House Bill 947

By: Representatives Knight of the 130th, Hatchett of the 150th, England of the 116th, Newton of the 123rd, Hawkins of the 27th, and others

A BILL TO BE ENTITLED

AN ACT

To amend Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to Medicaid generally, so as to require the Department of Community Health to engage an actuary to conduct an actuarial study of the fiscal impact of carving out pharmacy benefits from the state's current Medicaid care management organizations; to provide for actions based on the results of the actuarial study; to provide for submission of a waiver if necessary; to provide for related matters; to provide for legislative findings; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

The General Assembly finds that:

(1) The Department of Community Health administers Medicaid benefits to Georgia's aged, blind, and disabled directly through its fee-for-service program and offers Medicaid benefits for low income beneficiaries and its children's health insurance program through four Medicaid care management organizations (CMOs), along with benefits for children in foster care receiving adoption assistance and select youth in the juvenile justice system, through a single CMO;

(2) The State of Georgia should conduct an actuarial study to assess the potential savings associated with carving out prescription drug benefits from its Medicaid managed care delivery system and providing those benefits through its Medicaid fee-for-service program;

(3) West Virginia carved out prescription drug benefits from its Medicaid managed care delivery system and undertook providing prescription drug benefits through its fee-for-service program. West Virginia's Medicaid actuary conducted an actuarial assessment and found that the West Virginia carve out saved over $50 million in 2018;

(4) On November 5, 2019, three members of the Georgia General Assembly requested that the Department of Community Health engage an actuary to conduct an actuarial

assessment and prepare a public report on the impact of a Medicaid managed care carve out of prescription drug benefits, with a goal of having the public report completed by the second week of Georgia's 2020 legislative session;

(5) On November 26, 2019, the Department of Community Health declined the request for the actuarial assessment and public report, indicating that it was unable to identify appropriations or financial resources to conduct the assessment, which cost approximately $150,000.00;

(6) In 2018, according to annual reports submitted to Georgia's insurance department by Georgia's four CMOs:

(A) Their general administrative expenses were over $499.8 million;

(B) Their combined claim adjustment expenses were over $118 million;

(C) All four organizations contracted with affiliated entities for the provision of administrative services;

(D) The combined underwriting gain for three of the CMOs was over $141 million, with the fourth company showing an underwriting loss; and

(E) Dividends issued to parent companies of three of the four CMOs totaled $146 million. These CMOs also provide managed care services in Georgia under non-Medicaid programs, and so it is not clear to the General Assembly exactly how much of these dividends were derived from Georgia's Medicaid managed care program. As a reference point, in 2018, approximately $3.6 billion of the $4.4 billion of net income received by the three dividend-paying CMOs came from Georgia's Medicaid managed care program;

(7) The Line 920 Report prepared for the chairmen of the House Appropriations Committee and the Senate Appropriations Committee of the Georgia General Assembly for state fiscal year 2018 found that:

(A) The practice of spread pricing resulted in a price differential between payments by Medicaid CMOs to their pharmacy benefit managers (PBMs) and payments to pharmacies of more than $50 million; and

(B) One CMO had a spread in excess of $29.8 million;

(8) Self-dealing between CMOs and their affiliated pharmacies or their contracted PBM affiliated pharmacies raise concerns regarding conflict of interest. For example, based on 2018 Medicaid claims data provided by the Department of Community Health:

(A) One CMO paid $24,772,230 on claims filled by its affiliated pharmacy out of a total of $109,514,298 paid for claims. The CMO paid approximately 22 percent of its total drug expenditure on claims filled by its affiliated pharmacy, despite the pharmacy having just one in-state location and several out-of-state locations;

(B) Another CMO paid $12,402,679 on claims filled by its PBM affiliated pharmacy out of a total of $91,822,324 paid for claims. The CMO paid approximately 13 percent of its total drug expenditure on claims filled by its PBM affiliated pharmacy, despite the pharmacy having just one in-state location and several out-of-state locations; and

(C) One CMO's affiliated pharmacy filled all 300 units of imatinib, a drug used to treat leukemia, which were paid for by the CMO for the year. That same CMO's affiliated pharmacy also filled all 5,250 units of capecitabine, a drug used to treat cancer, which were paid for by the CMO for the year. For another CMO, its contracted PBM affiliated pharmacy filled all 480 units of imatinib, which were paid for by the CMO for the year. That same CMO's contracted PBM affiliated pharmacy also filled all 4,858 units of capecitabine, which were paid for by the CMO for the year.

