A Review of Subscription-Based Payment Model for Hepatitis C Medications

Preface

This report was written in response to Item 401, Paragraph D, from Chapter 1289 of the 2020 Acts of Assembly:

> The Department of Corrections shall assess the costs, benefits, and feasibility of adopting a "subscription model" for the purchase of Hepatitis C antiviral medication and necessary ancillary services (i) for a pre-determined period of time and (ii) at an annual fixed rate to be administered to state-responsible inmates held in state correctional facilities. The assessment shall include an evaluation of the terms and conditions of models adopted for correctional systems operated by other state and local governments, and the feasibility of implementing such models in Virginia. The scope of this assessment shall not preclude the collection of appropriate non-proprietary information from pharmaceutical manufacturers, if such information is deemed necessary by the department to complete the assessment. The department shall report the findings of its assessment, and any relevant recommendations, to the Secretary of Public Safety and Homeland Security and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees no later than November 30, 2020.

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Executive Summary

Hepatitis C is a viral infection that can cause serious health problems including cirrhosis (or scarring of the liver), cancer, and death. The Hepatitis C virus (HCV) is the most common blood borne viral infection in the United States. Compared to the non-institutionalized population, offenders in state prisons bear much of the burden associated with the disease. Hepatitis C is spread mainly through drug injection use, and since 20 to 55 percent of state offenders have injected drugs (Beckman et al., 2016), treating this population can prevent community transmission. Providing HCV treatment to state inmates therefore presents a unique opportunity to reduce the nation's Hepatitis C epidemic. Historically, many prisoners have not received treatment due to the high cost of direct-acting HCV antivirals as well as insufficient provider capacity to treat infected individuals. Two states (Louisiana and Washington) are attempting to address these issues by entering into subscription payment arrangements with pharmaceutical manufacturers. Through these arrangements, the states are seeking to purchase antivirals at reduced prices in an effort to treat as many people as possible.

The subscription payment model represents one option for purchasing HCV antivirals, and the 2020 General Assembly directed the Virginia Department of Corrections (VADOC) to report on the feasibility of using it in the Commonwealth's correctional system. To that end, VADOC staff collected documents on Hepatitis C and the subscription payment model and interviewed staff in Louisiana, Washington, and the National Governors Association. Based on the review, three key findings were identified. First, because only two states have entered into subscription arrangements with drug manufacturers, there is limited evidence for assessing the effectiveness of the subscription model at lowering antiviral costs while improving HCV treatment outcomes. Second, implementing the subscription model requires the participation of multiple state agencies to generate patient volumes of roughly 30,000 individuals as well as access to adequate numbers of providers to treat individuals in the target populations. Third, VADOC already purchases HCV antivirals at substantially reduced cost through the federal 340B Drug Discount Program and a direct contract with a drug manufacturer. Considering the narrow scope of this report, VADOC's limited access to providers, and that VADOC is already purchasing HCV drugs at reduced cost, the General Assembly may wish to defer consideration of the subscription model until more information is available on its effectiveness or direct a second study that examines the model's feasibility across multiple state health care agencies.

I. Background on Hepatitis C and the Criminal Justice System

Hepatitis C is a blood-borne infection caused by the hepatitis C virus (HCV). It is the most frequently reported viral infection in the United States and is a leading cause of liver-related illness and death. Although roughly 20 percent of individuals with HCV infection develop acute hepatitis, a short-term condition often resolving within a few months, others develop chronic hepatitis, a long-term condition resulting in progressive liver disease, cirrhosis, and hepatocellular carcinoma (Blackard, 2008; Rosenberg et al., 2018). Because many individuals with HCV are asymptomatic, they may not know they are infected. If illness occurs, symptoms may include fever, fatigue, jaundice, and loss of appetite. Symptoms can occur during the acute stage of infection, or throughout the chronic stage, often lasting for decades (Virginia Department of Health [VDH], 2016).

