State of Minnesota

HOUSE OF REPRESENTATIVES

NINETIETH SESSION

H. F. No. 1440

02/20/2017 Authored by Baker, Hamilton, Schomacker, Poston, Kresha and others
The bill was read for the first time and referred to the Committee on Health and Human Services Reform
03/19/2018 Adoption of Report: Amended and re-referred to the Committee on Civil Law and Data Practices Policy
03/21/2018 Adoption of Report: Amended and re-referred to the Committee on Government Operations and Elections Policy
03/26/2018 Adoption of Report: Amended and re-referred to the Committee on Health and Human Services Finance
04/24/2018 Adoption of Report: Amended and re-referred to the Committee on Ways and Means
Pursuant to Joint Rule 2.03, re-referred to the Committee on Rules and Legislative Administration
05/03/2018 Adoption of Report: Re-referred to the Committee on Ways and Means
Joint Rule 2.03 has been waived for any subsequent committee action on this bill
05/14/2018 Adoption of Report: Placed on the General Register as Amended
Read for the Second Time
Referred to the Chief Clerk for Comparison with S. F. No. 730

A bill for an act

relating to health; establishing the Opioid Addiction Prevention and Treatment Advisory Council; establishing the opioid addiction prevention and treatment account; modifying substance use disorder treatment provider requirements; modifying provisions related to opioid addiction prevention, education, research, intervention, treatment, and recovery; appropriating money; requiring reports; amending Minnesota Statutes 2016, sections 145.9269, subdivision 1; 151.01, subdivision 27; 151.214, subdivision 2; 151.37, subdivision 12; 151.71, by adding a subdivision; 152.11, subdivision 2d, by adding subdivisions; 214.12, by adding a subdivision; 256B.0625, subdivision 13e; Minnesota Statutes 2017 Supplement, sections 120B.021, subdivision 1; 152.105, subdivision 2; 245G.05, subdivision 1; 254A.03, subdivision 3; 254B.12, subdivision 3; proposing coding for new law in Minnesota Statutes, chapters 120B; 145; 151.

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

ARTICLE 1

OPIOID ADDICTION ADVISORY COUNCIL AND ACCOUNT

Section 1. **[151.255] OPIOID ADDICTION PREVENTION AND TREATMENT ADVISORY COUNCIL.**

Subdivision 1. **Establishment of advisory council.** (a) The Opioid Addiction Prevention and Treatment Advisory Council is established to confront the opioid addiction and overdose epidemic in this state and focus on:

(1) prevention and education, including public education and awareness for adults and youth, prescriber education, and the development and sustainability of substance use disorder programs;

(2) the expansion and enhancement of a continuum of care for opioid-related substance use disorders, including primary prevention, early intervention, treatment, and recovery services;

(3) training on the treatment of opioid addiction, including the use of all FDA-approved opioid addiction medications, detoxification, relapse prevention, patient assessment, individual treatment planning, counseling, recovery supports, diversion control, and other best practices; and

(4) services to ensure overdose prevention as well as public safety and community well-being, including expanding access to FDA-approved opioid addiction medications and providing social services to families affected by the opioid overdose epidemic.

(b) The council shall:

(1) review local, state, and federal initiatives and activities related to education, prevention, and services for individuals and families experiencing and affected by opioid addiction;

(2) establish priorities and actions to address the state's opioid epidemic for the purpose of allocating funds;

(3) ensure optimal allocation of available funding and alignment of existing state and federal funding to achieve the greatest impact and ensure a coordinated state effort;

(4) develop criteria and procedures to be used in awarding grants and allocating available funds from the opioid addiction prevention and treatment account; and

(5) develop measurable outcomes to determine the effectiveness of the funds allocated.

(c) The council shall make recommendations on grant and funding options for the funds annually appropriated to the commissioner of human services from the opioid addiction prevention and treatment account. The options for funding may include, but are not limited to: prescriber education; the development and sustainability of prevention programs; the creation of a continuum of care for opioid-related substance abuse disorders, including primary prevention, early intervention, treatment, and recovery services; and additional funding for child protection case management services for children and families affected by opioid addiction. The council shall submit recommendations for funding options to the commissioner of human services and to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by March 1 of each year, beginning March 1, 2019.

Subd. 2. **Membership.** (a) The council shall consist of 21 members appointed by the commissioner of human services, except as otherwise specified:

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

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

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

(4) one member who is a medical doctor appointed by the Minnesota chapter of the American College of Emergency Physicians;

(5) one member representing programs licensed under chapter 245G that specialize in serving people with opioid use disorders;

(6) one member representing the National Alliance on Mental Illness (NAMI);

(7) one member who is a medical doctor appointed by the Minnesota Society of Addiction Medicine;

(8) one member representing professionals providing alternative pain management therapies;

(9) the commissioner of education or a designee;

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

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

(12) one member representing the Minnesota Hospital Association;

(13) one member representing an Indian tribe;

(14) the commissioner of human services or a designee;

(15) the commissioner of corrections or a designee;

(16) one advanced practice registered nurse appointed by the Board of Nursing;

(17) the commissioner of health or a designee;

(18) one member representing a local health department; and

(19) one member representing a nonprofit entity specializing in providing support to persons recovering from substance use disorder.

