

**SENATE**  
**STATE OF MINNESOTA**  
**NINETY-FIRST SESSION**

**S.F. No. 751**

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DATE	D-PG	OFFICIAL STATUS
01/31/2019	226	Introduction and first reading Referred to Health and Human Services Finance and Policy
02/14/2019	360a	Comm report: To pass as amended and re-refer to State Government Finance and Policy and Elections
02/18/2019		Comm report: To pass as amended and re-refer to Judiciary and Public Safety Finance and Policy

1.1 A bill for an act

1.2 relating to health; establishing an opiate epidemic response; establishing an Opiate

1.3 Epidemic Response Advisory Council; establishing an opiate epidemic response

1.4 account; increasing the annual license fee for drug manufacturers and wholesale

1.5 drug distributors; establishing an opiate product registration fee for certain opiate

1.6 manufacturers; requiring a prescriber to access the prescription monitoring program

1.7 before prescribing a controlled substance; limiting the quantity of opiates and

1.8 narcotics that can be prescribed for acute pain at any one time; requiring a report;

1.9 appropriating money; amending Minnesota Statutes 2018, sections 151.01,

1.10 subdivision 27; 151.065, subdivisions 1, 3, by adding a subdivision; 151.252,

1.11 subdivision 1; 152.105, subdivision 2; 152.11, subdivisions 1, 2, 2d, 4; 152.126,

1.12 subdivisions 6, 10; 214.12, by adding a subdivision; Laws 2017, First Special

1.13 Session chapter 6, article 10, section 144; proposing coding for new law in

1.14 Minnesota Statutes, chapters 151; 256.

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

1.16 style="text-align:center">**ARTICLE 1**

1.17 style="text-align:center">**OPIATE EPIDEMIC RESPONSE**

1.18 Section 1. Minnesota Statutes 2018, section 151.065, subdivision 1, is amended to read:

1.19 Subdivision 1. **Application fees.** Application fees for licensure and registration are as

1.20 follows:

1.21 (1) pharmacist licensed by examination, \$145;

1.22 (2) pharmacist licensed by reciprocity, \$240;

1.23 (3) pharmacy intern, \$37.50;

1.24 (4) pharmacy technician, \$37.50;

1.25 (5) pharmacy, \$225;

- 2.1 (6) drug wholesaler, legend drugs only, ~~\$235~~ \$5,000;
- 2.2 (7) drug wholesaler, legend and nonlegend drugs, ~~\$235~~ \$5,000;
- 2.3 (8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~\$210~~ \$5,000;
- 2.4 (9) drug wholesaler, medical gases, ~~\$175~~ \$5,000;
- 2.5 (10) drug wholesaler, also licensed as a pharmacy in Minnesota, ~~\$150~~ \$5,000;
- 2.6 (11) drug manufacturer, nonopiate legend drugs only, ~~\$235~~ \$5,000;
- 2.7 (12) drug manufacturer, nonopiate legend and nonlegend drugs, ~~\$235~~ \$5,000;
- 2.8 (13) drug manufacturer, nonlegend or veterinary legend drugs, ~~\$210~~ \$5,000;
- 2.9 (14) drug manufacturer, medical gases, ~~\$185~~ \$5,000;
- 2.10 (15) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~\$150~~ \$5,000;
- 2.11 (16) drug manufacturer of opiate-containing controlled substances listed in section
- 2.12 152.02, subdivisions 3 to 5, \$55,000;
- 2.13 ~~(16)~~ (17) medical gas distributor, ~~\$110~~ \$5,000;
- 2.14 ~~(17)~~ (18) controlled substance researcher, \$75; and
- 2.15 ~~(18)~~ (19) pharmacy professional corporation, \$125.

2.16 **EFFECTIVE DATE.** This section is effective July 1, 2019, and applies to any license

2.17 issued on or after that date.

2.18 Sec. 2. Minnesota Statutes 2018, section 151.065, subdivision 3, is amended to read:

2.19 Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as

2.20 follows:

- 2.21 (1) pharmacist, \$145;
- 2.22 (2) pharmacy technician, \$37.50;
- 2.23 (3) pharmacy, \$225;
- 2.24 (4) drug wholesaler, legend drugs only, ~~\$235~~ \$5,000;
- 2.25 (5) drug wholesaler, legend and nonlegend drugs, ~~\$235~~ \$5,000;
- 2.26 (6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~\$210~~ \$5,000;
- 2.27 (7) drug wholesaler, medical gases, ~~\$185~~ \$5,000;
- 2.28 (8) drug wholesaler, also licensed as a pharmacy in Minnesota, ~~\$150~~ \$5,000;

- 3.1 (9) drug manufacturer, nonopiate legend drugs only, \$235 \$5,000;
- 3.2 (10) drug manufacturer, nonopiate legend and nonlegend drugs, \$235 \$5,000;
- 3.3 (11) drug manufacturer, nonlegend, veterinary legend drugs, or both, \$210 \$5,000;
- 3.4 (12) drug manufacturer, medical gases, \$185 \$5,000;
- 3.5 (13) drug manufacturer, also licensed as a pharmacy in Minnesota, \$150 \$5,000;
- 3.6 (14) drug manufacturer of opiate-containing controlled substances listed in section
- 3.7 152.02, subdivisions 3 to 5, \$55,000;
- 3.8 ~~(14)~~ (15) medical gas distributor, \$110 \$5,000;
- 3.9 ~~(15)~~ (16) controlled substance researcher, \$75; and
- 3.10 ~~(16)~~ (17) pharmacy professional corporation, \$75.

3.11 **EFFECTIVE DATE.** This section is effective July 1, 2019, and applies to any license

3.12 renewed on or after that date.

3.13 Sec. 3. Minnesota Statutes 2018, section 151.065, is amended by adding a subdivision to

3.14 read:

3.15 **Subd. 7. Deposit of fees.** (a) The license fees collected under this section, with the

3.16 exception of the fees identified in paragraph (b), shall be deposited in the state government

3.17 special revenue fund.

3.18 (b) \$5,000 of each fee collected under subdivision 1, clauses (6) to (15) and (17), and

3.19 subdivision 3, clauses (4) to (13) and (15), and the fees collected under subdivision 1, clause

3.20 (16), and subdivision 3, clause (14), shall be deposited in the opiate epidemic response

3.21 account.

3.22 Sec. 4. **[151.066] OPIATE PRODUCT REGISTRATION FEE.**

3.23 **Subdivision 1. Definition.** (a) For purposes of this section, the following terms have the

3.24 meanings given to them in this subdivision.

3.25 (b) "Manufacturer" means a manufacturer licensed under section 151.252 that is engaged

3.26 in the manufacturing of an opiate.

3.27 (c) "Opiate" means any opiate-containing controlled substance listed in section 152.02,

3.28 subdivisions 3 to 5, that is distributed, delivered, sold, or dispensed into or within this state.

4.1 (d) "Wholesaler" means a wholesale drug distributor licensed under section 151.47 that  
4.2 is engaged in the wholesale drug distribution of an opiate.

4.3 Subd. 2. **Reporting requirements.** (a) By March 1 of each year, beginning March 1,  
4.4 2020, each manufacturer and each wholesaler must report to the board every sale, delivery,  
4.5 or other distribution within or into this state of any opiate that is made to any practitioner,  
4.6 pharmacy, hospital, veterinary hospital, or other person who is permitted by section 151.37  
4.7 to possess controlled substances for administration or dispensing to patients that occurred  
4.8 during the previous calendar year. Reporting must be in the automation of reports and  
4.9 consolidated orders system format unless otherwise specified by the board. If a manufacturer  
4.10 or wholesaler fails to provide information required under this paragraph on a timely basis,  
4.11 the board may assess an administrative penalty of \$100 per day. This penalty shall not be  
4.12 considered a form of disciplinary action.