According to the Centers for Disease Control and Prevention (CDC), approximately 2.4 million adults are infected with HCV, representing roughly one percent of the nation's population (CDC, 2020). Historically, HCV has been highest among individuals born between 1945 and 1965, mostly due to unsafe medical practices common during that time (Spaulding & Miller, 2016). Changes over the last decade have also reshaped the HCV epidemic. Since 2013, the rate of HCV infection has increased among adults under the age of 40 largely because of the opioid and heroin use epidemics (CDC, 2018). In addition, direct-acting antivirals (DAAs) have become available for treating individuals with Hepatitis C. Compared to older medications, DAAs have cure rates over 95 percent, require shorter treatment spans, and have little or no side effects (VDH, 2016). The antivirals offer a means for eliminating Hepatitis C, but there have been barriers to expanding access among some patients and health insurers. However, over the last six years, as payers began covering DAAs, restrictions on specialty providers, patient abstinence, and prior authorizations were removed from Medicaid and other health insurers. Although these coverage changes support the goal of Hepatitis C elimination, access to community providers willing to treat individuals with HCV infection has not increased as much.

Injection drug users are disproportionately represented in local jails and state prisons, and it is estimated that at least 17 percent of all offenders are infected with Hepatitis C (Daniels & Studdert, 2020). While many were infected prior to incarceration, some may have become infected while in prison by sharing contaminated needles, toothbrushes, or razors (Thanthong-Knight, 2018). Despite a 1976 Supreme Court ruling that incarcerated individuals cannot be denied access to care, some states are hesitant to treat all offenders with HCV due to the enormous costs involved, while others that are willing to treat infected offenders are hindered due to insufficient provider capacity (Beckman et al., 2016; Sterling et al., 2018; Daniels & Studdert, 2020). For states concerned with the cost of treatment, consideration has been given to new value-based purchasing strategies. These strategies were mostly developed in an effort to expand access to care within state Medicaid, correctional, and other vulnerable populations by reducing treatment costs. One such strategy is the subscription payment model, where a state negotiates directly with a pharmaceutical manufacturer to purchase a certain amount of

HCV antivirals at a set price over a predefined period to treat as many people as possible (Johnson et al., 2018).[1]

The sections that follow provide information on the procedures used by VADOC staff to evaluate the subscription payment model's appropriateness, the results of the review, and a summary of important findings.

II. Study Methods

To conduct the review, VADOC staff collected background information on Hepatitis C and the subscription payment model. Additional information was obtained by interviewing Medicaid, correctional, and health department staff in Louisiana and Washington, two states that recently entered into subscription contracts with pharmaceutical manufacturers, as well as staff at the National Governors Association. Finally, VADOC staff reviewed the data to assess the financial implications of using the model in the state's correctional system.

III. State Payment Approaches for Hepatitis C Antiviral Medications

To determine the appropriateness of the subscription payment model, VADOC staff reviewed and compared the agency's current approach for purchasing antivirals against the subscription arrangements implemented in Louisiana and Washington.[2] The results are presented below.

***Virginia*.** While the exact number is unknown, it is estimated that at least 5,000 state offenders and up to 40,000 residents in Virginia may be infected with HCV (Rosenberg et al., 2018; Sterling et al., 2018; Syed et al., 2020). Within VADOC, since 2019, all offenders are tested for HCV infection at intake unless they opt-out, and are also offered opt-in tests within 180 days of their release date. Due to limited provider capacity to treat all offenders testing positive for HCV, infected offenders are prioritized for treatment based on various prescreening criteria including disease severity, presence of certain comorbidities, and recent tattoos and/or substance abuse activities (VADOC, 2020).[3] Individuals with the highest level of disease progression meeting the screening criteria are referred for HCV treatment via a telemedicine appointment with Virginia Commonwealth University (VCU) Health's Hepatitis C Clinic that VADOC supports financially. If HCV treatment is indicated, clinic providers prescribe antivirals that are filled by the university's outpatient pharmacy (Sterling et al., 2018). Because VCU Health participates in the federal 340B Drug Discount Program, VADOC is able to purchase

[1] The subscription model is also referred to as the "Netflix" model. Netflix is a streaming service offering unlimited content for a flat fee. For Hepatitis C, the analogy is a pharmaceutical manufacturer that provides an unlimited supply of antivirals to all infected individuals in a state (or nation) in exchange for a flat recurring fee (Trusheim et al., 2018).

[2] Only three subscription payment models have been initiated by public payers for Hepatitis C. Two subscription models were initiated by the states of Louisiana and Washington, while the third was initiated by the Australian Government (Liu et al., 2020).

