SENATE
STATE OF MINNESOTA
EIGHTY-NINTH SESSION

S.F. No. 1172

(SENATE AUTHORS: LOUREY)

DATE	D-PG	OFFICIAL STATUS
02/26/2015	442	Introduction and first reading Referred to State and Local Government
03/11/2015		Comm report: To pass as amended and re-refer to Finance

A bill for an act

relating to state government; enacting the Radon Mitigation Licensing Act; changing provisions for lead work standards and methods; modifying supplemental nursing services provisions; establishing an Excellence in Mental Health demonstration project; establishing an opioid prescribing improvement program; amending Minnesota Statutes 2014, sections 144.9508; 144A.72; proposing coding for new law in Minnesota Statutes, chapters 144; 245; 256B.

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

Section 1. **[144.4961] MINNESOTA RADON LICENSING ACT.**

Subdivision 1. **Citation.** This section may be cited as the "Minnesota Radon Licensing Act."

Subd. 2. **Definitions.** (a) As used in this section, the following terms have the meanings given them.

(b) "Mitigation" means the act of repairing or altering a building or building design for the purpose in whole or in part of reducing the concentration of radon in the indoor atmosphere.

(c) "Radon" means both the radioactive, gaseous element produced by the disintegration of radium, and the short-lived radionuclides that are decay products of radon.

Subd. 3. **Rulemaking.** The commissioner of health is responsible for adopting rules for licensure and enforcement of applicable laws and rules relating to indoor radon in dwellings and other buildings, with the exception of newly constructed Minnesota homes according to section 326B.106, subdivision 6. The commissioner is responsible for coordination, oversight, and implementation of all state functions in matters concerning the presence, effects, measurement, and mitigation of risks of radon in dwellings and other buildings.

Subd. 4. **System tag.** All radon mitigation systems installed in Minnesota on or after July 1, 2016, must have a radon mitigation system tag provided by the commissioner. A radon mitigation professional must attach the tag to the radon mitigation system in a visible location.

Subd. 5. **License required annually.** A license is required annually for every person, firm, or corporation that sells a device or performs a service for compensation to detect the presence of radon in the indoor atmosphere, performs laboratory analysis, or performs a service to mitigate radon in the indoor atmosphere. This section does not apply to retail stores that only sell or distribute radon sampling but are not engaged in the manufacture of radon sampling devices.

Subd. 6. **Exemptions.** Radon systems installed in newly constructed Minnesota homes according to section 326B.106, subdivision 6, prior to the issuance of a certificate of occupancy are not required to follow the requirements of this section.

Subd. 7. **License applications and other reports.** The professionals, companies, laboratories, and examinees listed in subdivision 8 must submit applications for licenses, system tags, and any other reporting required under this section and Minnesota Rules on forms prescribed by the commissioner.

Subd. 8. **Licensing fees.** (a) All radon license applications submitted to the commissioner of health must be accompanied by the required fees. If the commissioner determines that insufficient fees were paid, the necessary additional fees must be paid before the commissioner approves the application. The commissioner shall charge the following fees for each radon license:

(1) Each measurement professional license, $600 per year. "Measurement professional" means any person who does not require supervision and performs a test to determine the presence and concentration of radon; provides professional or expert advice on radon testing, radon exposure, or health risks related to radon exposure; provides direct supervision of a measurement technician; or makes representations of doing any of these activities.

(2) Each measurement technician license, $300 per year. "Measurement technician" means any person who is under the direct supervision of a measurement professional, and who performs a test to determine the presence and concentration of radon; provides professional or expert advice on radon testing, radon exposure, or health risks related to radon exposure; or makes representations of doing any of these activities.

(3) Each mitigation professional license, $600 per year. "Mitigation professional" means an individual who does not require supervision and performs radon mitigation; provides professional or expert advice on radon mitigation or radon entry routes; or

provides on-site supervision of radon mitigation and mitigation technicians; or makes representations of doing any of these activities.

(4) Each mitigation technician license, $300 per year. "Mitigation technician" means any person who is under the direct supervision of a mitigation professional and who performs radon mitigation; provides professional or expert advice on radon mitigation or radon entry routes; or makes representations of doing any of these activities.

(5) Each mitigation company license, $800 per year. "Mitigation company" means any business or government entity that performs or authorizes employees to perform radon mitigation. This fee is waived if the company is a sole proprietorship.

