

31.4

ARTICLE 4

31.5

PHARMACY BENEFITS

191.1

ARTICLE 5

191.2

PHARMACY BENEFITS

191.3

Section 1. **[62Q.83] FORMULARY CHANGES.**

191.4

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

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(b) "Drug" has the meaning given in section 151.01, subdivision 5.

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(c) "Enrollee" has the meaning given in section 62Q.01, subdivision 2b.

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(d) "Formulary" means a current list of covered prescription drug products that is subject to periodic review and update.

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(e) "Health plan" has the meaning given in section 62Q.01, subdivision 3.

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(f) "Pharmacy benefit manager" has the meaning given in section 62W.02, subdivision

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(g) "Prescription" has the meaning given in section 151.01, subdivision 16a.

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Subd. 2. **Formulary changes.** (a) Except as provided in paragraphs (b) and (c), a health plan must not, with respect to an enrollee who was previously prescribed the drug during the plan year, remove a drug from the health plan's formulary or place a drug in a benefit category that increases the enrollee's cost for the duration of the enrollee's plan year.

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(b) Paragraph (a) does not apply if a health plan changes the health plan's formulary:

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(1) for a drug that has been deemed unsafe by the United States Food and Drug Administration (FDA);

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(2) for a drug that has been withdrawn by the FDA or the drug manufacturer; or

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(3) when an independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes with respect to a drug's use for reasons related to previously unknown and imminent patient harm.

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(c) Paragraph (a) does not apply if a health plan removes a brand name drug from the health plan's formulary or places a brand name drug in a benefit category that increases the enrollee's cost if the health plan:

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(1) adds to the health plan's formulary a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book, a biologic drug rated as

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- 191.30 interchangeable according to the FDA Purple Book, or a biosimilar at the same or lower
 191.31 cost to the enrollee; and
- 192.1 (2) provides at least a 60-day notice to prescribers, pharmacists, and affected enrollees.
- 192.2 **EFFECTIVE DATE.** This section is effective January 1, 2026, and applies to health
 192.3 plans offered, sold, issued, or renewed on or after that date.
- 192.4 Sec. 2. Minnesota Statutes 2024, section 256B.0625, subdivision 13, is amended to read:
- 192.5 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when
 192.6 specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed
 192.7 by a licensed pharmacist, by a physician enrolled in the medical assistance program as a
 192.8 dispensing physician, or by a physician, a physician assistant, or an advanced practice
 192.9 registered nurse employed by or under contract with a community health board as defined
 192.10 in section 145A.02, subdivision 5, for the purposes of communicable disease control.
- 192.11 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply unless
 192.12 authorized by the commissioner or as provided in paragraph (h) or the drug appears on the
 192.13 90-day supply list published by the commissioner. The 90-day supply list shall be published
 192.14 by the commissioner on the department's website. The commissioner may add to, delete
 192.15 from, and otherwise modify the 90-day supply list after providing public notice and the
 192.16 opportunity for a 15-day public comment period. The 90-day supply list may include
 192.17 cost-effective generic drugs and shall not include controlled substances.
- 192.18 (c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical
 192.19 ingredient" is defined as a substance that is represented for use in a drug and when used in
 192.20 the manufacturing, processing, or packaging of a drug becomes an active ingredient of the
 192.21 drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle
 192.22 for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and
 192.23 excipients which are included in the medical assistance formulary. Medical assistance covers
 192.24 selected active pharmaceutical ingredients and excipients used in compounded prescriptions
 192.25 when the compounded combination is specifically approved by the commissioner or when
 192.26 a commercially available product:
- 192.27 (1) is not a therapeutic option for the patient;
- 192.28 (2) does not exist in the same combination of active ingredients in the same strengths
 192.29 as the compounded prescription; and
- 192.30 (3) cannot be used in place of the active pharmaceutical ingredient in the compounded
 192.31 prescription.
- 192.32 (d) Medical assistance covers the following over-the-counter drugs when prescribed by
 192.33 a licensed practitioner or by a licensed pharmacist who meets standards established by the
 193.1 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family
 193.2 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults
 193.3 with documented vitamin deficiencies, vitamins for children under the age of seven and

193.4 pregnant or nursing women, and any other over-the-counter drug identified by the
193.5 commissioner, in consultation with the Formulary Committee, as necessary, appropriate,
193.6 and cost-effective for the treatment of certain specified chronic diseases, conditions, or
193.7 disorders, and this determination shall not be subject to the requirements of chapter 14. A
193.8 pharmacist may prescribe over-the-counter medications as provided under this paragraph
193.9 for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter
193.10 drugs under this paragraph, licensed pharmacists must consult with the recipient to determine
193.11 necessity, provide drug counseling, review drug therapy for potential adverse interactions,
193.12 and make referrals as needed to other health care professionals.

193.13 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable
193.14 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and
193.15 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible
193.16 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and
193.17 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these
193.18 individuals, medical assistance may cover drugs from the drug classes listed in United States
193.19 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to
193.20 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
193.21 not be covered.

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

193.26 (g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal
193.27 contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section
193.28 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a
193.29 licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists
193.30 used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed
193.31 pharmacist in accordance with section 151.37, subdivision 16.

193.32 (h) Medical assistance coverage for a prescription contraceptive must provide a 12-month
193.33 supply for any prescription contraceptive if a 12-month supply is prescribed by the
193.34 prescribing health care provider. The prescribing health care provider must determine the
193.35 appropriate duration for which to prescribe the prescription contraceptives, up to 12 months.
194.1 For purposes of this paragraph, "prescription contraceptive" means any drug or device that
194.2 requires a prescription and is approved by the Food and Drug Administration to prevent
194.3 pregnancy. Prescription contraceptive does not include an emergency contraceptive drug
194.4 approved to prevent pregnancy when administered after sexual contact. For purposes of this
194.5 paragraph, "health plan" has the meaning provided in section 62Q.01, subdivision 3.

