..... moves to amend S.F. No. 3656, the second engrossment, in conference committee, as follows:

Page 433, delete article 26 and insert:

"ARTICLE 26

OPIOIDS AND PRESCRIPTION DRUGS

Section 1. Minnesota Statutes 2017 Supplement, section 152.105, subdivision 2, is amended to read:

Subd. 2. **Sheriff to maintain collection receptacle or medicine disposal program.** (a) The sheriff of each county shall maintain or contract for the maintenance of at least one collection receptacle or implement a medicine disposal program for the disposal of noncontrolled substances, pharmaceutical controlled substances, and other legend drugs, as permitted by federal law. For purposes of this section, "legend drug" has the meaning given in section 151.01, subdivision 17. The collection receptacle and medicine disposal program must comply with federal law. In maintaining and operating the collection receptacle or medicine disposal program, the sheriff shall follow all applicable provisions of Code of Federal Regulations, title 21, parts 1300, 1301, 1304, 1305, 1307, and 1317, as amended through May 1, 2017.

(b) For purposes of this subdivision:

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

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

Sec. 2. Minnesota Statutes 2016, section 152.11, subdivision 2, is amended to read:

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

Sec. 3. Minnesota Statutes 2016, section 152.11, is amended by adding a subdivision to read:

Subd. 5. **Limitations on the dispensing of opioid prescription drug orders.** (a) No prescription drug order for an opioid drug listed in Schedule II may be dispensed by a pharmacist or other dispenser more than 30 days after the date on which the prescription drug order was issued.

(b) No prescription drug order for an opioid drug listed in Schedules III through V may be initially dispensed by a pharmacist or other dispenser more than 30 days after the date on which the prescription drug order was issued. No prescription drug order for an opioid drug listed in Schedules III through V may be refilled by a pharmacist or other dispenser more than 45 days after the previous date on which it was dispensed.

(c) For purposes of this section, "dispenser" has the meaning given in section 152.126, subdivision 1.

Sec. 4. Minnesota Statutes 2016, section 152.126, subdivision 2, is amended to read:

Subd. 2. **Prescription electronic reporting system.** (a) The board shall establish by January 1, 2010, an electronic system for reporting the information required under subdivision 4 for all controlled substances dispensed within the state.

(b) The board may contract with a vendor for the purpose of obtaining technical assistance in the design, implementation, operation, and maintenance of the electronic reporting system.

(c) Before entering into a new contract or before renegotiating a current contract with a private vendor for the operation of the prescription monitoring program, the Board of Pharmacy must: (1) ensure that the vendor complies with the National Institute Standards and Technology standards for interoperability, security, and ongoing support; and (2) provide at least 30 days' notice to the Legislative Advisory Commission. The board may enter into a new contract or renegotiate a current contract only if the Legislative Advisory Commission provides a positive recommendation or no recommendation, and shall not enter into a new contract or renegotiate a current contract if the Legislative Advisory Commission provides a negative recommendation.

Sec. 5. Minnesota Statutes 2016, section 152.126, subdivision 6, is amended to read:

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

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

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

(i) prescribing or considering prescribing any controlled substance;

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

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

(iv) providing other medical treatment for which access to the data may be necessary for a clinically valid purpose and the patient has consented to access to the submitted data, and with the provision that the prescriber remains responsible for the use or misuse of data accessed by a delegated agent or employee;

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Notwithstanding paragraph (b), beginning January 1, 2020, a prescriber who is practicing in an emergency department, urgent care clinic, or a walk-in health clinic offering health care services, or an agent or employee of the prescriber to whom the prescriber has delegated the task of accessing the data, must access the data submitted under subdivision 4 to the extent the information relates specifically to the patient before the prescriber issues a prescription order to the patient for a Schedule II through IV opiate controlled substance.