(6) Each radon analysis laboratory license, $500 per year. "Radon analysis laboratory" means a business entity or government entity that analyzes passive radon detection devices to determine the presence and concentration of radon in the devices.

(7) Each Minnesota Department of Health radon measurement exam, $125 per exam. "Minnesota Department of Health radon measurement exam" means a radon measurement exam administered by the commissioner of health.

(8) Each Minnesota Department of Health radon mitigation exam, $125 per exam. "Minnesota Department of Health radon mitigation exam" means a radon mitigation exam administered by the commissioner of health.

(9) Each Minnesota Department of Health radon mitigation system tag, $50 per tag. "Minnesota Department of Health radon mitigation system tag" or "system tag" means a unique identifiable radon system label provided by the commissioner of health.

(b) Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

Subd. 9. **Enforcement.** The commissioner shall enforce this section under the provisions of sections 144.989 to 144.993.

EFFECTIVE DATE. This section is effective July 1, 2015, except subdivisions 4 and 5, which are effective July 1, 2016.

Sec. 2. Minnesota Statutes 2014, section 144.9508, is amended to read:

144.9508 RULES.

Subdivision 1. **Sampling and analysis.** The commissioner shall adopt, by rule, methods for:

(1) lead inspections, lead hazard screens, lead risk assessments, and clearance inspections;

(2) environmental surveys of lead in paint, soil, dust, and drinking water to determine areas at high risk for toxic lead exposure;

(3) soil sampling for soil used as replacement soil;

(4) drinking water sampling, which shall be done in accordance with lab certification requirements and analytical techniques specified by Code of Federal Regulations, title 40, section 141.89; and

(5) sampling to determine whether at least 25 percent of the soil samples collected from a census tract within a standard metropolitan statistical area contain lead in concentrations that exceed 100 parts per million.

Subd. 2. **Regulated lead work standards and methods.** (a) The commissioner shall adopt rules establishing regulated lead work standards and methods in accordance with the provisions of this section, for lead in paint, dust, drinking water, and soil in a manner that protects public health and the environment for all residences, including residences also used for a commercial purpose, child care facilities, playgrounds, and schools.

(b) In the rules required by this section, the commissioner shall require lead hazard reduction of intact paint only if the commissioner finds that the intact paint is on a chewable or lead-dust producing surface that is a known source of actual lead exposure to a specific individual. The commissioner shall prohibit methods that disperse lead dust into the air that could accumulate to a level that would exceed the lead dust standard specified under this section. The commissioner shall work cooperatively with the commissioner of administration to determine which lead hazard reduction methods adopted under this section may be used for lead-safe practices including prohibited practices, preparation, disposal, and cleanup. The commissioner shall work cooperatively with the commissioner of the Pollution Control Agency to develop disposal procedures. In adopting rules under this section, the commissioner shall require the best available technology for regulated lead work methods, paint stabilization, and repainting.

(c) The commissioner of health shall adopt regulated lead work standards and methods for lead in bare soil in a manner to protect public health and the environment. The commissioner shall adopt a maximum standard of 100 parts of lead per million in bare soil. The commissioner shall set a soil replacement standard not to exceed 25 parts of lead per million. Soil lead hazard reduction methods shall focus on erosion control and covering of bare soil.

(d) The commissioner shall adopt regulated lead work standards and methods for lead in dust in a manner to protect the public health and environment. Dust standards shall use a weight of lead per area measure and include dust on the floor, on the window sills, and

on window wells. Lead hazard reduction methods for dust shall focus on dust removal and other practices which minimize the formation of lead dust from paint, soil, or other sources.

(e) The commissioner shall adopt lead hazard reduction standards and methods for lead in drinking water both at the tap and public water supply system or private well in a manner to protect the public health and the environment. The commissioner may adopt the rules for controlling lead in drinking water as contained in Code of Federal Regulations, title 40, part 141. Drinking water lead hazard reduction methods may include an educational approach of minimizing lead exposure from lead in drinking water.

(f) The commissioner of the Pollution Control Agency shall adopt rules to ensure that removal of exterior lead-based coatings from residences and steel structures by abrasive blasting methods is conducted in a manner that protects health and the environment.

(g) All regulated lead work standards shall provide reasonable margins of safety that are consistent with more than a summary review of scientific evidence and an emphasis on overprotection rather than underprotection when the scientific evidence is ambiguous.