194.6 (i) Notwithstanding a removal of a drug from the drug formulary under subdivision 13d,
194.7 except as provided in paragraphs (j) and (k), medical assistance covers a drug, with respect
194.8 to an enrollee who was previously prescribed the drug during the calendar year when the

31.6 Section 1. Minnesota Statutes 2024, section 256B.0625, subdivision 13c, is amended to
 31.7 read:

31.8 Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations
 31.9 from professional medical associations and professional pharmacy associations, and consumer
 31.10 groups shall designate a Formulary Committee to carry out duties as described in subdivisions
 31.11 13 to 13g. The Formulary Committee shall be comprised of at least five licensed physicians
 31.12 actively engaged in the practice of medicine in Minnesota, one of whom is an actively
 31.13 practicing psychiatrist, one of whom specializes in the diagnosis and treatment of rare
 31.14 diseases, one of whom specializes in pediatrics, and one of whom actively treats persons
 31.15 with disabilities; at least three licensed pharmacists actively engaged in the practice of
 31.16 pharmacy in Minnesota, one of whom practices outside the metropolitan counties listed in
 31.17 section 473.121, subdivision 4, one of whom practices in the metropolitan counties listed
 31.18 in section 473.121, subdivision 4, and one of whom is a practicing hospital pharmacist; at
 31.19 least two consumer representatives, all of whom must have a personal or professional
 31.20 connection to medical assistance; and one representative designated by the Minnesota Rare
 31.21 Disease Advisory Council established under section 256.4835; the remainder to be made
 31.22 up of health care professionals who are licensed in their field and have recognized knowledge
 31.23 in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient
 31.24 drugs. Members of the Formulary Committee shall not be employed by the Department of

194.9 drug was on the formulary, at the same level until January 1 of the calendar year following
 194.10 the year in which the commissioner removed the drug from the formulary.

194.11 (j) Paragraph (i) does not apply if the commissioner changes the drug formulary:

194.12 (1) for a drug that has been deemed unsafe by the United States Food and Drug
 194.13 Administration (FDA);

194.14 (2) for a drug that has been withdrawn by the FDA or the drug manufacturer; or

194.15 (3) when an independent source of research, clinical guidelines, or evidence-based
 194.16 standards has issued drug-specific warnings or recommended changes with respect to a
 194.17 drug's use for reasons related to previously unknown and imminent patient harm.

194.18 (k) Paragraph (i) does not apply if the commissioner removes a brand name drug from
 194.19 the formulary if the commissioner:

194.20 (1) adds to the formulary a generic or multisource brand name drug rated as
 194.21 therapeutically equivalent according to the FDA Orange Book, or a biologic drug rated as
 194.22 interchangeable according to the FDA Purple Book, at the same or lower cost to the enrollee;
 194.23 and

194.24 (2) provides at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

194.25 **EFFECTIVE DATE.** This section is effective January 1, 2026, or upon federal approval,
 194.26 whichever is later. The commissioner of human services shall notify the revisor of statutes
 194.27 when federal approval is obtained.

194.28 Sec. 3. Minnesota Statutes 2024, section 256B.0625, subdivision 13c, is amended to read:

194.29 Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations
 194.30 from professional medical associations and professional pharmacy associations, and consumer
 194.31 groups shall designate a Formulary Committee to carry out duties as described in subdivisions
 194.32 13 to 13g. The Formulary Committee shall be comprised of at least five licensed physicians
 195.1 actively engaged in the practice of medicine in Minnesota, one of whom is an actively
 195.2 practicing psychiatrist, one of whom specializes in the diagnosis and treatment of rare
 195.3 diseases, one of whom specializes in pediatrics, and one of whom actively treats persons
 195.4 with disabilities; at least three licensed pharmacists actively engaged in the practice of
 195.5 pharmacy in Minnesota, one of whom practices outside the metropolitan counties listed in
 195.6 section 473.121, subdivision 4, one of whom practices in the metropolitan counties listed
 195.7 in section 473.121, subdivision 4, and one of whom is a practicing hospital pharmacist; at
 195.8 least two consumer representatives, all of whom must have a personal or professional
 195.9 connection to medical assistance; and one representative designated by the Minnesota Rare
 195.10 Disease Advisory Council established under section 256.4835; the remainder to be made
 195.11 up of health care professionals who are licensed in their field and have recognized knowledge
 195.12 in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient
 195.13 drugs. Members of the Formulary Committee shall not be employed by the Department of

31.25 Human Services or have a personal interest in a pharmaceutical company, pharmacy benefits
 31.26 manager, health plan company, or their affiliate organizations, but the committee shall be
 31.27 staffed by an employee of the department who shall serve as an ex officio, nonvoting member
 31.28 of the committee. For the purposes of this subdivision, "personal interest" means that a
 31.29 person owns at least five percent of the voting interest or equity interest in the entity, the
 31.30 equity interest owned by a person represents at least five percent of that person's net worth,
 31.31 or more than five percent of a person's gross income for the preceding year was derived
 31.32 from the entity. A committee member must notify the committee of any potential conflict
 31.33 of interest and recuse themselves from any communications, discussion, or vote on any
 31.34 matter where a conflict of interest exists. A conflict of interest alone, without a personal
 32.1 interest, does not preclude an applicant from serving as a member of the Formulary
 32.2 Committee. Members may be removed from the committee for cause after a recommendation
 32.3 for removal by a majority of the committee membership. For the purposes of this subdivision,
 32.4 "cause" does not include offering a differing or dissenting clinical opinion on a drug or drug
 32.5 class. The department's medical director shall also serve as an ex officio, nonvoting member
 32.6 for the committee. Committee members shall serve three-year terms and may be reappointed
 32.7 twice by the commissioner. The committee members shall vote on a chair and vice chair
 32.8 from among their membership. The chair shall preside over all committee meetings, and
 32.9 the vice chair shall preside over the meetings if the chair is not present. The Formulary
 32.10 Committee shall meet at least three times per year. The commissioner may require more
 32.11 frequent Formulary Committee meetings as needed. An honorarium of \$100 per meeting
 32.12 and reimbursement for mileage shall be paid to each committee member in attendance. The
 32.13 Formulary Committee expires June 30, ~~2027~~ 2029. The Formulary Committee is subject to
 32.14 the Open Meeting Law under chapter 13D. For purposes of establishing a quorum to transact
 32.15 business, vacant committee member positions do not count in the calculation as long as at
 32.16 least 60 percent of the committee member positions are filled.