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

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

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

(f) Only permissible users identified in paragraph (b), clauses (1), (2), (3), (6), (7), (9), and (10), may directly access the data electronically. No other permissible users may directly

access the data electronically. If the data is directly accessed electronically, the permissible user shall implement and maintain a comprehensive information security program that contains administrative, technical, and physical safeguards that are appropriate to the user's size and complexity, and the sensitivity of the personal information obtained. The permissible user shall identify reasonably foreseeable internal and external risks to the security, confidentiality, and integrity of personal information that could result in the unauthorized disclosure, misuse, or other compromise of the information and assess the sufficiency of any safeguards in place to control the risks.

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

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

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

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

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

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

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

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

~~(j)~~ (l) The board shall review the data submitted under subdivision 4 on at least a quarterly basis and shall establish criteria, in consultation with the advisory task force, for referring information about a patient to prescribers and dispensers who prescribed or dispensed the prescriptions in question if the criteria are met. The board shall also submit an annual report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance that provides information on the prescribing trends for opiates, including the number of opiate prescriptions issued for the previous calendar year.

Sec. 6. Minnesota Statutes 2016, section 152.126, subdivision 10, is amended to read:

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

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

(c) The board shall have the authority to modify its contract with its vendor as provided in subdivision 2, to authorize that vendor to provide a service to prescribers and pharmacies that allows them to access prescription monitoring program data from within the electronic health record system or pharmacy software used by those prescribers and pharmacists. The

board must ensure that the integration of access shall not modify any requirements or procedures in this section regarding the information that must be reported to the database, who can access the database and for what purpose, and the data classification of information in the database, and shall not require a prescriber to access the database prior to issuing a prescription for a controlled substance, other than as required under subdivision 6, paragraph (d). The board must also ensure that the vendor complies with the encryption of data requirement and the time limit on data retention specified in subdivision 5. Beginning July 1, 2018, the board has the authority to collect an annual fee from each prescriber or pharmacist who accesses prescription monitoring program data through the service offered by the vendor. The annual fee collected must not exceed $50 per user. The fees collected by the board under this paragraph shall be deposited in the state government special revenue fund and are appropriated to the board for the purposes of this paragraph.

Sec. 7. Minnesota Statutes 2017 Supplement, section 254B.12, subdivision 3, is amended to read:

Subd. 3. **Chemical dependency provider rate increase.** For the chemical dependency services listed in section 254B.05, subdivision 5, and provided on or after July 1, ~~2017~~ 2018, payment rates shall be increased by ~~one~~ 1.74 percent over the rates in effect on January 1, ~~2017~~ 2018, for vendors who meet the requirements of section 254B.05.

Sec. 8. **[256.043] OPIATE EPIDEMIC RESPONSE ACCOUNT.**

Subdivision 1. **Establishment.** The opiate epidemic response account is established in the special revenue fund in the state treasury.

Subd. 2. **Proposed grants.** By February 15 of each year, beginning February 15, 2019, the commissioner of human services, in consultation with the commissioners of health, education, and public safety, shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services, education, and public safety, outlining proposed projects to achieve the greatest impact and ensure a coordinated state effort to address the state's opioid addiction and overdose epidemic.

Subd. 3. **Use of account funds.** (a) Beginning in fiscal year 2019, money in the account shall be appropriated each fiscal year as specified in this subdivision.

(b) $213,000 is appropriated to the commissioner of management and budget for evaluation activities for selected projects.

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

(d) Money remaining in the opiate epidemic response account after making the appropriations required in paragraphs (b) and (c) is appropriated to the commissioner of human services to be allocated as grants as specified by the legislature or as otherwise appropriated by the legislature.

Subd. 4. **Evaluations.** The commissioner of human services, in consultation with the commissioner of management and budget, and within available appropriations, shall select from the awarded grants, projects that include promising practices or theory-based activities for which the commissioner of management and budget shall conduct evaluations using experimental or quasi-experimental design. Grants awarded to proposals that are selected for an evaluation shall be administered to support the experimental or quasi-experimental evaluation and shall require the grantee to collect and report information that is needed to complete the evaluation. The commissioner of management and budget, under section 15.08, may obtain additional relevant data to support the experimental or quasi-experimental evaluation studies.