(h) No unit of local government shall have an ordinance or regulation governing regulated lead work standards or methods for lead in paint, dust, drinking water, or soil that require a different regulated lead work standard or method than the standards or methods established under this section.

(i) Notwithstanding paragraph (h), the commissioner may approve the use by a unit of local government of an innovative lead hazard reduction method which is consistent in approach with methods established under this section.

(j) The commissioner shall adopt rules for issuing lead orders required under section 144.9504, rules for notification of abatement or interim control activities requirements, and other rules necessary to implement sections 144.9501 to 144.9512.

(k) The commissioner shall adopt rules consistent with section 402(c)(3) of the Toxic Substances Control Act to ensure that renovation in a pre-1978 affected property where a child or pregnant female resides is conducted in a manner that protects health and the environment. Notwithstanding sections 14.125 and 14.128, the authority to adopt these rules does not expire.

(l) The commissioner shall adopt rules consistent with sections 406(a) and 406(b) of the Toxic Substances Control Act. Notwithstanding sections 14.125 and 14.128, the authority to adopt these rules does not expire.

Subd. 2a. **Lead standards for exterior surfaces and street dust.** The commissioner may, by rule, establish lead standards for exterior horizontal surfaces, concrete or other impervious surfaces, and street dust on residential property to protect the public health and the environment.

Subd. 3. **Licensure and certification.** The commissioner shall adopt rules to license lead supervisors, lead workers, lead project designers, lead inspectors, lead risk assessors, and lead sampling technicians. The commissioner shall also adopt rules requiring certification of firms that perform regulated lead work. The commissioner shall require periodic renewal of licenses and certificates and shall establish the renewal periods.

Subd. 4. **Lead training course.** The commissioner shall establish by rule requirements for training course providers and the renewal period for each lead-related training course required for certification or licensure. The commissioner shall establish criteria in rules for the content and presentation of training courses intended to qualify trainees for licensure under subdivision 3. The commissioner shall establish criteria in rules for the content and presentation of training courses for lead renovation and lead sampling technicians. ~~Training course permit fees shall be nonrefundable and must be submitted with each application in the amount of $500 for an initial training course, $250 for renewal of a permit for an initial training course, $250 for a refresher training course, and $125 for renewal of a permit of a refresher training course.~~

Subd. 5. **Variances.** In adopting the rules required under this section, the commissioner shall provide variance procedures for any provision in rules adopted under this section, except for the numerical standards for the concentrations of lead in paint, dust, bare soil, and drinking water. A variance shall be considered only according to the procedures and criteria in Minnesota Rules, parts 4717.7000 to 4717.7050.

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

Sec. 3. Minnesota Statutes 2014, section 144A.72, is amended to read:

144A.72 REGISTRATION REQUIREMENTS; PENALTIES.

Subdivision 1. **Minimum criteria.** (a) The commissioner shall require that, as a condition of registration:

(1) the supplemental nursing services agency shall document that each temporary employee provided to health care facilities currently meets the minimum licensing, training, and continuing education standards for the position in which the employee will be working;

(2) the supplemental nursing services agency shall comply with all pertinent requirements relating to the health and other qualifications of personnel employed in health care facilities;

(3) the supplemental nursing services agency must not restrict in any manner the employment opportunities of its employees;

(4) the supplemental nursing services agency shall carry medical malpractice insurance to insure against the loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in the provision of health care services by the supplemental nursing services agency or by any employee of the agency;

(5) the supplemental nursing services agency shall carry an employee dishonesty bond in the amount of $10,000;

(6) the supplemental nursing services agency shall maintain insurance coverage for workers' compensation for all nurses, nursing assistants, nurse aides, and orderlies provided or procured by the agency;

(7) the supplemental nursing services agency shall file with the commissioner of revenue: (i) the name and address of the bank, savings bank, or savings association in which the supplemental nursing services agency deposits all employee income tax withholdings; and (ii) the name and address of any nurse, nursing assistant, nurse aide, or orderly whose income is derived from placement by the agency, if the agency purports the income is not subject to withholding;

(8) the supplemental nursing services agency must not, in any contract with any employee or health care facility, require the payment of liquidated damages, employment fees, or other compensation should the employee be hired as a permanent employee of a health care facility; ~~and~~

(9) the supplemental nursing services agency shall document that each temporary employee provided to health care facilities is an employee of the agency and is not an independent contractor~~.~~; and

(10) the supplemental nursing services agency shall retain all records for five calendar years. All records of the supplemental nursing services agency must be immediately available to the department.