195.14 Human Services or have a personal interest in a pharmaceutical company, pharmacy benefits
 195.15 manager, health plan company, or their affiliate organizations, but the committee shall be
 195.16 staffed by an employee of the department who shall serve as an ex officio, nonvoting member
 195.17 of the committee. For the purposes of this subdivision, "personal interest" means that a
 195.18 person owns at least five percent of the voting interest or equity interest in the entity, the
 195.19 equity interest owned by a person represents at least five percent of that person's net worth,
 195.20 or more than five percent of a person's gross income for the preceding year was derived
 195.21 from the entity. A committee member must notify the committee of any potential conflict
 195.22 of interest and recuse themselves from any communications, discussion, or vote on any
 195.23 matter where a conflict of interest exists. A conflict of interest alone, without a personal
 195.24 interest, does not preclude an applicant from serving as a member of the Formulary
 195.25 Committee. Members may be removed from the committee for cause after a recommendation
 195.26 for removal by a majority of the committee membership. For the purposes of this subdivision,
 195.27 "cause" does not include offering a differing or dissenting clinical opinion on a drug or drug
 195.28 class. The department's medical director shall also serve as an ex officio, nonvoting member
 195.29 for the committee. Committee members shall serve three-year terms and may be reappointed
 195.30 twice by the commissioner. The committee members shall vote on a chair and vice chair
 195.31 from among their membership. The chair shall preside over all committee meetings, and
 195.32 the vice chair shall preside over the meetings if the chair is not present. The Formulary
 195.33 Committee shall meet at least three times per year. The commissioner may require more
 195.34 frequent Formulary Committee meetings as needed. An honorarium of \$100 per meeting
 195.35 and reimbursement for mileage shall be paid to each committee member in attendance. The
 195.36 Formulary Committee expires June 30, ~~2027~~ 2029. The Formulary Committee is subject to
 196.1 the Open Meeting Law under chapter 13D. For purposes of establishing a quorum to transact
 196.2 business, vacant committee member positions do not count in the calculation as long as at
 196.3 least 60 percent of the committee member positions are filled.

196.4 **EFFECTIVE DATE.** This section is effective the day following final enactment.

196.5 Sec. 4. Minnesota Statutes 2024, section 256B.0625, subdivision 13d, is amended to read:

196.6 Subd. 13d. **Drug formulary.** (a) The commissioner shall establish a drug formulary. Its
 196.7 establishment and publication shall not be subject to the requirements of the Administrative
 196.8 Procedure Act, but the Formulary Committee shall review and comment on the formulary
 196.9 contents.

196.10 (b) The formulary shall not include:

196.11 (1) drugs, active pharmaceutical ingredients, or products for which there is no federal
 196.12 funding;

196.13 (2) over-the-counter drugs, except as provided in subdivision 13;

196.14 (3) drugs or active pharmaceutical ingredients when used for the treatment of impotence
 196.15 or erectile dysfunction;

- 196.16 (4) drugs or active pharmaceutical ingredients for which medical value has not been
196.17 established;
- 196.18 (5) drugs from manufacturers who have not signed a rebate agreement with the
196.19 Department of Health and Human Services pursuant to section 1927 of title XIX of the
196.20 Social Security Act; and
- 196.21 (6) medical cannabis flower as defined in section 342.01, subdivision 54, or medical
196.22 cannabinoid products as defined in section 342.01, subdivision 52.
- 196.23 (c) If a single-source drug used by at least two percent of the fee-for-service medical
196.24 assistance recipients is removed from the formulary due to the failure of the manufacturer
196.25 to sign a rebate agreement with the Department of Health and Human Services, the
196.26 commissioner shall notify prescribing practitioners within 30 days of receiving notification
196.27 from the Centers for Medicare and Medicaid Services (CMS) that a rebate agreement was
196.28 not signed.
- 196.29 (d) Within ten calendar days of any commissioner determination to change the drug
196.30 formulary, the commissioner must provide written notice to all enrollees affected by the
196.31 change. The notice must include a description of the change, the reason for the change, and
196.32 the date the change will become effective.
- 197.1 (e) By January 15, 2026, and annually thereafter, the commissioner of human services
197.2 must provide a report with data and information related to the effects on enrollees of drug
197.3 formulary changes made in the prior calendar year to the chairs and ranking minority
197.4 members of the legislative committees with jurisdiction over health and human services
197.5 policy and finance. The report must include but is not limited to data and information on:
- 197.6 (1) the number of times the formulary was changed;
- 197.7 (2) the reasons for the formulary changes and how frequently the formulary was changed
197.8 for each reason;
- 197.9 (3) the drugs that were removed from the formulary;
- 197.10 (4) for each drug that was removed from the formulary, the number of enrollees who
197.11 were prescribed that drug when it was removed;
- 197.12 (5) for each drug that was removed from the formulary, whether a therapeutically
197.13 equivalent drug was added;
- 197.14 (6) the drugs that were added to the formulary;
- 197.15 (7) the fiscal impacts to the Department of Human Services resulting from the changes
197.16 to the formulary; and
- 197.17 (8) enrollee populations or medical conditions disproportionately affected by the
197.18 formulary changes.

