Senator Rosen from the Committee on Finance, to which was re-referred

S.F. No. 3249: A bill for an act relating to mental health; creating a mental health provider supervision grant program; modifying adult mental health initiatives; modifying intensive residential treatment services; modifying mental health fee-for-service payment rate; removing county share; creating mental health urgency room grant program; directing the commissioner to develop medical assistance mental health benefit for children; establishing forensic navigator services; creating an online music instruction grant program; creating an exception to the hospital construction moratorium for projects that add mental health beds; appropriating money; amending Minnesota Statutes 2020, sections 144.55, subdivisions 4, 6; 144.551, by adding a subdivision; 245.4661, as amended; 256B.0622, subdivision 5a; Minnesota Statutes 2021 Supplement, sections 245I.23, by adding a subdivision; 256B.0625, subdivisions 5, 56a; proposing coding for new law in Minnesota Statutes, chapters 144; 245; 611; repealing Minnesota Statutes 2020, section 245.4661, subdivision 8.

Reports the same back with the recommendation that the bill be amended as follows:

Page 7, line 6, after the first "commissioner" insert "of management and budget"

Page 7, line 7, delete "management and budget" and insert "human services"

Page 7, delete line 10 and insert "The commissioner of management and budget, in consultation with the commissioner of human services, shall"

Page 7, line 13, after "services" insert ", in consultation with the commissioner of management and budget,"

Page 7, line 16, before "evaluation" insert "inventory and"

Page 7, line 18, before "experimental" insert "inventory and the"

Page 14, after line 30, insert:

"Sec. 10. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The professional dispensing fee shall be $10.77 for prescriptions filled with legend drugs meeting the definition of "covered outpatient

drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions that must be compounded by the pharmacist shall be $10.77 per claim. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be $10.77 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered outpatient drugs shall be $3.65 for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The National Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug. For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for a provider participating in the federal 340B Drug Pricing Program shall be either the 340B Drug Pricing Program ceiling price established by the Health Resources and Services Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to the actual acquisition cost of the drug product and no higher than the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

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

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

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

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

(f) Notwithstanding paragraph (e), payment for injectable drugs used to treat substance use disorder or mental illness administered by a practitioner or pharmacist in an outpatient setting shall be made either to the administering facility, the practitioner, the administering pharmacy or pharmacist, or directly to the dispensing pharmacy. The practitioner, administering facility, or administering pharmacy or pharmacist shall submit the claim for the drug if they purchase the drug directly from a wholesale distributor licensed under section 151.47 or from a manufacturer licensed under section 151.252. The dispensing pharmacy shall submit the claim if the pharmacy dispenses the drug pursuant to a prescription issued by the practitioner and delivers the filled prescription to the practitioner for subsequent administration. Payment shall be made according to this section. The commissioner shall

ensure that claims are not duplicated. A pharmacy shall not dispense a practitioner-administered injectable drug described in this paragraph directly to an enrollee.

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

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

~~(h)~~ (i) The commissioner shall contract with a vendor to conduct a cost of dispensing survey for all pharmacies that are physically located in the state of Minnesota that dispense outpatient drugs under medical assistance. The commissioner shall ensure that the vendor has prior experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the department to dispense outpatient prescription drugs to fee-for-service members must respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The commissioner shall require the vendor to measure a single statewide cost of dispensing for specialty prescription drugs and a single statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies to measure the mean, mean weighted by total prescription volume, mean weighted by medical assistance prescription volume, median, median weighted by total prescription volume, and median weighted by total medical assistance prescription volume. The commissioner shall post a copy of the final cost of dispensing survey report on the

department's website. The initial survey must be completed no later than January 1, 2021, and repeated every three years. The commissioner shall provide a summary of the results of each cost of dispensing survey and provide recommendations for any changes to the dispensing fee to the chairs and ranking members of the legislative committees with jurisdiction over medical assistance pharmacy reimbursement.