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

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

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

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

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

Sec. 2. **[151.256] OPIOID ADDICTION PREVENTION AND TREATMENT ACCOUNT.**

Subdivision 1. **Establishment.** The opioid addiction prevention and treatment account is established in the special revenue fund in the state treasury. All state appropriations to the account, and any federal funds or grant dollars received for the prevention and treatment of opioid addiction, shall be deposited into the account.

Subd. 2. **Use of account funds.** (a) For fiscal year 2019, money in the account is appropriated as provided in this act.

(b) For fiscal year 2020 and subsequent fiscal years, money in the opioid addiction prevention and treatment account is appropriated to the commissioner of human services, to be awarded, in consultation with the Opioid Addiction Prevention and Treatment Advisory Council, as grants or as other funding as determined appropriate to address the opioid epidemic in the state. Grants or other funding may be provided to continue or expand initiatives funded by this act for fiscal year 2019. Each recipient of grants or funding shall report to the commissioner and the advisory council on how the funds were spent and the outcomes achieved, in the form and manner specified by the commissioner.

Subd. 3. **Annual report.** Beginning December 1, 2019, and each December 1 thereafter, the commissioner, in consultation with the Opioid Addiction Prevention and Treatment Advisory Council, shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on the

grants and funds awarded under this section and the outcomes achieved. Each report must also identify those instances for which the commissioner did not follow the recommendations of the advisory council and the commissioner's rationale for taking this action.

Sec. 3. **ADVISORY COUNCIL FIRST MEETING.**

The commissioner of human services shall convene the first meeting of the Opioid Addiction Prevention and Treatment Advisory Council established under Minnesota Statutes, section 151.255, no later than October 1, 2018. The members shall elect a chair at the first meeting.

ARTICLE 2

PROVIDER AND OTHER REQUIREMENTS

Section 1. Minnesota Statutes 2016, section 151.214, subdivision 2, is amended to read:

Subd. 2. **No prohibition on disclosure.** No contracting agreement between an employer-sponsored health plan or health plan company, or its contracted pharmacy benefit manager, and a resident or nonresident pharmacy ~~registered~~ licensed under this chapter, may prohibit ~~the~~:

(1) a pharmacy from disclosing to patients information a pharmacy is required or given the option to provide under subdivision 1; or

(2) a pharmacist from informing a patient when the amount the patient is required to pay under the patient's health plan for a particular drug is greater than the amount the patient would be required to pay for the same drug if purchased out-of-pocket at the pharmacy's usual and customary price.

Sec. 2. Minnesota Statutes 2016, section 151.71, is amended by adding a subdivision to read:

Subd. 3. **Lowest cost to consumers.** (a) A health plan company or pharmacy benefits manager shall not require an individual to make a payment at the point of sale for a covered prescription medication in an amount greater than the allowable cost to consumers, as defined in paragraph (b).

(b) For purposes of paragraph (a), "allowable cost to consumers" means the lowest of: (1) the applicable co-payment for the prescription medication; or (2) the amount an individual would pay for the prescription medication if the individual purchased the prescription medication without using a health plan benefit.

Sec. 3. Minnesota Statutes 2017 Supplement, section 245G.05, subdivision 1, is amended to read:

Subdivision 1. **Comprehensive assessment.** (a) A comprehensive assessment of the client's substance use disorder must be administered face-to-face by an alcohol and drug counselor within three calendar days after service initiation for a residential program or during the initial session for all other programs. A program may permit a licensed staff person who is not qualified as an alcohol and drug counselor to interview the client in areas of the comprehensive assessment that are otherwise within the competencies and scope of practice of that licensed staff person and an alcohol and drug counselor does not need to be face-to-face with the client during this interview. The alcohol and drug counselor must review all of the information contained in a comprehensive assessment and, by signature, confirm the information is accurate and complete and meets the requirements for the comprehensive assessment. If the comprehensive assessment is not completed during the initial session, the client-centered reason for the delay must be documented in the client's file and the planned completion date. If the client received a comprehensive assessment that authorized the treatment service, an alcohol and drug counselor must review the assessment to determine compliance with this subdivision, including applicable timelines. If available, the alcohol and drug counselor may use current information provided by a referring agency or other source as a supplement. Information gathered more than 45 days before the date of admission is not considered current. The comprehensive assessment must include sufficient information to complete the assessment summary according to subdivision 2 and the individual treatment plan according to section 245G.06. The comprehensive assessment must include information about the client's needs that relate to substance use and personal strengths that support recovery, including:

(1) age, sex, cultural background, sexual orientation, living situation, economic status, and level of education;

(2) circumstances of service initiation;

(3) previous attempts at treatment for substance misuse or substance use disorder, compulsive gambling, or mental illness;

