were dual-eligible) included a hepatitis C test, followed within 6 months by a claim indicating a hepatitis C diagnosis.[52] For each of these beneficiaries, we then identified the earliest 2023 test date among the claims that met our 6-month testing/diagnosis criteria.

We used each beneficiary's selected test date to identify and exclude beneficiaries whose 2022 or 2023 claims indicated they received hepatitis C treatment in the 6 months leading up to their test date, as they may have been in post-treatment surveillance. We also excluded beneficiaries under the age of 3 because treatment is not recommended for this age group. Lastly, we excluded beneficiaries who did not have full-scope or comprehensive Medicaid benefits during our treatment search period.

### Analyzing hepatitis C treatment rates

For the remaining hepatitis C study population, we used 2023 or 2024 Medicaid and Medicare pharmacy claims to determine whether each beneficiary received hepatitis C direct-acting antiviral treatment ("treatment") within 6 months of their selected 2023 test date.[53]

To determine the national Medicaid treatment rate, we divided the number of Medicaid beneficiaries who received treatment in Medicaid or, if they were dual-eligible, Medicare by the number of beneficiaries we identified as having hepatitis C.

To determine treatment rates by State, we divided the number of Medicaid beneficiaries who received treatment in each State by the number of beneficiaries we identified as having hepatitis C in that State. We excluded dual-eligible beneficiaries from our State-level analysis because Medicare, rather than State Medicaid programs, is the primary payer for dual-eligible beneficiaries.

**Determining prescriber provider type**

To determine prescriber provider types, we first identified the prescribing National Provider Identifier (NPI) on each beneficiary's initial hepatitis C drug claim.[54] We then extracted taxonomy and specialty data from CMS's Master Data Management system for these providers. We considered a prescriber to be a primary care provider if their taxonomy or specialty data included: primary care, general practice, family medicine, geriatrics, internal medicine, or pediatrics. We considered a prescriber to be a hepatitis C-related specialist if their taxonomy or specialty data included: gastroenterology, hepatology, or infectious disease.

## Limitations

This data brief relied on Medicaid and Medicare administrative claims data to estimate Medicaid beneficiaries' hepatitis C diagnosis and treatment. Some beneficiaries may have received treatment outside of Medicaid or Medicare, which is not captured by our study. We did not analyze medical records or test results to confirm a beneficiary's actual infection status. Further, we did not verify the completeness or accuracy of the claims data (e.g., whether a provider correctly assigned a hepatitis C diagnosis code to a beneficiary's claim).[55] However, we did assess known T-MSIS data quality issues and verified that they did not impact our key analyses.[56] We did not verify taxonomy and specialty data, which are self-reported by providers.

## Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued in 2020 by the Council of the Inspectors General on Integrity and Efficiency.

# APPENDICES

## Appendix A: Hepatitis C Treatment Rates Among Medicaid-Only Beneficiaries by State

The below rates represent approximately 156,000 Medicaid-only beneficiaries (i.e., beneficiaries who were not dual-eligible for Medicare) whom we identified as having hepatitis C in 2023.

| State/Territory* | Number of beneficiaries identified with hepatitis C | Percentage who received treatment within 6 months |
|---|---|---|
| Indiana | 4,239 | 41% |
| Kentucky | 10,661 | 40% |
| Vermont | 43 | 40% |
| Oregon | 2,398 | 39% |
| Ohio | 12,268 | 37% |
| Missouri | 3,267 | 37% |
| Idaho | 524 | 37% |
| Virginia | 2,786 | 35% |
| Utah | 913 | 35% |
| Arizona | 4,128 | 35% |
| Alaska | 736 | 35% |
| Wisconsin | 1,721 | 34% |
| Oklahoma | 2,229 | 34% |
| Pennsylvania | 11,193 | 33% |
| Colorado | 1,940 | 32% |
| Washington | 3,376 | 32% |
| Louisiana | 4,876 | 31% |
| Maine | 1,061 | 31% |
| Minnesota | 1,588 | 31% |
| New Hampshire | 756 | 30% |
| Iowa | 916 | 30% |
| Montana | 893 | 30% |
| South Dakota | 189 | 29% |
| Tennessee | 2,941 | 29% |
| Kansas | 288 | 28% |