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

Page 18, line 5, delete "Funds" and insert "Distribution of appropriated amounts"

Page 21, after line 28, insert:

"Sec. 17. **MENTAL HEALTH GRANTS FOR HEALTH CARE PROFESSIONALS.**

Subdivision 1. **Grants authorized.** (a) The commissioner of health shall develop a grant program to award grants to health care entities, including but not limited to health care systems, hospitals, nursing facilities, community health clinics or consortium of clinics, federally qualified health centers, rural health clinics, or health professional associations for the purpose of establishing or expanding programs focused on improving the mental health of health care professionals.

(b) Grants shall be awarded for programs that are evidenced-based or evidenced-informed and are focused on addressing the mental health of health care professionals by:

(1) identifying and addressing the barriers to and stigma among health care professionals associated with seeking self-care, including mental health and substance use disorder services;

(2) encouraging health care professionals to seek support and care for mental health and substance use disorder concerns;

(3) identifying risk factors associated with suicide and other mental health conditions; or

(4) developing and making available resources to support health care professionals with self-care and resiliency.

Subd. 2. **Allocation of grants.** (a) To receive a grant, a health care entity must submit an application to the commissioner by the deadline established by the commissioner. An application must be on a form and contain information as specified by the commissioner and at a minimum must contain:

(1) a description of the purpose of the program for which the grant funds will be used;

(2) a description of the achievable objectives of the program and how these objectives will be met; and

(3) a process for documenting and evaluating the results of the program.

(b) The commissioner shall give priority to programs that involve peer-to-peer support.

Subd. 3. **Evaluation.** The commissioner shall evaluate the overall effectiveness of the grant program by conducting a periodic evaluation of the impact and outcomes of the grant program on health care professional burnout and retention. The commissioner shall submit the results of the evaluation and any recommendations for improving the grant program to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by October 15, 2024."

Page 22, after line 23, insert:

"Sec. 20. **APPROPRIATION; REDUCTION.**

(a) $2,343,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of health for the health care professionals mental health grant program. This is a one time appropriation.

(b) The general fund appropriation to the commissioner of health for the office of medical cannabis, estimated to be $781,000, is eliminated."

Page 22, line 27, delete everything after the first period

Page 23, line 1, delete "EXPAND"

Page 23, line 2, delete "for additional funding"

Page 23, line 8, delete "in section 12"

Page 23, line 29, delete "$1,500,000" and insert "(a) $2,914,000"

Page 24, line 2, delete "This is a onetime appropriation." and insert "The base for this appropriation is $180,000 in fiscal year 2024 and $0 in fiscal year 2025."

Page 24, after line 2, insert:

"(b) Of this appropriation, $115,000 in fiscal year 2023 is for administration and $3,000 in fiscal year 2023 is for systems costs.

(c) The base for administration is $179,000 in fiscal year 2024 and is available until June 30, 2025. The base for systems costs is $1,000 in fiscal year 2024 and $0 in fiscal year 2025."

Page 24, line 3, delete "INITIATIVES FUNDING" and insert "INITIATIVE GRANTS"

Page 24, line 5, before the period, insert "and thereafter, and is increased by an additional $10,232,000 in fiscal year 2026 and thereafter"

Page 24, line 13, delete "the"

Page 24, line 17, delete "to award" and insert "for"

Page 24, line 22, delete "rates" and insert "expenditures"

Page 24, line 27, delete "$500,000" and insert "$92,000"

Page 25, line 1, delete "FEE-FOR-SERVICE" and insert "MANAGED CARE DIRECTED PAYMENT RATE FOR" and delete "RATES" and insert "SERVICES"

Page 25, line 2, delete "$19,000" and insert "$28,000"

Page 25, line 5, delete "$22,000" and insert "$32,000" and delete "$22,000" and insert "$32,000"

Renumber the sections in sequence

Amend the title accordingly

And when so amended the bill do pass. Amendments adopted. Report adopted.

Julie Rosen
.....
(Committee Chair)

April 26, 2022.....
(Date of Committee recommendation)