(4) substance use history including amounts and types of substances used, frequency and duration of use, periods of abstinence, and circumstances of relapse, if any. For each substance used within the previous 30 days, the information must include the date of the most recent use and previous withdrawal symptoms;

(5) specific problem behaviors exhibited by the client when under the influence of substances;

(6) family status, family history, including history or presence of physical or sexual abuse, level of family support, and substance misuse or substance use disorder of a family member or significant other;

(7) physical concerns or diagnoses, the severity of the concerns, and whether the concerns are being addressed by a health care professional;

(8) mental health history and psychiatric status, including symptoms, disability, current treatment supports, and psychotropic medication needed to maintain stability; the assessment must utilize screening tools approved by the commissioner pursuant to section 245.4863 to identify whether the client screens positive for co-occurring disorders;

(9) arrests and legal interventions related to substance use;

(10) ability to function appropriately in work and educational settings;

(11) ability to understand written treatment materials, including rules and the client's rights;

(12) risk-taking behavior, including behavior that puts the client at risk of exposure to blood-borne or sexually transmitted diseases;

(13) social network in relation to expected support for recovery and leisure time activities that are associated with substance use;

(14) whether the client is pregnant and, if so, the health of the unborn child and the client's current involvement in prenatal care;

(15) whether the client recognizes problems related to substance use and is willing to follow treatment recommendations; and

(16) collateral information. If the assessor gathered sufficient information from the referral source or the client to apply the criteria in Minnesota Rules, parts 9530.6620 and 9530.6622, a collateral contact is not required.

(b) If the client is identified as having opioid use disorder or seeking treatment for opioid use disorder, the program must provide educational information to the client concerning:

(1) risks for opioid use disorder and dependence;

(2) treatment options, including the use of a medication for opioid use disorder;

(3) the risk of and recognizing opioid overdose; and

(4) the use, availability, and administration of naloxone to respond to opioid overdose.

(c) The commissioner shall develop educational materials that are supported by research and updated periodically. The license holder must use the educational materials that are approved by the commissioner to comply with this requirement.

(d) If the comprehensive assessment is completed to authorize treatment service for the client, at the earliest opportunity during the assessment interview the assessor shall determine if:

(1) the client is in severe withdrawal and likely to be a danger to self or others;

(2) the client has severe medical problems that require immediate attention; or

(3) the client has severe emotional or behavioral symptoms that place the client or others at risk of harm.

If one or more of the conditions in clauses (1) to (3) are present, the assessor must end the assessment interview and follow the procedures in the program's medical services plan under section 245G.08, subdivision 2, to help the client obtain the appropriate services. The assessment interview may resume when the condition is resolved.

Sec. 4. Minnesota Statutes 2017 Supplement, section 254A.03, subdivision 3, is amended to read:

Subd. 3. **Rules for substance use disorder care.** (a) The commissioner of human services shall establish by rule criteria to be used in determining the appropriate level of chemical dependency care for each recipient of public assistance seeking treatment for substance misuse or substance use disorder. Upon federal approval of a comprehensive assessment as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding the criteria in Minnesota Rules, parts 9530.6600 to 9530.6655, an eligible vendor of comprehensive assessments under section 254B.05 may determine and approve the appropriate level of substance use disorder treatment for a recipient of public assistance. The process for determining an individual's financial eligibility for the consolidated chemical dependency treatment fund or determining an individual's enrollment in or eligibility for a publicly subsidized health plan is not affected by the individual's choice to access a comprehensive assessment for placement.

(b) The commissioner shall develop and implement a utilization review process for publicly funded treatment placements to monitor and review the clinical appropriateness and timeliness of all publicly funded placements in treatment.

(c) Notwithstanding section 254B.05, subdivision 5, paragraph (b), clause (2), an individual employed by a county on July 1, 2018, who has been performing assessments for the purpose of Minnesota Rules, part 9530.6615, is qualified to perform a comprehensive assessment if the following conditions are met as of July 1, 2018:

(1) the individual is exempt from licensure under section 148F.11, subdivision 1;

(2) the individual is qualified as an assessor under Minnesota Rules, part 9530.6615, subpart 2; and

(3) the individual has three years employment as an assessor or is under the supervision of an individual who meets the requirements of an alcohol and drug counselor supervisor under section 245G.11, subdivision 4.

After June 30, 2020, an individual qualified to do a comprehensive assessment under this paragraph must additionally demonstrate completion of the applicable coursework requirements of section 245G.11, subdivision 5, paragraph (b).

ARTICLE 3

PREVENTION, EDUCATION, AND RESEARCH

Section 1. Minnesota Statutes 2017 Supplement, section 120B.021, subdivision 1, is amended to read:

Subdivision 1. **Required academic standards.** (a) The following subject areas are required for statewide accountability:

(1) language arts;

(2) mathematics;

(3) science;

(4) social studies, including history, geography, economics, and government and citizenship that includes civics consistent with section 120B.02, subdivision 3;

(5) physical education;

(6) health, for which locally developed academic standards apply, consistent with paragraph (e); and

(7) the arts, for which statewide or locally developed academic standards apply, as determined by the school district. Public elementary and middle schools must offer at least three and require at least two of the following four arts areas: dance; music; theater; and

visual arts. Public high schools must offer at least three and require at least one of the following five arts areas: media arts; dance; music; theater; and visual arts.

