..... moves to amend H.F. No. 2242 as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2024, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain, unless the prescription savings club or prescription discount club is one in which an individual pays a recurring monthly access fee for unlimited access to a defined list of drugs for which the pharmacy does not bill the member or a payer on a per-standard-transaction basis. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The professional dispensing fee shall be $11.55 for prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions that must be compounded by the pharmacist shall be $11.55 per claim. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be $11.55 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less

than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered outpatient drugs shall be $3.65 for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The ingredient cost for a drug is the lowest of the National Average Drug Acquisition Cost (NADAC) ~~shall be used to determine the ingredient cost of a drug~~; the Minnesota actual acquisition cost (MNAAC), as defined in paragraph (i); or the maximum allowable cost. For drugs for which a NADAC, MNAAC, or maximum allowable cost is not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for a provider participating in the federal 340B Drug Pricing Program shall be ~~either~~ the 340B Drug Pricing Program ceiling price established by the Health Resources and Services Administration ~~or~~, the NADAC, the MNAAC, or the maximum allowable cost, whichever is ~~lower~~ lowest. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a ~~multisource~~ drug may be set by the commissioner and it shall be comparable to the actual acquisition cost of the drug product and no higher than the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) Pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system meeting the requirements of section 151.58, or a packaging system meeting the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ retrospective billing for prescription drugs dispensed to long-term care facility residents. A retrospectively billing pharmacy must submit a claim only for the quantity of medication used by the enrolled recipient during the defined billing period. A retrospectively billing pharmacy must use a billing period not less than one calendar month or 30 days.

(c) A pharmacy provider using packaging that meets the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective

billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(d) If a pharmacy dispenses a multisource drug, the ingredient cost shall be the lesser of the NADAC of the generic product, the MNAAC of the generic product, or the maximum allowable cost of the generic product established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2. If prior authorization is granted, the ingredient cost shall be the lesser of the NADAC of the brand name product, the MNAAC of the brand name product, or the maximum allowable cost of the brand name product. A generic product includes a generic drug, an authorized generic drug, and a biosimilar biological product as defined in Code of Federal Regulations, title 42, section 423.4. A brand name product includes a brand name drug, a brand name biological product, and an unbranded biological product as defined in Code of Federal Regulations, title 42, section 423.4.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the ~~specialty pharmacy rate~~ MNAAC, or the maximum allowable cost set by the commissioner. If average sales price ~~is~~, MNAAC, and the maximum allowable cost are unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider~~,~~ or the wholesale acquisition cost~~, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner~~. The commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

~~(f) The commissioner may establish maximum allowable cost rates for specialty pharmacy products that are lower than the ingredient cost formulas specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions~~

~~include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the Formulary Committee to develop a list of specialty pharmacy products subject to maximum allowable cost reimbursement. In consulting with the Formulary Committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the maximum allowable cost to prevent access to care issues.~~

~~(g)~~ (f) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

~~(h)~~ (g) The commissioner shall contract with a vendor to conduct a cost of dispensing survey for all pharmacies that are physically located in the state of Minnesota that dispense outpatient drugs under medical assistance. The commissioner shall ensure that the vendor has prior experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the department to dispense outpatient prescription drugs to fee-for-service members must respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The commissioner shall require the vendor to measure a single statewide cost of dispensing for specialty prescription drugs and a single statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies to measure the mean, mean weighted by total prescription volume, mean weighted by medical assistance prescription volume, median, median weighted by total prescription volume, and median weighted by total medical assistance prescription volume. The commissioner shall post a copy of the final cost of dispensing survey report on the department's website. The initial survey must be completed no later than January 1, 2021, and repeated every three years. The commissioner shall provide a summary of the results of each cost of dispensing survey and provide recommendations for any changes to the dispensing fee to the chairs and ranking minority members of the legislative committees with jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section 256.01, subdivision 42, this paragraph does not expire.

~~(i)~~ (h) The commissioner shall increase the ingredient cost reimbursement calculated in paragraphs (a) and ~~(f)~~ (e) by ~~1.8 percent~~ the amount of the wholesale drug distributor tax

for prescription and nonprescription drugs subject to the wholesale drug distributor tax under section 295.52.

