SENATE
STATE OF MINNESOTA
EIGHTY-SEVENTH LEGISLATURE

S.F. No. 1348

(SENATE AUTHORS: BERGLIN)

DATE	D-PG	OFFICIAL STATUS
05/02/2011	1606	Introduction and first reading Referred to Health and Human Services

A bill for an act

relating to human services; expanding a medication therapy management demonstration project to provide culturally specific care; establishing a medication reconciliation demonstration program; amending Minnesota Statutes 2010, section 256B.0625, subdivision 13h.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2010, section 256B.0625, subdivision 13h, is amended to read:

Subd. 13h. **Medication therapy management services.** (a) Medical assistance and general assistance medical care cover medication therapy management services for a recipient taking ~~four or more~~ prescriptions to treat or prevent ~~two~~ one or more chronic medical conditions, or a recipient with a drug therapy problem that is identified or prior authorized by the commissioner that has resulted or is likely to result in significant nondrug program costs. The commissioner may cover medical therapy management services under MinnesotaCare if the commissioner determines this is cost-effective. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing or obtaining necessary assessments of the patient's health status;

(2) formulating a medication treatment plan;

(3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

(4) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

(1) have a valid license issued under chapter 151;

(2) have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements;

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, excluding long-term care and group homes, if the service is ordered by the provider-directed care coordination team; and

(4) make use of an electronic patient record system that meets state standards.

(c) For purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance and general assistance medical care providers. The commissioner may also establish contact requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

(d) If there are no pharmacists who meet the requirements of paragraph (b) practicing within a reasonable geographic distance of the patient, a pharmacist who meets the requirements may provide the services via two-way interactive video. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b), and must be located within an ambulatory care setting approved by the commissioner. The patient must also

be located within an ambulatory care setting approved by the commissioner. Services provided under this paragraph may not be transmitted into the patient's residence.

(e) The commissioner shall establish a pilot project for an intensive medication therapy management program for patients identified by the commissioner with multiple chronic conditions and a high number of medications who are at high risk of preventable hospitalizations, emergency room use, medication complications, and suboptimal treatment outcomes due to medication-related problems. For purposes of the pilot project, medication therapy management services may be provided in a patient's home or community setting, in addition to other authorized settings. The commissioner may waive existing payment policies and establish special payment rates for the pilot project. The pilot project must be designed to produce a net savings to the state compared to the estimated costs that would otherwise be incurred for similar patients without the program. The pilot project must begin by January 1, 2010, and end June 30, 2012.

(f) Beginning January 1, 2012, the commissioner of human services shall expand the pilot project established under paragraph (e) to allow an organization with experience in providing culturally specific medication therapy management services to American Indian and other medically underserved communities to contract with pharmacists meeting the requirements in paragraph (b) to provide medication therapy management services to enrollees who are American Indian or from underserved communities experiencing health disparities. The standards and patient eligibility criteria for the original demonstration project established under paragraph (e) shall otherwise apply, except that the organization may modify patient eligibility criteria for medication therapy management and may provide medication therapy management services under this paragraph through June 30, 2014.

Sec. 2. **MEDICATION RECONCILIATION DEMONSTRATION PROJECT.**

(a) The commissioner of health shall establish a two-year medication reconciliation demonstration project to evaluate the quality and effectiveness of various methods of providing pharmacy-based medication histories, documentation, and medication reconciliation.

(b) The commissioner shall request proposals from hospitals or health care systems to implement, beginning January 1, 2012, medication reconciliation projects. The projects may incorporate innovative practice roles for pharmacists, pharmacy interns, and pharmacy technicians. Applicants must submit proposals to the commissioner by September 1, 2011. A proposal must specify the method for providing or compiling

medication histories, documentation, and medication reconciliation, define the duties of health care professionals, and incorporate an evaluation process.

(c) The commissioner shall establish a medication reconciliation task force to assist the commissioner in reviewing project applications and working with the hospital or health system to implement approved projects. The task force shall consist of one representative from each of the following organizations: the Minnesota Board of Pharmacy, the Minnesota Hospital Association, the Minnesota Medical Association, the Minnesota Pharmacists Association, and the Minnesota Society of Hospital Pharmacists.

(d) Hospitals or health care systems implementing a project must submit a progress report to the commissioner and the medication reconciliation task force by November 1, 2012, and a final report by December 1, 2013. The task force shall present recommendations on whether the demonstration project should be continued or expanded to the commissioner of health, the Minnesota Board of Medical Practice, the Minnesota Board of Nursing, and the Minnesota Board of Pharmacy by January 15, 2014.