(b) For purposes of applicable federal law, the academic standards for language arts, mathematics, and science apply to all public school students, except the very few students with extreme cognitive or physical impairments for whom an individualized education program team has determined that the required academic standards are inappropriate. An individualized education program team that makes this determination must establish alternative standards.

(c) The department must adopt the most recent SHAPE America (Society of Health and Physical Educators) kindergarten through grade 12 standards and benchmarks for physical education as the required physical education academic standards. The department may modify and adapt the national standards to accommodate state interest. The modification and adaptations must maintain the purpose and integrity of the national standards. The department must make available sample assessments, which school districts may use as an alternative to local assessments, to assess students' mastery of the physical education standards beginning in the 2018-2019 school year.

(d) A school district may include child sexual abuse prevention instruction in a health curriculum, consistent with paragraph (a), clause (6). Child sexual abuse prevention instruction may include age-appropriate instruction on recognizing sexual abuse and assault, boundary violations, and ways offenders groom or desensitize victims, as well as strategies to promote disclosure, reduce self-blame, and mobilize bystanders. A school district may provide instruction under this paragraph in a variety of ways, including at an annual assembly or classroom presentation. A school district may also provide parents information on the warning signs of child sexual abuse and available resources.

(e) A school district must include instruction in a health curriculum for students in grades 5, 6, 8, 10, and 12 on substance misuse prevention, including opioids; controlled substances as defined in section 152.01, subdivision 4; prescription and nonprescription medications; and illegal drugs. A school district is not required to use a specific methodology or curriculum.

~~(e)~~ (f) District efforts to develop, implement, or improve instruction or curriculum as a result of the provisions of this section must be consistent with sections 120B.10, 120B.11, and 120B.20.

EFFECTIVE DATE. This section is effective for the 2019-2020 school year and later.

Sec. 2. **[120B.215] SUBSTANCE MISUSE PREVENTION.**

(a) This section may be cited as "Jake's Law."

(b) School districts and charter schools are encouraged to provide substance misuse prevention instruction for students in grades 5 through 12 integrated into existing programs, curriculum, or the general school environment of a district or charter school. The commissioner of education, in consultation with the director of the Alcohol and Other Drug Abuse Section under section 254A.03 and substance misuse prevention and treatment organizations, must, upon request, provide districts and charter schools with:

(1) information regarding substance misuse prevention services; and

(2) assistance in using Minnesota student survey results to inform prevention programs.

EFFECTIVE DATE. This section is effective July 1, 2018.

Sec. 3. **[151.72] VOLUNTARY NONOPIOID DIRECTIVE.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Board" means the Board of Pharmacy.

(c) "Opioid" means any product containing opium or opiates listed in section 152.02, subdivision 3, paragraphs (b) and (c); any product containing narcotics listed in section 152.02, subdivision 4, paragraphs (e) and (h); or any product containing narcotic drugs listed in section 152.02, subdivision 5, paragraph (b), other than products containing difenoxin or eluxadoline.

Subd. 2. **Execution of directive.** (a) An individual who is 18 years of age or older or an emancipated minor, a parent or legal guardian of a minor, or an individual's guardian or other person appointed by the individual or the court to manage the individual's health care may execute a voluntary nonopioid directive instructing health care providers that an opioid may not be administered or prescribed to the individual or the minor. The directive must be in the format prescribed by the board. The person executing the directive may submit the directive to a health care provider or hospital.

(b) An individual executing a directive may revoke the directive at any time in writing or orally.

Subd. 3. **Duties of the board.** (a) The board shall adopt rules establishing guidelines to govern the use of voluntary nonopioid health care directives. The guidelines must:

(1) include verification by a health care provider and comply with the written consent requirements under United States Code, title 42, section 290dd-2(b);

(2) specify standard procedures for the person executing a directive to use when submitting the directive to a health care provider or hospital;

(3) specify procedures to include the directive in the individual's medical record or interoperable electronic health record, and to submit the directive to the prescription monitoring program database;

(4) specify procedures to modify, override, or revoke a directive;

(5) include exemptions for the administration of naloxone or other opioid overdose drugs in an emergency situation;

(6) ensure the confidentiality of a voluntary nonopioid directive; and

(7) ensure exemptions for an opioid used to treat substance abuse or opioid dependence.

Subd. 4. **Exemption from liability.** (a) A health care provider, a hospital, or an employee of a health care provider or hospital may not be subject to disciplinary action by the health care provider's or employee's professional licensing board or held civilly or criminally liable for failure to administer, prescribe, or dispense an opioid, or for inadvertent administration of an opioid, to an individual or minor who has a voluntary nonopioid directive.