[3] Although health insurers routinely cover HCV antiviral medications, some impose access restrictions on the basis of disease progression and recent substance abuse activities (Daniels & Studdert, 2020).

antivirals at substantial discounts, which are approximately 50 percent off the U.S. list price for the drugs (Herrick, 2017).[4,5] Since 2015, VCU Health has treated 1,095 offenders for HCV infection at a cost of $30.7 million.

To expand clinic capacity, VADOC recently hired a dedicated provider allowing treatment of an additional number of offenders. Since December 2019, this provider has treated 216 offenders at a cost of $4.6 million. Antivirals prescribed to offenders treated internally are purchased through Diamond Pharmacy Services, the Department's pharmacy contractor. Since Diamond Pharmacy does not participate in the 340B program, the cost of antivirals purchased through the contractor are roughly 25 percent higher on average than the cost of the same antivirals purchased through VCU Health. To lower costs for the agency, Diamond Pharmacy contracted directly with Gilead Sciences, Inc. in September 2020 to purchase Epclusa at a cost comparable to 340B pricing. Through this new contract, VADOC is able to obtain a commonly used HCV antiviral at substantially discounted prices when prescribed to a majority of internally treated offenders.

***Louisiana*.** In Louisiana, at least 91,000 residents have Hepatitis C. Of these, roughly 39,000 are in the state's Medicaid program and correctional system. Prior to 2019, Louisiana was only able to treat a small fraction of its Medicaid beneficiaries and offenders with HCV due to high treatment costs (Gee, 2019). As part of a statewide strategy to reduce and eventually eliminate Hepatitis C, Louisiana entered into a five-year contract with Asegua Therapeutics (a subsidiary of Gilead Sciences, Inc.) in July 2019 and January 2020 for its Medicaid and correctional populations, respectively.[6] Under the contract, Asegua is providing the state an unlimited supply of its generic antiviral, Epclusa, along with additional services to promote screening and linkage to care to treat up to 31,000 individuals in its target populations.[7] While the exact amount of the contract is unknown, the annual payment for the drug is not to exceed the $35 million the state spent to treat 1,100 patients during 2018 (Louisiana Department of Health, 2019; Liu et al., 2020). This represents a cost per treatment course of approximately $31,818. After reaching the annual expenditure cap, Asegua provides antivirals to all remaining patients receiving treatment during the year at no cost through a supplemental rebate agreement. If Louisiana successfully treats all individuals in the two target populations during the contract period ending in 2024, then it may pay Asegua a total of $175 million, representing around $5,645 per treatment course.[8] If successful, the subscription arrangement will allow Louisiana

[4] The 340B Drug Discount Program was created under the Veterans Health Care Act of 1992 and offers discounted drug prices to eligible health care organizations serving large, low-income, and vulnerable patient populations (Beckman et al., 2016).

[5] In addition to HCV antivirals, VADOC purchases high-cost, specialty drugs for HIV and other diseases along with biological products at 340B prices through the VCU Health System. VADOC staff estimate that VCU saves the agency roughly $10 million annually by purchasing these drugs through the 340B program (Herrick, 2017).

[6] In Louisiana, the Medicaid program operates on a state fiscal year, while corrections operates on a Calendar Year.

[7] Louisiana staff reported that their state did not regularly screen all offenders for Hepatitis C prior to January 2020. Moreover, the COVID-19 pandemic has limited the state's ability to test offenders for the virus. Staff were therefore unable to provide an estimate of the number offenders with HCV infection.

[8] These numbers may be specific to Medicaid. Data on Louisiana's correctional population were not available.

to provide HCV treatment to more individuals than previously while limiting the state's total cost (Liu et al., 2020). However, success depends on having enough providers to treat 31,000 individuals (or roughly 6,200 individuals annually) within the contract's five-year period. Should Louisiana not have adequate provider capacity to treat this number each year, the state may actually spend more per treatment course than it would have with a non-subscription payment model, such as 340B purchasing.

