Value in Pharmacy Care Act

A BILL TO BE ENTITLED THE "VALUE IN PHARMACY CARE ACT," RELATING TO THE DEVELOPMENT OF METRICS TO SHIFT PHARMACEUTICAL PAYMENT BY INCENTIVIZING THE ADOPTION OF VALUE-BASED CARE MODELS, AMENDING _____

PURPOSE: Value-based payment (VBP) models, in which providers are rewarded for providing cost-effective and quality care, can offer states greater flexibility in health care delivery. Aligning payment incentives and performance measures across multiple payers, or "payer alignment," can simplify participation in multiple VBP models through standardized quality metrics, reporting, and expectations.

BE IT ENACTED:

SECTION 1: Definitions. Section _____ is amended to read:

For the purpose of this Act, the following definitions shall apply:

(1) "Healthcare Provider" shall have the same meaning as defined in Section _____.

(2) "Health Plan" shall have the same meaning as defined in Section _____.

SECTION 2: Applicability. Section _____ is amended to read:

(1) The measure applies to the state _____, value-based purchasing agreements between health plans and drug manufacturers, and performance-based contracts between health plans and pharmacies operating within the state.

CONTACT | **ADAM COLBORN**
Senior Manager, Policy and Government Relations
703 684 2627 • acolborn@amcp.org
www.amcp.org • *@amcporg*

SECTION 3: Medicaid Authority to Enter Value-based Arrangements. Section _____ is amended to read:

(1) The measure authorizes the [State Medicaid Program] to enter into a value-based arrangement, including a rebate, discount, or price reduction, with drug manufacturers based on outcome data or other metrics, as determined by the Department and the drug manufacturers, pursuant to those contracts. This Act also authorizes the Department of _____ to enter into performance-based contracts with pharmacies.

(2) The Commissioner of Health shall develop a standardized set of measures by which to assess the quality of health care services offered by health care providers. Quality measures must be based on medical evidence and be developed through a process in which providers participate. The measures shall be used for the quality incentive payment system developed in subdivision 2 and must:

a) Include uniform definitions, measures, and forms for submission of data, to the greatest extent possible;

b) Seek to avoid increasing the administrative burden on health care providers;

c) Be initially based on existing quality indicators for physician and hospital services, which are measured and reported publicly by quality measurement organizations, including, but not limited to the [State Medicaid Program];

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d) Place a priority on measures of health care outcomes, rather than process measures, wherever possible; and

e) Incorporate measures for primary care, including preventive services and other measures as determined by the Commissioner.

(3) The measures shall be reviewed at least annually by the Commissioner.

SECTION 4: Medicaid. Section _____ is amended to read:

(1) The Commissioner shall employ a value-based care model for administering the Medicaid program and its enrollees to provide for services for all Medicaid populations throughout the state. Services to be managed within the model shall include all mandatory Medicaid covered services and may include, but are not limited to, care coordination, utilization management, disease management, pharmacy benefit management, provider network management, quality management, pharmacies, and customer services.

(2) The Medicaid Commissioner shall issue a 5-year request for proposals to enter into contracts with vendors that demonstrate the greatest ability to satisfy the state's need for value, quality, efficiency, innovation, and savings. The request for proposals shall be released no later than _____. The vendors of the value-based care model or combination of models demonstrating the greatest ability to satisfy the state's need for value, quality, efficiency, innovation, and savings shall be selected no later than _____ with final contracts submitted to ____ no later than _____ unless this date is extended by the fiscal committee. After the bidding process, the Commissioner shall establish a

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www.amcp.org • *@amcporg*

capitated rate based on the bids by the appropriate model for the contract that is full risk to the vendors.

(3) In establishing minimum standards, the Department shall consult and use, where appropriate, standards established by national accreditation organizations.

