CHAPTER 62J

HEALTH CARE COST CONTAINMENT

62J.04 MONITORING THE RATE OF GROWTH OF HEALTH CARE SPENDING.

[For text of subds 1 and 1a, see M.S.2002]

Subd. 3. **Cost containment duties.** The commissioner shall:

(1) establish statewide and regional cost containment goals for total health care spending under this section and collect data as described in sections 62J.38 to 62J.41 to monitor statewide achievement of the cost containment goals;

(2) divide the state into no fewer than four regions, with one of those regions being the Minneapolis/St. Paul metropolitan statistical area but excluding Chisago, Isanti, Wright, and Sherburne Counties, for purposes of fostering the development of regional health planning and coordination of health care delivery among regional health care systems and working to achieve the cost containment goals;

(3) monitor the quality of health care throughout the state and take action as necessary to ensure an appropriate level of quality;

(4) issue recommendations regarding uniform billing forms, uniform electronic billing procedures and data interchanges, patient identification cards, and other uniform claims and administrative procedures for health care providers and private and public sector payers. In developing the recommendations, the commissioner shall review the work of the work group on electronic data interchange (WEDI) and the American National Standards Institute (ANSI) at the national level, and the work being done at the state and local level. The commissioner may adopt rules requiring the use of the Uniform Bill 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic version, the Centers for Medicare and Medicaid Services 1500 form, or other standardized forms or procedures;

(5) undertake health planning responsibilities;

(6) authorize, fund, or promote research and experimentation on new technologies and health care procedures;

(7) within the limits of appropriations for these purposes, administer or contract for statewide consumer education and wellness programs that will improve the health of Minnesotans and increase individual responsibility relating to personal health and the delivery of health care services, undertake prevention programs including initiatives to improve birth outcomes, expand childhood immunization efforts, and provide start-up grants for worksite wellness programs;

(8) undertake other activities to monitor and oversee the delivery of health care services in Minnesota with the goal of improving affordability, quality, and accessibility of health care for all Minnesotans; and

(9) make the cost containment goal data available to the public in a consumer-oriented manner.

[For text of subds 5 to 9, see M.S.2002]

History: *1Sp2003 c 14 art 7 s 88*

62J.06 IMMUNITY FROM LIABILITY.

No member of the Health Technology Advisory Committee shall be held civilly or criminally liable for an act or omission by that person if the act or omission was in good faith and within the scope of the member's responsibilities under this chapter.

History: *1Sp2003 c 14 art 7 s 88*

62J.15 Subdivision 1.[Repealed, 1Sp2003 c 14 art 7 s 89]

Subd. 1a. [Repealed, 1Sp2003 c 14 art 7 s 89]

Subd. 2. [Repealed, 1993 c 345 art 4 s 7; 1Sp2003 c 14 art 7 s 89]

62J.152 Subdivision 1.[Repealed, 1Sp2003 c 14 art 7 s 89]

Subd. 1a. [Repealed, 1Sp2003 c 14 art 7 s 89]

Subd. 2. [Repealed, 1Sp2003 c 14 art 7 s 89]

Subd. 3. [Repealed, 1Sp2003 c 14 art 7 s 89]

Subd. 4. [Repealed, 1Sp2003 c 14 art 7 s 89]

Subd. 5. [Repealed, 1Sp2003 c 14 art 7 s 89]

Subd. 6. [Repealed, 1995 c 234 art 3 s 10; 1Sp2003 c 14 art 7 s 89]

Subd. 7. [Repealed, 1Sp2003 c 14 art 7 s 89]

Subd. 8. [Repealed, 1Sp2003 c 14 art 7 s 89]

62J.156 CLOSED COMMITTEE HEARINGS.

Notwithstanding chapter 13D, the Health Technology Advisory Committee may meet in closed session to discuss a specific technology or procedure that involves data received that have been classified as nonpublic data, where disclosure of the data would cause harm to the competitive or economic position of the source of the data.