Washington. Currently, over 65,000 individuals in Washington State suffer from Hepatitis C. Within the state, the Health Care Authority along with the Departments of Corrections, Social and Health Services, and Labor and Industries have responsibility for treating most residents with HCV infection.[9] Since 2014, these agencies have treated 10,377 individuals at a cost of $387 million, or about $37,294 per treatment course. In response, the Governor of Washington issued a directive in 2018 requiring the agencies to develop and implement a statewide plan to eliminate Hepatitis C by 2030 (Washington Health Care Authority [HCA], 2019). As part of the plan, Washington entered into a four-year contract with AbbVie in July 2019, to purchase an unlimited supply of its generic antiviral, Mavyret, along with a package of services to identify and treat approximately 30,000 individuals (Aleccia et al., 2019; Washington HCA, 2019). Under the contract, the annual payment is not to exceed the $80.4 million that Washington spent during 2018 to treat 3,300 HCV patients. During the 4-year contract period, the state may spend approximately $321 million to treat all individuals in the four target populations, representing about $10,700 per treatment course, although actual costs will likely vary by population (Aleccia et al., 2019).[10] While no evaluations have been performed, Washington staff reported that the number of individuals treated for HCV has increased since the contract was implemented, while treatment costs for the Medicaid and other populations declined by up to 40 percent and 15 percent, respectively.[11]

Similar to Louisiana, success for Washington depends on having enough providers to treat 30,000 individuals within the contract's four year term (representing roughly 7,500 individuals annually). However, Washington's subscription arrangement differs in two important respects.

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[9] Individuals targeted under Washington's contract are covered by one of the following health plans: Health Care Authority (Medicaid and Public and School Employee Benefits programs), Department of Corrections, Department of Social and Health Services (two state psychiatric hospitals) and Department of Labor and Industries (retirees) (Washington HCA, 2019). Washington staff did not provide a breakdown of the populations, but they did report that the majority of individuals are in Medicaid followed by the correctional system.

[10] While similar to Louisiana, Washington's contract differs in two respects. First, it includes a modified subscription arrangement consisting of a supplemental rebate agreement with AbbVie that only applies to generic antivirals purchased for the Medicaid population, and second, it requires AbbVie to provide a guaranteed best price to antivirals purchased for non-Medicaid populations. Washington's modified model is based on a low guaranteed net unit price (GNUP) for antivirals with an annual maximum dollar threshold, at which point any additional purchases of drugs will be at a minimal to no cost. The model allows AbbVie to sustain its revenue, while ensuring that the state can treat as many Medicaid beneficiaries as possible. For example, a GNUP for a drug might be $1 per day with a $1 million threshold. After the state pays the total threshold, the GNUP then falls to $0.01 per day (Washington HCA, 2019).

[11] Washington staff declined to provide specifics on the number of individuals treated per target population and the associated costs or unit prices.

First, the arrangement consists of a supplemental rebate agreement with AbbVie that only applies to generic antivirals purchased for the Medicaid population, and second, it requires AbbVie to provide a guaranteed best price on antivirals purchased for non-Medicaid populations. Washington's modified model is based on a low guaranteed net unit price (GNUP) for antivirals with an annual maximum spend threshold, at which point any additional purchases of drugs are at a minimal to no cost amount. The model allows the manufacturer to sustain its revenue, while ensuring that the state can treat as many individuals as possible. For example, a GNUP for a drug might be $1 per day with a $1 million spend threshold. After the state pays the total threshold, the GNUP then falls to $0.01 per day (Washington HCA, 2019).

Comparing Payment Approaches. Each payment approach discussed above has certain benefits and challenges that should be considered when determining the feasibility of the subscription model (see Table 1). Similar to at least 16 other states (Beckman et al., 2016; Huh et al., 2017), Virginia obtains antivirals for its correctional population through the 340B program. Because VADOC is not eligible to participate, it contracts with VCU Health. A benefit of this approach is that the 340B program provides drugs at substantially discounted prices, typically ranging between 20 to 60 percent off the list price (Beckman et al., 2016). Under 340B rules, services must be provided to patients at the covered entities or through telehealth consultations. This creates a secondary benefit of ensuring specialty care via VCU Health's Hepatitis C Clinic. Because VADOC has telehealth capabilities, offenders are treated at their facilities without having to be transported to VCU's clinic in central Virginia. The Department is also working to expand the use of the 340B program by developing a relationship with the University of Virginia (UVA) to treat HCV infected offenders within the agency's female facilities. An agreement with UVA will allow VADOC to obtain additional savings on antivirals, while expanding provider capacity to approximately 150 more HCV infected offenders per year. Because evidence is limited that subscription arrangements can actually lower spending, a third benefit of VADOC's approach is that by not allocating resources to an unproven payment model, the agency can pursue other strategies that have demonstrated cost-effectiveness such as multistate pooled purchasing agreements or direct negotiations with drug manufacturers (Liu et al., 2020). In fact, the agency recently pursued one of these strategies by contracting with Gilead Sciences, Inc. to purchase Epclusa at a reduced cost.