(i) The commissioner shall contract with a vendor to create the Minnesota actual acquisition cost (MNAAC) through a periodic survey of enrolled pharmacy providers. Each pharmacy enrolled with the department to dispense outpatient prescription drugs must respond to the periodic surveys. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The current MNAAC rates must be publicly available on the department's or vendor's website. The commissioner must require that the MNAAC is measured and calculated at least quarterly, but the MNAAC can be measured and calculated more frequently. The commissioner must ensure that the vendor has an appeal process available to providers for the time between the measurement and calculation of the periodically updated MNAAC rates if price fluctuations result in a MNAAC that is lower than what enrolled providers can purchase a drug for. Establishment of the MNAAC and survey reporting requirements shall not be subject to the requirements of the Administrative Procedure Act. Data provided by pharmacies for the measurement and calculation of the MNAAC is nonpublic data as defined under section 13.02, subdivision 9.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 2. Minnesota Statutes 2024, section 256B.064, subdivision 1a, is amended to read:

Subd. 1a. **Grounds for sanctions.** (a) The commissioner may impose sanctions against any individual or entity that receives payments from medical assistance or provides goods or services for which payment is made from medical assistance for any of the following: (1) fraud, theft, or abuse in connection with the provision of goods and services to recipients of public assistance for which payment is made from medical assistance; (2) a pattern of presentment of false or duplicate claims or claims for services not medically necessary; (3) a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the individual or entity is legally entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally established under this section; (7) failure to correct errors in the maintenance of health service or financial records for which a fine was imposed or after issuance of a warning by the commissioner; and (8) any reason for which an

individual or entity could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act. For the purposes of this section, goods or services for which payment is made from medical assistance includes but is not limited to care and services identified in section 256B.0625 or provided pursuant to any federally approved waiver.

(b) The commissioner may impose sanctions against a pharmacy provider for failure to respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph (h).

(c) The commissioner may impose sanctions against a pharmacy provider for failure to respond to a Minnesota drug acquisition cost survey under section 256B.0625, subdivision 13e, paragraph (i).

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. Minnesota Statutes 2024, section 256B.69, subdivision 6d, is amended to read:

Subd. 6d. **Prescription drugs.** (a) The commissioner may exclude or modify coverage for prescription drugs from the prepaid managed care contracts entered into under this section in order to increase savings to the state by collecting additional prescription drug rebates.

(b) The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and utilization, the contracts may authorize the managed care plans to use preferred drug lists and prior authorization. The contracts must require that the managed care plans enter into contracts with the state pharmacy benefit manager under section 256B.696, to administer the pharmacy benefit.

(c) This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates.

Sec. 4. **[256B.696] PRESCRIPTION DRUGS; STATE PHARMACY BENEFIT MANAGER.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

(b) "Managed care enrollees" means medical assistance and MinnesotaCare enrollees receiving coverage from managed care plans.

(c) "Managed care plans" means health plans and county-based purchasing organizations providing coverage to medical assistance and MinnesotaCare enrollees under the managed care delivery system.

(d) "State pharmacy benefit manager" means the pharmacy benefit manager selected pursuant to the procurement process in subdivision 2.

Subd. 2. **Procurement process.** (a) The commissioner must, through a competitive procurement process in compliance with paragraph (b), select a single pharmacy benefit manager to comply with the requirements set forth in subdivision 3.

(b) The commissioner must, when selecting the single pharmacy benefit manager, do the following:

(1) accept applications for entities seeking to become the single pharmacy benefit manager;

(2) establish eligibility criteria an entity must meet in order to become the single pharmacy benefit manager; and

(3) enter into a master contract with a single pharmacy benefit manager.

(c) The contract required under paragraph (b), clause (3), must include a prohibition on:

(1) the single pharmacy benefit manager requiring an enrollee to obtain a drug from a pharmacy owned or otherwise affiliated with the single pharmacy benefit manager; and

(2) paying or reimbursing a pharmacy or pharmacist for the ingredient drug product component of pharmacist services, including a prescription drug, less than the lesser of the national average drug acquisition cost, the Minnesota actual acquisition cost (MNAAC), defined in section 256B.0625, subdivision 13e, paragraph (j), or the maximum allowable cost, defined in section 62W.08, of that pharmacy service or prescription drug, or, if the national average drug acquisition cost is unavailable, the wholesale acquisition cost minus two percent at the time the drug is administered or dispensed, plus a professional dispensing fee equal to the amount of the dispensing fee if it were determined pursuant to section 256B.0625, subdivision 13e.