History: *1Sp2003 c 14 art 7 s 88*

62J.17 EXPENDITURE REPORTING.

[For text of subd 1, see M.S.2002]

Subd. 2. **Definitions.** For purposes of this section, the terms defined in this subdivision have the meanings given.

(a) "Access" means the financial, temporal, and geographic availability of health care to individuals who need it.

(b) "Capital expenditure" means an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance.

(c) "Cost" means the amount paid by consumers or third party payers for health care services or products.

(d) "Date of the major spending commitment" means the date the provider formally obligated itself to the major spending commitment. The obligation may be incurred by entering into a contract, making a down payment, issuing bonds or entering a loan agreement to provide financing for the major spending commitment, or taking some other formal, tangible action evidencing the provider's intention to make the major spending commitment.

(e) "Health care service" means:

(1) a service or item that would be covered by the medical assistance program under chapter 256B if provided in accordance with medical assistance requirements to an eligible medical assistance recipient; and

(2) a service or item that would be covered by medical assistance except that it is characterized as experimental, cosmetic, or voluntary.

"Health care service" does not include retail, over-the-counter sales of nonprescription drugs and other retail sales of health-related products that are not generally paid for by medical assistance and other third-party coverage.

(f) "Major spending commitment" means an expenditure in excess of $1,000,000 for:

(1) acquisition of a unit of medical equipment;

(2) a capital expenditure for a single project for the purposes of providing health care services, other than for the acquisition of medical equipment;

(3) offering a new specialized service not offered before;

(4) planning for an activity that would qualify as a major spending commitment under this paragraph; or

(5) a project involving a combination of two or more of the activities in clauses (1) to (4).

The cost of acquisition of medical equipment, and the amount of a capital expenditure, is the total cost to the provider regardless of whether the cost is distributed over time through a lease arrangement or other financing or payment mechanism.

(g) "Medical equipment" means fixed and movable equipment that is used by a provider in the provision of a health care service. "Medical equipment" includes, but is not limited to, the following:

(1) an extracorporeal shock wave lithotripter;

(2) a computerized axial tomography (CAT) scanner;

(3) a magnetic resonance imaging (MRI) unit;

(4) a positron emission tomography (PET) scanner; and

(5) emergency and nonemergency medical transportation equipment and vehicles.

(h) "New specialized service" means a specialized health care procedure or treatment regimen offered by a provider that was not previously offered by the provider, including, but not limited to:

(1) cardiac catheterization services involving high-risk patients as defined in the Guidelines for Coronary Angiography established by the American Heart Association and the American College of Cardiology;

(2) heart, heart-lung, liver, kidney, bowel, or pancreas transplantation service, or any other service for transplantation of any other organ;

(3) megavoltage radiation therapy;

(4) open heart surgery;

(5) neonatal intensive care services; and

(6) any new medical technology for which premarket approval has been granted by the United States Food and Drug Administration, excluding implantable and wearable devices.

[For text of subds 3 to 8, see M.S.2002]

History: *1Sp2003 c 14 art 7 s 11*

62J.23 PROVIDER CONFLICTS OF INTEREST.

[For text of subds 1 to 4, see M.S.2002]

Subd. 5. **Audits of exempt providers.** The commissioner may audit the referral patterns of providers that qualify for exceptions under the federal Stark Law, United States Code, title 42, section 1395nn. The commissioner has access to provider records according to section 144.99, subdivision 2. The commissioner shall report to the legislature any audit results that reveal a pattern of referrals by a provider for the

furnishing of health services to an entity with which the provider has a direct or indirect financial relationship.

History: *1Sp2003 c 14 art 7 s 12*

62J.26 EVALUATION OF PROPOSED HEALTH COVERAGE MANDATES.

