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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETIETH SESSION

H. F. No. 1269

02/15/2017 Authored by Zerwas, Fischer, Moran, Gruenhagen, Albright and others
The bill was read for the first time and referred to the Committee on Health and Human Services Reform
02/23/2017 Adoption of Report: Amended and re-referred to the Committee on Health and Human Services Finance

A bill for an act

relating to human services; requiring the commissioner of human services to develop a process to identify and report 340B drugs; establishing an alternative payment methodology for federally qualified health centers and rural health clinics; clarifying allowable costs for change of scope of services; permitting federally qualified health centers to submit claims for payment directly to the commissioner of human services; amending Minnesota Statutes 2016, section 256B.0625, subdivisions 13, 30.

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

Section 1. Minnesota Statutes 2016, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner.

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers

selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

(1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals. Over-the-counter medications must be dispensed in a quantity that is the lowest of: (1) the number of dosage units contained in the manufacturer's original package; (2) the number of dosage units required to complete the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed from a system using retrospective billing, as provided under subdivision 13e, paragraph (b).

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to

13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

(g) Notwithstanding paragraph (f), effective January 1, 2018, medical assistance shall cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by a 340B contract pharmacy to a patient of a federally qualified health center as defined in section 145.9269, subdivision 1.

Sec. 2. Minnesota Statutes 2016, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center (FQHC) that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. ~~A federally qualified health center~~ An FQHC that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, ~~a federally qualified health center~~ an FQHC shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. ~~Federally qualified health centers~~ FQHCs that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), ~~a federally qualified health center~~ an FQHC or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those ~~federally qualified health centers~~ FQHCs and rural health clinics

that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For ~~federally qualified health centers~~ FQHCs and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not ~~federally qualified health centers~~ FQHCs or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring ~~a federally qualified health center~~ an FQHC or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, through December 31, 2018, each ~~federally qualified health center~~ FQHC and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) Effective for services provided on or after January 1, 2019, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner, according to an annual election by the FQHC or rural health clinic, under the current prospective payment system described in paragraph (f), the alternative payment methodology described in paragraph (f), or the alternative payment methodology described in paragraph (l).

~~(g)~~ (h) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

~~(h)~~ (i) Effective for services provided on or after January 1, 2015, all claims for payment of clinic services provided by ~~federally qualified health centers~~ FQHCs and rural health clinics shall be paid by the commissioner. Effective for services provided on or after January 1, 2015, through July 1, 2017, the commissioner shall determine the most feasible method for paying claims from the following options:

(1) ~~federally qualified health centers~~ FQHCs and rural health clinics submit claims directly to the commissioner for payment, and the commissioner provides claims information for recipients enrolled in a managed care or county-based purchasing plan to the plan, on a regular basis; or

(2) ~~federally qualified health centers~~ FQHCs and rural health clinics submit claims for recipients enrolled in a managed care or county-based purchasing plan to the plan, and those claims are submitted by the plan to the commissioner for payment to the clinic.

Effective for services provided on or after July 1, 2017, FQHCs and rural health clinics shall submit claims directly to the commissioner for payment and the commissioner shall provide claims information for recipients enrolled in a managed care plan or county-based purchasing plan to the plan on a regular basis to be determined by the commissioner.

~~(i)~~ (j) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics, and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1, 2017. Upon final agreement between the commissioner and a clinic on issues identified under this subdivision, and in accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

~~(j)~~ (k) The commissioner shall seek a federal waiver, authorized under section 1115 of the Social Security Act, to obtain federal financial participation at the 100 percent federal matching percentage available to facilities of the Indian Health Service or tribal organization in accordance with section 1905(b) of the Social Security Act for expenditures made to organizations dually certified under Title V of the Indian Health Care Improvement Act, Public Law 94-437, and as a federally qualified health center under paragraph (a) that provides services to American Indian and Alaskan Native individuals eligible for services under this subdivision.