4.13 (b) By March 1 of each year, beginning March 1, 2020, each owner of a pharmacy with  
4.14 at least one location within this state must report to the board any intracompany delivery  
4.15 or distribution into this state, of any opiate, to the extent that those deliveries and distributions  
4.16 are not reported to the board by a licensed wholesaler owned by, under contract to, or  
4.17 otherwise operating on behalf of the owner of the pharmacy. Reporting must be in the  
4.18 manner and format specified by the board for deliveries and distributions that occurred  
4.19 during the previous calendar year.

4.20 Subd. 3. **Determination of an opiate product registration fee.** (a) The board shall  
4.21 annually assess an opiate product registration fee on any manufacturer of an opiate that  
4.22 annually sells, delivers, or distributes an opiate within or into the state 2,000,000 or more  
4.23 units as reported to the board under subdivision 2.

4.24 (b) The annual registration fee for each manufacturer meeting the requirement under  
4.25 paragraph (a) is \$250,000.

4.26 (c) In conjunction with the data reported under this section, and notwithstanding section  
4.27 152.126, subdivision 6, the board may use the data reported under section 152.126,  
4.28 subdivision 4, to determine which manufacturers meet the requirement under paragraph (a)  
4.29 and are required to pay the registration fees under this subdivision.

4.30 (d) By April 1 of each year, beginning April 1, 2020, the board shall notify a manufacturer  
4.31 that the manufacturer meets the requirement in paragraph (a) and is required to pay the  
4.32 annual registration fee in accordance with section 151.252, subdivision 1, paragraph (b).

4.33 (e) A manufacturer may dispute the board's determination that the manufacturer must  
4.34 pay the registration fee no later than 30 days after the date of notification. However, the

5.1 manufacturer must still remit the fee as required by section 151.252, subdivision 1, paragraph  
5.2 (b). The dispute must be filed with the board in the manner and using the forms specified  
5.3 by the board. A manufacturer must submit, with the required forms, data satisfactory to the  
5.4 board that demonstrates that the assessment of the registration fee was incorrect. The board  
5.5 must make a decision concerning a dispute no later than 60 days after receiving the required  
5.6 dispute forms. If the board determines that the manufacturer has satisfactorily demonstrated  
5.7 that the fee was incorrectly assessed, the board must refund the amount paid in error.

5.8 Subd. 4. **Report.** (a) The Board of Pharmacy shall evaluate the registration fee on drug  
5.9 manufacturers established under this section, and whether the registration fee and the  
5.10 increased licensure fees have impacted the prescribing practices of opiates by reducing the  
5.11 number of opiate prescriptions issued during calendar years 2020, 2021, and 2022, to the  
5.12 extent the board has the ability to effectively identify a correlation. Notwithstanding section  
5.13 152.126, subdivision 6, the board may access the data reported under section 152.126,  
5.14 subdivision 4, to conduct this evaluation.

5.15 (b) The board shall submit the results of its evaluation to the chairs and ranking minority  
5.16 members of the legislative committees with jurisdiction over health and human services  
5.17 policy and finance by March 1, 2023.

5.18 Subd. 5. **Legislative review.** The legislature shall review the reports from the Opiate  
5.19 Epidemic Response Advisory Council under section 256.042, subdivision 5, paragraph (a),  
5.20 the reports from the commissioner of management and budget on the Results First evaluation  
5.21 activities under section 256.042, subdivision 5, paragraph (b), the report from the Board of  
5.22 Pharmacy under subdivision 4, and any other relevant report or information related to the  
5.23 opioid crisis in Minnesota, to make a determination about whether the opiate product  
5.24 registration fee assessed under this section should continue beyond July 1, 2023.

5.25 Sec. 5. Minnesota Statutes 2018, section 151.252, subdivision 1, is amended to read:

5.26 Subdivision 1. **Requirements.** (a) No person shall act as a drug manufacturer without  
5.27 first obtaining a license from the board and paying any applicable fee specified in section  
5.28 151.065.

5.29 (b) In addition to the license required under paragraph (a), each manufacturer required  
5.30 to pay the registration fee under section 151.066 must pay the fee by June 1 of each year,  
5.31 beginning June 1, 2020. In the event of a change of ownership of the manufacturer, the new  
5.32 owner must pay the registration fee specified under section 151.066, subdivision 3, that the  
5.33 original owner would have been assessed had the original owner retained ownership. The

6.1 registration fee collected under this paragraph shall be deposited in the opiate epidemic  
 6.2 response account established under section 256.043.

6.3 ~~(b)~~ (c) Application for a drug manufacturer license under this section shall be made in  
 6.4 a manner specified by the board.

6.5 ~~(e)~~ (d) No license shall be issued or renewed for a drug manufacturer unless the applicant  
 6.6 agrees to operate in a manner prescribed by federal and state law and according to Minnesota  
 6.7 Rules.

6.8 ~~(d)~~ (e) No license shall be issued or renewed for a drug manufacturer that is required to  
 6.9 be registered pursuant to United States Code, title 21, section 360, unless the applicant  
 6.10 supplies the board with proof of registration. The board may establish by rule the standards  
 6.11 for licensure of drug manufacturers that are not required to be registered under United States  
 6.12 Code, title 21, section 360.

6.13 ~~(e)~~ (f) No license shall be issued or renewed for a drug manufacturer that is required to  
 6.14 be licensed or registered by the state in which it is physically located unless the applicant  
 6.15 supplies the board with proof of licensure or registration. The board may establish, by rule,  
 6.16 standards for the licensure of a drug manufacturer that is not required to be licensed or  
 6.17 registered by the state in which it is physically located.

6.18 ~~(f)~~ (g) The board shall require a separate license for each facility located within the state  
 6.19 at which drug manufacturing occurs and for each facility located outside of the state at  
 6.20 which drugs that are shipped into the state are manufactured.

6.21 ~~(g)~~ (h) The board shall not issue an initial or renewed license for a drug manufacturing  
 6.22 facility unless the facility passes an inspection conducted by an authorized representative  
 6.23 of the board. In the case of a drug manufacturing facility located outside of the state, the  
 6.24 board may require the applicant to pay the cost of the inspection, in addition to the license  
 6.25 fee in section 151.065, unless the applicant furnishes the board with a report, issued by the  
 6.26 appropriate regulatory agency of the state in which the facility is located or by the United  
 6.27 States Food and Drug Administration, of an inspection that has occurred within the 24  
 6.28 months immediately preceding receipt of the license application by the board. The board  
 6.29 may deny licensure unless the applicant submits documentation satisfactory to the board  
 6.30 that any deficiencies noted in an inspection report have been corrected.

6.31 Sec. 6. **[256.042] OPIATE EPIDEMIC RESPONSE ADVISORY COUNCIL.**

6.32 Subdivision 1. Establishment of the advisory council. (a) The Opiate Epidemic  
 6.33 Response Advisory Council is established to develop and implement a comprehensive and

- 7.1 effective statewide effort to address the opioid addiction and overdose epidemic in Minnesota.
- 7.2 The council shall focus on:
- 7.3 (1) prevention and education, including public education and awareness for adults and
- 7.4 youth, prescriber education, the development and sustainability of opioid overdose prevention
- 7.5 and education programs, and providing financial support to local law enforcement agencies
- 7.6 for opiate antagonist programs;
- 7.7 (2) treatment, including statewide access to effective treatment and recovery services
- 7.8 that is aligned with Minnesota's model of care approach to promoting access to treatment
- 7.9 and recovery services. This includes ensuring that individuals throughout the state have
- 7.10 access to treatment and recovery services, including care coordination services; peer recovery
- 7.11 services; medication-assisted treatment and office-based opioid treatment; integrative and
- 7.12 multidisciplinary therapies; and culturally specific services; and
- 7.13 (3) innovation and capacity building, including development of evidence-based practices,
- 7.14 using research and evaluation to understand which policies and programs promote efficient
- 7.15 and effective prevention, treatment, and recovery results. This also includes ensuring that
- 7.16 there are qualified providers and a comprehensive set of treatment and recovery services
- 7.17 throughout the state.
- 7.18 (b) The council shall:
- 7.19 (1) review local, state, and federal initiatives and funding related to prevention and
- 7.20 education, treatment, and services for individuals and families experiencing and affected
- 7.21 by opioid abuse, and promoting innovation and capacity building to address the opioid
- 7.22 addiction and overdose epidemic;
- 7.23 (2) establish priorities to address the state's opioid addiction and overdose epidemic for
- 7.24 the purpose of allocating funds and consult with the commissioner of management and
- 7.25 budget to determine whether proposals are for evidence-based practices, promising practices,
- 7.26 or theory-based practices;
- 7.27 (3) ensure that available funding under this section is allocated to align with existing
- 7.28 state and federal funding to achieve the greatest impact and ensure a coordinated state effort
- 7.29 to address the opioid addiction and overdose epidemic;
- 7.30 (4) develop criteria and procedures to be used in awarding grants and allocating available
- 7.31 funds from the opiate epidemic response account and select proposals to receive grant
- 7.32 funding. The council is encouraged to select proposals that are promising practices or

8.1 theory-based practices, in addition to evidence-based practices, to help identify new  
8.2 approaches to effective prevention, treatment, and recovery; and

8.3 (5) in consultation with the commissioner of management and budget, and within  
8.4 available appropriations, select from the awarded grants projects that include promising  
8.5 practices or theory-based activities for which the commissioner of management and budget  
8.6 shall conduct evaluations using experimental or quasi-experimental design. Grants awarded  
8.7 to proposals that include promising practices or theory-based activities and that are selected  
8.8 for an evaluation shall be administered to support the experimental or quasi-experimental  
8.9 evaluation and require grantees to collect and report information that is needed to complete  
8.10 the evaluation. The commissioner of management and budget, under section 15.08, may  
8.11 obtain additional relevant data to support the experimental or quasi-experimental evaluation  
8.12 studies.

8.13 Subd. 2. **Membership.** (a) The council shall consist of 18 members appointed by the  
8.14 commissioner of human services, except as otherwise specified:

8.15 (1) two members of the house of representatives, one from the majority party appointed  
8.16 by the speaker of the house and one from the minority party appointed by the minority  
8.17 leader;

8.18 (2) two members of the senate, one from the majority party appointed by the senate  
8.19 majority leader and one from the minority party appointed by the senate minority leader;

8.20 (3) one member appointed by the Board of Pharmacy;

8.21 (4) one member who is a physician appointed by the Minnesota chapter of the American  
8.22 College of Emergency Physicians;

8.23 (5) one member representing opioid treatment programs or sober living programs;

8.24 (6) one member who is a physician appointed by the Minnesota Hospital Association;

8.25 (7) one member who is a physician appointed by the Minnesota Society of Addiction  
8.26 Medicine;

8.27 (8) one member who is a pain psychologist;

8.28 (9) one member appointed by the Steve Rummeler Hope Network;

8.29 (10) one member appointed by the Minnesota Ambulance Association;

8.30 (11) one member representing the Minnesota courts who is a judge or law enforcement  
8.31 officer;



9.1 (12) one public member who is a Minnesota resident and who has been impacted by the  
9.2 opioid epidemic;

9.3 (13) one member representing a manufacturer of opiates;

9.4 (14) one member representing an Indian tribe;

9.5 (15) the commissioner of human services or designee; and

9.6 (16) the commissioner of health or designee.

9.7 (b) The commissioner of human services shall coordinate appointments to provide  
9.8 geographic diversity and shall ensure that at least one-half of council members reside outside  
9.9 of the seven-county metropolitan area.

9.10 (c) The council is governed by section 15.059, except that members of the council shall  
9.11 receive no compensation other than reimbursement for expenses. Notwithstanding section  
9.12 15.059, subdivision 6, the council shall not expire.

9.13 (d) The chair shall convene the council at least quarterly, and may convene other meetings  
9.14 as necessary. The chair shall convene meetings at different locations in the state to provide  
9.15 geographic access, and shall ensure that at least one-half of the meetings are held at locations  
9.16 outside of the seven-county metropolitan area.

9.17 (e) The commissioner of human services shall provide staff and administrative services  
9.18 for the advisory council.

9.19 (f) The council is subject to chapter 13D.

9.20 Subd. 3. **Conflict of interest.** Advisory council members must disclose to the council  
9.21 and recuse themselves from voting on any matter before the council if the member has a  
9.22 conflict of interest. A conflict of interest means a financial association that has the potential  
9.23 to bias or have the appearance of biasing a council member's decision related to the opiate  
9.24 epidemic response grant decision process or other council activities under this section.

9.25 Subd. 4. **Grants.** (a) The commissioner of human services shall submit a report of the  
9.26 grants proposed by the advisory council to be awarded for the upcoming fiscal year to the  
9.27 chairs and ranking minority members of the legislative committees with jurisdiction over  
9.28 health and human services policy and finance, by March 1 of each year, beginning March  
9.29 1, 2020.

9.30 (b) The commissioner of human services shall award grants from the opiate epidemic  
9.31 response account under section 256.043. The grants shall be awarded to proposals selected  
9.32 by the advisory council that address the priorities in subdivision 1, paragraph (a), clauses

10.1 (1) to (3), unless otherwise appropriated by the legislature. No more than three percent of  
10.2 the grant amount may be used by a grantee for administration.

10.3 Subd. 5. **Reports.** (a) The advisory council shall report annually to the chairs and ranking  
10.4 minority members of the legislative committees with jurisdiction over health and human  
10.5 services policy and finance by January 1 of each year beginning January 1, 2022, information  
10.6 about the individual projects that receive grants and the overall role of the project in  
10.7 addressing the opioid addiction and overdose epidemic in Minnesota. The report must  
10.8 describe the grantees and the activities implemented, along with measurable outcomes as  
10.9 determined by the council in consultation with the commissioner of human services and the  
10.10 commissioner of management and budget. At a minimum, the report must include information  
10.11 about the number of individuals who received information or treatment, the outcomes the  
10.12 individuals achieved, and demographic information about the individuals participating in  
10.13 the project; an assessment of the progress toward achieving statewide access to qualified  
10.14 providers and comprehensive treatment and recovery services; and an update on the  
10.15 evaluation implemented by the commissioner of management and budget for the promising  
10.16 practices and theory-based projects that receive funding.

10.17 (b) The commissioner of management and budget, in consultation with the Opiate  
10.18 Epidemic Response Advisory Council, shall report to the chairs and ranking minority  
10.19 members of the legislative committees with jurisdiction over health and human services  
10.20 policy and finance when an evaluation study described in subdivision 1, paragraph (b),  
10.21 clause (5), is complete on the promising practices or theory-based projects that are selected  
10.22 for evaluation activities. The report shall include demographic information; outcome  
10.23 information for the individuals in the program; the results for the program in promoting  
10.24 recovery, employment, family reunification, and reducing involvement with the criminal  
10.25 justice system; and other relevant outcomes determined by the commissioner of management  
10.26 and budget that are specific to the projects that are evaluated. The report shall include  
10.27 information about the ability of grant programs to be scaled to achieve the statewide results  
10.28 that the grant project demonstrated.

