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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-THIRD SESSION

H. F. No. 3902

02/19/2024 Authored by Bahner
The bill was read for the first time and referred to the Committee on Health Finance and Policy

1.1 A bill for an act
1.2 relating to human services; increasing the medical assistance dispensing fee;
1.3 amending Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision
1.4 13e.

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

1.6 Section 1. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 13e, is
1.7 amended to read:

1.8 Subd. 13e. Payment rates. (a) The basis for determining the amount of payment shall
1.9 be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the
1.10 usual and customary price charged to the public. The usual and customary price means the
1.11 lowest price charged by the provider to a patient who pays for the prescription by cash,
1.12 check, or charge account and includes prices the pharmacy charges to a patient enrolled in
1.13 a prescription savings club or prescription discount club administered by the pharmacy or
1.14 pharmacy chain. The amount of payment basis must be reduced to reflect all discount
1.15 amounts applied to the charge by any third-party provider/insurer agreement or contract for
1.16 submitted charges to medical assistance programs. The net submitted charge may not be
1.17 greater than the patient liability for the service. The professional dispensing fee shall be
1.18 \$10.77 \$11.55 for prescriptions filled with legend drugs meeting the definition of "covered
1.19 outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The
1.20 dispensing fee for intravenous solutions that must be compounded by the pharmacist shall
1.21 be \$10.77 \$11.55 per claim. The professional dispensing fee for prescriptions filled with
1.22 over-the-counter drugs meeting the definition of covered outpatient drugs shall be \$10.77
1.23 \$11.55 for dispensed quantities equal to or greater than the number of units contained in
1.24 the manufacturer's original package. The professional dispensing fee shall be prorated based

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

2.22 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using
2.23 an automated drug distribution system meeting the requirements of section 151.58, or a
2.24 packaging system meeting the packaging standards set forth in Minnesota Rules, part
2.25 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ
2.26 retrospective billing for prescription drugs dispensed to long-term care facility residents. A
2.27 retrospectively billing pharmacy must submit a claim only for the quantity of medication
2.28 used by the enrolled recipient during the defined billing period. A retrospectively billing
2.29 pharmacy must use a billing period not less than one calendar month or 30 days.

2.30 (c) A pharmacy provider using packaging that meets the standards set forth in Minnesota
2.31 Rules, part 6800.2700, is required to credit the department for the actual acquisition cost
2.32 of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective
2.33 billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that
2.34 is less than a 30-day supply.

3.1 (d) If a pharmacy dispenses a multisource drug, the ingredient cost shall be the NADAC
3.2 of the generic product or the maximum allowable cost established by the commissioner
3.3 unless prior authorization for the brand name product has been granted according to the
3.4 criteria established by the Drug Formulary Committee as required by subdivision 13f,
3.5 paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in
3.6 a manner consistent with section 151.21, subdivision 2.

3.7 (e) The basis for determining the amount of payment for drugs administered in an
3.8 outpatient setting shall be the lower of the usual and customary cost submitted by the
3.9 provider, 106 percent of the average sales price as determined by the United States
3.10 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
3.11 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
3.12 set by the commissioner. If average sales price is unavailable, the amount of payment must
3.13 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition
3.14 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.
3.15 The commissioner shall discount the payment rate for drugs obtained through the federal
3.16 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an
3.17 outpatient setting shall be made to the administering facility or practitioner. A retail or
3.18 specialty pharmacy dispensing a drug for administration in an outpatient setting is not
3.19 eligible for direct reimbursement.

3.20 (f) The commissioner may establish maximum allowable cost rates for specialty pharmacy
3.21 products that are lower than the ingredient cost formulas specified in paragraph (a). The
3.22 commissioner may require individuals enrolled in the health care programs administered
3.23 by the department to obtain specialty pharmacy products from providers with whom the
3.24 commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are
3.25 defined as those used by a small number of recipients or recipients with complex and chronic
3.26 diseases that require expensive and challenging drug regimens. Examples of these conditions
3.27 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C,
3.28 growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of
3.29 cancer. Specialty pharmaceutical products include injectable and infusion therapies,
3.30 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that
3.31 require complex care. The commissioner shall consult with the Formulary Committee to
3.32 develop a list of specialty pharmacy products subject to maximum allowable cost
3.33 reimbursement. In consulting with the Formulary Committee in developing this list, the
3.34 commissioner shall take into consideration the population served by specialty pharmacy
3.35 products, the current delivery system and standard of care in the state, and access to care

4.1 issues. The commissioner shall have the discretion to adjust the maximum allowable cost
4.2 to prevent access to care issues.

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

4.5 (h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey
4.6 for all pharmacies that are physically located in the state of Minnesota that dispense outpatient
4.7 drugs under medical assistance. The commissioner shall ensure that the vendor has prior
4.8 experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the
4.9 department to dispense outpatient prescription drugs to fee-for-service members must
4.10 respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under
4.11 section 256B.064 for failure to respond. The commissioner shall require the vendor to
4.12 measure a single statewide cost of dispensing for specialty prescription drugs and a single
4.13 statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies
4.14 to measure the mean, mean weighted by total prescription volume, mean weighted by
4.15 medical assistance prescription volume, median, median weighted by total prescription
4.16 volume, and median weighted by total medical assistance prescription volume. The
4.17 commissioner shall post a copy of the final cost of dispensing survey report on the
4.18 department's website. The initial survey must be completed no later than January 1, 2021,
4.19 and repeated every three years. The commissioner shall provide a summary of the results
4.20 of each cost of dispensing survey and provide recommendations for any changes to the
4.21 dispensing fee to the chairs and ranking members of the legislative committees with
4.22 jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section
4.23 256.01, subdivision 42, this paragraph does not expire.

4.24 (i) The commissioner shall increase the ingredient cost reimbursement calculated in
4.25 paragraphs (a) and (f) by 1.8 percent for prescription and nonprescription drugs subject to
4.26 the wholesale drug distributor tax under section 295.52.

4.27 **EFFECTIVE DATE.** This section is effective July 1, 2024.