(l) All claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner according to the following requirements:

(1) each FQHC and rural health clinic must receive a single medical and a single dental organization rate;

(2) the commissioner shall reimburse FQHCs and rural health clinics their allowable costs, including direct patient care costs and patient-related support services. These costs include but are not limited to the costs of:

(i) acquisition, implementation, and maintenance of electronic health records and patient management systems;

(ii) community health workers who need acute and chronic care management;

(iii) care coordination;

(iv) the new FQHC or rural health clinic service that is not incorporated in the baseline prospective payment system rate, or a deletion of an FQHC or rural health clinic service that is incorporated in the baseline rate;

(v) a change in service due to amended regulatory requirements or rules;

(vi) a change in service resulting from relocating or remodeling an FQHC or rural health clinic;

(vii) a change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic;

(viii) an increase in service intensity attributable to changes in the types of patients served, including but not limited to populations with HIV or AIDS, mental health or chemical dependency conditions, or other chronic diseases, or homeless, elderly, migrant, or other special populations;

(ix) a change in the services described in United States Code, title 42, section 1396d(a)(2)(B) and (C), or in the provider mix of an FQHC or rural health clinic or one of its sites;

(x) a change in operating costs attributable to capital expenditures associated with a modification of the scope of the services described in United States Code, title 42, section 1396d(a)(2)(B) and (C), including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic;

(xi) indirect health care education adjustments and a direct graduate health care education payment that reflects the costs of providing teaching and precepting services to interns and residents; and

(xii) a change in the scope of a project approved by the federal Health Resources and Service Administration;

(3) the base year payment rates for FQHCs and rural health clinics:

(i) must be determined using each FQHC's and rural health clinic's Medicare cost reports from 2015 and 2016;

(ii) must be according to current Medicare cost principles as applicable to FQHCs and rural health clinics without the application of productivity screens and upper payment limits or the Medicare prospective payment system FQHC aggregate mean upper payment limit; and

(iii) provide for a 90-day appeals process under section 14.57;

(4) the commissioner shall annually inflate the payment rates for FQHCs and rural health clinics from the base year payment rate to the effective date by using the Bureau of Economic Analysis' Personal Consumption Expenditures medical care inflator;

(5) FQHCs' and rural health clinics' payment rates shall be rebased by the commissioner every two years and adjusted biannually by the Medicare Economic Index;

(6) the commissioner shall seek approval from the Centers for Medicare and Medicaid Services to modify payments to FQHCs and rural health clinics according to subdivision 63;

(7) the commissioner shall reimburse FQHCs and rural health clinics an additional two percent of their medical and dental rates established under this subdivision, only if the payment of the two percent provider tax is required to be paid according to section 295.52;

(8) for FQHCs and rural health clinics seeking a change of scope of services:

(i) FQHCs and rural health clinics shall submit requests with the commissioner if the change of scope would result in a 2-1/2 percent increase or decrease in the medical or dental rate currently received by the FQHC or rural health clinic;

(ii) FQHCs and rural health clinics shall submit the request to the commissioner within seven business days of submission of the scope change to the federal Health Resources Services Administration;

(iii) the effective date of the payment change is the date the Health Resources Services Administration approved the FQHC's or rural health clinic's change of scope request;

(iv) for change of scope requests that do not require Health Resources Services Administration approval, the FQHC and rural health clinic shall submit the request to the commissioner before implementing the change, and the effective date of the change is the date the commissioner received the FQHC's or rural health clinic's request; and

(v) the commissioner shall provide a response to the FQHC's or rural health clinic's request within 45 days of submission and provide a final approval within 120 days of submission. This timeline may be waived at the mutual agreement of the commissioner and the FQHC or rural health clinic if more information is needed to evaluate the request; and

(9) the commissioner shall establish a rate setting process for new FQHCs and rural health clinics considering a comparison of patient caseload of FQHCs and rural health clinics in a 60-mile radius for organizations established outside of the seven-county metropolitan area and in a five-mile radius for organizations in the seven-county metropolitan area. If a comparison is not feasible, the commissioner may use Medicare cost reports or audited financial statements to establish base rate.

Sec. 3. **ENCOUNTER REPORTING OF 340B ELIGIBLE DRUGS.**

(a) By January 1, 2018, the commissioner of human services, in consultation with federally qualified health centers, managed care organizations, and contract pharmacies shall develop a process to identify and report at point of sale the 340B drugs that are dispensed to enrollees of managed care organizations who are patients of a federally qualified health center to exclude these claims from the Medicaid drug rebate program. In developing this process, the commissioner shall ensure that federally qualified health centers are allowed to utilize the 340B Drug Pricing Program drug discounts if a federally qualified health center utilizes a contract pharmacy for a patient enrolled in the prepaid medical assistance program and ensure that duplicate discounts for drugs does not occur.

(b) By January 1, 2018, the commissioner shall notify the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over medical assistance when the process described in paragraph (a) was developed or, in the alternative, report the reasons why the process was not developed.