32.17 Sec. 2. Minnesota Statutes 2024, section 256B.0625, subdivision 13e, is amended to read:

32.18 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall
 32.19 be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the
 32.20 usual and customary price charged to the public. The usual and customary price means the
 32.21 lowest price charged by the provider to a patient who pays for the prescription by cash,
 32.22 check, or charge account and includes prices the pharmacy charges to a patient enrolled in
 32.23 a prescription savings club or prescription discount club administered by the pharmacy or
 32.24 pharmacy chain, unless the prescription savings club or prescription discount club is one
 32.25 in which an individual pays a recurring monthly access fee for unlimited access to a defined
 32.26 list of drugs for which the pharmacy does not bill the member or a payer on a
 32.27 per-standard-transaction basis. The amount of payment basis must be reduced to reflect all
 32.28 discount amounts applied to the charge by any third-party provider/insurer agreement or
 32.29 contract for submitted charges to medical assistance programs. The net submitted charge
 32.30 may not be greater than the patient liability for the service. The professional dispensing fee
 32.31 shall be \$11.55 for prescriptions filled with legend drugs meeting the definition of "covered
 32.32 outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The
 32.33 dispensing fee for intravenous solutions that must be compounded by the pharmacist shall
 32.34 be \$11.55 per claim. The professional dispensing fee for prescriptions filled with
 32.35 over-the-counter drugs meeting the definition of covered outpatient drugs shall be \$11.55
 33.1 for dispensed quantities equal to or greater than the number of units contained in the
 33.2 manufacturer's original package. The professional dispensing fee shall be prorated based
 33.3 on the percentage of the package dispensed when the pharmacy dispenses a quantity less
 33.4 than the number of units contained in the manufacturer's original package. The pharmacy
 33.5 dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered
 33.6 outpatient drugs shall be \$3.65 for quantities equal to or greater than the number of units
 33.7 contained in the manufacturer's original package and shall be prorated based on the
 33.8 percentage of the package dispensed when the pharmacy dispenses a quantity less than the
 33.9 number of units contained in the manufacturer's original package. The ingredient cost for
 33.10 a drug is the lowest of the National Average Drug Acquisition Cost (NADAC) shall be used
 33.11 to determine the ingredient cost of a drug; the Minnesota actual acquisition cost (MNAAC),
 33.12 as defined in paragraph (i), or the maximum allowable cost. For drugs for which a NADAC,
 33.13 MNAAC, or maximum allowable cost is not reported, the commissioner shall estimate the
 33.14 ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost of
 33.15 a drug for a provider participating in the federal 340B Drug Pricing Program shall be ~~either~~
 33.16 the 340B Drug Pricing Program ceiling price established by the Health Resources and
 33.17 Services Administration ~~or, the NADAC, the MNAAC, or the maximum allowable cost,~~
 33.18 whichever is lower lowest. Wholesale acquisition cost is defined as the manufacturer's list
 33.19 price for a drug or biological to wholesalers or direct purchasers in the United States, not
 33.20 including prompt pay or other discounts, rebates, or reductions in price, for the most recent
 33.21 month for which information is available, as reported in wholesale price guides or other
 33.22 publications of drug or biological pricing data. The maximum allowable cost of a ~~multisource~~
 33.23 drug may be set by the commissioner and it shall be comparable to the actual acquisition
 33.24 cost of the drug product and no higher than the NADAC of the generic product. Establishment

197.19 Sec. 5. Minnesota Statutes 2024, section 256B.0625, subdivision 13e, is amended to read:

197.20 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall
 197.21 be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the
 197.22 usual and customary price charged to the public. The usual and customary price means the
 197.23 lowest price charged by the provider to a patient who pays for the prescription by cash,
 197.24 check, or charge account and includes prices the pharmacy charges to a patient enrolled in
 197.25 a prescription savings club or prescription discount club administered by the pharmacy or
 197.26 pharmacy chain, unless the prescription savings club or prescription discount club is one
 197.27 in which an individual pays a recurring monthly access fee for unlimited access to a defined
 197.28 list of drugs for which the pharmacy does not bill the member or a payer on a
 197.29 per-standard-transaction basis. The amount of payment basis must be reduced to reflect all
 197.30 discount amounts applied to the charge by any third-party provider/insurer agreement or
 197.31 contract for submitted charges to medical assistance programs. The net submitted charge
 197.32 may not be greater than the patient liability for the service. The professional dispensing fee
 198.1 shall be \$11.55 for prescriptions filled with legend drugs meeting the definition of "covered
 198.2 outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The
 198.3 dispensing fee for intravenous solutions that must be compounded by the pharmacist shall
 198.4 be \$11.55 per claim. The professional dispensing fee for prescriptions filled with
 198.5 over-the-counter drugs meeting the definition of covered outpatient drugs shall be \$11.55
 198.6 for dispensed quantities equal to or greater than the number of units contained in the
 198.7 manufacturer's original package. The professional dispensing fee shall be prorated based
 198.8 on the percentage of the package dispensed when the pharmacy dispenses a quantity less
 198.9 than the number of units contained in the manufacturer's original package. The pharmacy
 198.10 dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered
 198.11 outpatient drugs shall be \$3.65 for quantities equal to or greater than the number of units
 198.12 contained in the manufacturer's original package and shall be prorated based on the
 198.13 percentage of the package dispensed when the pharmacy dispenses a quantity less than the
 198.14 number of units contained in the manufacturer's original package. The ingredient cost for
 198.15 a drug is the lower of the National Average Drug Acquisition Cost (NADAC) shall be used
 198.16 to determine the ingredient cost of a drug; the Minnesota actual acquisition cost (MNAAC),
 198.17 as defined in paragraph (i), or the maximum allowable cost. For drugs for which a NADAC,
 198.18 a MNAAC, or a maximum allowable cost is not reported, the commissioner shall estimate
 198.19 the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost
 198.20 of a drug for a provider participating in the federal 340B Drug Pricing Program shall be
 198.21 ~~either~~ the 340B Drug Pricing Program ceiling price established by the Health Resources
 198.22 and Services Administration ~~or, the NADAC, the MNAAC, or the maximum allowable~~
 198.23 cost, whichever is lower. Wholesale acquisition cost is defined as the manufacturer's list
 198.24 price for a drug or biological to wholesalers or direct purchasers in the United States, not
 198.25 including prompt pay or other discounts, rebates, or reductions in price, for the most recent
 198.26 month for which information is available, as reported in wholesale price guides or other
 198.27 publications of drug or biological pricing data. The maximum allowable cost of a ~~multisource~~
 198.28 drug may be set by the commissioner and it shall be comparable to the actual acquisition
 198.29 cost of the drug product and no higher than the NADAC of the generic product. Establishment

33.25 of the amount of payment for drugs shall not be subject to the requirements of the
33.26 Administrative Procedure Act.