| State/Territory* | Number of beneficiaries identified with hepatitis C | Percentage who received treatment within 6 months |
|---|---|---|
| Michigan | 4,693 | 28% |
| Mississippi | 458 | 27% |
| New Mexico | 2,030 | 26% |
| Massachusetts | 5,144 | 26% |
| District of Columbia | 128 | 26% |
| Maryland | 3,000 | 26% |
| Nebraska | 379 | 25% |
| West Virginia | 4,584 | 25% |
| Connecticut | 1,684 | 25% |
| New Jersey | 4,119 | 24% |
| Texas | 3,066 | 23% |
| North Carolina | 2,423 | 23% |
| California | 15,802 | 23% |
| Hawaii | 214 | 23% |
| Georgia | 1,008 | 22% |
| Florida | 4,404 | 22% |
| Alabama | 1,253 | 22% |
| North Dakota | 520 | 21% |
| Delaware | 716 | 20% |
| Rhode Island | 815 | 19% |
| New York | 9,928 | 19% |
| Nevada | 996 | 19% |
| South Carolina | 1,304 | 16% |
| Puerto Rico | 3,878 | 10% |
| Illinois | 7,371 | 9% |
| Arkansas | 1,049 | 7% |

*We did not display results for Wyoming due to small totals—the percentage of beneficiaries in Wyoming who received treatment was less than 22 percent.
Note: A small proportion of beneficiaries were associated with more than one State.
Source: OIG analysis of 2023-2024 Medicaid claims data.

# Appendix B: Agency Comments

Following this page are the official comments from CMS.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*
Washington, DC 20201

**DATE:** September 25, 2026

**TO:** Ann Maxwell
Deputy Inspector General
for Evaluations and Inspections

**FROM:** Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services

**SUBJECT:** Office of Inspector General Draft Data Brief: *Less Than 25 Percent of Medicaid Beneficiaries with Hepatitis C Received Treatment Within 6 Months* (OEI-BL-24-00450)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. Timely testing, diagnosis, and treatment of hepatitis C can prevent serious liver damage and improve health outcomes. CMS is committed to working with states to ensure that people with Medicaid, including people who are dually-eligible for Medicare, are able to get the care that they want, need, and deserve in a health care system that fosters prevention, wellness, and chronic disease management.

The Medicaid Adult Core Set serves as a set of measures which, taken together, can be used to estimate the overall national quality of health care for people with Medicaid. CMS and states use data from the Adult Core Set to inform, and measure the success of, efforts to improve quality of care and health outcomes. The Adult Core Set comprises quality measures collected at the state level, and these state-level data are then used to calculate national estimates. In order to be publicly reported, measures must be reported by 25 or more states, and must meet CMS standards for data quality. States are required to report the behavioral health measures on the Adult Core Set; the remainder of the measures on the Adult Core Set remain voluntary for states to report.

As required by section 1139B of the Social Security Act (the Act), the Adult Core Set is updated annually, and in consultation with stakeholders as required by section 1139A of the Act. The Core Set Workgroup convenes each year to suggest, discuss, and vote on annual revisions to the measures on the Medicaid Adult Core Set. A draft report from the Workgroup meeting is then made available for public comment, and a final report, including the Workgroup recommendations and public comments, is provided to CMS. CMS then issues annual updates to the Adult Core Set based on the Workgroup recommendations. Most recently, the 2027 Adult Core Set was released in a December 2025 State Health Official Letter.[1] Based on the input received through the annual review process, a new measure looking at the evaluation of Hepatitis B and C was added to the 2027 Adult Core Set for voluntary

[1] CMS, 2027 Updates to the Child and Adult Core Health Care Quality Measurement Sets and Mandatory Reporting Guidance, Accessed at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho25005.pdf

reporting. This measure will assess the number and percentage of adult, non-dually eligible Medicaid beneficiaries who were tested for Hepatitis B, tested for Hepatitis C, and treated for Hepatitis C. Reporting on the 2027 Adult Core Set, for services primarily provided during 2026, will take place in Fall 2027.