10.29 Sec. 7. **[256.043] OPIATE EPIDEMIC RESPONSE ACCOUNT.**

10.30 Subdivision 1. **Establishment.** The opiate epidemic response account is established in  
10.31 the special revenue fund in the state treasury. The registration fees assessed by the Board  
10.32 of Pharmacy under section 151.066 and the license fees identified in section 151.065,  
10.33 subdivision 7, paragraph (b), shall be deposited into the account.

11.1 Subd. 2. Use of account funds. (a) Beginning in fiscal year 2020, money in the account  
11.2 shall be appropriated each fiscal year as specified in this subdivision.

11.3 (b) \$300,000 is appropriated to the commissioner of management and budget for  
11.4 evaluation activities under section 256.042.

11.5 (c) \$249,000 is appropriated to the commissioner of human services for the provision  
11.6 of administrative services to the Opiate Epidemic Response Advisory Council and for the  
11.7 administration of the grants awarded under paragraph (f).

11.8 (d) \$33,000 is appropriated to the Board of Pharmacy for the collection of the registration  
11.9 fees under section 151.066.

11.10 (e) \$384,000 is appropriated to the commissioner of public safety for Bureau of Criminal  
11.11 Apprehension drug scientists and lab supplies.

11.12 (f) \$600,000 is appropriated to the commissioner of health for grants of \$300,000 each  
11.13 year to CHI St. Gabriel's Health Family Medical Center for Project Echo and \$300,000 each  
11.14 year to Hennepin Healthcare for Project Echo.

11.15 (g) Money remaining in the opiate epidemic response account after making the  
11.16 appropriations required in paragraphs (b) to (f) is appropriated to the commissioner of human  
11.17 services. The commissioner shall distribute the appropriations as follows:

11.18 (1) at least 50 percent shall be distributed to county social service agencies to provide  
11.19 child protection services to children and families who are affected by addiction. The  
11.20 commissioner shall distribute this money proportionally to counties based on the number  
11.21 of open child protection case management cases in the county using data from the previous  
11.22 calendar year; and

11.23 (2) the remaining money shall be awarded as specified by the Opiate Epidemic Response  
11.24 Advisory Council as grants in accordance with section 256.042, unless otherwise appropriated  
11.25 by the legislature.

11.26 Sec. 8. Laws 2017, First Special Session chapter 6, article 10, section 144, is amended to  
11.27 read:

11.28 Sec. 144. **OPIOID ABUSE PREVENTION PILOT PROJECTS.**

11.29 (a) The commissioner of health shall establish opioid abuse prevention pilot projects in  
11.30 geographic areas throughout the state based on the most recently available data on opioid  
11.31 overdose and abuse rates, to reduce opioid abuse through the use of controlled substance

12.1 care teams and community-wide coordination of abuse-prevention initiatives. The  
12.2 commissioner shall award grants to health care providers, health plan companies, local units  
12.3 of government, tribal governments, or other entities to establish pilot projects.

12.4 (b) Each pilot project must:

12.5 (1) be designed to reduce emergency room and other health care provider visits resulting  
12.6 from opioid use or abuse, and reduce rates of opioid addiction in the community;

12.7 (2) establish multidisciplinary controlled substance care teams, that may consist of  
12.8 physicians, pharmacists, social workers, nurse care coordinators, and mental health  
12.9 professionals;

12.10 (3) deliver health care services and care coordination, through controlled substance care  
12.11 teams, to reduce the inappropriate use of opioids by patients and rates of opioid addiction;

12.12 (4) address any unmet social service needs that create barriers to managing pain  
12.13 effectively and obtaining optimal health outcomes;

12.14 (5) provide prescriber and dispenser education and assistance to reduce the inappropriate  
12.15 prescribing and dispensing of opioids;

12.16 (6) promote the adoption of best practices related to opioid disposal and reducing  
12.17 opportunities for illegal access to opioids; and

12.18 (7) engage partners outside of the health care system, including schools, law enforcement,  
12.19 and social services, to address root causes of opioid abuse and addiction at the community  
12.20 level.

12.21 (c) The commissioner shall contract with an accountable community for health that  
12.22 operates an opioid abuse prevention project, and can document success in reducing opioid  
12.23 use through the use of controlled substance care teams, to assist the commissioner in  
12.24 administering this section, and to provide technical assistance to the commissioner and to  
12.25 entities selected to operate a pilot project.

12.26 (d) The contract under paragraph (c) shall require the accountable community for health  
12.27 to evaluate the extent to which the pilot projects were successful in reducing the inappropriate  
12.28 use of opioids. The evaluation must analyze changes in the number of opioid prescriptions,  
12.29 the number of emergency room visits related to opioid use, and other relevant measures.  
12.30 The accountable community for health shall report evaluation results to the chairs and  
12.31 ranking minority members of the legislative committees with jurisdiction over health and  
12.32 human services policy and finance and public safety by December 15, 2019, for projects

13.1 that received funding in fiscal year 2018, and by December 15, 2022, for projects that  
 13.2 received funding in fiscal year 2020.

13.3 (e) The commissioner may award one grant that, in addition to the other requirements  
 13.4 of this section, allows a root cause approach to reduce opioid abuse in an American Indian  
 13.5 community.

13.6 **Sec. 9. OPIATE EPIDEMIC RESPONSE ADVISORY COUNCIL FIRST MEETING.**

13.7 The commissioner of human services shall convene the first meeting of the Opiate  
 13.8 Epidemic Response Advisory Council established under Minnesota Statutes, section 256.042,  
 13.9 no later than October 1, 2019. The members shall elect a chair at the first meeting.

13.10 **ARTICLE 2**

13.11 **OTHER OPIATE PROVISIONS**

13.12 Section 1. Minnesota Statutes 2018, section 151.01, subdivision 27, is amended to read:

13.13 Subd. 27. **Practice of pharmacy.** "Practice of pharmacy" means:

13.14 (1) interpretation and evaluation of prescription drug orders;

13.15 (2) compounding, labeling, and dispensing drugs and devices (except labeling by a  
 13.16 manufacturer or packager of nonprescription drugs or commercially packaged legend drugs  
 13.17 and devices);

13.18 (3) participation in clinical interpretations and monitoring of drug therapy for assurance  
 13.19 of safe and effective use of drugs, including the performance of laboratory tests that are  
 13.20 waived under the federal Clinical Laboratory Improvement Act of 1988, United States Code,  
 13.21 title 42, section 263a et seq., provided that a pharmacist may interpret the results of laboratory  
 13.22 tests but may modify drug therapy only pursuant to a protocol or collaborative practice  
 13.23 agreement;

13.24 (4) participation in drug and therapeutic device selection; drug administration for first  
 13.25 dosage and medical emergencies; intramuscular and subcutaneous administration of drugs  
 13.26 used for the treatment of alcohol or opioid dependence and treatment of mental health  
 13.27 conditions; drug regimen reviews; and drug or drug-related research;

13.28 (5) participation in administration of influenza vaccines to all eligible individuals six  
 13.29 years of age and older and all other vaccines to patients 13 years of age and older by written  
 13.30 protocol with a physician licensed under chapter 147, a physician assistant authorized to

