

**SENATE
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S.F. No. 3022

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OFFICIAL STATUS
Introduction and first reading
Referred to Health and Human Services Finance and Policy

1.1 A bill for an act
1.2 relating to health care; requiring the commissioner of human services to develop
1.3 a process to identify and report 340B drugs; permitting federally qualified health
1.4 centers to submit claims for payment directly to the commissioner of human
1.5 services; appropriating money for subsidies to federally qualified health centers;
1.6 amending Minnesota Statutes 2016, section 256B.0625, subdivisions 13, 30.

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

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

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

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

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

2.1 when the compounded combination is specifically approved by the commissioner or when
2.2 a commercially available product:

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

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

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

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

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

3.1 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
3.2 not be covered.

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

3.7 (g) Notwithstanding paragraph (f), effective January 1, 2018, medical assistance shall
3.8 cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by a
3.9 340B contract pharmacy to a patient of a federally qualified health center as defined in
3.10 section 145.9269, subdivision 1.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.1 (h) Effective for services provided on or after January 1, 2015, all claims for payment
5.2 of clinic services provided by federally qualified health centers and rural health clinics shall
5.3 be paid by the commissioner. Effective for services provided on or after January 1, 2015,
5.4 through July 1, 2018, the commissioner shall determine the most feasible method for paying
5.5 claims from the following options:

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

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

5.13 Effective for services provided on or after July 1, 2018, federally qualified health centers
5.14 and rural health clinics shall submit claims directly to the commissioner for payment and
5.15 the commissioner shall provide claims information for recipients enrolled in a managed
5.16 care plan or county-based purchasing plan to the plan on a regular basis to be determined
5.17 by the commissioner.

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

5.29 (j) The commissioner shall seek a federal waiver, authorized under section 1115 of the
5.30 Social Security Act, to obtain federal financial participation at the 100 percent federal
5.31 matching percentage available to facilities of the Indian Health Service or tribal organization
5.32 in accordance with section 1905(b) of the Social Security Act for expenditures made to
5.33 organizations dually certified under Title V of the Indian Health Care Improvement Act,
5.34 Public Law 94-437, and as a federally qualified health center under paragraph (a) that

6.1 provides services to American Indian and Alaskan Native individuals eligible for services
6.2 under this subdivision.

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

6.4 (a) By January 1, 2019, the commissioner of human services, in consultation with
6.5 federally qualified health centers, shall develop a process to identify and report at point of
6.6 sale the 340B drugs that are dispensed to enrollees of managed care organizations who are
6.7 patients of a federally qualified health center in order to exclude these claims from the
6.8 Medicaid drug rebate program. In developing this process, the commissioner shall work
6.9 with federally qualified health centers, managed care organizations, and contract pharmacies
6.10 to ensure federally qualified health centers are allowed to maximize the 340B Drug Pricing
6.11 Program discounts when a federally qualified health center utilizes contract pharmacies for
6.12 patients enrolled in the prepaid medical assistance program, while ensuring that duplicate
6.13 discounts for these drugs do not occur.

6.14 (b) The commissioner shall inform the chairs and ranking minority members of the
6.15 legislative committees with jurisdiction over medical assistance once the process described
6.16 in paragraph (a) has been developed or, in the alternative, the reasons why this process could
6.17 not be developed as required.

6.18 **Sec. 4. APPROPRIATION.**

6.19 \$2,000,000 in fiscal year 2019 is appropriated from the general fund to the commissioner
6.20 of health to distribute as subsidies to federally qualified health centers under Minnesota
6.21 Statutes, section 145.9269.