The OIG's recommendations and CMS's responses are below.

**OIG Recommendation 1**

Take additional steps to increase hepatitis C treatment rates in Medicaid.

**CMS Response**

CMS concurs with this recommendation. CMS regularly partners with states to share promising practices and provide technical assistance to improve access and the quality of care for people with Medicaid. CMS will build on this work to help states increase hepatitis C treatment rates in Medicaid. CMS will also work with states to support reporting on the voluntary Hepatitis B and C quality measure in the 2027 Adult Core Set.

**OIG Recommendation 2**

Take steps to increase hepatitis C treatment rates among dual-eligible beneficiaries.

**CMS Response**

CMS concurs with this recommendation. CMS will take steps to increase hepatitis C treatment rates among dual-eligible beneficiaries. CMS will review existing data, and work with partners to identify and implement options for increasing treatment rates.

# ENDNOTES

[1] HHS, *Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination (2021–2025)*, 2020. Accessed on May 14, 2026.

[2] For example, a Congressional Budget Office analysis found that increasing hepatitis C treatment rates in Medicaid would avert millions in Federal spending on complications from untreated infection. Congressional Budget Office, *Budgetary Effects of Policies That Would Increase Hepatitis C Treatment*, June 2024. Accessed on May 14, 2026.

[3] Office of the Assistant Secretary for Health, *State Activities To Combat Hepatitis C: Hepatitis C Medicaid Affinity Group Final Report*, October 2021. Accessed on May 14, 2026.

[4] Eric Hall et al., "Estimating hepatitis C prevalence in the United States, 2017–2020," *Hepatology*, vol. 81, no. 2 (February 2025), pp. 625-636. Accessed on May 14, 2026. CDC, "Hepatitis C Basics" (Sept. 2, 2025). Accessed on May 14, 2026.

[5] CDC, "Hepatitis C Virus – Reduce Infections" (Apr. 16, 2025). Accessed on May 14, 2026. CDC, "Hepatitis C Surveillance" (Apr. 15, 2025). Accessed on May 14, 2026.

[6] Office of the Assistant Secretary for Health, *State Activities To Combat Hepatitis C: Hepatitis C Medicaid Affinity Group Final Report*, October 2021. Accessed on May 14, 2026.

[7] CMS, "Estimated Impacts of Proposed National Hepatitis C Elimination Program on Medicaid and Medicare" (June 2024). Accessed on May 14, 2026.

[8] The Congressional Budget Office noted that spending on expanded testing and treatment would increase, but that savings from averted spending on hepatitis C complications would offset direct spending. Congressional Budget Office, *Budgetary Effects of Policies That Would Increase Hepatitis C Treatment*, June 2024. Accessed on May 14, 2026.

[9] Although not specific to Medicaid, a 2026 CDC study found that hepatitis C treatment can avert tens of thousands of dollars in lifetime medical costs per person. Taiwo O. Abimbola et al., "Lifetime medical costs of chronic hepatitis C in the United States," *BMC Health Services Research*, vol. 26, no. 609 (Mar. 21, 2026). Accessed on July 21, 2026.

[10] CDC, "Hepatitis C Basics" (Sept. 2, 2025). Accessed on May 14, 2026.

[11] AASLD-IDSA Hepatitis C Guidance Panel, "Hepatitis C Guidance 2019 Update: AASLD-IDSA Recommendations for Testing, Managing, and Treating Hepatitis C Virus Infection," *Hepatology*, vol. 71, no. 2 (February 2020), pp. 686-721. Accessed on May 14, 2026. CDC, "Clinical Overview of Hepatitis C" (Aug. 29, 2025). Accessed on May 14, 2026.

