MINNESOTA PHARMACISTS ASSOCIATION
1000 Westgate Drive, Suite 252, St. Paul, MN 55114
p. 651.697.1771 | f. 651.290.2266 | info@mpha.org

MPhA 2019 Advocacy Accomplishments

About the MPhA Public Affairs Committee

Group meets to:

1. Monitor regulatory activities to identify issues likely to come before the Legislature.
2. Review bills introduced and provide guidance to staff consistent with MPhA policies.
3. Make recommendations to the board of directors on issues for which policy positions have not yet been developed, or for modifications to existing policy positions.
4. Provide input on developing strategies and grassroots initiatives to advance legislative and regulatory initiatives identified as association priorities.

Issues addressed by the Committee in 2019

PBM Licensure and Regulation

At the beginning of the session, MPhA was approached by the Senate HHS Committee Chair and her Committee Administrator with a proposal for PBM licensure and regulation. MPhA worked to influence the language in that legislation as much as possible and then worked to get companion legislation introduced and moving in the house. After one of the most extensive and exhaustive lobbying efforts in MPhA history, SF 278 was passed and signed by the Governor.

Key features of the legislation are:

- All PBMs must be licensed to operate in Minnesota.
- The statutes are listed under the Department of Commerce, who also regulates insurance.
- Commissioner of Commerce has authority to create rules around the statutes and enforcement authority.
- Specialty drugs and specialty pharmacy are defined in the statute.
- A PBM must exercise good faith and fair dealing in the performance of its contractual duties and must inform the plan sponsor of any conflicts of interest.
- PBMs must meet prescribed pharmacy access standards.
- Transparency reports on aggregate and claims level data are required to plan sponsors and the Commissioner of Commerce.
- A PBM cannot require or offer incentives to patients to use a PBM-owned pharmacy unless they offer the same terms and conditions to other pharmacies to participate in the same incentives.
- The language on pharmacy audits and MAC pricing in the pharmacy statutes is transferred to the Department of Commerce statutes.
- PBMs must remove claims processing barriers to synchronizing patients' medications.
- Gag clauses for pharmacists in PBM contracts are prohibited.
- A PBM may not charge a patient a co-pay greater than the lesser of: The patient's usual co-pay; The pharmacy's cash price; The claim price.
- Retroactive claim adjustments are prohibited.

Change in Methodology for Pharmacy Medicaid Reimbursement

In February, 2016, CMS enacted the Covered Outpatient Drug Rule that required states to change the methodology for reimbursing pharmacies for fee-for-service Medicaid prescriptions. States are given latitude in the methodology, but must be able to demonstrate that product cost reimbursement is actual acquisition cost and the professional dispensing fee represents the true cost of dispensing. States were required to come into compliance with the rule by April 1, 2017. Minnesota is one of only two states not yet in compliance with this rule and CMS recently informed DHS that we risked losing $190 million in federal matching funds if we don't come into compliance this year. We have an additional issue, in that the change to actual acquisition cost means that Medicaid MUST reimburse the 2% wholesale tax that has not been reimbursed in the past, in order for pharmacies to remain whole.

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MPhA has been working with DHS since 2016 to present the legislature with a proposal to come into compliance with the rule, but the legislature has declined consideration of the rule. Last session, in the very last days of the session, the proposed changes were inserted into the HHS omnibus bill that was sent to the Governor. This is the bill that was vetoed by the Governor. This session has also been a struggle to keep the change in the legislature's plan, especially with the uncertainty over whether the legislature would allow the sunset of the Minnesota Care Tax. In the interim between the end of session and the special session called to approve all budget bills, reimbursement of NADAC, plus a professional dispensing fee of $10.48 (a compromise from our original agreement with DHS) plus 1.8% reimbursement for the wholesale tax (the tax goes to 1.8% January 1, 2019) was included in the final HHS omnibus bill passed by the legislature and signed by the Governor. This change represents a significant increase in reimbursement for pharmacies over the current rate.

Medication Administration Authority for Pharmacists

This issue was also a priority for MPhA and the Alliance. We sought unlimited authority for pharmacists to administer medications but were unable to advance legislation this session. Language authorizing pharmacists to administer IM and Sub-Q injections for the treatment of alcohol and opioid dependence and IM and Sub-Q injections for treatment of mental health conditions was included in opioid stewardship legislation. Exercising this authority requires either an order from the prescriber or a collaborative practice agreement. We will be back at the legislature next year to work on our goal of complete medication administration authority.

Prescribing Authority for Pharmacists

During the last three sessions, MPhA and the Alliance have advocated for authority for pharmacists to prescribe one or more categories of medications that do not require diagnosis, including naloxone, self-administered hormonal contraceptives, tobacco-cessation products and travel medications. During the 2018-2019 session, we advocated for authority for naloxone, tobacco cessation and hormonal contraceptives. Bills were introduced in the House and Senate, but no hearings were granted. These bills will remain active next session and will remain a top priority for MPhA and the Alliance next year.

Opioid Stewardship

Opioid stewardship was not a proactive agenda issue for MPhA, but it did consume a considerable amount of time and resources, working to prevent potential negative consequences for pharmacies and the patients we serve. Our two greatest concerns were: 1) Taxes or fees on manufacturers and wholesalers might be passed on only to Minnesota pharmacies. Since PBM reimbursement schedules are usually regionally or nationally based, it would be unlikely that these Minnesota-only higher costs would be reimbursed. 2) Taxes or fees might be high enough that some generic opioid manufacturers might find their best business decision in response to the higher costs to be exiting the Minnesota market, resulting in significant drug shortages. The bill was passed, but we will have to wait and see whether or to what extent either of the above play out. The bill also contained several other sections that impact pharmacy practice:

- As mentioned above, it includes authorization for pharmacists to provide IM and Sub-Q injections for the treatment of alcohol and opioid dependence and for the treatment of mental health conditions.
- It creates new limitations on the quantity of opioids that can be prescribed for several acute pain conditions.
- It prohibits the initial filling of a Schedule II-IV opioid prescription more than 30 days beyond the date it was written. It also prohibits the refilling of a Schedule III-IV opioid prescription more than 30 days beyond the last date of fill.
- The bill also expands the situations in which a pharmacy must check the ID of a "purchaser" of a controlled substance prescription. The requirement is now to check ID for all controlled substance prescriptions, Schedule II-V, whether cash or third party, unless the patient is known to the dispenser.

For more information or to join and become part of this committee visit www.mpha.org and click on "Get Involved" under the membership tab.