(b) A prescription presented to a pharmacy is presumed to be valid, and a pharmacist may not be subject to disciplinary action by the pharmacist's professional licensing board or held civilly or criminally liable for dispensing an opioid in contradiction to an individual's or minor's voluntary nonopioid directive.

Subd. 5. **Construction.** Nothing in this section shall be construed to:

(1) alter a health care directive under chapter 145C;

(2) limit the prescribing, dispensing, or administering of an opioid overdose drug; or

(3) limit an authorized health care provider or pharmacist from prescribing, dispensing, or administering an opioid for the treatment of substance abuse or opioid dependence.

Sec. 4. Minnesota Statutes 2017 Supplement, section 152.105, subdivision 2, is amended to read:

Subd. 2. **Sheriff to maintain collection receptacle.** The sheriff of each county shall maintain or contract for the maintenance of at least one collection receptacle 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 must comply with federal law. In maintaining and operating the collection receptacle, 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. The sheriff of each county may meet the requirements of this subdivision though the use of an alternative method for the disposal of noncontrolled substances, pharmaceutical controlled substances, and other legend drugs that has been approved by the Board of Pharmacy. This may include making available to the public, without charge, at-home prescription drug deactivation and disposal products that render drugs and medications inert and irretrievable.

Sec. 5. Minnesota Statutes 2016, section 152.11, subdivision 2d, is amended to read:

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

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

Sec. 6. 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 30 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. 7. Minnesota Statutes 2016, section 152.11, is amended by adding a subdivision to read:

Subd. 6. **Limit on quantity of opiates prescribed for acute pain associated with a major trauma or surgical procedure.** (a) When used for the treatment of acute pain associated with a major trauma or surgical procedure, initial prescriptions for opiate or narcotic pain relievers listed in Schedules II through IV of section 152.02 shall not exceed a seven-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.

(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.

(c) Notwithstanding paragraph (a), if in the professional clinical judgment of a practitioner more than a seven-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.

(d) This subdivision does not apply to the treatment of acute dental pain or acute pain associated with refractive surgery, and the quantity of opiates that may be prescribed for those conditions is governed by subdivision 4.

Sec. 8. Minnesota Statutes 2016, section 214.12, is amended by adding a subdivision to read:

Subd. 6. **Opioid and controlled substances prescribing.** (a) The Board of Medical Practice, the Board of Nursing, the Board of Dentistry, the Board of Optometry, and the Board of Podiatric Medicine shall require that licensees with the authority to prescribe controlled substances obtain at least two hours of continuing education credit on best practices in prescribing opioids and controlled substances, as part of the continuing education requirements for licensure renewal. Licensees shall not be required to complete more than two credit hours of continuing education on best practices in prescribing opioids and controlled substances before this subdivision expires. Continuing education credit on best practices in prescribing opioids and controlled substances must meet board requirements.

(b) This subdivision expires January 1, 2023.

EFFECTIVE DATE. This section is effective January 1, 2019.

ARTICLE 4

INTERVENTION, TREATMENT, AND RECOVERY

Section 1. Minnesota Statutes 2016, section 145.9269, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section and section 145.9272, "federally qualified health center" means an entity that is receiving a grant under United States Code, title 42, section 254b, or, based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the secretary to meet the requirements for receiving such a grant.

Sec. 2. **[145.9272] FEDERALLY QUALIFIED HEALTH CENTERS; GRANTS FOR INTEGRATED COMMUNITY-BASED OPIOID ADDICTION AND SUBSTANCE USE DISORDER TREATMENT, RECOVERY, AND PREVENTION PROGRAMS.**

Subdivision 1. **Grant program established.** The commissioner of health shall distribute grants to federally qualified health centers operating in Minnesota as of January 1, 2018, for integrated, community-based programs in primary care settings to treat, prevent, and raise awareness of opioid addiction and substance use disorders.

Subd. 2. **Grant allocation.** (a) For each grant cycle, the commissioner shall allocate grants to federally qualified health centers operating in Minnesota as of January 1, 2018, through a competitive process and according to the following guidelines:

(1) 25 percent of the funds shall be for federally qualified health centers to establish new opioid addiction and substance use disorder programs;

(2) 70 percent of the funds shall be for federally qualified health centers with existing opioid addiction and substance use disorder programs to expand these programs to serve additional low-income patients; and

(3) five percent of the funds shall be for federally qualified health centers to invest in network infrastructure and evaluation activities, to identify and document successful opioid addiction and substance use disorder prevention and treatment strategies for rural or underserved populations.

(b) The commissioner shall ensure, for each grant cycle, that at least 30 percent of the funds are allocated to federally qualified health centers in the state located outside the

seven-county metropolitan area and that each federally qualified health center in the state is allocated at least three percent of the total amount available for that grant cycle.

(c) The commissioner shall consult with a state organization representing Minnesota's community health centers to assess and classify the levels of substance use disorder services and programs available at federally qualified health centers in the state as of July 1, 2018, and to develop measures for federally qualified health centers to use in assessing the effectiveness of substance use disorder programs funded under this section in supporting sobriety and long-term recovery, stopping cycles of intergenerational substance use, enabling patients to return to work or school, and supporting family unity.

Subd. 3. **Allowable uses for grant funds.** In establishing a new opioid addiction and substance use disorder program or expanding an existing program, a federally qualified health center must use grant funds distributed under this section for one or more of the following activities:

(1) integrating behavioral health services and substance use disorder services on-site at the federally qualified health center or off-site through partnerships with other providers;

(2) establishing or expanding programs in which patients with substance use disorders receive services using integrated, interprofessional care teams;

(3) implementing or expanding patient care coordination, outreach, and education services related to substance use disorders;

(4) implementing or expanding medication assisted treatment by providing, directly or by referral, all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder, including maintenance, detoxification, overdose reversal, and relapse prevention;

(5) implementing and evaluating specific, effective substance use disorder interventions tailored to specific populations, including but not limited to communities of color, individuals experiencing homelessness, veterans, and adolescents;

(6) developing infrastructure, including infrastructure to allow for telehealth services, for federally qualified health center networks to support coordinated interventions across delivery systems; and

(7) training current and future health care professionals and students, including dental providers.

Subd. 4. **Reports.** After the conclusion of each grant cycle, each federally qualified health center shall report to the commissioner, at a time and in a manner specified by the

commissioner, data regarding the effectiveness measures developed under subdivision 2. The commissioner shall compile this information into a report for each grant cycle and shall provide the report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care.

Sec. 3. Minnesota Statutes 2016, section 151.01, subdivision 27, is amended to read:

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

(1) interpretation and evaluation of prescription drug orders;

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

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

(4) participation in drug and therapeutic device selection; drug administration for first dosage, injectable or implantable medications to treat substance use disorders, and medical emergencies; drug regimen reviews; and drug or drug-related research;

(5) participation in administration of influenza vaccines to all eligible individuals six years of age and older and all other vaccines to patients 13 years of age and older by written protocol with a physician licensed under chapter 147, a physician assistant authorized to prescribe drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe drugs under section 148.235, provided that:

(i) the protocol includes, at a minimum:

(A) the name, dose, and route of each vaccine that may be given;

(B) the patient population for whom the vaccine may be given;

(C) contraindications and precautions to the vaccine;

(D) the procedure for handling an adverse reaction;

(E) the name, signature, and address of the physician, physician assistant, or advanced practice registered nurse;

(F) a telephone number at which the physician, physician assistant, or advanced practice registered nurse can be contacted; and

(G) the date and time period for which the protocol is valid;

(ii) the pharmacist has successfully completed a program approved by the Accreditation Council for Pharmacy Education specifically for the administration of immunizations or a program approved by the board;

(iii) the pharmacist utilizes the Minnesota Immunization Information Connection to assess the immunization status of individuals prior to the administration of vaccines, except when administering influenza vaccines to individuals age nine and older;

(iv) the pharmacist reports the administration of the immunization to the Minnesota Immunization Information Connection; and

(v) the pharmacist complies with guidelines for vaccines and immunizations established by the federal Advisory Committee on Immunization Practices, except that a pharmacist does not need to comply with those portions of the guidelines that establish immunization schedules when administering a vaccine pursuant to a valid, patient-specific order issued by a physician licensed under chapter 147, a physician assistant authorized to prescribe drugs under chapter 147A, or an advanced practice nurse authorized to prescribe drugs under section 148.235, provided that the order is consistent with the United States Food and Drug Administration approved labeling of the vaccine;

(6) participation in the initiation, management, modification, and discontinuation of drug therapy according to a written protocol or collaborative practice agreement between: (i) one or more pharmacists and one or more dentists, optometrists, physicians, podiatrists, or veterinarians; or (ii) one or more pharmacists and one or more physician assistants authorized to prescribe, dispense, and administer under chapter 147A, or advanced practice nurses authorized to prescribe, dispense, and administer under section 148.235. Any changes in drug therapy made pursuant to a protocol or collaborative practice agreement must be documented by the pharmacist in the patient's medical record or reported by the pharmacist to a practitioner responsible for the patient's care;

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

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

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

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

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

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

Sec. 4. Minnesota Statutes 2016, section 151.37, subdivision 12, is amended to read:

Subd. 12. **Administration of opiate antagonists for drug overdose.** (a) A licensed physician, a licensed advanced practice registered nurse authorized to prescribe drugs pursuant to section 148.235, or a licensed physician assistant authorized to prescribe drugs pursuant to section 147A.18 may authorize the following individuals to administer opiate antagonists, as defined in section 604A.04, subdivision 1:

(1) an emergency medical responder registered pursuant to section 144E.27;

(2) a peace officer as defined in section 626.84, subdivision 1, paragraphs (c) and (d); ~~and~~

(3) staff of community-based health disease prevention or social service programs~~.~~;

(4) a probation or supervised release officer; and

(5) a volunteer firefighter.

(b) For the purposes of this subdivision, opiate antagonists may be administered by one of these individuals only if:

(1) the licensed physician, licensed physician assistant, or licensed advanced practice registered nurse has issued a standing order to, or entered into a protocol with, the individual; and

(2) the individual has training in the recognition of signs of opiate overdose and the use of opiate antagonists as part of the emergency response to opiate overdose.

(c) Nothing in this section prohibits the possession and administration of naloxone pursuant to section 604A.04.

Sec. 5. 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 percent~~ a percentage established by the commissioner, based on the available appropriation, over the rates in effect on January 1, ~~2017~~ 2018, for vendors who meet the requirements of section 254B.05.

Sec. 6. Minnesota Statutes 2016, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs or the maximum allowable cost by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65 for legend prescription drugs, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. The pharmacy dispensing fee for over-the-counter drugs shall be $3.65, except that the fee shall be $1.31 for retrospectively billing pharmacies when billing for quantities less than the number of units contained in the manufacturer's original package. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. A "designated rural area" means an area defined as a small rural area or isolated rural area according to the four-category classification of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration. Effective January 1, 2014, the actual acquisition cost of a drug acquired through the federal 340B Drug Pricing Program shall be estimated by the commissioner at wholesale acquisition cost minus 40 percent. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors

in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

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

(c) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. A pharmacy provider using packaging that meets the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(d) Whenever a maximum allowable cost has been set for a multisource drug, payment shall be the lower of the usual and customary price charged to the public or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost

set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider, the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. Effective January 1, 2014, the commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by 20 percent. With the exception of paragraph (f), the payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

(f) Notwithstanding paragraph (e), payment for injectable drugs used to treat substance abuse administered by a practitioner in an outpatient setting shall be made either to the administering facility or the practitioner, or directly to the dispensing pharmacy. The practitioner or administering facility shall submit the claim for the drug, if the practitioner purchases the drug directly from a wholesale distributor licensed under section 151.47 or from a manufacturer licensed under section 151.252. The dispensing pharmacy shall submit the claim if the pharmacy dispenses the drug pursuant to a prescription issued by the practitioner and delivers the filled prescription to the practitioner for subsequent administration. Payment shall be made according to this section. The administering practitioner and pharmacy shall ensure that claims are not duplicated. A pharmacy shall not dispense a practitioner-administered injectable drug described in this paragraph directly to an enrollee. For purposes of this paragraph, "dispense" and "dispensing" have the meaning provided in section 151.01, subdivision 30.

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

by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

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

Sec. 7. **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 following an opioid overdose episode, develop personalized care plans for those patients, 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 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: a home safety assessment including whether there is a need to dispose of prescription drugs that are expired or no longer needed, medication reconciliation, an HIV risk assessment, instruction on the use of naloxone hydrochloride, and a basic needs assessment;

(3) provide patients with health assessments, medication management, 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.

Subd. 3. **Evaluation.** An ambulance service that receives a grant under this section must 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 must submit the information required by the commissioner to the commissioner and the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services by December 1, 2019.

ARTICLE 5

APPROPRIATIONS

Section 1. **APPROPRIATIONS**

The appropriations shown are from the general fund, or other named fund, and are available for the fiscal years indicated for each purpose. The figures "2018" and "2019" used in this article mean that the appropriation noted under them are available for the fiscal year ending June 30, 2018, or June 30, 2019, respectively.

	APPROPRIATIONS Available for the Year Ending June 30	
	2018	**2019**
Sec. 2. **CRIMINAL APPREHENSION**	**$ 0**	**$ 420,000**
Bureau of Criminal Apprehension Special Agents. $420,000 in fiscal year 2019 is for two additional special agent positions within the Bureau of Criminal Apprehension focused on drug interdiction and drug trafficking. The special agents whose positions are authorized under this section shall, whenever possible, coordinate with the federal Drug Enforcement Administration in efforts to address drug trafficking in Minnesota.		
Sec. 3. **COMMISSIONER OF HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**$ 0**	**$ 4,900,000**

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Central Office Operations** 0 900,000

Native American Juvenile Treatment Center; White Earth Reservation. $900,000 in fiscal year 2019 is for a grant to the tribal council of the White Earth Nation to refurbish and equip the White Earth Opiate Treatment Facility on the White Earth Reservation. The facility shall treat Native Americans and provide culturally specific programming to individuals placed in the treatment center. This appropriation is available until the project is completed or abandoned, subject to Minnesota Statutes, section 16A.642. This is a onetime appropriation.

Subd. 3. **Forecasted Programs; Medical Assistance** 0 4,000,000

Sec. 4. **COMMISSIONER OF HEALTH** **$** **0** **$** **5,000,000**

(a) **FQHC Grants.** $1,000,000 in fiscal year 2019 is for grants to federally qualified health centers for opioid addiction and substance use disorder programs under Minnesota Statutes, section 145.9272. This is a onetime appropriation.