- 14.1 prescribe drugs under chapter 147A, or an advanced practice registered nurse authorized to  
14.2 prescribe drugs under section 148.235, provided that:
- 14.3 (i) the protocol includes, at a minimum:
- 14.4 (A) the name, dose, and route of each vaccine that may be given;
- 14.5 (B) the patient population for whom the vaccine may be given;
- 14.6 (C) contraindications and precautions to the vaccine;
- 14.7 (D) the procedure for handling an adverse reaction;
- 14.8 (E) the name, signature, and address of the physician, physician assistant, or advanced  
14.9 practice registered nurse;
- 14.10 (F) a telephone number at which the physician, physician assistant, or advanced practice  
14.11 registered nurse can be contacted; and
- 14.12 (G) the date and time period for which the protocol is valid;
- 14.13 (ii) the pharmacist has successfully completed a program approved by the Accreditation  
14.14 Council for Pharmacy Education specifically for the administration of immunizations or a  
14.15 program approved by the board;
- 14.16 (iii) the pharmacist utilizes the Minnesota Immunization Information Connection to  
14.17 assess the immunization status of individuals prior to the administration of vaccines, except  
14.18 when administering influenza vaccines to individuals age nine and older;
- 14.19 (iv) the pharmacist reports the administration of the immunization to the Minnesota  
14.20 Immunization Information Connection; and
- 14.21 (v) the pharmacist complies with guidelines for vaccines and immunizations established  
14.22 by the federal Advisory Committee on Immunization Practices, except that a pharmacist  
14.23 does not need to comply with those portions of the guidelines that establish immunization  
14.24 schedules when administering a vaccine pursuant to a valid, patient-specific order issued  
14.25 by a physician licensed under chapter 147, a physician assistant authorized to prescribe  
14.26 drugs under chapter 147A, or an advanced practice nurse authorized to prescribe drugs  
14.27 under section 148.235, provided that the order is consistent with the United States Food  
14.28 and Drug Administration approved labeling of the vaccine;
- 14.29 (6) participation in the initiation, management, modification, and discontinuation of  
14.30 drug therapy according to a written protocol or collaborative practice agreement between:
- 14.31 (i) one or more pharmacists and one or more dentists, optometrists, physicians, podiatrists,  
14.32 or veterinarians; or (ii) one or more pharmacists and one or more physician assistants

15.1 authorized to prescribe, dispense, and administer under chapter 147A, or advanced practice  
 15.2 nurses authorized to prescribe, dispense, and administer under section 148.235. Any changes  
 15.3 in drug therapy made pursuant to a protocol or collaborative practice agreement must be  
 15.4 documented by the pharmacist in the patient's medical record or reported by the pharmacist  
 15.5 to a practitioner responsible for the patient's care;

15.6 (7) participation in the storage of drugs and the maintenance of records;

15.7 (8) patient counseling on therapeutic values, content, hazards, and uses of drugs and  
 15.8 devices;

15.9 (9) offering or performing those acts, services, operations, or transactions necessary in  
 15.10 the conduct, operation, management, and control of a pharmacy; and

15.11 (10) participation in the initiation, management, modification, and discontinuation of  
 15.12 therapy with opiate antagonists, as defined in section 604A.04, subdivision 1, pursuant to:

15.13 (i) a written protocol as allowed under clause (6); or

15.14 (ii) a written protocol with a community health board medical consultant or a practitioner  
 15.15 designated by the commissioner of health, as allowed under section 151.37, subdivision 13.

15.16 Sec. 2. Minnesota Statutes 2018, section 152.105, subdivision 2, is amended to read:

15.17 Subd. 2. **Sheriff to maintain collection receptacle or medicine disposal program.** (a)

15.18 The sheriff of each county shall maintain or contract for the maintenance of at least one  
 15.19 collection receptacle or implement a medicine disposal program for the disposal of  
 15.20 noncontrolled substances, pharmaceutical controlled substances, and other legend drugs,  
 15.21 as permitted by federal law. For purposes of this section, "legend drug" has the meaning  
 15.22 given in section 151.01, subdivision 17. The collection receptacle and medicine disposal  
 15.23 program must comply with federal law. In maintaining and operating the collection receptacle  
 15.24 or medicine disposal program, the sheriff shall follow all applicable provisions of Code of  
 15.25 Federal Regulations, title 21, parts 1300, 1301, 1304, 1305, 1307, and 1317, as amended  
 15.26 through May 1, 2017.

15.27 (b) For purposes of this subdivision:

15.28 (1) a medicine disposal program means providing to the public educational information,  
 15.29 and making materials available for safely destroying unwanted legend drugs, including but  
 15.30 not limited to drug destruction bags or drops; and

15.31 (2) a collection receptacle means the operation and maintenance of at least one drop-off  
 15.32 receptacle.

16.1 Sec. 3. Minnesota Statutes 2018, section 152.11, subdivision 1, is amended to read:

16.2 Subdivision 1. **General prescription requirements for controlled substances.** (a) A  
16.3 written prescription or an oral prescription reduced to writing, when issued for a controlled  
16.4 substance in Schedule II, III, IV, or V, is void unless (1) it is written in ink and contains the  
16.5 name and address of the person for whose use it is intended; (2) it states the amount of the  
16.6 controlled substance to be compounded or dispensed, with directions for its use; (3) if a  
16.7 written prescription, it contains the handwritten signature, address, and federal registry  
16.8 number of the prescriber and a designation of the branch of the healing art pursued by the  
16.9 prescriber; and if an oral prescription, the name and address of the prescriber and a  
16.10 designation of the prescriber's branch of the healing art; and (4) it shows the date when  
16.11 signed by the prescriber, or the date of acceptance in the pharmacy if an oral prescription.

16.12 (b) An electronic prescription for a controlled substance in Schedule II, III, IV, or V is  
16.13 void unless it complies with the standards established pursuant to section 62J.497 and with  
16.14 those portions of Code of Federal Regulations, title 21, parts 1300, 1304, 1306, and 1311,  
16.15 that pertain to electronic prescriptions.

16.16 (c) A prescription for a controlled substance in Schedule II, III, IV, or V that is transmitted  
16.17 by facsimile, either computer to facsimile machine or facsimile machine to facsimile machine,  
16.18 is void unless it complies with the applicable requirements of Code of Federal Regulations,  
16.19 title 21, part 1306.

16.20 (d) Every licensed pharmacy that dispenses a controlled substance prescription shall  
16.21 retain the original prescription in a file for a period of not less than two years, open to  
16.22 inspection by any officer of the state, county, or municipal government whose duty it is to  
16.23 aid and assist with the enforcement of this chapter. An original electronic or facsimile  
16.24 prescription may be stored in an electronic database, provided that the database provides a  
16.25 means by which original prescriptions can be retrieved, as transmitted to the pharmacy, for  
16.26 a period of not less than two years.

16.27 (e) Every licensed pharmacy shall distinctly label the container in which a controlled  
16.28 substance is dispensed with the directions contained in the prescription for the use of that  
16.29 controlled substance.

16.30 (f) No prescription for an opiate or narcotic pain reliever listed in Schedules II through  
16.31 IV of section 152.02 shall be dispensed more than 30 days after the date on which the  
16.32 prescription was issued. After 30 days from the date of issuance of the prescription, no  
16.33 additional authorizations may be accepted for that prescription. If continued therapy is  
16.34 necessary, a new prescription must be issued by the prescriber.