Despite these benefits, however, Virginia's approach has certain limitations such as the fact that its reduced cost purchasing arrangements are currently restricted to one contract with VCU Health and one negotiated contract with a drug manufacturer. Moreover, although the agency has worked to expand provider capacity to treat offenders with HCV, expansion remains problematic due to the limited number of providers available.

The benefits of Louisiana and Washington's subscription contracts revolve around affordability, certainty, and access (Liu et al. 2020). By entering into the arrangements, the states are seeking to obtain more affordable prices per treatment through exclusive use of two

Table 1. Comparing State Payment Approaches for Hepatitis C Drugs

State	Benefits	Challenges
Virginia	● Ability to treat offenders and obtain antivirals at 340B prices by contracting with VCU Health. Depending on funding, potential to expand HCV treatment and obtain 340B pricing by contracting with UVA as part of the Correctional Health Care Pilot ● Potential to achieve additional savings through demonstrated cost-effective strategies such as multistate pooled purchasing arrangements ● Ability to use agency providers to treat additional numbers of offenders with HCV internally by purchasing antivirals at discounted prices through a direct contract Gilead Sciences, Inc.	● Ability to expand upon 340B savings is currently restricted to one contract through which only about 200 offenders with HCV are treated annually as well as one direct contract with a pharmaceutical manufacturer ● Limited provider capacity to expand treatment to more offenders with HCV under any payment arrangement
Louisiana and Washington	● States obtain more affordable prices per treatment courses through exclusive use of one generic antiviral drug from each manufacturer ● States gain budget certainty by capping spending while manufacturers gain steady revenue flows by expanding products to more individuals who would otherwise not have access to them ● States eliminate utilization rationing, thus broadening access to HCV treatment to more individuals that will eventually improve population health outcomes	● State correctional systems may need to partner with Medicaid and other agencies to generate adequate patient volume for the model to be cost effective and to generate enough revenue to attract drug manufacturers ● States may have to allocate resources toward identifying individuals with Hepatitis C, linking them to trained providers for treatment, and ensuring that antivirals are dispensed and treatment courses are completed ● The model is a new arrangement and it remains to be seen whether it will save states money by reducing prices for antivirals while increasing access to HCV treatment

antivirals.[12] The contracts may also benefit the states through budget certainty by capping

[12] By obtaining federal approval to use the subscription model to contract with only one drug manufacturer each, the states were able to gain more leverage in negotiation with the manufacturers (similar to private insurers), which may account for the low unit price obtained by Louisiana's Medicaid program. Thus, the subscription model may not be more advantageous than traditional price negotiation between payers and manufacturers over a per-dose or per-unit price (Liu et al., 2020)

spending on HCV drugs as well as by increasing the number of residents treated for HCV infection by improving patient access. While these benefits may suggest that the subscription model is an effective strategy for purchasing antivirals for Virginia's correctional system, several challenges exist that could limit its effectiveness. For instance, the subscription contracts represent statewide strategies for eliminating Hepatitis C that involve multiple agencies with target populations of at least 30,000 individuals. As a result, the Commonwealth may be required to assemble all state agencies involved in health care to include enough individuals in the target population for the subscription contract to be cost-effective and to generate large enough revenue streams for manufacturers to be interested. Similar to Louisiana and Washington, once the contract is initiated, Virginia will be responsible for identifying individuals with HCV, linking them to providers, dispensing antivirals, and ensuring that patient treatments are completed. Thus, the state may have to allocate resources and positions to ensure that these processes are completed for non-incarcerated populations. While these processes may be easier to achieve in correctional settings, they could be more challenging in non-correctional settings if Medicaid and other populations are included. Finally, it should be noted that because the model represents a new approach to paying for antivirals, it remains to be determined if the financial and utilization parameters established in the two contracts will generate savings and increased access to HCV treatment across Medicaid, correctional, and other populations over time.

When considering the benefits of VADOC's current approach for purchasing antivirals along with the challenges associated with the subscription payment model, the General Assembly may wish to defer consideration of implementing the payment model in the state's correctional system until more information is available about its effects in Louisiana and Washington. Alternatively, the General Assembly may consider directing a larger study that examines the feasibility of implementing the subscription payment model across multiple state health care agencies.