[12] Prior to 2019, premier guidance from the American Association for the Study of Liver Diseases (AASLD) and the Infectious Diseases Society of America (IDSA) recommended monitoring patients with acute hepatitis C for several weeks before initiating treatment, as some patients can spontaneously clear the virus during the acute

period. The joint panel has since updated its guidance to recommend treatment for all hepatitis C patients at the time of initial diagnosis. CDC also discourages waiting to treat hepatitis C patients.

[13] For prior AASLD-IDSA recommendations, see AASLD-IDSA HCV Guidance Panel, "Hepatitis C Guidance 2018 Update: AASLD-IDSA Recommendations for Testing, Managing, and Treating Hepatitis C Virus Infection," *Clinical Infectious Diseases*, vol. 67, no. 10 (Sept. 12, 2018), pp. 1477-1492. See AASLD-IDSA's revised guidance at: AASLD-IDSA Hepatitis C Guidance Panel, "Hepatitis C Guidance 2019 Update: AASLD-IDSA Recommendations for Testing, Managing, and Treating Hepatitis C Virus Infection," *Hepatology*, vol. 71, no. 2 (February 2020), pp. 686-721. CDC's current guidance was accessed at CDC, "Clinical Care of Hepatitis C" (Jan. 31, 2025) on May 14, 2026.

[14] Treatment is not recommended for children under the age of 3. In addition, some patients, such as those with a short life expectancy, may be advised against treatment by their provider.

[15] OIG review of hepatitis C drug labels.

[16] According to FDA, once it has approved a drug, providers generally may prescribe the drug for unapproved use when they judge that it is medically appropriate for their patient. FDA, "Understanding Unapproved Use of Approved Drugs 'Off Label'" (Feb. 5, 2018). Accessed on May 14, 2026.

[17] AbbVie, "U.S. FDA Approves Expanded Indication for AbbVie's MAVYRET® (Glecaprevir/Pibrentasvir) as First and Only Treatment for People with Acute Hepatitis C Virus" (press release, June 11, 2025). Accessed on May 14, 2026.

[18] According to OIG's analysis of 2023-2024 Medicaid pharmacy claims, all States and the District of Columbia reimbursed for hepatitis C drugs.

[19] In addition to applying utilization management controls, States have discretion in which of the several available hepatitis C drugs they include on their preferred drug lists.

[20] Sonya Davey et al., "Changes in Use of Hepatitis C Direct-Acting Antivirals After Access Restrictions Were Eased by State Medicaid Programs," *JAMA Health Forum*, vol. 5, no. 4 (Apr. 5, 2024). Accessed on May 14, 2026.

[21] The Center for Health Law and Policy Innovation & National Viral Hepatitis Roundtable track State Medicaid coverage restrictions through their "Hepatitis C: State of Medicaid Access" project. According to their research, between February 2023 and February 2024 seven States effectively removed prior authorization requirements for certain hepatitis C drugs. See their "August 2023 Snapshot Update" and "February 2024 Snapshot Update" for more information. Accessed on June 9, 2026.

[22] CMS, "Seniors & Medicare and Medicaid Enrollees." Accessed on June 9, 2026.

[23] HHS, *Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination (2021–2025)*, 2020. Accessed on May 14, 2026.

[24] CDC, *Division of Viral Hepatitis 2025 Strategic Plan*, 2020. Accessed on May 14, 2026. CDC, "Integrated Viral Hepatitis Surveillance & Prevention for Health Departments" (May 10, 2024). Accessed on July 16, 2026.

[25] CDC has also conducted research on hepatitis C treatment and clearance rates. For example, CDC found that only 17 percent of Medicaid patients received hepatitis C treatment within 6 months of diagnosis during 2019–2020. William W. Thompson et al., "*Vital Signs:* Hepatitis C Treatment Among Insured Adults — United States, 2019–2020," *Morbidity and Mortality Weekly Report*, vol. 71, no. 32 (Aug. 12, 2022). Accessed on July 21, 2026.

[26] CMS, "2027 Updates to the Child and Adult Core Health Care Quality Measurement Sets and Mandatory Reporting Guidance (SHO # 25-005)" (Dec. 30, 2025). Accessed on May 14, 2026.