17.1 Sec. 4. Minnesota Statutes 2018, section 152.11, subdivision 2, is amended to read:

17.2 Subd. 2. **Prescription requirements for Schedule III or IV controlled substances.** No  
 17.3 person may dispense a controlled substance included in Schedule III or IV of section 152.02  
 17.4 without a prescription issued, as permitted under subdivision 1, by a doctor of medicine, a  
 17.5 doctor of osteopathic medicine licensed to practice medicine, a doctor of dental surgery, a  
 17.6 doctor of dental medicine, a doctor of podiatry, a doctor of optometry limited to Schedule  
 17.7 IV, or a doctor of veterinary medicine, lawfully licensed to prescribe in this state or from  
 17.8 a practitioner licensed to prescribe controlled substances by the state in which the prescription  
 17.9 is issued, and having a current federal drug enforcement administration registration number.  
 17.10 Such prescription may not be dispensed or refilled except with the documented consent of  
 17.11 the prescriber, ~~and in no event more than six months after the date on which such prescription~~  
 17.12 ~~was issued~~ and no such prescription may be refilled more than five times.

17.13 Sec. 5. Minnesota Statutes 2018, section 152.11, subdivision 2d, is amended to read:

17.14 Subd. 2d. **Identification requirement for ~~Schedule II or III~~ controlled substance**  
 17.15 **prescriptions.** ~~(a)~~ No person may dispense a controlled substance included in ~~Schedule II~~  
 17.16 ~~or III~~ Schedules II through V without requiring the person purchasing the controlled  
 17.17 substance, who need not be the ~~person~~ patient for whom the controlled substance prescription  
 17.18 is written, to present valid photographic identification, unless the person purchasing the  
 17.19 controlled substance, ~~or if applicable the person for whom the controlled substance~~  
 17.20 ~~prescription is written~~, is known to the dispenser. A doctor of veterinary medicine who  
 17.21 dispenses a controlled substance must comply with this subdivision.

17.22 ~~(b) This subdivision applies only to purchases of controlled substances that are not~~  
 17.23 ~~covered, in whole or in part, by a health plan company or other third-party payor.~~

17.24 Sec. 6. Minnesota Statutes 2018, section 152.11, subdivision 4, is amended to read:

17.25 Subd. 4. **Limit on quantity of opiates prescribed for ~~acute dental and ophthalmic~~**  
 17.26 **~~pain.~~** (a) When used for the treatment of acute pain, prescriptions for opiates or narcotic  
 17.27 pain relievers listed in Schedules II through IV in section 152.02 shall not exceed a seven-day  
 17.28 supply for an adult and shall not exceed a five-day supply for a minor under 18 years of  
 17.29 age.

17.30 ~~(a)~~ (b) Notwithstanding paragraph (a), when used for the treatment of acute dental pain,  
 17.31 including acute pain associated with wisdom teeth extraction surgery or acute pain associated  
 17.32 with refractive surgery, prescriptions for opiate or narcotic pain relievers listed in Schedules  
 17.33 II through IV of section 152.02 shall not exceed a four-day supply. The quantity prescribed

18.1 ~~shall be consistent with the dosage listed in the professional labeling for the drug that has~~  
 18.2 ~~been approved by the United States Food and Drug Administration.~~

18.3 ~~(b)~~ (c) For the purposes of this subdivision, "acute pain" means pain resulting from  
 18.4 disease, accidental or intentional trauma, surgery, or another cause, that the practitioner  
 18.5 reasonably expects to last only a short period of time. Acute pain does not include chronic  
 18.6 pain or pain being treated as part of cancer care, palliative care, or hospice or other end-of-life  
 18.7 care.

18.8 ~~(e) Notwithstanding paragraph (a), if in the professional clinical judgment of a practitioner~~  
 18.9 ~~more than a four-day supply of a prescription listed in Schedules II through IV of section~~  
 18.10 ~~152.02 is required to treat a patient's acute pain, the practitioner may issue a prescription~~  
 18.11 ~~for the quantity needed to treat such acute pain.~~

18.12 (d) Notwithstanding paragraph (a) or (b), if, in the professional clinical judgment of a  
 18.13 practitioner, more than the limit specified in paragraph (a) or (b) is required to treat a patient's  
 18.14 acute pain, the practitioner may issue a prescription for the quantity needed to treat the  
 18.15 patient's acute pain.

18.16 Sec. 7. Minnesota Statutes 2018, section 152.126, subdivision 6, is amended to read:

18.17 Subd. 6. **Access to reporting system data.** (a) Except as indicated in this subdivision,  
 18.18 the data submitted to the board under subdivision 4 is private data on individuals as defined  
 18.19 in section 13.02, subdivision 12, and not subject to public disclosure.

18.20 (b) Except as specified in subdivision 5, the following persons shall be considered  
 18.21 permissible users and may access the data submitted under subdivision 4 in the same or  
 18.22 similar manner, and for the same or similar purposes, as those persons who are authorized  
 18.23 to access similar private data on individuals under federal and state law:

18.24 (1) a prescriber or an agent or employee of the prescriber to whom the prescriber has  
 18.25 delegated the task of accessing the data, to the extent the information relates specifically to  
 18.26 a current patient, to whom the prescriber is:

18.27 (i) prescribing or considering prescribing any controlled substance;

18.28 (ii) providing emergency medical treatment for which access to the data may be necessary;

18.29 (iii) providing care, and the prescriber has reason to believe, based on clinically valid  
 18.30 indications, that the patient is potentially abusing a controlled substance; or

18.31 (iv) providing other medical treatment for which access to the data may be necessary  
 18.32 for a clinically valid purpose and the patient has consented to access to the submitted data,

19.1 and with the provision that the prescriber remains responsible for the use or misuse of data  
19.2 accessed by a delegated agent or employee;

19.3 (2) a dispenser or an agent or employee of the dispenser to whom the dispenser has  
19.4 delegated the task of accessing the data, to the extent the information relates specifically to  
19.5 a current patient to whom that dispenser is dispensing or considering dispensing any  
19.6 controlled substance and with the provision that the dispenser remains responsible for the  
19.7 use or misuse of data accessed by a delegated agent or employee;

19.8 (3) a licensed pharmacist who is providing pharmaceutical care for which access to the  
19.9 data may be necessary to the extent that the information relates specifically to a current  
19.10 patient for whom the pharmacist is providing pharmaceutical care: (i) if the patient has  
19.11 consented to access to the submitted data; or (ii) if the pharmacist is consulted by a prescriber  
19.12 who is requesting data in accordance with clause (1);

19.13 (4) an individual who is the recipient of a controlled substance prescription for which  
19.14 data was submitted under subdivision 4, or a guardian of the individual, parent or guardian  
19.15 of a minor, or health care agent of the individual acting under a health care directive under  
19.16 chapter 145C. For purposes of this clause, access by individuals includes persons in the  
19.17 definition of an individual under section 13.02;

19.18 (5) personnel or designees of a health-related licensing board listed in section 214.01,  
19.19 subdivision 2, or of the Emergency Medical Services Regulatory Board, assigned to conduct  
19.20 a bona fide investigation of a complaint received by that board that alleges that a specific  
19.21 licensee is impaired by use of a drug for which data is collected under subdivision 4, has  
19.22 engaged in activity that would constitute a crime as defined in section 152.025, or has  
19.23 engaged in the behavior specified in subdivision 5, paragraph (a);

19.24 (6) personnel of the board engaged in the collection, review, and analysis of controlled  
19.25 substance prescription information as part of the assigned duties and responsibilities under  
19.26 this section;

19.27 (7) authorized personnel of a vendor under contract with the state of Minnesota who are  
19.28 engaged in the design, implementation, operation, and maintenance of the prescription  
19.29 monitoring program as part of the assigned duties and responsibilities of their employment,  
19.30 provided that access to data is limited to the minimum amount necessary to carry out such  
19.31 duties and responsibilities, and subject to the requirement of de-identification and time limit  
19.32 on retention of data specified in subdivision 5, paragraphs (d) and (e);