(4) Notwithstanding the foregoing, the Department shall not be bound by the standards established by such organizations, provided, however, that wherever the Department promulgates standards different from the national standards, it shall state the reason for such variation take into consideration any projected compliance costs for such variation. In order to reduce health care costs and improve access to health care services, the _____shall establish by regulation as a condition of accreditation that carriers use uniform standards and methodologies for credentialing of providers, including any health care provider type licensed under chapter _____ that provide identical services. The Department shall, before adopting regulations under this section, consult with _____. Accreditation by the Department shall be valid for a period of 24 months.

SECTION 5: Requirements and Standards. Section _____ is amended to read:

(1) This section applies to value-based care contracts entered into in this state between any entity listed under this Act.

(2) In contracting for a value-based model and the various rate cells, a health plan shall ensure no reduction in the quality of care of services provided to enrollees in the model and shall exercise all due diligence to maintain or increase the current level of quality of care provided.

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www.amcp.org • *@amcporg*

(3) The Commissioner may, in consultation with the fiscal committee, adopt rules, if necessary, to implement the provisions of this section. The Department shall seek, with the approval of the fiscal committee, all necessary and appropriate waivers to implement the provisions of this section.

SECTION 6: Performance-Based Contract Requirements and Standards. Section _____ is amended to read:

(1) Performance-based contracts between health plans or their contract pharmacy benefits managers and pharmacies regarding the provision of pharmacy services must:

a) Use measures that are fair, attainable, meaningful, and applicable to the pharmacy type being evaluated.

b) Clearly describe performance measures and financial incentives prior to the start date of a measurement period. Contracts with retroactive start dates shall exempt performance prior to the date of execution of the contract from evaluation.

c) Not structure price incentives as claw-backs, where payment for a prescription product may be owed from the pharmacy to the health plan irrespective of pharmacy performance. Nothing in this section shall prohibit use of performance-based recoupment agreements.

SECTION 7: Quality-Based Contract Requirements and Standards. Section _____ is amended to read:

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(1) By _____ 20__, the Commissioner shall develop a system of quality incentive payments under which providers are eligible for quality-based payments that are in addition to existing payment levels, based upon a comparison of provider performance against specified targets, and improvement over time. The targets must be based upon and consistent with the quality measures established under this Act.

(2) To the extent possible, the payment system must adjust for variations in patient population in order to reduce incentives to health care providers to avoid high-risk patients or populations.

SECTION 8: Reporting. Section _____ is amended to read:

(1) The measure requires the Department to report to the Legislature on how value-based arrangements may be implemented in the Medicaid program or other program.

(2) The measure requires entities to report the results of their value-based arrangement each year.

(3) Every health care provider, as defined by Section 1 or otherwise shall track and report quality information at least annually under regulations promulgated by the department.

(4) The report shall include the collective results, including, but not limited to, the level of participation among _____for participation, the number and type of screenings and diagnostic tests conducted, the instance of undiagnosed

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risks defined as out-of-range diagnostic tests and number of employees seeking and receiving preventative treatment.

(5) The Department shall use this information in the negotiating and purchasing, on such terms as it deems in the best interest of the Department and its employees, from 1 or more insurance companies, savings banks or non-profit hospital or medical service corporations, of a policy or policies of group life and accidental death and dismemberment insurance covering persons in the service of the commonwealth and group general or blanket insurance providing Pharmacy, hospital, surgical, medical, dental, and other health insurance benefits covering persons in the service of the state and their dependents.

(6) Beginning 1 year after the end of the fiscal year in which the Department has implemented the program, the Department shall annually submit a report to the governor, secretary of administration and finance, the chairs of the joint committee on health care financing, the chairs of the house and senate committees on ways and means, the speaker of the house of representatives and the senate president on the savings that have been achieved in procuring such insurance policies since implementing the program.

SECTION 7: Rule Promulgation and Effective Date. Section _____ is amended to read:

(1) Pursuant to Section _____, the Commissioner is empowered to promulgate rules to enforce the provisions of this Act.

(2) This Act shall go into effect on _____.

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