[27] A small proportion of claims included in our analysis represented Children's Health Insurance Program (CHIP) claims. We collectively refer to Medicaid and CHIP as "Medicaid" throughout this data brief. We use "beneficiary" to collectively refer to individuals in fee-for-service and/or managed care Medicaid programs.

[28] We excluded certain beneficiaries from our analysis, including beneficiaries whose 2022 or 2023 claims indicated they received hepatitis C treatment in the 6 months leading up to their test date as they might have been in post-treatment surveillance.

[29] Our analysis included both full-benefit and partial-benefit dual-eligible beneficiaries.

[30] We considered a beneficiary to have active hepatitis C if their 2023 Medicaid claims (or Medicare claims if they were dual-eligible) included a hepatitis C test, followed within 6 months by a claim indicating a hepatitis C diagnosis. We excluded beneficiaries who received hepatitis C treatment in the 6 months leading up to testing (and therefore might be in post-treatment surveillance); beneficiaries who did not have full-scope or comprehensive Medicaid benefits; and beneficiaries under the age of 3 (for whom treatment is not recommended).

[31] AASLD-IDSA, *HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C*, Dec. 19, 2023. Accessed on May 14, 2026. CDC, "Clinical Care of Hepatitis C" (Jan. 31, 2025). Accessed on May 14, 2026.

[32] CDC, "Treatment of Hepatitis C" (Dec. 20, 2023). Accessed on May 14, 2026. AASLD-IDSA, *HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C*, Dec. 19, 2023. Accessed on May 14, 2026.

[33] AASLD-IDSA Hepatitis C Guidance Panel, "Hepatitis C Guidance 2019 Update: AASLD-IDSA Recommendations for Testing, Managing, and Treating Hepatitis C Virus Infection," *Hepatology*, vol. 71, no. 2 (February 2020), pp. 686-721. Accessed on May 14, 2026.

[34] OIG review of hepatitis C drug labels.

[35] OIG analysis of Medicaid and Medicare claims data.

[36] AbbVie, "U.S. FDA Approves Expanded Indication for AbbVie's MAVYRET® (Glecaprevir/Pibrentasvir) as First and Only Treatment for People with Acute Hepatitis C Virus" (press release, June 11, 2025). Accessed on May 14, 2026.

[37] We included dual-eligible beneficiaries in our national Medicaid analysis because they represented a significant share (one-third) of the Medicaid beneficiaries we identified with hepatitis C. We did not analyze treatment among Medicare beneficiaries who were not dual-eligible for Medicaid, meaning we are unable to determine whether treatment rates are lower among Medicare beneficiaries as a whole or just among dual-eligible beneficiaries.

[38] CDC, "Table 3.8 – Hepatitis C: Death Rates by Demographics" (Apr. 15, 2025). Accessed on June 17, 2026.

[39] Approximately 2,000 beneficiaries in our hepatitis C study population were aged 3 to 18; 184,000 were aged 19 to 64; and 47,000 were aged 65 or older.

[40] The middle 50 percent of beneficiaries began treatment between 23 and 91 days after testing.

[41] CDC, "Treatment of Hepatitis C" (Dec. 20, 2023). Accessed on May 14, 2026. AASLD-IDSA Hepatitis C Guidance Panel, "Hepatitis C Guidance 2019 Update: AASLD-IDSA Recommendations for Testing, Managing, and Treating Hepatitis C Virus Infection," *Hepatology*, vol. 71, no. 2 (February 2020), pp. 686-721. Accessed on May 14, 2026.

[42] Among the remaining 26 percent of beneficiaries, 10 percent were treated by other provider types (for example, providers whose taxonomy or specialty data referenced addiction medicine, acute care, etc.) and 16 percent were treated by providers with undefined taxonomy/specialty data.

[43] Shashi N Kapadia et al., "Hepatitis C treatment by non-specialist providers in the direct-acting antiviral era," *Med Care*, vol. 59, no. 9 (Sept. 1, 2021), pp. 795-800. Accessed May 14, 2026.