(b) In order to retain registration, the supplemental nursing services agency must provide services to a health care facility during the year preceding the supplemental nursing services agency's registration renewal date.

Subd. 2. **Penalties.** ~~A pattern of~~ Failure to comply with this section shall subject the supplemental nursing services agency to revocation or nonrenewal of its registration. Violations of section 144A.74 are subject to a fine equal to 200 percent of the amount billed or received in excess of the maximum permitted under that section.

Subd. 3. **Revocation.** Notwithstanding subdivision 2, the registration of a supplemental nursing services agency that knowingly supplies to a health care facility a person with an illegally or fraudulently obtained or issued diploma, registration, license,

certificate, or background study shall be revoked by the commissioner. The commissioner shall notify the supplemental nursing services agency 15 days in advance of the date of revocation.

Subd. 4. **Hearing.** (a) No supplemental nursing services agency's registration may be revoked without a hearing held as a contested case in accordance with ~~chapter 14. The hearing must commence within 60 days after the proceedings are initiated~~ section 144A.475, subdivisions 3a and 7, except the hearing must be conducted by an administrative law judge within 60 calendar days of the request for assignment.

(b) If a controlling person has been notified by the commissioner of health that the supplemental nursing services agency will not receive an initial registration or that a renewal of the registration has been denied, the controlling person or a legal representative on behalf of the supplemental nursing services agency may request and receive a hearing on the denial. ~~This~~ The hearing shall be ~~held as a contested case in accordance with chapter 14~~ a contested case in accordance with section 144A.475, subdivisions 3a and 7, except the hearing must be conducted by an administrative law judge within 60 calendar days of the request for assignment.

Subd. 5. **Period of ineligibility.** (a) The controlling person of a supplemental nursing services agency whose registration has not been renewed or has been revoked because of noncompliance with the provisions of sections 144A.70 to 144A.74 shall not be eligible to apply for nor will be granted a registration for five years following the effective date of the nonrenewal or revocation.

(b) The commissioner shall not issue or renew a registration to a supplemental nursing services agency if a controlling person includes any individual or entity who was a controlling person of a supplemental nursing services agency whose registration was not renewed or was revoked as described in paragraph (a) for five years following the effective date of nonrenewal or revocation.

Sec. 4. **[245.735] EXCELLENCE IN MENTAL HEALTH DEMONSTRATION PROJECT.**

Subdivision 1. **Excellence in Mental Health demonstration project.** The commissioner shall develop and execute projects to reform the mental health system by participating in the Excellence in Mental Health demonstration project.

Subd. 2. **Federal proposal.** The commissioner shall develop and submit to the United States Department of Health and Human Services a proposal for the Excellence in Mental Health demonstration project. The proposal shall include any necessary state

plan amendments, waivers, requests for new funding, realignment of existing funding, and other authority necessary to implement the projects specified in subdivision 4.

Subd. 3. **Rules.** By January 15, 2017, the commissioner shall adopt rules that meet the criteria in subdivision 4, paragraph (a), to establish standards for state certification of community behavioral health clinics, and rules that meet the criteria in subdivision 4, paragraph (b), to implement a prospective payment system for medical assistance payment of mental health services delivered in certified community behavioral health clinics. These rules shall comply with federal requirements for certification of community behavioral health clinics and the prospective payment system and shall apply to community mental health centers, mental health clinics, mental health residential treatment centers, essential community providers, federally qualified health centers, and rural health clinics. The commissioner may adopt rules under this subdivision using the expedited process in section 14.389.

Subd. 4. **Reform projects.** (a) The commissioner shall establish standards for state certification of a clinic as a certified community behavioral health clinic, in accordance with the criteria published on or before September 1, 2015, by the United States Department of Health and Human Services. Certification standards established by the commissioner shall require that:

(1) clinic staff have backgrounds in diverse disciplines, include licensed mental health professionals, and are culturally and linguistically trained to serve the needs of the clinic's patient population;

(2) clinic services are available and accessible and that crisis management services are available 24 hours per day;

(3) fees for clinic services are established using a sliding fee scale and services to patients are not denied or limited due to a patient's inability to pay for services;

(4) clinics provide coordination of care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral needs. Care coordination may be accomplished through partnerships or formal contracts with federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, community-based mental health providers, and other community services, supports, and providers including schools, child welfare agencies, juvenile and criminal justice agencies, Indian Health Services clinics, tribally licensed health care and mental health facilities, urban Indian health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics;

(5) services provided by clinics include crisis mental health services, emergency crisis intervention services, and stabilization services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; patient-centered treatment planning; outpatient mental health and substance use services; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family support services; and intensive community-based mental health services, including mental health services for members of the armed forces and veterans; and

(6) clinics comply with quality assurance reporting requirements and other reporting requirements, including any required reporting of encounter data, clinical outcomes data, and quality data.