(b) **Community Paramedic Teams.** $1,000,000 in fiscal year 2019 is for an opioid overdose reduction pilot program using community paramedic teams. This appropriation is available until June 30, 2021. Of this appropriation, the commissioner may use up to $50,000 to administer the program. This is a onetime appropriation.

(c) **Opioid Prevention Pilot Project.** $2,000,000 in fiscal year 2019 is for opioid abuse prevention pilot projects under Laws 2017, First Special Session chapter 6, article 10, section 144. Of this amount, $1,400,000 is for the opioid abuse prevention pilot project through CHI St. Gabriel's Health Family Medical Center, also known as Unity Family Health Care. $600,000 is for Project Echo through CHI St. Gabriel's Health Family Medical Center for e-learning sessions centered around opioid case management and best practices for opioid abuse prevention. This is a onetime appropriation.

(d) **Prescription Drug Deactivation And Disposal.** $1,000,000 in fiscal year 2019 is to provide grants to prescription drug dispensers and health care providers to purchase omnidegradeable, at-home prescription drug deactivation and disposal products to assist individuals in the disposal of prescription drugs in a safe, environmentally sound manner. Grant awards shall not exceed $25,000 per dispenser or provider, or $100,000 for applicants applying on behalf of a group of dispensers or providers. Grant recipients must provide these deactivation and disposal products free of charge to members of the public. In awarding grants, the commissioner shall give priority to regions of the state with the highest rates of opioid overdoses and opioid-related deaths. This is a onetime appropriation.

Sec. 5. **DEPARTMENT OF EDUCATION** **$ 0 $ 400,000**

For Jake's Sake Foundation. (a) $400,000 in fiscal year 2019 is for a grant to the For Jake's Sake Foundation to collaborate with school districts throughout Minnesota to integrate evidence-based substance misuse prevention instruction on the dangers of substance misuse, particularly the use of opioids, into school district programs and curricula, including health education curricula.

(b) Funds appropriated in this section are to:

(1) identify effective substance misuse prevention tools and strategies, including innovative uses of technology and media;

(2) develop and promote a comprehensive substance misuse prevention curriculum for students in grades 5 through 12 that educates students and families about the dangers of substance misuse;

(3) integrate substance misuse prevention into curricula across subject areas;

(4) train school district teachers, athletic coaches, and other school staff in effective substance misuse prevention strategies; and

(5) collaborate with school districts to evaluate the effectiveness of districts' substance misuse prevention efforts.

(c) By February 15, 2019, the grantee must submit a report detailing expenditures and outcomes of the grant to the chairs and ranking minority members of the legislative committees with primary jurisdiction over kindergarten through grade 12 education policy and finance. The report must identify the school districts that have implemented or

plan to implement the substance misuse prevention curriculum.

(d) The department may retain up to five percent of the appropriation amount to administer the grant program and assist school districts with implementation of substance misuse prevention instruction.

Sec. 6. **HEALTH RELATED BOARDS**

Subdivision 1. **Total Appropriation** **$** **0** **$** **985,000**

Appropriations by Fund

	2018	2019
General	0	965,000
State Government Special Revenue	0	20,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Board of Dentistry** 0 5,000

Continuing Education. $5,000 in fiscal year 2019 is from the state government special revenue fund for costs associated with continuing education on prescribing opioids and controlled substances. This is a onetime appropriation.

Subd. 3. **Board of Nursing** 0 5,000

Continuing Education. $5,000 in fiscal year 2019 is from the state government special revenue fund for costs associated with continuing education on prescribing opioids and controlled substances. This is a onetime appropriation.

Subd. 4. **Board of Optometry** 0 5,000

Continuing Education. $5,000 in fiscal year 2019 is from the state government special revenue fund for costs associated with continuing education on prescribing opioids and controlled substances. This is a onetime appropriation.

Subd. 5. **Board of Pharmacy** 0 965,000

Prescription Monitoring Program and Electronic Health Records. $965,000 in fiscal year 2019 is from the general fund to integrate the prescription monitoring program database with electronic health records on a statewide basis. The integration of access to the prescription monitoring database with electronic health records shall not modify any requirements or procedures in Minnesota Statutes, section 152.126, 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. The board may use this funding to contract with a vendor for technical assistance, provide grants to health care providers, and to make any necessary technological modifications to the prescription monitoring program database. This funding does not cancel and is available until expended. This is a onetime appropriation.

Subd. 6. **Board of Podiatric Medicine** 0 5,000

Continuing Education. $5,000 in fiscal year 2019 is from the state government special

revenue fund for costs associated with continuing education on prescribing opioids and controlled substances. This is a onetime appropriation.

Sec. 7. **DUPLICATE APPROPRIATIONS.**

If an appropriation in this act is enacted more than once in the 2018 legislative session, the appropriation must be given effect only once.

APPENDIX
Article locations in HF1440-5

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