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given unless the context otherwise requires:

(1) "commissioner" means the commissioner of commerce;

(2) "health plan" means a health plan as defined in section 62A.011, subdivision 3, but includes coverage listed in clauses (7) and (10) of that definition;

(3) "mandated health benefit proposal" means a proposal that would statutorily require a health plan to do the following:

(i) provide coverage or increase the amount of coverage for the treatment of a particular disease, condition, or other health care need;

(ii) provide coverage or increase the amount of coverage of a particular type of health care treatment or service or of equipment, supplies, or drugs used in connection with a health care treatment or service; or

(iii) provide coverage for care delivered by a specific type of provider.

"Mandated health benefit proposal" does not include health benefit proposals amending the scope of practice of a licensed health care professional.

Subd. 2. **Evaluation process and content.** (a) The commissioner, in consultation with the commissioners of health and employee relations, must evaluate mandated health benefit proposals as provided under subdivision 3.

(b) The purpose of the evaluation is to provide the legislature with a complete and timely analysis of all ramifications of any mandated health benefit proposal. The evaluation must include, in addition to other relevant information, the following:

(1) scientific and medical information on the proposed health benefit, on the potential for harm or benefit to the patient, and on the comparative benefit or harm from alternative forms of treatment;

(2) public health, economic, and fiscal impacts of the proposed mandate on persons receiving health services in Minnesota, on the relative cost-effectiveness of the benefit, and on the health care system in general;

(3) the extent to which the service is generally utilized by a significant portion of the population;

(4) the extent to which insurance coverage for the proposed mandated benefit is already generally available;

(5) the extent to which the mandated coverage will increase or decrease the cost of the service; and

(6) the commissioner may consider actuarial analysis done by health insurers in determining the cost of the proposed mandated benefit.

(c) The commissioner must summarize the nature and quality of available information on these issues, and, if possible, must provide preliminary information to the public. The commissioner may conduct research on these issues or may determine that existing research is sufficient to meet the informational needs of the legislature. The commissioner may seek the assistance and advice of researchers, community leaders, or other persons or organizations with relevant expertise.

Subd. 3. **Requests for evaluation.** (a) Whenever a legislative measure containing a mandated health benefit proposal is introduced as a bill or offered as an amendment to a bill, or is likely to be introduced as a bill or offered as an amendment, a chair of any standing legislative committee that has jurisdiction over the subject matter of the proposal may request that the commissioner complete an evaluation of the proposal under this section, to inform any committee of floor action by either house of the legislature.

(b) The commissioner must conduct an evaluation described in subdivision 2 of each mandated health benefit proposal for which an evaluation is requested under paragraph (a), unless the commissioner determines under paragraph (c) or subdivision 4 that priorities and resources do not permit its evaluation.

(c) If requests for evaluation of multiple proposals are received, the commissioner must consult with the chairs of the standing legislative committees having jurisdiction over the subject matter of the mandated health benefit proposals to prioritize the requests and establish a reporting date for each proposal to be evaluated. The commissioner is not required to direct an unreasonable quantity of the commissioner's resources to these evaluations.

Subd. 4. **Sources of funding.** (a) The commissioner need not use any funds for purposes of this section other than as provided in this subdivision or as specified in an appropriation.

(b) The commissioner may seek and accept funding from sources other than the state to pay for evaluations under this section to supplement or replace state appropriations. Any money received under this paragraph must be deposited in the state treasury, credited to a separate account for this purpose in the special revenue fund, and is appropriated to the commissioner for purposes of this section.

(c) If a request for an evaluation under this section has been made, the commissioner may use for purposes of the evaluation:

(1) any funds appropriated to the commissioner specifically for purposes of this section; or

(2) funds available under paragraph (b), if use of the funds for evaluation of that mandated health benefit proposal is consistent with any restrictions imposed by the source of the funds.

(d) The commissioner must ensure that the source of the funding has no influence on the process or outcome of the evaluation.

Subd. 5. **Report to legislature.** The commissioner must submit a written report on the evaluation to the legislature no later than 180 days after the request. The report must be submitted in compliance with sections 3.195 and 3.197.