(b) The commissioner shall establish standards and methodologies for a prospective payment system for medical assistance payments for mental health services delivered by certified community behavioral health clinics, in accordance with guidance issued on or before September 1, 2015, by the Centers for Medicare and Medicaid Services. During the operation of the demonstration project, payments shall comply with federal requirements for a 90 percent enhanced federal medical assistance percentage.

Subd. 5. **Public participation.** In developing the projects under subdivision 4, the commissioner shall consult with mental health providers, advocacy organizations, licensed mental health professionals, and Minnesota health care program enrollees who receive mental health services and their families.

Subd. 6. **Information systems support.** The commissioner and the state chief information officer shall provide information systems support to the projects as necessary to comply with federal requirements and the deadlines in subdivision 3.

Sec. 5. **[256B.0638] OPIOID PRESCRIBING IMPROVEMENT PROGRAM.**

Subdivision 1. **Program established.** The commissioner of human services and the commissioner of health shall coordinate and implement a statewide opioid prescribing improvement program to reduce opioid dependency and substance use by Minnesotans due to the prescribing of opioid analgesics by health care providers.

Subd. 2. **Definitions.** (a) The terms defined in this section have the meanings given them.

(b) "Commissioner" means the commissioner of human services.

(c) "Commissioners" means the commissioner of human services and the commissioner of health.

(d) "DEA" means the United States Drug Enforcement Administration.

(e) "MHCP" means Minnesota health care programs.

(f) "MHCP opioid disenrollment standards" means parameters of opioid prescribing practices that fall outside community standard thresholds for prescribing to such a degree that a provider must be disenrolled from MHCP.

(g) "MHCP opioid prescriber" means a licensed health care provider who prescribes opioids to MHCP recipients.

(h) "Nonpublic data" has the meaning given in section 13.02, subdivision 9.

(i) "OPWG" means the opioid prescribing work group.

(j) "Private data on individuals" has the meaning given in section 13.02, subdivision 12.

(k) "Program" means the statewide opioid prescribing improvement program established under this section.

(l) "Provider group" means a clinic, hospital, or primary or specialty practice group that employs, contracts with, or is affiliated with an MHCP opioid prescriber. Provider group does not include a professional association supported by dues-paying members.

(m) "MHCP opioid quality improvement standard thresholds" means parameters of opioid prescribing practices that fall outside community standards for prescribing to such a degree that quality improvement is required.

(n) "Sentinel measures" means measures of opioid use that identify variations in prescribing practices during the prescribing intervals.

Subd. 3. **Opioid prescribing work group.** (a) The commissioners shall establish an opioid prescribing work group. The commissioners shall appoint to the OPWG the voting members listed in paragraph (b) and the nonvoting members listed in paragraph (c).

(b) The OPWG's voting members shall consist of:

(1) at least two consumer members who have been impacted by opioid abuse disorder or opioid dependence disorder, either personally or in their families;

(2) one licensed physician actively practicing in Minnesota and registered as a practitioner with the DEA;

(3) one licensed pharmacist actively practicing in Minnesota and registered as a practitioner with the DEA;

(4) one licensed nurse practitioner actively practicing in Minnesota and registered as a practitioner with the DEA;

(5) one licensed dentist actively practicing in Minnesota and registered as a practitioner with the DEA;

(6) one nonphysician health care professional who is licensed or registered in that profession, who is actively engaged in the practice of that profession in Minnesota, and whose practice includes treating pain;

(7) one health or mental health professional who is licensed or registered in that profession, who is actively engaged in the practice of that profession in Minnesota, and whose practice includes treating patients with chemical dependency or substance abuse;

(8) one medical examiner for a Minnesota county;

(9) one voting member of the Health Services Policy Committee established under section 256B.0625, subdivisions 3c to 3e;

(10) at least one medical director of a health plan company doing business in Minnesota;

(11) at least one pharmacy director of a health plan company doing business in Minnesota; and

(12) one representative of Minnesota law enforcement.