33.27 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using
33.28 an automated drug distribution system meeting the requirements of section 151.58, or a
33.29 packaging system meeting the packaging standards set forth in Minnesota Rules, part
33.30 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ
33.31 retrospective billing for prescription drugs dispensed to long-term care facility residents. A
33.32 retrospectively billing pharmacy must submit a claim only for the quantity of medication
33.33 used by the enrolled recipient during the defined billing period. A retrospectively billing
33.34 pharmacy must use a billing period not less than one calendar month or 30 days.

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

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

34.19 (e) The basis for determining the amount of payment for drugs administered in an
34.20 outpatient setting shall be the lower of the usual and customary cost submitted by the
34.21 provider, 106 percent of the average sales price as determined by the United States
34.22 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
34.23 federal Social Security Act, the ~~specialty pharmacy rate~~ MNAAC, or the maximum allowable
34.24 cost set by the commissioner. If average sales price is, MNAAC, and the maximum allowable
34.25 cost are unavailable, the amount of payment must be lower of the usual and customary cost
34.26 submitted by the provider; or the wholesale acquisition cost; the specialty pharmacy rate;
34.27 or the maximum allowable cost set by the commissioner. The commissioner shall discount
34.28 the payment rate for drugs obtained through the federal 340B Drug Pricing Program by
34.29 28.6 percent. The payment for drugs administered in an outpatient setting shall be made to
34.30 the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug
34.31 for administration in an outpatient setting is not eligible for direct reimbursement.

198.30 of the amount of payment for drugs shall not be subject to the requirements of the
198.31 Administrative Procedure Act.

198.32 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using
198.33 an automated drug distribution system meeting the requirements of section 151.58, or a
198.34 packaging system meeting the packaging standards set forth in Minnesota Rules, part
198.35 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ
198.36 retrospective billing for prescription drugs dispensed to long-term care facility residents. A
199.1 retrospectively billing pharmacy must submit a claim only for the quantity of medication
199.2 used by the enrolled recipient during the defined billing period. A retrospectively billing
199.3 pharmacy must use a billing period not less than one calendar month or 30 days.

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

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

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

34.32 (f) The commissioner may establish maximum allowable cost rates for specialty pharmacy
 34.33 products that are lower than the ingredient cost formulas specified in paragraph (a). The
 34.34 commissioner may require individuals enrolled in the health care programs administered
 34.35 by the department to obtain specialty pharmacy products from providers with whom the
 35.1 commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are
 35.2 defined as those used by a small number of recipients or recipients with complex and chronic
 35.3 diseases that require expensive and challenging drug regimens. Examples of these conditions
 35.4 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C,
 35.5 growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of
 35.6 cancer. Specialty pharmaceutical products include injectable and infusion therapies,
 35.7 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that
 35.8 require complex care. The commissioner shall consult with the Formulary Committee to
 35.9 develop a list of specialty pharmacy products subject to maximum allowable cost
 35.10 reimbursement. In consulting with the Formulary Committee in developing this list, the
 35.11 commissioner shall take into consideration the population served by specialty pharmacy
 35.12 products, the current delivery system and standard of care in the state, and access to care
 35.13 issues. The commissioner shall have the discretion to adjust the maximum allowable cost
 35.14 to prevent access to care issues.

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

35.17 ~~(h)~~ (g) The commissioner shall contract with a vendor to conduct a cost of dispensing
 35.18 survey for all pharmacies that are physically located in the state of Minnesota that dispense
 35.19 outpatient drugs under medical assistance. The commissioner shall ensure that the vendor
 35.20 has prior experience in conducting cost of dispensing surveys. Each pharmacy enrolled with
 35.21 the department to dispense outpatient prescription drugs to fee-for-service members must
 35.22 respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under
 35.23 section 256B.064 for failure to respond. The commissioner shall require the vendor to
 35.24 measure a single statewide cost of dispensing for specialty prescription drugs and a single
 35.25 statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies
 35.26 to measure the mean, mean weighted by total prescription volume, mean weighted by
 35.27 medical assistance prescription volume, median, median weighted by total prescription
 35.28 volume, and median weighted by total medical assistance prescription volume. The
 35.29 commissioner shall post a copy of the final cost of dispensing survey report on the
 35.30 department's website. The initial survey must be completed no later than January 1, 2021,
 35.31 and repeated every ~~three~~ years. The commissioner shall provide a summary of the results
 35.32 of each cost of dispensing survey and provide recommendations for any changes to the
 35.33 dispensing fee to the chairs and ranking minority members of the legislative committees
 35.34 with jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section
 35.35 256.01, subdivision 42, this paragraph does not expire.

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

200.1 (f) The commissioner may establish maximum allowable cost rates for specialty pharmacy
 200.2 products that are lower than the ingredient cost formulas specified in paragraph (a). The
 200.3 commissioner may require individuals enrolled in the health care programs administered
 200.4 by the department to obtain specialty pharmacy products from providers with whom the
 200.5 commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are
 200.6 defined as those used by a small number of recipients or recipients with complex and chronic
 200.7 diseases that require expensive and challenging drug regimens. Examples of these conditions
 200.8 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C,
 200.9 growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of
 200.10 cancer. Specialty pharmaceutical products include injectable and infusion therapies,
 200.11 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that
 200.12 require complex care. The commissioner shall consult with the Formulary Committee to
 200.13 develop a list of specialty pharmacy products subject to maximum allowable cost
 200.14 reimbursement. In consulting with the Formulary Committee in developing this list, the
 200.15 commissioner shall take into consideration the population served by specialty pharmacy
 200.16 products, the current delivery system and standard of care in the state, and access to care
 200.17 issues. The commissioner shall have the discretion to adjust the maximum allowable cost
 200.18 to prevent access to care issues.

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

200.21 ~~(h)~~ (g) The commissioner shall contract with a vendor to conduct a cost of dispensing
 200.22 survey for all pharmacies that are physically located in the state of Minnesota that dispense
 200.23 outpatient drugs under medical assistance. The commissioner shall ensure that the vendor
 200.24 has prior experience in conducting cost of dispensing surveys. Each pharmacy enrolled with
 200.25 the department to dispense outpatient prescription drugs to fee-for-service members must
 200.26 respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under
 200.27 section 256B.064 for failure to respond. The commissioner shall require the vendor to
 200.28 measure a single statewide cost of dispensing for specialty prescription drugs and a single
 200.29 statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies
 200.30 to measure the mean, mean weighted by total prescription volume, mean weighted by
 200.31 medical assistance prescription volume, median, median weighted by total prescription
 200.32 volume, and median weighted by total medical assistance prescription volume. The
 200.33 commissioner shall post a copy of the final cost of dispensing survey report on the
 200.34 department's website. The initial survey must be completed no later than January 1, 2021,
 200.35 and repeated every ~~three~~ two years. The commissioner shall provide a summary of the
 201.1 results of each cost of dispensing survey and provide recommendations for any changes to
 201.2 the dispensing fee to the chairs and ranking minority members of the legislative committees
 201.3 with jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section
 201.4 256.01, subdivision 42, this paragraph does not expire.

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

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

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

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

36.22 Sec. 3. Minnesota Statutes 2024, section 256B.064, subdivision 1a, is amended to read:

36.23 Subd. 1a. **Grounds for sanctions.** (a) The commissioner may impose sanctions against
36.24 any individual or entity that receives payments from medical assistance or provides goods
36.25 or services for which payment is made from medical assistance for any of the following:
36.26 (1) fraud, theft, or abuse in connection with the provision of goods and services to recipients
36.27 of public assistance for which payment is made from medical assistance; (2) a pattern of
36.28 presentment of false or duplicate claims or claims for services not medically necessary; (3)
36.29 a pattern of making false statements of material facts for the purpose of obtaining greater
36.30 compensation than that to which the individual or entity is legally entitled; (4) suspension
36.31 or termination as a Medicare vendor; (5) refusal to grant the state agency access during
36.32 regular business hours to examine all records necessary to disclose the extent of services
36.33 provided to program recipients and appropriateness of claims for payment; (6) failure to
36.34 repay an overpayment or a fine finally established under this section; (7) failure to correct
37.1 errors in the maintenance of health service or financial records for which a fine was imposed
37.2 or after issuance of a warning by the commissioner; and (8) any reason for which an
37.3 individual or entity could be excluded from participation in the Medicare program under
37.4 section 1128, 1128A, or 1866(b)(2) of the Social Security Act. For the purposes of this
37.5 section, goods or services for which payment is made from medical assistance includes but
37.6 is not limited to care and services identified in section 256B.0625 or provided pursuant to
37.7 any federally approved waiver.

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

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

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

201.26 Sec. 6. Minnesota Statutes 2024, section 256B.064, subdivision 1a, is amended to read:

201.27 Subd. 1a. **Grounds for sanctions.** (a) The commissioner may impose sanctions against
201.28 any individual or entity that receives payments from medical assistance or provides goods
201.29 or services for which payment is made from medical assistance for any of the following:
201.30 (1) fraud, theft, or abuse in connection with the provision of goods and services to recipients
201.31 of public assistance for which payment is made from medical assistance; (2) a pattern of
201.32 presentment of false or duplicate claims or claims for services not medically necessary; (3)
201.33 a pattern of making false statements of material facts for the purpose of obtaining greater
201.34 compensation than that to which the individual or entity is legally entitled; (4) suspension
202.1 or termination as a Medicare vendor; (5) refusal to grant the state agency access during
202.2 regular business hours to examine all records necessary to disclose the extent of services
202.3 provided to program recipients and appropriateness of claims for payment; (6) failure to
202.4 repay an overpayment or a fine finally established under this section; (7) failure to correct
202.5 errors in the maintenance of health service or financial records for which a fine was imposed
202.6 or after issuance of a warning by the commissioner; and (8) any reason for which an
202.7 individual or entity could be excluded from participation in the Medicare program under
202.8 section 1128, 1128A, or 1866(b)(2) of the Social Security Act. For the purposes of this
202.9 section, goods or services for which payment is made from medical assistance includes but
202.10 is not limited to care and services identified in section 256B.0625 or provided pursuant to
202.11 any federally approved waiver.

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

37.11 (c) The commissioner may impose sanctions against a pharmacy provider for failure to
 37.12 respond to a Minnesota drug acquisition cost survey under section 256B.0625, subdivision
 37.13 13e, paragraph (i).

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

37.17 Sec. 4. Minnesota Statutes 2024, section 256B.69, subdivision 6d, is amended to read:

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

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

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

38.1 Sec. 5. **[256B.696] PRESCRIPTION DRUGS; STATE PHARMACY BENEFIT**
 38.2 **MANAGER.**

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

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

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

38.10 (d) "State pharmacy benefit manager" means the pharmacy benefit manager that is a
 38.11 prepaid ambulatory plan as defined in Code of Federal Regulations, title 42, section 438.2,
 38.12 selected pursuant to the procurement process in subdivision 2.

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

202.15 (c) The commissioner may impose sanctions against a pharmacy provider for failure to
 202.16 respond to a Minnesota drug acquisition cost survey under section 256B.0625, subdivision
 202.17 13e, paragraph (i).

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

202.21 Sec. 7. Minnesota Statutes 2024, section 256B.69, subdivision 6d, is amended to read:

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

202.26 (b) The contracts must maintain incentives for the managed care plan to manage drug
 202.27 costs and utilization and may require that the managed care plans maintain an open drug
 202.28 formulary. In order to manage drug costs and utilization, the contracts may authorize the
 202.29 managed care plans to use preferred drug lists and prior authorization. The contracts must
 202.30 require that the managed care plans enter into contracts with the state's selected pharmacy
 202.31 benefit manager vendor to administer the pharmacy benefit.

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

204.10 Sec. 9. **[256B.696] PRESCRIPTION DRUGS; STATE PHARMACY BENEFIT**
 204.11 **MANAGER.**

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

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

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

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

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

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

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

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

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

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

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

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

204.21 Subd. 2. **Procurement process.** (a) The commissioner must, through a competitive
 204.22 procurement process in compliance with paragraph (b), select a single pharmacy benefit
 204.23 manager to comply with the requirements set forth in subdivision 3. The single pharmacy
 204.24 benefit manager selected under this subdivision must be a prepaid ambulatory health plan,
 204.25 as defined in Code of Federal Regulations, title 42, section 438.2.

204.26 (b) When selecting the single pharmacy benefit manager, the commissioner must:

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

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

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

205.1 (c) The contract required under paragraph (b), clause (3), must include provisions that
 205.2 prohibit the single pharmacy benefit manager from:

205.3 (1) requiring, enticing, or coercing an enrollee to obtain pharmacy services, including
 205.4 a prescription drug, from a pharmacy owned or otherwise affiliated with the single pharmacy
 205.5 benefit manager;

205.16 (5) paying or reimbursing a pharmacy or pharmacist for the ingredient drug product
 205.17 component of pharmacist services, including a prescription drug, less than the lesser of
 205.18 national average drug acquisition cost; the Minnesota actual acquisition cost (MNAAC) as
 205.19 defined in section 256B.0625, subdivision 13e, paragraph (i); or the maximum allowable
 205.20 cost as defined in section 62W.08 of that pharmacy service or prescription drug, or, if the
 205.21 national average drug acquisition cost is unavailable, the wholesale acquisition cost minus
 205.22 two percent at the time the drug is administered or dispensed, plus a professional dispensing
 205.23 fee equal to the amount of the dispensing fee if it were determined pursuant to section
 205.24 256B.0625, subdivision 13e; and

205.6 (2) communicating to an enrollee, in any manner, that the enrollee is required to obtain
 205.7 pharmacy services or have a prescription dispensed at, or pharmacy services provided by,
 205.8 a particular pharmacy owned or affiliated with the single pharmacy benefit manager if there
 205.9 are other nonaffiliated pharmacies that have the ability to dispense the medication or provide
 205.10 the services and are also in network;

205.11 (3) requiring an enrollee to obtain pharmacy services, including a prescription drug,
 205.12 exclusively through a mail order pharmacy;

205.13 (4) directly or indirectly retroactively denying or reducing a claim or aggregate of claims
 205.14 for pharmacy services, including prescription drugs, after adjudication of the claim or
 205.15 aggregate of claims;

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

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

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

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

39.14 (ii) a county-based purchasing organization;

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

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

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

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

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

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

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

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

205.25 (6) denying a pharmacy or pharmacist the right to participate as a contract provider under
205.26 the health plan if the pharmacy or pharmacist agrees to provide pharmacy services, including
205.27 but not limited to prescription drugs that meet the terms and requirements set forth by the
205.28 health plan and agrees to the terms of reimbursement set forth by the health plan company.

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

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

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

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

206.8 (ii) a county-based purchasing organization;

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

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

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

206.13 (vi) a pharmacy and its affiliates;

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

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

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

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

40.1 (b) The state pharmacy benefit manager is responsible for processing all point of sale
 40.2 outpatient pharmacy claims under the managed care delivery system. Managed care plans
 40.3 must use the state pharmacy benefit manager pursuant to the terms of the master contract
 40.4 required under subdivision 2, paragraph (b), clause (3). The pharmacy benefit manager
 40.5 selected is the exclusive pharmacy benefit manager used by health plan companies and
 40.6 county-based purchasing organizations when providing coverage to enrollees. The
 40.7 commissioner may require the managed care plans and pharmacy benefit manager to directly
 40.8 exchange data and files for members enrolled with managed care plans.

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

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

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

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

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

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

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

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

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

206.26 (b) The state pharmacy benefit manager is responsible for processing all point of sale
 206.27 outpatient pharmacy claims under the managed care delivery system. Managed care plans
 206.28 must use the state pharmacy benefit manager pursuant to the terms of the master contract
 206.29 required under subdivision 2, paragraph (b), clause (3). The pharmacy benefit manager
 206.30 selected is the exclusive pharmacy benefit manager used by health plan companies and
 206.31 county-based purchasing organizations when providing coverage to enrollees. The
 207.1 commissioner may require the managed care plans and state pharmacy benefit manager to
 207.2 directly exchange data and files for members enrolled with managed care plans.

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

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

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

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

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

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

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

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

207.26 (2) unredacted copies of contracts between the state pharmacy benefit manager and
 207.27 enrolled pharmacies;

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

41.1 (3) any changes to the information previously disclosed under subdivision 2, paragraph
41.2 (d); and

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

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

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

41.10 Subd. 5. **Program authority.** (a) To accomplish the requirements of subdivision 3, the
41.11 commissioner, in consultation with the Formulary Committee established under section
41.12 256B.0625, subdivision 13c, has the authority to:

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

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

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

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

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

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

41.28 **EFFECTIVE DATE.** Subdivisions 1 to 6 are effective January 1, 2027, or upon federal
41.29 approval, whichever is later. The commissioner of human services shall notify the revisor
41.30 of statutes when federal approval is obtained. Subdivision 7 is effective the day following
41.31 final enactment.

42.1 Sec. 6. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
42.2 **DIRECTED PHARMACY DISPENSING PAYMENTS.**

42.3 (a) For plan year 2026, the commissioner shall provide a directed pharmacy dispensing
42.4 payment of \$1.84 per filled prescription under the medical assistance program to eligible
42.5 outpatient retail pharmacies in Minnesota to improve and maintain access to pharmaceutical

207.30 (4) any changes to the information previously disclosed in accordance with subdivision
207.31 2, paragraph (d); and

207.32 (5) any other information required by the commissioner.

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

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

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

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

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

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

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

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

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

208.24 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,
208.25 whichever is later, except that subdivision 7 is effective the day following final enactment.
208.26 The commissioner of human services shall notify the revisor of statutes when federal approval
208.27 is obtained.

203.1 Sec. 8. Minnesota Statutes 2024, section 256B.69, is amended by adding a subdivision to
203.2 read:

203.3 Subd. 6i. **Directed pharmacy dispensing payment.** (a) The commissioner shall provide
203.4 a directed pharmacy dispensing payment of \$4.50 per filled prescription to eligible outpatient
203.5 retail pharmacies in Minnesota to improve and maintain access to pharmaceutical services

42.6 services in rural and underserved areas of the state. Managed care and county-based
 42.7 purchasing plans delivering services under Minnesota Statutes, section 256B.69 or 256B.692,
 42.8 and any pharmacy benefit managers under contract with these entities, must pay the directed
 42.9 pharmacy dispensing payment to eligible outpatient retail pharmacies for drugs dispensed
 42.10 to medical assistance enrollees. The directed pharmacy dispensing payment is in addition
 42.11 to, and must not supplant or reduce, any other dispensing fee paid by these entities to the
 42.12 pharmacy. Entities paying the directed pharmacy dispensing payment must not reduce other
 42.13 payments to the pharmacy as a result of payment of the directed pharmacy dispensing
 42.14 payment.

42.15 (b) For purposes of this section, "eligible outpatient retail pharmacy" means an outpatient
 42.16 retail pharmacy licensed under chapter 151 that is not owned, either directly or indirectly
 42.17 or through an affiliate or subsidiary, by a pharmacy benefit manager licensed under chapter
 42.18 62W or a health carrier, as defined in Minnesota Statutes, section 62A.011, subdivision 2,
 42.19 and that:

42.20 (1) is located in a medically underserved area or primarily serves a medically underserved
 42.21 population, as defined by the United States Department of Health and Human Services
 42.22 Health Resources and Services Administration under United States Code, title 42, section
 42.23 254; or

42.24 (2) shares common ownership with 13 or fewer Minnesota pharmacies.

42.25 (c) In order to receive the directed pharmacy dispensing payment, a pharmacy must
 42.26 submit to the commissioner a form, developed by the commissioner, attesting that the
 42.27 pharmacy meets the requirements of paragraph (b).

42.28 (d) The commissioner shall set and adjust the amount of the directed pharmacy dispensing
 42.29 payment to reflect the available state and federal funding.

42.30 (e) Managed care and county-based purchasing plans, and any pharmacy benefit managers
 42.31 under contract with these entities, shall pay the directed pharmacy dispensing payment to
 42.32 eligible outpatient retail pharmacies. The commissioner shall monitor the effect of this
 42.33 requirement on access to pharmaceutical services in rural and underserved areas of the state.
 42.34 If, for any contract year, federal approval is not received for this section, the commissioner
 43.1 must adjust the capitation rates paid to managed care plans and county-based purchasing
 43.2 plans for that contract year to reflect removal of this section. Contracts between managed
 43.3 care plans and county-based purchasing plans, and any pharmacy benefit managers under
 43.4 contract with these entities, and providers to whom this section applies, must allow recovery
 43.5 of payments from those providers if capitation rates are adjusted in accordance with this
 43.6 paragraph. Payment recoveries must not exceed the amount equal to any increase in rates
 43.7 that results from this section. This section expires if federal approval is not received for this
 43.8 section at any time.

203.6 in rural and underserved areas of Minnesota. Managed care and county-based purchasing
 203.7 plans delivering services under section 256B.69 or 256B.692, and any pharmacy benefit
 203.8 managers under contract with these entities, must pay the directed pharmacy dispensing
 203.9 payment to eligible outpatient retail pharmacies for drugs dispensed to medical assistance
 203.10 enrollees. The directed pharmacy dispensing payment is in addition to, and must not supplant
 203.11 or reduce, any other dispensing fee paid by these entities to the pharmacy. Entities paying
 203.12 the directed pharmacy dispensing payment must not reduce other payments to the pharmacy
 203.13 as a result of payment of the directed pharmacy dispensing payment.

203.14 (b) For purposes of this subdivision, "eligible outpatient retail pharmacy" means an
 203.15 outpatient retail pharmacy licensed under chapter 151 that is not owned, either directly or
 203.16 indirectly or through an affiliate or subsidiary, by a pharmacy benefit manager licensed
 203.17 under chapter 62W or a health carrier, as defined in section 62A.011, subdivision 2, and
 203.18 that:

203.19 (1) is located in a medically underserved area or primarily serves a medically underserved
 203.20 population, as defined by the United States Department of Health and Human Services
 203.21 Health Resources and Services Administration under United States Code, title 42, section
 203.22 254; or

203.23 (2) shares common ownership with 12 or fewer Minnesota pharmacies.

203.24 (c) In order to receive the directed pharmacy dispensing payment, a pharmacy must
 203.25 submit to the commissioner a form, developed by the commissioner, attesting that the
 203.26 pharmacy meets the requirements of paragraph (b).

203.27 (d) Managed care and county-based purchasing plans, and any pharmacy benefit managers
 203.28 under contract with these entities, shall pay the directed pharmacy dispensing payment to
 203.29 eligible outpatient retail pharmacies. The commissioner shall monitor the effect of this
 203.30 requirement on access to pharmaceutical services in rural and underserved areas of
 203.31 Minnesota. If, for any contract year, federal approval is not received for this subdivision,
 203.32 the commissioner must adjust the capitation rates paid to managed care plans and
 203.33 county-based purchasing plans for that contract year to reflect removal of this subdivision.
 203.34 Contracts between managed care plans and county-based purchasing plans, and any pharmacy
 204.1 benefit managers under contract with these entities, and providers to whom this subdivision
 204.2 applies, must allow recovery of payments from those providers if capitation rates are adjusted
 204.3 in accordance with this paragraph. Payment recoveries must not exceed the amount equal
 204.4 to any increase in rates that results from this subdivision. This subdivision expires if federal
 204.5 approval is not received for this subdivision at any time.

204.6 (e) This subdivision expires on December 31, 2026.

43.9 EFFECTIVE DATE. This section is effective **January 1, 2026**, or upon federal approval,
43.10 whichever is later. The commissioner of human services shall notify the revisor of statutes
43.11 when federal approval is obtained.

204.7 EFFECTIVE DATE. This section is effective **July 1, 2025**, or upon federal approval,
204.8 whichever is later. The commissioner of human services shall notify the revisor of statutes
204.9 when federal approval is obtained.