[44] Sonya Davey et al., "Changes in Use of Hepatitis C Direct-Acting Antivirals After Access Restrictions Were Eased by State Medicaid Programs" *JAMA Health Forum*, vol. 5, no. 4 (Apr. 5, 2024). Accessed on May 14, 2026.

[45] Allison E. Wang et al., "Integrating Management of Hepatitis C Infection into Primary Care: the Key to Hepatitis C Elimination Efforts," *Journal of General Internal Medicine*, vol. 37, no. 13 (Apr. 28, 2022), pp. 3435-3443. Accessed on May 14, 2026. AASLD-IDSA Hepatitis C Guidance Panel, "Hepatitis C Guidance 2019 Update: AASLD-IDSA Recommendations for Testing, Managing, and Treating Hepatitis C Virus Infection," *Hepatology*, vol. 71, no. 2 (February 2020), pp. 686-721. Accessed on May 14, 2026.

[46] Sonya Davey et al., "Changes in Use of Hepatitis C Direct-Acting Antivirals After Access Restrictions Were Eased by State Medicaid Programs," *JAMA Health Forum*, vol. 5, no. 4 (Apr. 5, 2024). Accessed on May 14, 2026.

[47] As of June 2026, Territories that currently submit T-MSIS data include Puerto Rico, U.S. Virgin Islands, and Guam. We excluded Guam from our analysis because it began submitting T-MSIS data during our period of review. Our collected data did not contain any claims for hepatitis C drugs from the U.S. Virgin Islands.

[48] Other research has demonstrated an association between restrictive Medicaid coverage policies and lower hepatitis C treatment rates. For example, see Nathan W. Furukawa et al., "Medicaid Expansion and Restriction Policies for Hepatitis C Treatment," *JAMA Network Open*, vol. 7, no. 7 (July 16, 2024). Accessed on July 22, 2026.

[49] The 6-month hepatitis C treatment rate was 30 percent among rural beneficiaries and 21 percent among urban beneficiaries.

[50] Under the Cell and Gene Therapy Access Model, CMS negotiated pricing discounts and outcomes-based rebate agreements with pharmaceutical manufacturers on behalf of State Medicaid agencies. State Medicaid agencies that choose to participate must implement the agreed-upon access policies (for example, standardized prior authorization criteria). CMS provides technical assistance and funding to States to support implementation. CMS, "CGT (Cell and Gene Therapy Access) Model" (May 7, 2026). Accessed on May 14, 2026.

[51] Hepatitis C is primarily diagnosed through sequential blood tests consisting of hepatitis C virus antibody testing followed by confirmatory RNA testing if the antibody test is reactive. Because test results were not available for our analysis, we considered a beneficiary to have hepatitis C if their claims included a hepatitis C test followed by a hepatitis C diagnosis. Our testing claims search included procedure codes for hepatitis C screening, hepatitis C antibody testing, hepatitis C RNA testing, and hepatitis C genotype testing. Our diagnosis claims search included ICD-10-CM codes for acute, chronic, and unspecified hepatitis C.

[52] Throughout our analyses, we defined 6 months as 180 days.

[53] We used National Drug Codes to identify claims for hepatitis C direct-acting antivirals (i.e., "hepatitis C drugs" or "hepatitis C treatment"). Our search results included claims for the following hepatitis C drugs: Epclusa, Harvoni, ledipasvir/sofosbuvir, Mavyret, sofosbuvir/velpatasvir, Sovaldi, Vosevi, and Zepatier.

[54] Hepatitis C treatment may be prescribed by physicians or other qualified practitioners with prescribing authority (e.g., nurse practitioners, physician assistants).

[55] For example, a provider may have assigned a hepatitis C diagnosis code to a beneficiary's claim after a positive antibody test without waiting for a confirmatory RNA test. This could result in misclassification that may artificially reduce measured treatment rates.

[56] T-MSIS is the most comprehensive national Medicaid and CHIP data set; however, its size, complexity, and frequency of updates influence the quality of its data. See CMS, "DQ (Data Quality) Atlas," for more information about Medicaid data quality.

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