19.33 (8) federal, state, and local law enforcement authorities acting pursuant to a valid search  
19.34 warrant;

20.1 (9) personnel of the Minnesota health care programs assigned to use the data collected  
20.2 under this section to identify and manage recipients whose usage of controlled substances  
20.3 may warrant restriction to a single primary care provider, a single outpatient pharmacy, and  
20.4 a single hospital;

20.5 (10) personnel of the Department of Human Services assigned to access the data pursuant  
20.6 to paragraph (i);

20.7 (11) personnel of the health professionals services program established under section  
20.8 214.31, to the extent that the information relates specifically to an individual who is currently  
20.9 enrolled in and being monitored by the program, and the individual consents to access to  
20.10 that information. The health professionals services program personnel shall not provide this  
20.11 data to a health-related licensing board or the Emergency Medical Services Regulatory  
20.12 Board, except as permitted under section 214.33, subdivision 3-; and

20.13 ~~For purposes of clause (4), access by an individual includes persons in the definition of~~  
20.14 ~~an individual under section 13.02; and~~

20.15 (12) personnel or designees of a health-related licensing board listed in section 214.01,  
20.16 subdivision 2, assigned to conduct a bona fide investigation of a complaint received by that  
20.17 board that alleges that a specific licensee is inappropriately prescribing controlled substances  
20.18 as defined in this section.

20.19 (c) By July 1, 2017, every prescriber licensed by a health-related licensing board listed  
20.20 in section 214.01, subdivision 2, practicing within this state who is authorized to prescribe  
20.21 controlled substances for humans and who holds a current registration issued by the federal  
20.22 Drug Enforcement Administration, and every pharmacist licensed by the board and practicing  
20.23 within the state, shall register and maintain a user account with the prescription monitoring  
20.24 program. Data submitted by a prescriber, pharmacist, or their delegate during the registration  
20.25 application process, other than their name, license number, and license type, is classified  
20.26 as private pursuant to section 13.02, subdivision 12.

20.27 (d) Notwithstanding paragraph (b), beginning January 1, 2021, a prescriber or an agent  
20.28 or employee of the prescriber to whom the prescriber has delegated the task of accessing  
20.29 the data, must access the data submitted under subdivision 4 to the extent the information  
20.30 relates specifically to the patient:

20.31 (1) before the prescriber issues an initial prescription order for a Schedules II through  
20.32 IV opiate controlled substance to the patient; and

21.1 (2) at least once every three months for patients receiving an opiate for treatment of  
21.2 chronic pain or participating in medically assisted treatment for an opioid addiction.

21.3 (e) Paragraph (d) does not apply if:

21.4 (1) the patient is receiving palliative care, or hospice or other end-of-life care;

21.5 (2) the patient is being treated for pain due to cancer or the treatment of cancer;

21.6 (3) the prescription order is for a number of doses that is intended to last the patient five  
21.7 days or less and is not subject to a refill;

21.8 (4) the prescriber and patient have a current or ongoing provider/patient relationship of  
21.9 a duration longer than one year;

21.10 (5) the prescription order is issued within 14 days following surgery or three days  
21.11 following oral surgery or follows the prescribing protocols established under the opioid  
21.12 prescribing improvement program under section 256B.0638;

21.13 (6) the controlled substance is prescribed or administered to a patient who is admitted  
21.14 to an inpatient hospital;

21.15 (7) the controlled substance is lawfully administered by injection, ingestion, or any other  
21.16 means to the patient by the prescriber, a pharmacist, or by the patient at the direction of a  
21.17 prescriber and in the presence of the prescriber or pharmacist;

21.18 (8) due to a medical emergency, it is not possible for the prescriber to review the data  
21.19 before the prescriber issues the prescription order for the patient; or

21.20 (9) the prescriber is unable to access the data due to operational or other technological  
21.21 failure of the program so long as the prescriber reports the failure to the board.

21.22 (f) Only permissible users identified in paragraph (b), clauses (1), (2), (3), (6), (7), (9),  
21.23 and (10), may directly access the data electronically. No other permissible users may directly  
21.24 access the data electronically. If the data is directly accessed electronically, the permissible  
21.25 user shall implement and maintain a comprehensive information security program that  
21.26 contains administrative, technical, and physical safeguards that are appropriate to the user's  
21.27 size and complexity, and the sensitivity of the personal information obtained. The permissible  
21.28 user shall identify reasonably foreseeable internal and external risks to the security,  
21.29 confidentiality, and integrity of personal information that could result in the unauthorized  
21.30 disclosure, misuse, or other compromise of the information and assess the sufficiency of  
21.31 any safeguards in place to control the risks.

22.1 ~~(e)~~ (g) The board shall not release data submitted under subdivision 4 unless it is provided  
22.2 with evidence, satisfactory to the board, that the person requesting the information is entitled  
22.3 to receive the data.

22.4 ~~(f)~~ (h) The board shall maintain a log of all persons who access the data for a period of  
22.5 at least three years and shall ensure that any permissible user complies with paragraph (c)  
22.6 prior to attaining direct access to the data.

22.7 ~~(g)~~ (i) Section 13.05, subdivision 6, shall apply to any contract the board enters into  
22.8 pursuant to subdivision 2. A vendor shall not use data collected under this section for any  
22.9 purpose not specified in this section.

22.10 ~~(h)~~ (j) The board may participate in an interstate prescription monitoring program data  
22.11 exchange system provided that permissible users in other states have access to the data only  
22.12 as allowed under this section, and that section 13.05, subdivision 6, applies to any contract  
22.13 or memorandum of understanding that the board enters into under this paragraph.

22.14 ~~(i)~~ (k) With available appropriations, the commissioner of human services shall establish  
22.15 and implement a system through which the Department of Human Services shall routinely  
22.16 access the data for the purpose of determining whether any client enrolled in an opioid  
22.17 treatment program licensed according to chapter 245A has been prescribed or dispensed a  
22.18 controlled substance in addition to that administered or dispensed by the opioid treatment  
22.19 program. When the commissioner determines there have been multiple prescribers or multiple  
22.20 prescriptions of controlled substances, the commissioner shall:

22.21 (1) inform the medical director of the opioid treatment program only that the  
22.22 commissioner determined the existence of multiple prescribers or multiple prescriptions of  
22.23 controlled substances; and

22.24 (2) direct the medical director of the opioid treatment program to access the data directly,  
22.25 review the effect of the multiple prescribers or multiple prescriptions, and document the  
22.26 review.

22.27 If determined necessary, the commissioner of human services shall seek a federal waiver  
22.28 of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section  
22.29 2.34, paragraph (c), prior to implementing this paragraph.

22.30 ~~(j)~~ (l) The board shall review the data submitted under subdivision 4 on at least a quarterly  
22.31 basis and shall establish criteria, in consultation with the advisory task force, for referring  
22.32 information about a patient to prescribers and dispensers who prescribed or dispensed the  
22.33 prescriptions in question if the criteria are met.

23.1 Sec. 8. Minnesota Statutes 2018, section 152.126, subdivision 10, is amended to read:

23.2 Subd. 10. **Funding.** (a) The board may seek grants and private funds from nonprofit  
23.3 charitable foundations, the federal government, and other sources to fund the enhancement  
23.4 and ongoing operations of the prescription monitoring program established under this section.  
23.5 Any funds received shall be appropriated to the board for this purpose. The board may not  
23.6 expend funds to enhance the program in a way that conflicts with this section without seeking  
23.7 approval from the legislature.