Sec. 9. Laws 2017, First Special Session chapter 6, article 10, section 144, is amended to read:

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

(a) The commissioner of health shall establish opioid abuse prevention pilot projects in geographic areas throughout the state based on the most recently available data on opioid overdose and abuse rates, to reduce opioid abuse through the use of controlled substance care teams and community-wide coordination of abuse-prevention initiatives. The commissioner shall award grants to health care providers, health plan companies, local units of government, tribal governments, or other entities to establish pilot projects.

(b) Each pilot project must:

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

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

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

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

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

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

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

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

(d) The contract under paragraph (c) shall require the accountable community for health to evaluate the extent to which the pilot projects were successful in reducing the inappropriate use of opioids. The evaluation must analyze changes in the number of opioid prescriptions, the number of emergency room visits related to opioid use, and other relevant measures. The accountable community for health shall report evaluation results to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance and public safety by December 15, 2019, for projects that received funding in fiscal year 2018, and by December 15, 2021, for projects that received funding in fiscal year 2019.

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

Sec. 10. Laws 2017, First Special Session chapter 6, article 12, section 2, subdivision 4, is amended to read:

Subd. 4. **Limit on quantity of opiates prescribed ~~for acute dental and ophthalmic pain.~~** (a) ~~When used for the treatment of acute dental pain or acute pain associated with refractive surgery, prescriptions for opiate or narcotic pain relievers listed in Schedules II through IV of section 152.02 shall not exceed a four-day supply. The quantity prescribed shall be consistent with the dosage listed in the professional labeling for the drug that has~~

~~been approved by the United States Food and Drug Administration.~~ This subdivision applies to prescriptions issued for opiates or narcotic pain relievers listed in Schedule II through IV in Minnesota Statutes, section 152.02, that are prescribed for the treatment of acute pain. For purposes of this subdivision, "acute pain" means pain resulting from disease, accidental or intentional trauma, surgery, or another cause, that the practitioner reasonably expects to last only a short period of time. Acute pain does not include chronic pain or pain being treated as part of cancer care, palliative care, or hospice or other end-of-life care.

(b) ~~For the purposes of this subdivision, "acute pain" means pain resulting from disease, accidental or intentional trauma, surgery, or another cause, that the practitioner reasonably expects to last only a short period of time. Acute pain does not include chronic pain or pain being treated as part of cancer care, palliative care, or hospice or other end-of-life care.~~ For practitioners who are practicing in an emergency department, urgency care clinic, or a walk-in health care clinic, a prescription as described in paragraph (a) issued to a patient shall not exceed a three-day supply.

(c) ~~Notwithstanding paragraph (a), if in the professional clinical judgment of a practitioner more than a four-day supply of a prescription listed in Schedules II through IV of section 152.02 is required to treat a patient's acute pain, the practitioner may issue a prescription for the quantity needed to treat such acute pain.~~ For practitioners issuing a prescription for a drug described in paragraph (a) for the treatment of acute dental pain or acute pain associated with refractive surgery, the quantity prescribed shall not exceed a four-day supply.

(d) For practitioners issuing a prescription for a drug described in paragraph (a), and paragraphs (b) and (c) do not apply, the quantity prescribed shall not exceed a seven-day supply for an adult and a five-day supply for a minor under 18 years of age.

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

Sec. 11. **OPIOID OVERDOSE REDUCTION PILOT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of health shall provide grants to ambulance services to fund activities by community paramedic teams to reduce opioid overdoses in the state. Under this pilot program, ambulance services shall develop and implement projects in which community paramedics connect with patients who are discharged from a hospital or emergency department following an opioid overdose episode, develop

personalized care plans for those patients in consultation with the ambulance service medical director, and provide follow-up services to those patients.

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

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

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

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

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

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

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

Subd. 3. **Evaluation.** An ambulance service that receives a grant under this section shall evaluate the extent to which the project was successful in reducing the number of opioid overdoses and opioid overdose deaths among patients who received services and in reducing the inappropriate use of opioids by patients who received services. The commissioner of health shall develop specific evaluation measures and reporting timelines for ambulance services receiving grants. Ambulance services shall submit the information required by the commissioner to the commissioner and the commissioner shall submit a summary of the information reported by the ambulance services to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services by December 1, 2019."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly