..... moves to amend H.F. No. 3138, the delete everything amendment (A18-0776), as follows:

Page 7, after line 21, insert:

"(8) a dentist licensed and practicing in the state with experience treating rare diseases;"

Renumber the clauses in sequence

Page 70, after line 29, insert:

"Sec. 4. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17d. **Transportation services oversight.** The commissioner shall contract with a vendor or dedicate staff for oversight of providers of nonemergency medical transportation services pursuant to the commissioner's authority in section 256B.04 and Minnesota Rules, parts 9505.2160 to 9505.2245.

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

Sec. 5. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17e. **Transportation provider termination.** (a) A terminated nonemergency medical transportation provider, including all named individuals on the current enrollment disclosure form and known or discovered affiliates of the nonemergency medical transportation provider, is not eligible to enroll as a nonemergency medical transportation provider for five years following the termination.

(b) After the five-year period in paragraph (a), if a provider seeks to reenroll as a nonemergency medical transportation provider, the nonemergency medical transportation provider must be placed on a one-year probation period. During a provider's probation

period the commissioner shall complete unannounced site visits and request documentation to review compliance with program requirements.

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

Page 73, after line 23, insert:

"Sec. 5. **[256B.0759] DIRECT CONTRACTING PILOT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner shall establish a direct contracting pilot program, to test alternative and innovative methods of delivering care through community-based collaborative care networks to medical assistance and MinnesotaCare enrollees. The pilot program shall be designed to coordinate care delivery to enrollees who demonstrate a combination of medical, economic, behavioral health, cultural, and geographic risk factors, including persons determined to be at risk of substance abuse and opioid addiction. The commissioner shall issue a request for proposals to select care networks to deliver care through the pilot program for a three-year period beginning January 1, 2020.

Subd. 2. **Eligible individuals.** (a) The pilot program shall serve individuals who:

(1) are eligible for medical assistance under section 256B.055 or MinnesotaCare under chapter 256L;

(2) reside in the service area of the care network;

(3) have a combination of multiple risk factors identified by the care network and approved by the commissioner;

(4) have elected to participate in the pilot project, as an alternative to receiving services under fee-for-service or through a managed care or county-based purchasing plan or integrated health partnership; and

(5) agree to participate in risk mitigation strategies as provided in subdivision 4, clause (4), if determined to be at risk of opioid addiction or substance abuse.

(b) The commissioner may identify individuals who are potentially eligible to be enrolled with a care network based on zip code or other geographic designation, utilization history, or other factors indicating whether an individual resides in the service area of a care network. The commissioner shall coordinate pilot program enrollment with the enrollment and procurement process for managed care and county-based purchasing plans, and integrated health partnerships.

Subd. 3. **Selection of care networks.** Participation in the pilot program is limited to no more than six care networks. The commissioner shall ensure that the care networks selected

serve different geographic areas of the state. The commissioner shall consider the following criteria when selecting care networks to participate in the program:

(1) the ability of the care network to provide or arrange for the full range of health care services required to be provided under section 256B.69, including but not limited to: primary care, inpatient hospital care, specialty care, behavioral health services, and chemical dependency and substance abuse treatment services;

(2) at least 25,000 individuals reside in the service area of the care network;

(3) the care network serves a high percentage of patients who are enrolled in Minnesota health care programs or are uninsured, compared to the overall Minnesota population; and

(4) the care network can demonstrate the capacity to improve health outcomes and reduce total cost of care for the population in its service area, through better patient engagement, coordination of care, and the provision of specialized services to address risk factors related to opioid addiction and substance abuse, and address nonclinical risk factors and barriers to access.

Subd. 4. **Requirements for participating care networks.** (a) A care network selected to participate in the pilot program must:

(1) accept a capitation rate for enrollees equal to the capitation rate that would otherwise apply to these enrollees under section 256B.69;

(2) comply with all requirements in section 256B.69 related to performance targets, capitation rate withholds, and administrative expenses;

(3) maintain adequate reserves and demonstrate the ability to bear risk, based upon criteria established by the commissioner under the request for proposals, or demonstrate to the commissioner that this requirement has been met through a contract with a health plan company, third-party administrator, stop-loss insurer, or other entity; and

(4) assess all enrollees for risk factors related to opioid addiction and substance abuse, and based upon the professional judgment of the health care provider, require enrollees determined to be at risk to enter into a patient provider agreement, submit to urine drug screening, and participate in other risk mitigation strategies; and

(5) participate in quality of care and financial reporting initiatives, in the form and manner specified by the commissioner.

(b) An existing integrated health partnership that meets the criteria in this section is eligible to participate in the pilot program while continuing as an integrated health partnership.

Subd. 5. **Requirements for the commissioner.** (a) The commissioner shall provide all participating care networks with enrollee utilization and cost information similar to that provided by the commissioner to integrated health partnerships.

(b) The commissioner, in consultation with the commissioner of health and care networks, shall design and administer the pilot program in a manner that allows the testing of new care coordination models and quality-of-care measures, to determine the extent to which the care delivered by the pilot program, relative to care delivered under fee-for-service and by managed care and county-based purchasing plans and integrated health partnerships:

(1) improves outcomes and reduces the total cost of care for the population served; and

(2) reduces administrative burdens and costs for health care providers and state agencies.

(c) The commissioner, based on the analysis under paragraph (b), shall evaluate the pilot program and present recommendations as to whether the pilot program should be continued or expanded, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, by February 15, 2022.

Sec. 6. Minnesota Statutes 2016, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract

effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) The commissioner shall require that managed care plans use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659.

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(f) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous calendar year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospital admission rate compared to the hospital admission rates in calendar year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting

this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(g) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(h) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(i) Effective for services rendered on or after January 1, 2014, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July

31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(j) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

(k) Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

(l) The return of the withhold under paragraphs (h) and (i) is not subject to the requirements of paragraph (c).

(m) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

(n) Effective for services provided on or after January 1, 2019, through December 31, 2019, the commissioner shall withhold two percent of the capitation payment provided to managed care plans under this section, and county-based purchasing plans under section 256B.692, for each medical assistance enrollee. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year, for capitation payments for enrollees for whom the plan has submitted to the commissioner a verification of coverage form completed and signed by the enrollee. The verification of coverage form must be developed by the commissioner and made available to managed care and county-based purchasing plans. The form must require the enrollee to provide the enrollee's name and street address and the name of the managed care or county-based purchasing plan selected by or assigned to the enrollee, and must include a signature block that allows the enrollee to attest that the information provided is accurate. A plan shall request that all enrollees complete the verification of coverage form, and shall submit all completed forms to the

commissioner by February 28, 2019. If a completed form for an enrollee is not received by the commissioner by that date:

(1) the commissioner shall not return to the plan funds withheld for that enrollee;

(2) the commissioner shall cease making capitation payments to the plan for that enrollee, effective with the April 2019 coverage month; and

(3) the commissioner shall disenroll the enrollee from medical assistance, subject to any enrollee appeal."

Page 76, after line 20, insert:

"Sec. .... **MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY WORK GROUP.**

Subdivision 1. **Establishment; membership.** (a) A mental health and substance use disorder parity work group is established and shall include the following members:

(1) two members representing health plan companies that offer health plans in the individual market, appointed by the commissioner of commerce;

(2) two members representing health plan companies that offer health plans in the group markets, appointed by the commissioner of commerce;

(3) the commissioner of health or a designee;

(4) the commissioner of commerce or a designee;

(5) the commissioner of management and budget or a designee;

(6) two members representing employers, appointed by the commissioner of commerce;

(7) two members who are providers representing the mental health and substance use disorder community, appointed by the commissioner of commerce; and

(8) two members who are advocates representing the mental health and substance use disorder community, appointed by the commissioner of commerce.

(b) Members of the work group must have expertise in standards for evidence-based care, benefit design, or knowledge relating to the analysis of mental health and substance use disorder parity under federal and state law, including nonquantitative treatment limitations.

Subd. 2. **First appointments; first meeting; chair.** Appointing authorities shall appoint members to the work group by July 1, 2018. The commissioner of commerce or a designee

shall convene the first meeting of the work group on or before August 1, 2018. The commissioner of commerce or the commissioner's designee shall act as chair.

Subd. 3. **Duties.** The mental health and substance use disorder work group shall:

(1) develop recommendations on the most effective approach to determine and demonstrate mental health and substance use disorder parity, in accordance with state and federal law for individual and group health plans offered in Minnesota; and

(2) report recommendations to the legislature.

Subd. 4. **Report.** (a) By February 15, 2019, the work group shall submit a report with recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance.

(b) The report must include the following:

(1) a summary of completed state enforcement actions relating to individual and group health plans offered in Minnesota during the preceding 12-month period regarding compliance with parity in mental health and substance use disorders benefits in accordance with state and federal law, and a summary of the results of completed state enforcement actions. Data that is protected under state or federal law as nonpublic, private, or confidential shall remain nonpublic, private, or confidential. This summary must include:

(i) the number of formal enforcement actions taken;

(ii) the benefit classifications examined in each enforcement action; and

(iii) the subject matter of each enforcement action, including quantitative and nonquantitative treatment limitations;

(2) detailed information about any regulatory actions the commissioner of health or commissioner of commerce has taken as a result of a completed state enforcement action pertaining to health plan compliance with Minnesota Statutes, sections 62Q.47 and 62Q.53, and United States Code, title 42, section 18031(j);

(3) a description of the work group's recommendations on educating the public about alcoholism, mental health, or chemical dependency parity protections under state and federal law; and

(4) recommendations on the most effective approach to determine and demonstrate mental health and substance use disorder parity, in accordance with state and federal law for individual and group health plans offered in Minnesota.

(c) In developing the report and recommendations, the work group may consult with the Substance Abuse and Mental Health Services Agency and the National Association of Insurance Commissioners for the latest developments on evaluation of mental health and substance use disorder parity.

(d) The report must be written in plain language and must be made available to the public by being posted on the Web sites of the Department of Health and Department of Commerce. The work group may make the report publicly available in additional ways, at its discretion.

(e) The report must include any draft legislation necessary to implement the recommendations of the work group.

Subd. 5. **Expiration.** The mental health and substance use disorder parity work group expires February 16, 2019, or the day after submitting the report required in this section, whichever is earlier."

Page 85, after line 3, insert:

"Sec. .... 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) A structured assessment for alcohol or substance use disorder that is provided to a recipient of public assistance by a primary care clinic, hospital, or other medical setting establishes medical necessity and approval for an initial set of substance use disorder services identified in section 254B.05, subdivision 5, when the screen result is positive for alcohol

or substance misuse. The initial set of services approved for a recipient whose screen result is positive shall include four hours of individual or group substance use disorder treatment, two hours of substance use disorder care coordination, and two hours of substance use disorder peer support services. A recipient must obtain an assessment pursuant to paragraph (a) to be approved for additional treatment services.

EFFECTIVE DATE. This section is effective July 1, 2018, contingent on federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained or denied."

Page 86, after line 26, insert:

"Sec. 5. Minnesota Statutes 2017 Supplement, section 256.045, subdivision 3, is amended to read:

Subd. 3. **State agency hearings.** (a) State agency hearings are available for the following:

(1) any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the state agency or a county agency or the federal Food Stamp Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid;

(2) any patient or relative aggrieved by an order of the commissioner under section 252.27;

(3) a party aggrieved by a ruling of a prepaid health plan;

(4) except as provided under chapter 245C, any individual or facility determined by a lead investigative agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557;

(5) any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under section 626.556 is denied or not acted upon with reasonable promptness, regardless of funding source;

(6) any person to whom a right of appeal according to this section is given by other provision of law;

(7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15;

(8) an applicant aggrieved by an adverse decision to an application or redetermination for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;

(9) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under section 626.556, after the individual or facility has exercised the right to administrative reconsideration under section 626.556;

(10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, following a reconsideration decision issued under section 245C.23, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (9) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services judge shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment;

(11) any person with an outstanding debt resulting from receipt of public assistance, medical care, or the federal Food Stamp Act who is contesting a setoff claim by the Department of Human Services or a county agency. The scope of the appeal is the validity of the claimant agency's intention to request a setoff of a refund under chapter 270A against the debt;

(12) a person issued a notice of service termination under section 245D.10, subdivision 3a, from residential supports and services as defined in section 245D.03, subdivision 1, paragraph (c), clause (3), that is not otherwise subject to appeal under subdivision 4a;

(13) an individual disability waiver recipient based on a denial of a request for a rate exception under section 256B.4914; ~~or~~

(14) a person issued a notice of service termination under section 245A.11, subdivision 11, that is not otherwise subject to appeal under subdivision 4a~~.~~; or

(15) a county disputes cost of care under section 246.54 based on administrative or other delay of a client's discharge from a state-operated facility after notification to a county that the client no longer meets medical criteria for the state-operated facility, when the county has developed a viable discharge plan.

(b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10), is the only administrative appeal to the final agency determination specifically, including

a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under paragraph (a), clauses (4), (9), and (10), is only available when there is no district court action pending. If such action is filed in district court while an administrative review is pending that arises out of some or all of the events or circumstances on which the appeal is based, the administrative review must be suspended until the judicial actions are completed. If the district court proceedings are completed, dismissed, or overturned, the matter may be considered in an administrative hearing.

(c) For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

(d) The scope of hearings involving claims to foster care payments under paragraph (a), clause (5), shall be limited to the issue of whether the county is legally responsible for a child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(e) The scope of hearings under paragraph (a), clauses (12) and (14), shall be limited to whether the proposed termination of services is authorized under section 245D.10, subdivision 3a, paragraph (b), or 245A.11, subdivision 11, and whether the requirements of section 245D.10, subdivision 3a, paragraphs (c) to (e), or 245A.11, subdivision 2a, paragraphs (d) to (f), were met. If the appeal includes a request for a temporary stay of termination of services, the scope of the hearing shall also include whether the case management provider has finalized arrangements for a residential facility, a program, or services that will meet the assessed needs of the recipient by the effective date of the service termination.

(f) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

(g) An applicant or recipient is not entitled to receive social services beyond the services prescribed under chapter 256M or other social services the person is eligible for under state law.

(h) The commissioner may summarily affirm the county or state agency's proposed action without a hearing when the sole issue is an automatic change due to a change in state or federal law.

(i) Unless federal or Minnesota law specifies a different time frame in which to file an appeal, an individual or organization specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause, as defined in section 256.0451, subdivision 13, why the request was not submitted within the 30-day time limit. The individual filing the appeal has the burden of proving good cause by a preponderance of the evidence."

Page 98, after line 32, insert:

"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. "

Page 103, line 20, delete "no later than" and insert "on"

Page 228, line 4, delete "18,997,000" and insert "19,865,000"

Page 228, line 5, delete "5,735,000" and insert "5,779,000"

Page 229, line 24, delete "$6,074,000" and insert "$6,136,000"

Page 229, line 25, delete "$6,083,000" and insert "$6,145,000"

Page 230, line 13, delete "1,150,000" and insert "1,836,000"

Page 230, line 21, delete "$858,000" and insert "$2,235,000"

Page 230, line 22, delete "$872,000" and insert "$2,255,000"

Page 230, line 23, delete "640,000" and insert "1,200,000"

Page 230, line 24, delete "$640,000" and insert "$612,000"

Page 230, line 31, delete "$730,000" and insert "$746,000"

Page 230, line 32, delete "$730,000" and insert "$746,000"

Page 231, line 5, delete "8,917,000" and insert "8,495,000"

Page 234, line 23, delete "11,937,000" and insert "11,565,000"

Page 234, line 26, delete "11,853,000" and insert "11,481,000"

Page 234, line 29, delete "9,127,000" and insert "8,505,000"

Page 235, after line 34, insert:

"(f) **Transfer; Mental Health and Substance Use Disorder Parity Work Group.** $75,000 in fiscal year 2019 is from the general fund for transfer to the commissioner of commerce for the mental health and substance use disorder parity work group."

Reletter the paragraphs in sequence

Page 237, line 30, delete "$2,707,000" and insert "4,677,000"

Page 237, line 31, delete "$4,112,000" and insert "$6,082,000"

Page 237, line 34, delete "2,726,000" and insert "2,976,000"

Page 238, after line 2, insert:

"(a) **Technology Upgrades.** $1,250,000 in fiscal year 2019 is from the general fund for technology upgrades at the Office of Health Facility Complaints. These technology upgrades must be provided by an external

vendor selected on a competitive basis by the commissioner of administration. The commissioner shall not transfer this appropriation or use the appropriated funds for any other purpose. This is a onetime appropriation and is available until June 30, 2022."

Page 238, line 4, delete "$1,980,000" and insert "$980,000"

Page 238, line 5, delete "$1,933,000" and insert "$933,000"

Renumber the sections in sequence and correct the internal references

Amend the title accordingly