(c) The OPWG's nonvoting members shall consist of:

(1) one representative of the Department of Health;

(2) the medical director for MHCP;

(3) one representative of the Department of Human Services' pharmacy program; and

(4) the medical director for the Department of Labor and Industry.

(d) An honorarium of $200 per meeting and reimbursement for mileage and parking shall be paid to each voting member in attendance.

Subd. 4. **Program components.** (a) The OPWG shall recommend to the commissioners the components of the statewide opioid prescribing improvement program, which shall include but are not limited to the following components:

(1) developing criteria for opioid prescribing protocols, including:

(i) prescribing for the interval of up to four days immediately after an acute painful event;

(ii) prescribing for the interval of up to 45 days after an acute painful event; and

(iii) prescribing for chronic pain, which means pain lasting longer than 45 days after an acute painful event;

(2) developing sentinel measures;

(3) developing educational resources for opioid prescribers about communicating with patients about pain management and the use of opioids to treat pain;

(4) developing MHCP opioid quality improvement standard thresholds and MHCP opioid disenrollment standards for MHCP opioid prescribers and provider groups. MHCP opioid disenrollment standards may be described in terms of the length of time in which prescribing practices fall outside community standards and the nature and amount of opioid prescribing that fall outside community standards; and

(5) addressing other program issues as determined by the commissioners.

(b) The program shall not apply to opioids prescribed for patients who are experiencing pain caused by a malignant condition or who are receiving hospice care, or to opioids prescribed as medication-assisted therapy to treat opioid dependency.

(c) Except as specified in subdivision 6, provider implementation of the program shall be voluntary.

Subd. 5. **Annual report to legislature.** By September 15, 2016, and annually thereafter, the commissioner of health shall report to the legislature on the status of the program statewide, and the commissioner of human services shall report to the legislature on the status of its implementation in MHCP. The reports shall include but not be limited to data on statewide utilization of opioids and the utilization of opioids within MHCP.

Subd. 6. **Program implementation.** (a) The commissioner shall implement the program within MHCP to improve the health of and quality of care provided to MHCP recipients. The commissioner shall annually collect and report to MHCP opioid prescribers, data showing the sentinel measures of their opioid prescribing patterns compared to their anonymized peers.

(b) The commissioner shall notify an MHCP opioid prescriber and all provider groups with which the MHCP opioid prescriber is employed or affiliated when the MHCP opioid prescriber's prescribing pattern exceeds the MHCP opioid quality improvement standard thresholds. A prescriber and any provider group that receives a notice under this paragraph shall submit a quality improvement plan for review and approval by the commissioner with the goal of bringing the prescriber's prescribing practices into alignment with community standards. A quality improvement plan must include but is not limited to:

(1) components of the program described in subdivision 4, paragraph (a);

(2) internal practice-based measures to review the prescribing practice of the MHCP opioid prescriber and, where appropriate, any other MHCP opioid prescribers employed by or affiliated with any of the provider groups with which the MHCP opioid prescriber is employed or affiliated; and

(3) appropriate use of the prescription monitoring program under section 152.126.

(c) If, after a year from the commissioner's notice under paragraph (b), the MHCP opioid prescriber's prescribing practices do not improve so that they are consistent with community standards, the commissioner shall take one or more of the following steps:

(1) monitor prescribing practices more frequently than annually;

(2) monitor more aspects of the prescriber's prescribing practices than the sentinel measures; or

(3) require the prescriber to participate in additional quality improvement efforts, including but not limited to mandatory use of the prescription monitoring program.

(d) The commissioner shall disenroll from MHCP all MHCP opioid prescribers and provider groups that meet applicable MHCP opioid disenrollment standards.

Subd. 7. **Data practices.** (a) Reports and data identifying an MHCP opioid prescriber are private data on individuals until an MHCP opioid prescriber is subject to disenrollment under this section. Notwithstanding this data classification, the commissioner shall share with all of the provider groups with which an MHCP opioid prescriber is employed or affiliated, a report identifying an MHCP opioid prescriber who is subject to quality improvement activities under subdivision 6, paragraph (b) or (c).

(b) Reports and data identifying a provider group are nonpublic data until the provider group is subject to disenrollment under this section.

(c) Upon disenrollment under this section, reports and data identifying an MHCP opioid prescriber or provider group are public, except that any identifying information for MHCP recipients must be redacted.