History: *1Sp2003 c 14 art 7 s 13*

62J.321 DATA COLLECTION AND PROCESSING PROCEDURES.

Subdivision 1. **Data collection.** (a) The commissioner shall collect data from health care providers, health plan companies, and individuals in the most cost-effective manner, which does not unduly burden them. The commissioner may require health care providers and health plan companies to collect and provide patient health records and claim files, and cooperate in other ways with the data collection process. The commissioner may also require health care providers and health plan companies to provide mailing lists of patients. Patient consent shall not be required for the release of data to the commissioner pursuant to sections 62J.301 to 62J.42 by any group purchaser, health plan company, health care provider; or agent, contractor, or association acting on behalf of a group purchaser or health care provider. Any group purchaser, health plan company, health care provider; or agent, contractor, or association acting on behalf of a group purchaser or health care provider, that releases data to the commissioner in good faith pursuant to sections 62J.301 to 62J.42 shall be immune from civil liability and criminal prosecution.

(b) When a group purchaser, health plan company, or health care provider submits patient identifying data to the commissioner pursuant to sections 62J.301 to 62J.42, and the data is submitted to the commissioner in electronic form, or through other electronic means including, but not limited to, the electronic data interchange system, the group purchaser, health plan company, or health care provider shall submit the patient identifying data in encrypted form, using an encryption method specified by the commissioner. Submission of encrypted data as provided in this paragraph satisfies the requirements of section 144.335, subdivision 3b.

(c) The commissioner shall require all health care providers, group purchasers, and state agencies to use a standard patient identifier and a standard identifier for providers and health plan companies when reporting data under this chapter. The commissioner must encrypt patient identifiers to prevent identification of individual patients and to enable release of otherwise private data to researchers, providers, and group purchasers in a manner consistent with chapter 13 and sections 62J.55 and 144.335. This encryption must ensure that any data released must be in a form that makes it impossible to identify individual patients.

[For text of subds 2 to 5a, see M.S.2002]

Subd. 6. **Rulemaking.** The commissioner may adopt rules to implement sections 62J.301 to 62J.42.

[For text of subds 7 and 8, see M.S.2002]

History: *1Sp2003 c 14 art 7 s 88*

62J.451 [Repealed, 1Sp2003 c 14 art 7 s 89]

62J.452 [Repealed, 1Sp2003 c 14 art 7 s 89]

62J.52 ESTABLISHMENT OF UNIFORM BILLING FORMS.

Subdivision 1. **Uniform billing form HCFA 1450.** (a) On and after January 1, 1996, all institutional inpatient hospital services, ancillary services, institutionally owned or operated outpatient services rendered by providers in Minnesota, and institutional or noninstitutional home health services that are not being billed using an equivalent electronic billing format, must be billed using the uniform billing form HCFA 1450, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form HCFA 1450 shall be in accordance with the uniform billing form manual specified by the commissioner. In promulgating these instructions, the commissioner may utilize the manual developed by the National Uniform Billing Committee, as adopted and finalized by the Minnesota Uniform Billing Committee.

(c) Services to be billed using the uniform billing form HCFA 1450 include: institutional inpatient hospital services and distinct units in the hospital such as psychiatric unit services, physical therapy unit services, swing bed (SNF) services, inpatient state psychiatric hospital services, inpatient skilled nursing facility services, home health services (Medicare part A), and hospice services; ancillary services, where benefits are exhausted or patient has no Medicare part A, from hospitals, state psychiatric hospitals, skilled nursing facilities, and home health (Medicare part B); institutional owned or operated outpatient services such as waivered services, hospital outpatient services, including ambulatory surgical center services, hospital referred laboratory services, hospital-based ambulance services, and other hospital outpatient services, skilled nursing facilities, home health, freestanding renal dialysis centers, comprehensive outpatient rehabilitation facilities (CORF), outpatient rehabilitation facilities (ORF), rural health clinics, and community mental health centers; home health services such as home health intravenous therapy providers, waivered services, personal care attendants, and hospice; and any other health care provider certified by the Medicare program to use this form.