(9) In 2018, Georgia's Medicaid managed care program ranked in the bottom twenty-fifth percentile in the nation for:

(A) Antidepressant medication management;

(B) Antipsychotic medication management for patients with schizophrenia;

(C) Medication management for patients with asthma;

(D) Statin adherence for patients with cardiovascular conditions;

(E) Statin adherence for patients with diabetes; and

(F) Controlling high blood pressure for cardiovascular conditions;

(10) Across all Healthcare Effectiveness Data and Information Set (HEDIS) performance rankings in 2018:

(A) One CMO had 27 percent of its performance measure rates ranked below the national Medicaid twenty-fifth percentile and 61.4 percent ranked below the national Medicaid fiftieth percentile; and

(B) One CMO had 19.8 percent of its performance measure rates ranked below the national Medicaid twenty-fifth percentile and 51.7 percent ranked below the national Medicaid fiftieth percentile;

(11) The Department of Community Health administers prescription drug benefits in its fee-for-service program in a transparent way, including its use of the publicly available National Average Drug Acquisition Cost (NADAC) data published by the federal Centers for Medicare and Medicaid Services and its use of a publicly available Select Specialty Pharmacy Rate (SSPR); and

(12) Due to high administrative costs, self-dealing, a lack of transparency, and poor performance, CMOs no longer have the trust of the General Assembly in connection with the administration of prescription drug benefits, and the General Assembly believes that the Department of Community Health's fee-for-service program being more transparent

and efficient will make it better equipped to administer prescription drug benefits for all Georgia beneficiaries moving forward.

SECTION 2.

Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to Medicaid generally, is amended by adding a new Code section to read as follows:

"49-4-159.

(a) The department shall engage an actuary to conduct an actuarial study, to be completed no later than December 1, 2020, of the fiscal impact of carving out the pharmacy benefits from the state's current Medicaid care management organizations and providing pharmacy benefits to care management organization members exclusively through the department's Medicaid fee-for-service program. The department shall cooperate fully with such actuarial study, including making its records and the records of any contractors and subcontractors available to the actuary.

(b) If the results of the actuarial study project a potential annual savings to the state and federal government combined of $20 million or more, then on and after July 1, 2021:

(1) The department shall provide the pharmacy benefits for a care management organization's members, and care management organizations shall not provide pharmacy benefits for their enrolled members; provided, however, that a care management organization shall have access to the department's pharmacy data for its enrolled members; and

(2) The department shall calculate an amount equal to 7.5 percent of a care management organization's net underwriting gain for the July 1, 2020, to June 30, 2021, contract year, as determined by the department's Medicaid actuary, and shall reduce the care management organization's subsequent contract term payment by such amount, for use by the department in providing pharmacy benefits for care management organization members, including any cost incurred in program implementation.

(c) If the results of the actuarial study project a potential annual savings to the state and federal government combined of at least $10 million but less than $20 million, the department shall have the authority but not the obligation to proceed with a carve out as set forth in subsection (b) of this Code section. In making its decision, the department may consider other factors, including transparency, economic benefits to the state of proceeding with a carve out, and the costs associated with providing increased oversight should the CMOs continue to administer pharmacy benefits for their enrolled members.

(d) The department shall submit any necessary modifications, if applicable, to the state plan for medical assistance filed pursuant to Code Section 49-4-12 in order to fulfill the requirements of this Code section."

SECTION 3.

All laws and parts of laws in conflict with this Act are repealed.