IV. Financial Implications of the Subscription Payment Model

As mentioned previously, VADOC spent $30.7 million since 2015 to treat HCV-infected offenders via VCU Health's Hepatitis C telemedicine clinic. To date, the clinic has treated 1,095 offenders, representing an average treatment cost of $28,036 per offender, which is below the average treatment costs noted for both comparison states prior to their subscription models (e.g., Louisiana's average treatment cost was $31,818 per individual, while Washington's average cost was of $37,294 per individual). Additionally, for offenders who cannot be treated by VCU Health, the agency hired dedicated provider staff to manage their Hepatitis C treatments and it entered into an agreement with Gilead Sciences, Inc. to purchase HCV antivirals at costs comparable to 340B pricing. For a subscription model to be cost effective for the Commonwealth, the treatment cost would therefore need to be at or below that of current 340B pricing. At this time, there is limited information indicating that states can develop subscription payment arrangements for HCV antivirals at or below this price threshold that do not require purchasing large volumes of drugs.

Another aspect of instituting a subscription arrangement is the fact that it only provides medications for treating HCV infection, but not adequate provider capacity that would be needed to manage treatment for increasing numbers of offenders. Currently, the treatment approach used by the agency first ensures that there are enough providers available to treat a set number of offenders. When VADOC leverages VCU Health's 340B pricing, it does so through its Hepatitis C clinic that can treat a set volume of offenders, and when it leverages comparable pricing through Diamond Pharmacy, it does so through agency providers who can appropriately manage treatment for a set number of offenders.

Instituting a subscription arrangement may provide a stock of available Hepatitis C medications at a seemingly cost-effective rate, but the contracts reviewed for this study are structured around guaranteed spend amounts. If VADOC or the Commonwealth enters into a contract with a set spend amount based on a certain provider capacity without first ensuring that the capacity actually exists, or in the event that the capacity unexpectedly decreases during the contract, then the agency may be forced to purchase treatments that are not actually provided to offenders.

Based on the information reviewed in this study, VADOC staff determined that in order for the Commonwealth to benefit from a Hepatitis C subscription payment arrangement, the following questions would need to be addressed in the contract.

- Will the cost of a course of treatment be comparable to or lower than 340B pricing? If so, how will moving from utilizing Hepatitis C drugs procured through the 340B program to a direct contract with a pharmaceutical manufacturer impact the Commonwealth?
- Will the contract require a minimum spend amount each year?
- Does the state have enough provider capacity to accommodate the budgeted number of treatment courses for each year of the contract?
- Would the Commonwealth benefit from having a subscription arrangement, as described in this report, for multiple agencies rather than just the VADOC offender population?
- Will the pharmaceutical manufacturer require a higher volume of business than what VADOC can provide in order to enter into the arrangement? That is, will a drug company be willing to provide antivirals to treat around 5,000 individuals only when the Louisiana and Washington contracts were based on target populations of at least 30,000?
- To account for limited annual provider capacity, can the contract have a longer term than 4 or 5 years for an identified patient volume without increasing the volume for the additional years?

V. Summary

To determine the appropriateness of using the subscription model in Virginia's correctional system, VADOC staff compared the agency's current approach for purchasing antivirals against arrangements implemented in Louisiana and Washington. Based on the review, VADOC staff found that while the subscription model offers some unique features and benefits(e.g.,

medication affordability, budget certainty, and access to HCV treatment) for purchasing antivirals, certain challenges exist that may make it inappropriate for the state's correctional system. In particular, since only two states recently implemented the arrangements, there is limited information that the model can lower the cost of antivirals while improving HCV treatment outcomes. Moreover, the subscription arrangements reviewed suggest that to be implemented, the arrangements require participation of multiple agencies to ensure target populations of at least 30,000 individuals along with adequate numbers of providers available to manage patient treatments. Finally, staff found that VADOC is already purchasing HCV antivirals through two other strategies (the 340B Drug Discount Program and a direct contract with a drug manufacturer) that are used by other states and have demonstrated cost-effectiveness. Based on these findings, the General Assembly may wish to either defer consideration of the subscription payment model until more information is available about its effectiveness or direct a second study that evaluates the feasibility of the model across multiple state health care agencies.

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