(d) On and after January 1, 1996, a mother and newborn child must be billed separately, and must not be combined on one claim form.

Subd. 2. **Uniform billing form HCFA 1500.** (a) On and after January 1, 1996, all noninstitutional health care services rendered by providers in Minnesota except dental or pharmacy providers, that are not currently being billed using an equivalent electronic billing format, must be billed using the health insurance claim form HCFA 1500, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form HCFA 1500 shall be in accordance with the manual developed by the Administrative Unifor-

mity Committee entitled standards for the use of the HCFA 1500 form, dated February 1994, as further defined by the commissioner.

(c) Services to be billed using the uniform billing form HCFA 1500 include physician services and supplies, durable medical equipment, noninstitutional ambulance services, independent ancillary services including occupational therapy, physical therapy, speech therapy and audiology, home infusion therapy, podiatry services, optometry services, mental health licensed professional services, substance abuse licensed professional services, nursing practitioner professional services, certified registered nurse anesthetists, chiropractors, physician assistants, laboratories, medical suppliers, and other health care providers such as day activity centers and freestanding ambulatory surgical centers.

[For text of subds 3 to 5, see M.S.2002]

History: *1Sp2003 c 14 art 7 s 14,15*

62J.66 [Repealed, 1Sp2003 c 14 art 2 s 57]

62J.68 [Repealed, 1Sp2003 c 14 art 2 s 57]

62J.692 MEDICAL EDUCATION.

[For text of subds 1 and 2, see M.S.2002]

Subd. 3. **Application process.** (a) A clinical medical education program conducted in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners, dentists, chiropractors, or physician assistants is eligible for funds under subdivision 4 if the program:

(1) is funded, in part, by patient care revenues;

(2) occurs in patient care settings that face increased financial pressure as a result of competition with nonteaching patient care entities; and

(3) emphasizes primary care or specialties that are in undersupply in Minnesota.

(b) A clinical medical education program for advanced practice nursing is eligible for funds under subdivision 4 if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College Council.

(c) Applications must be submitted to the commissioner by a sponsoring institution on behalf of an eligible clinical medical education program and must be received by October 31 of each year for distribution in the following year. An application for funds must contain the following information:

(1) the official name and address of the sponsoring institution and the official name and site address of the clinical medical education programs on whose behalf the sponsoring institution is applying;

(2) the name, title, and business address of those persons responsible for administering the funds;

(3) for each clinical medical education program for which funds are being sought; the type and specialty orientation of trainees in the program; the name, site address, and medical assistance provider number of each training site used in the program; the total number of trainees at each training site; and the total number of eligible trainee FTEs at each site. Only those training sites that host 0.5 FTE or more eligible trainees for a program may be included in the program's application; and

(4) other supporting information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable distribution of funds.

(d) An application must include the information specified in clauses (1) to (3) for each clinical medical education program on an annual basis for three consecutive years.

After that time, an application must include the information specified in clauses (1) to (3) in the first year of each biennium:

(1) audited clinical training costs per trainee for each clinical medical education program when available or estimates of clinical training costs based on audited financial data;

(2) a description of current sources of funding for clinical medical education costs, including a description and dollar amount of all state and federal financial support, including Medicare direct and indirect payments; and

(3) other revenue received for the purposes of clinical training.

(e) An applicant that does not provide information requested by the commissioner shall not be eligible for funds for the current funding cycle.

Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute 90 percent of available medical education funds to all qualifying applicants based on a distribution formula that reflects a summation of two factors:

(1) an education factor, which is determined by the total number of eligible trainee FTEs and the total statewide average costs per trainee, by type of trainee, in each clinical medical education program; and

(2) a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool.

In this formula, the education factor is weighted at 67 percent and the public program volume factor is weighted at 33 percent.