(d) Applicants for the single pharmacy benefit manager must disclose to the commissioner the following during the procurement process:

(1) any activity, policy, practice, contract, or arrangement of the single pharmacy benefit manager that may directly or indirectly present any conflict of interest with the pharmacy benefit manager's relationship with or obligation to the Department of Human Services, a health plan company, or county-based purchasing organization;

(2) all common ownership, members of a board of directors, managers, or other control of the pharmacy benefit manager or any of the pharmacy benefit manager's affiliated companies with:

(i) a health plan company administering the medical assistance or MinnesotaCare benefits or an affiliate of the health plan company;

(ii) a county-based purchasing organization;

(iii) an entity that contracts on behalf of a pharmacy or any pharmacy services administration organization and its affiliates;

(iv) a drug wholesaler or distributor and its affiliates;

(v) a third-party payer and its affiliates; or

(vi) a pharmacy and its affiliates that are enrolled to provide medical assistance or MinnesotaCare;

(3) any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in this state with which the pharmacy benefit manager shares common ownership, management, or control, or that are owned, managed, or controlled by any of the pharmacy benefit manager's affiliated companies;

(4) any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in this state; and

(5) any financial terms and arrangements between the pharmacy benefit manager and a prescription drug manufacturer or labeler, including formulary management, drug substitution programs, educational support claims processing, or data sales fees.

Subd. 3. **Drug coverage.** (a) The commissioner may require the pharmacy benefit manager to modify utilization review limitations, requirements, and strategies imposed by managed care plans on prescription drug coverage.

(b) The state pharmacy benefit manager is responsible for processing all point of sale outpatient pharmacy claims under the managed care delivery system. Managed care plans must use the state pharmacy benefit manager pursuant to the terms of the master contract required under subdivision 2, paragraph (b), clause (3). The pharmacy benefit manager

selected is the exclusive pharmacy benefit manager used by health plan companies and county-based purchasing organizations when providing coverage to enrollees. The commissioner may require the managed care plans and pharmacy benefit manager to directly exchange data and files for members enrolled with managed care plans.

(c) All payment arrangements between the Department of Human Services, managed care plans, and the state pharmacy benefit manager must comply with state and federal statutes, regulations adopted by the Centers for Medicare and Medicaid Services, and any other agreement between the department and the Centers for Medicare and Medicaid Services. The commissioner may change a payment arrangement to comply with this paragraph.

(d) The commissioner must administer and oversee this section to:

(1) ensure proper administration of prescription drug benefits for managed care enrollees; and

(2) increase the transparency of prescription drug prices and other information for the benefit of pharmacies.

Subd. 4. **Prescription drug disclosures.** (a) The state pharmacy benefit manager must, on request from the commissioner, disclose to the commissioner all sources of payment it receives for prescribed drugs, including any financial benefits including drug rebates, discounts, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other payments related to services provided for a managed care plan.

(b) Each managed care plan must disclose to the commissioner, in the format specified by the commissioner, the entity's administrative costs associated with providing pharmacy services under the managed care delivery system.

(c) The state pharmacy benefit manager must provide a written quarterly report to the commissioner containing the following information from the immediately preceding quarter:

(1) the prices the state pharmacy benefit manager negotiated for prescribed drugs under the managed care delivery system. The price must include any rebates the state pharmacy benefit manager received from the drug manufacturer;

(2) any rebate amounts the state pharmacy benefit manager passed on to individual pharmacies;

(3) any changes to the information previously disclosed that is described in subdivision 2, paragraph (d); and

(4) any other information required by the commissioner, including unredacted copies of contracts between the pharmacy benefit manager and enrolled pharmacies.

(d) The commissioner may request and collect additional information and clinical data from the state pharmacy benefit manager.

(e) At the time of contract execution, renewal, or modification, the commissioner must modify the reporting requirements under its managed care contracts as necessary to meet the requirements of this subdivision.

Subd. 5. **Program authority.** (a) To accomplish the requirements of subdivision 3, the commissioner, in consultation with the Formulary Committee established under section 256B.0625, subdivision 13c, has the authority to:

(1) adopt or develop a preferred drug list for managed care plans;

(2) at the commissioner's discretion, engage in price negotiations with prescription drug manufacturers, wholesalers, or group purchasing organizations in place of the state pharmacy benefit manager to obtain price discounts and rebates for prescription drugs for managed care enrollees; and

(3) develop and manage a drug formulary for managed care plans.

(b) The commissioner may contract with one or more entities to perform any of the functions described in paragraph (a).

Subd. 6. **Pharmacies.** The commissioner may review contracts between the state pharmacy benefit manager and pharmacies for compliance with this section and the master contract required under subdivision 2, paragraph (b), clause (3). The commissioner may amend any term or condition of a contract that does not comply with this section or the master contract.

Subd. 7. **Federal approval.** The commissioner must seek any necessary federal approvals to implement this section.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained."

Amend the title accordingly