23.8 (b) Notwithstanding any other section, the administrative services unit for the  
23.9 health-related licensing boards shall apportion between the Board of Medical Practice, the  
23.10 Board of Nursing, the Board of Dentistry, the Board of Podiatric Medicine, the Board of  
23.11 Optometry, the Board of Veterinary Medicine, and the Board of Pharmacy an amount to be  
23.12 paid through fees by each respective board. The amount apportioned to each board shall  
23.13 equal each board's share of the annual appropriation to the Board of Pharmacy from the  
23.14 state government special revenue fund for operating the prescription monitoring program  
23.15 under this section. Each board's apportioned share shall be based on the number of prescribers  
23.16 or dispensers that each board identified in this paragraph licenses as a percentage of the  
23.17 total number of prescribers and dispensers licensed collectively by these boards. Each  
23.18 respective board may adjust the fees that the boards are required to collect to compensate  
23.19 for the amount apportioned to each board by the administrative services unit.

23.20 (c) The board has the authority to modify its contract with its vendor as provided in  
23.21 subdivision 2, to authorize that vendor to provide a service to prescribers and pharmacies  
23.22 that allows them to access prescription monitoring program data from within the electronic  
23.23 health record system or pharmacy software used by those prescribers and pharmacists.  
23.24 Beginning July 1, 2019, the board has the authority to collect an annual fee from each  
23.25 prescriber or pharmacist who accesses prescription monitoring program data through the  
23.26 service offered by the vendor. The annual fee collected must not exceed \$50 per user. The  
23.27 fees collected by the board under this paragraph shall be deposited in the state government  
23.28 special revenue fund and are appropriated to the board for the purposes of this paragraph.

23.29 Sec. 9. Minnesota Statutes 2018, section 214.12, is amended by adding a subdivision to  
23.30 read:

23.31 Subd. 6. **Opioid and controlled substances prescribing.** (a) The Board of Medical  
23.32 Practice, the Board of Nursing, the Board of Dentistry, the Board of Optometry, and the  
23.33 Board of Podiatric Medicine shall require that licensees with the authority to prescribe  
23.34 controlled substances obtain at least two hours of continuing education credit on best practices

24.1 in prescribing opioids and controlled substances, as part of the continuing education  
 24.2 requirements for licensure renewal. Licensees shall not be required to complete more than  
 24.3 two credit hours of continuing education on best practices in prescribing opioids and  
 24.4 controlled substances before this subdivision expires. Continuing education credit on best  
 24.5 practices in prescribing opioids and controlled substances must meet board requirements.

24.6 (b) Paragraph (a) does not apply to any licensee who is participating in the opioid  
 24.7 prescribing improvement program under section 256B.0638, unless the licensee has been  
 24.8 terminated as a medical assistance provider under section 256B.0638, subdivision 5,  
 24.9 paragraph (d).

24.10 (c) This subdivision expires January 1, 2024.

24.11 **EFFECTIVE DATE.** This section is effective January 1, 2020.

24.12 **Sec. 10. OPIOID OVERDOSE REDUCTION PILOT PROGRAM.**

24.13 Subdivision 1. **Establishment.** The commissioner of health shall provide grants to  
 24.14 ambulance services to fund activities by community paramedic teams to reduce opioid  
 24.15 overdoses in the state. Under this pilot program, ambulance services shall develop and  
 24.16 implement projects in which community paramedics connect with patients who are discharged  
 24.17 from a hospital or emergency department following an opioid overdose episode, develop  
 24.18 personalized care plans for those patients in consultation with the ambulance service medical  
 24.19 director, and provide follow-up services to those patients.

24.20 Subd. 2. **Priority areas; services.** (a) In a project developed under this section, an  
 24.21 ambulance service must target community paramedic team services to portions of the service  
 24.22 area with high levels of opioid use, high death rates from opioid overdoses, and urgent needs  
 24.23 for interventions.

24.24 (b) In a project developed under this section, a community paramedic team shall:

24.25 (1) provide services to patients released from a hospital or emergency department  
 24.26 following an opioid overdose episode and place priority on serving patients who were  
 24.27 administered the opiate antagonist naloxone hydrochloride by emergency medical services  
 24.28 personnel in response to a 911 call during the opioid overdose episode;

24.29 (2) provide the following evaluations during an initial home visit: (i) a home safety  
 24.30 assessment including whether there is a need to dispose of prescription drugs that are expired  
 24.31 or no longer needed; (ii) medication compliance; (iii) an HIV risk assessment; (iv) instruction  
 24.32 on the use of naloxone hydrochloride; and (v) a basic needs assessment;



25.1 (3) provide patients with health assessments, chronic disease monitoring and education,  
25.2 and assistance in following hospital discharge orders; and

25.3 (4) work with a multidisciplinary team to address the overall physical and mental health  
25.4 needs of patients and health needs related to substance use disorder treatment.

25.5 (c) An ambulance service receiving a grant under this section may use grant funds to  
25.6 cover the cost of evidence-based training in opioid addiction and recovery treatment.

25.7 Subd. 3. **Evaluation.** An ambulance service that receives a grant under this section shall  
25.8 evaluate the extent to which the project was successful in reducing the number of opioid  
25.9 overdoses and opioid overdose deaths among patients who received services and in reducing  
25.10 the inappropriate use of opioids by patients who received services. The commissioner of  
25.11 health shall develop specific evaluation measures and reporting timelines for ambulance  
25.12 services receiving grants. Ambulance services shall submit the information required by the  
25.13 commissioner to the commissioner and the commissioner shall submit a summary of the  
25.14 information reported by the ambulance services to the chairs and ranking minority members  
25.15 of the legislative committees with jurisdiction over health and human services by December  
25.16 1, 2020.

25.17 Sec. 11. **APPROPRIATION.**

25.18 (a) \$1,000,000 in fiscal year 2020 is appropriated from the general fund to the  
25.19 commissioner of health for the opioid overdose reduction pilot program. This appropriation  
25.20 is available until June 30, 2021. Of this appropriation, the commissioner may use up to  
25.21 \$50,000 to administer the program.

25.22 (b) \$150,000 is appropriated in fiscal year 2020 from the general fund to the commissioner  
25.23 of health to award through a competitive request for proposal process a grant to an  
25.24 organization to conduct a statewide inventory of nonnarcotic pain management, prevention,  
25.25 and resiliency resources available through community organizations, health clinics, and  
25.26 health care systems. By January 15, 2021, the commissioner shall submit the completed  
25.27 inventory to the chairs and ranking minority members of the house of representatives and  
25.28 senate committees with jurisdiction over health and human services policy and finance.  
25.29 This is a onetime appropriation.

25.30 (c) \$2,000,000 in fiscal year 2020 and \$2,000,000 in fiscal year 2021 are appropriated  
25.31 from the general fund to the commissioner of public safety for violent crime enforcement  
25.32 team grants under Minnesota Statutes, section 299A.642, subdivision 9. In awarding these  
25.33 grants, the commissioner must place a priority on funding nonmetro teams. The commissioner

26.1 of public safety shall provide outreach, technical assistance, and program development  
26.2 support to increase the capacity of small communities to access grants under Minnesota  
26.3 Statutes, section 299A.642, subdivision 9, particularly in areas where violent crime  
26.4 enforcement teams have not been established, especially in greater Minnesota.

26.5 (d) \$1,000,000 in fiscal year 2020 is appropriated from the general fund to the  
26.6 commissioner of human services for grants to existing recipients of grants for Project Echo  
26.7 programs to continue their opioid-focused projects.