Public program revenue for the distribution formula includes revenue from medical assistance, prepaid medical assistance, general assistance medical care, and prepaid general assistance medical care. Training sites that receive no public program revenue are ineligible for funds available under this paragraph. Total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee in primary care clinical medical education programs for medical residents. Total statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students.

(b) The commissioner shall annually distribute ten percent of total available medical education funds to all qualifying applicants based on the percentage received by each applicant under paragraph (a). These funds are to be used to offset clinical education costs at eligible clinical training sites based on criteria developed by the clinical medical education program. Applicants may choose to distribute funds allocated under this paragraph based on the distribution formula described in paragraph (a). Applicants may also choose to distribute funds to clinical training sites with a valid Minnesota medical assistance identification number that host fewer than 0.5 eligible trainee FTEs for a clinical medical education program.

(c) Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

(d) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter. Each clinical medical education program must distribute funds allocated under paragraph (a) to the training sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited through an organization recognized by the Department of Education or the Centers for Medicare and Medicaid Services, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

(1) develop contracts specifying the terms, expectations, and outcomes of the clinical training conducted at sites; and

(2) take necessary action if the contract requirements are not met. Action may include the withholding of payments under this section or the removal of students from the site.

(e) Any funds not distributed in accordance with the commissioner's approval letter must be returned to the medical education and research fund within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

(f) The commissioner shall distribute by June 30 of each year an amount equal to the funds transferred under subdivision 10, plus five percent interest to the University of Minnesota Board of Regents for the instructional costs of health professional programs at the Academic Health Center and for interdisciplinary academic initiatives within the Academic Health Center.

(g) A maximum of $150,000 of the funds dedicated to the commissioner under section 297F.10, subdivision 1, paragraph (b), clause (2), may be used by the commissioner for administrative expenses associated with implementing this section.

Subd. 5. **Report.** (a) Sponsoring institutions receiving funds under this section must sign and submit a medical education grant verification report (GVR) to verify that the correct grant amount was forwarded to each eligible training site. If the sponsoring institution fails to submit the GVR by the stated deadline, or to request and meet the deadline for an extension, the sponsoring institution is required to return the full amount of funds received to the commissioner within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

(b) The reports must provide verification of the distribution of the funds and must include:

(1) the total number of eligible trainee FTEs in each clinical medical education program;

(2) the name of each funded program and, for each program, the dollar amount distributed to each training site;

(3) documentation of any discrepancies between the initial grant distribution notice included in the commissioner's approval letter and the actual distribution;

(4) a statement by the sponsoring institution describing the distribution of funds allocated under subdivision 4, paragraph (b), including information on which clinical training sites received funding and the rationale used for determining funding priorities;

(5) a statement by the sponsoring institution stating that the completed grant verification report is valid and accurate; and

(6) other information the commissioner, with advice from the advisory committee, deems appropriate to evaluate the effectiveness of the use of funds for medical education.

(c) By February 15 of each year, the commissioner, with advice from the advisory committee, shall provide an annual summary report to the legislature on the implementation of this section.

[For text of subd 6, see M.S.2002]

Subd. 7. **Transfers from the commissioner of human services.** (a) The amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (1), shall be distributed by the commissioner annually to clinical medical education programs that meet the qualifications of subdivision 3 based on the formula in subdivision 4, paragraph (a).

(b) Fifty percent of the amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (2), shall be distributed by the commissioner to the University of Minnesota Board of Regents for the purposes described in sections 137.38 to 137.40. Of the remaining amount transferred according to section 256B.69,

subdivision 5c, paragraph (a), clause (2), 24 percent of the amount shall be distributed by the commissioner to the Hennepin County Medical Center for clinical medical education. The remaining 26 percent of the amount transferred shall be distributed by the commissioner in accordance with subdivision 7a. If the federal approval is not obtained for the matching funds under section 256B.69, subdivision 5c, paragraph (a), clause (2), 100 percent of the amount transferred under this paragraph shall be distributed by the commissioner to the University of Minnesota Board of Regents for the purposes described in sections 137.38 to 137.40.

(c) The amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (3), shall be distributed by the commissioner upon receipt to the University of Minnesota Board of Regents for the purposes of clinical graduate medical education.

[For text of subd 7a, see M.S.2002]

Subd. 8. **Federal financial participation.** (a) The commissioner of human services shall seek to maximize federal financial participation in payments for medical education and research costs. If the commissioner of human services determines that federal financial participation is available for the medical education and research, the commissioner of health shall transfer to the commissioner of human services the amount of state funds necessary to maximize the federal funds available. The amount transferred to the commissioner of human services, plus the amount of federal financial participation, shall be distributed to medical assistance providers in accordance with the distribution methodology described in subdivision 4.

(b) For the purposes of paragraph (a), the commissioner shall use physician clinic rates where possible to maximize federal financial participation.

[For text of subd 9, see M.S.2002]

Subd. 10. **Transfers from University of Minnesota.** Of the funds dedicated to the Academic Health Center under section 297F.10, subdivision 1, paragraph (b), clause (1), $4,850,000 shall be transferred annually to the commissioner of health no later than April 15 of each year for distribution under subdivision 4, paragraph (f).

History: *1Sp2003 c 14 art 7 s 16-19; art 12 s 1; 1Sp2003 c 21 art 9 s 1,2*

NOTE: Subdivision 4, paragraph (e), was also stricken by Laws 2003, First Special Session chapter 14, article 7, section 17.

62J.694 MEDICAL EDUCATION ENDOWMENT FUND.

Subdivision 1. **Creation; use of cash reserves.** (a) The medical education endowment fund is created in the state treasury. The State Board of Investment shall invest the fund under section 11A.24. All earnings of the fund must be credited to the fund. The principal of the fund must be maintained inviolate, except that the principal may be used to make expenditures from the fund for the purposes specified in this section when the market value of the fund falls below 105 percent of the cumulative total of the tobacco settlement payments received by the state and credited to the tobacco settlement fund under section 16A.87, subdivision 2. For purposes of this section, "principal" means an amount equal to the cumulative total of the tobacco settlement payments received by the state and credited to the tobacco settlement fund under section 16A.87, subdivision 2.

(b) If the commissioner of finance determines that probable receipts to the general fund will be sufficient to meet the need for expenditures from the general fund for a fiscal biennium, after using the cash reserves of the tobacco use prevention and local public health endowment fund, excluding an amount sufficient to meet the annual appropriations in section 144.395, subdivision 2, the commissioner may use cash reserves of the medical education endowment fund, excluding the amounts needed to meet the appropriations described in subdivisions 2 and 2a, to pay expenses of the general fund. If cash reserves are transferred to the general fund to meet cash flow needs, the amount transferred, plus interest at a rate comparable to the rate earned by

the state on invested commissioner of finance cash, as determined monthly by the commissioner, must be returned to the endowment fund as soon as sufficient cash balances are available in the general fund, but in any event before the end of the fiscal biennium. An amount necessary to pay the interest is appropriated from the general fund. If cash reserves of the endowment fund are used to pay expenses for the general fund, notwithstanding subdivision 2, paragraph (d), the Academic Health Center shall be held harmless to the extent possible. When determining the fair market value of the fund, for the purposes described in subdivisions 2 and 2a, the value of the cash reserves transferred to the general fund must be included in the determination.

(c) The Academic Health Center account is created as a separate account in the medical education endowment fund. The account is invested under paragraph (a). All earnings of the account must be credited to the account. The principal of the account must be maintained inviolate, except that the principal may be used to make expenditures from the account for the purposes specified in subdivision 2a when the value of the account falls below an amount equal to deposits made to the account under section 16A.87, subdivision 3, paragraph (b).

[For text of subds 2 to 4, see M.S.2002]

Subd. 5. **Effective date.** This section is only in effect if there are funds available in the medical education endowment fund.

History: *2003 c 112 art 2 s 50; 1Sp2003 c 14 art 7 s 20*