radio tower construction. The value of the location of privately owned equipment on state-owned buildings or structures for the duration of the contract must be similar to the value of the tower constructed for the commissioner. A contract authorized under this section may be for a term of not more than 20 years. Notwithstanding Minnesota Statutes, sections 16A.15 and 16A.41, a contract authorized under this section may provide that the commissioner will pay for the unamortized cost of the tower if the contract is canceled before its expiration. Minnesota Statutes, chapters 16B and 16C, do not apply to a contract authorized under this section. A contract authorized by this section is not valid until approved by the attorney general.

Sec. 90. **REPORT.**

The commissioner of public safety shall report to the chairs of the senate and house of representatives committees on transportation policy and transportation finance on February 15, 2000, and February 15, 2001, on revenue from the sale of advertising in department publications and expenditure of that revenue.

Sec. 91. **INSTRUCTION TO REVISOR.**

The revisor of statutes shall make cross-reference changes in Minnesota Statutes and Minnesota Rules consistent with the renumbering of clauses in section 23.

Sec. 92. **REPEALER.**

(a) Minnesota Statutes 1998, sections 168.011, subdivision 36; 168.1281; 221.011, subdivisions 7, 9, 20, 21, 32, and 34; 221.041; 221.051; 221.061; 221.071; 221.081; 221.121, subdivisions 6b and 6h; 221.172, subdivision 9; 221.281; and 221.85, are repealed.

(b) Minnesota Statutes 1998, section 473.3998, is repealed.

Sec. 93. **EFFECTIVE DATE.**

Sections 21 and 22 are effective the day following final enactment, and are repealed on July 31, 2000. Sections 2, 15, 32, 33, 35 to 67, 72, 74, 75, 77, and 85 are effective January 1, 2000. Sections 7 to 14 are effective July 1, 2000. Section 27 is effective July 1, 1999, for Minnesota identification cards issued on and after that date. Sections 4, 5, and 30 are effective July 1, 2001.

Presented to the governor May 24, 1999

Signed by the governor May 25, 1999, 3:00 p.m.

CHAPTER 239—S.F.No. 1219

An act relating to health; establishing a uniform complaint resolution process for health plan companies; establishing an external review process; amending Minnesota Statutes 1998, sections 62D.11, subdivision 1; 62M.01; 62M.02, subdivisions 3, 4, 5, 6, 7, 9, 10, 11, 12, 17, 20, 21, and by adding a subdivision; 62M.03, subdivisions 1 and 3; 62M.04, subdivisions 1, 2, 3, and 4; 62M.05; 62M.06; 62M.07; 62M.09, subdivision 3; 62M.10, subdivisions 2, 5, and 7; 62M.12; 62M.15; 62Q.106; 62Q.19, subdivision 5a; 62T.04; 72A.201, subdivision 4a; and 256B.692, subdivision 2;

proposing coding for new law in Minnesota Statutes, chapters 62D; and 62Q; repealing Minnesota Statutes 1998, sections 62D.11, subdivisions 1b and 2; 62Q.105; 62Q.11; and 62Q.30; Minnesota Rules, parts 4685.0100, subparts 4 and 4a; 4685.1010, subpart 3; and 4685.1700.

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

Section 1. Minnesota Statutes 1998, section 62D.11, subdivision 1, is amended to read:

Subdivision 1. **ENROLLEE COMPLAINT SYSTEM.** Every health maintenance organization shall establish and maintain a complaint system, as required under ~~section 62Q.105~~ sections 62Q.68 to 62Q.72 to provide reasonable procedures for the resolution of written complaints initiated by or on behalf of enrollees concerning the provision of health care services. ~~"Provision of health services" includes, but is not limited to, questions of the scope of coverage, quality of care, and administrative operations. The health maintenance organization must inform enrollees that they may choose to use arbitration to appeal a health maintenance organization's internal appeal decision. The health maintenance organization must also inform enrollees that they have the right to use arbitration to appeal a health maintenance organization's internal appeal decision not to certify an admission, procedure, service, or extension of stay under section 62M.06. If an enrollee chooses to use arbitration, the health maintenance organization must participate.~~

Sec. 2. **[62D.124] GEOGRAPHIC ACCESSIBILITY.**

Subdivision 1. **PRIMARY CARE; MENTAL HEALTH SERVICES; GENERAL HOSPITAL SERVICES.** Within the health maintenance organization's service area, the maximum travel distance or time shall be the lesser of 30 miles or 30 minutes to the nearest provider of each of the following services: primary care services, mental health services, and general hospital services. The health maintenance organization must designate which method is used.

Subd. 2. **OTHER HEALTH SERVICES.** Within a health maintenance organization's service area, the maximum travel distance or time shall be the lesser of 60 miles or 60 minutes to the nearest provider of specialty physician services, ancillary services, specialized hospital services, and all other health services not listed in subdivision 1. The health maintenance organization must designate which method is used.

Subd. 3. **EXCEPTION.** The commissioner shall grant an exception to the requirements of this section according to Minnesota Rules, part 4685.1010, subpart 4, if the health maintenance organization can demonstrate with specific data that the requirement of subdivision 1 or 2 is not feasible in a particular service area or part of a service area.

Subd. 4. **APPLICATION.** (a) Subdivisions 1 and 2 do not apply if an enrollee is referred to a referral center for health care services.

(b) Subdivision 1 does not apply:

(1) if an enrollee has chosen a health plan with full knowledge that the health plan has no participating providers within 30 miles or 30 minutes of the enrollee's place of residence; or

(2) to service areas approved before May 24, 1993.

Sec. 3. Minnesota Statutes 1998, section 62M.01, is amended to read:

62M.01 **CITATION, JURISDICTION, AND SCOPE.**

Subdivision 1. **POPULAR NAME.** Sections 62M.01 to 62M.16 may be cited as the "Minnesota Utilization Review Act of 1992."

Subd. 2. **JURISDICTION.** Sections 62M.01 to 62M.16 apply to any insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third party administrator licensed under section 60A.23, subdivision 8, that provides utilization review services for the administration of benefits under a health benefit plan as defined in section 62M.02; or any entity performing utilization review on behalf of a business entity in this state pursuant to a health benefit plan covering a Minnesota resident.

Subd. 3. **SCOPE.** ~~Sections 62M.02, 62M.07, and 62M.09, subdivision 4, apply to prior authorization of services.~~ Nothing in sections 62M.01 to 62M.16 applies to review of claims after submission to determine eligibility for benefits under a health benefit plan. The appeal procedure described in section 62M.06 applies to any complaint as defined under section 62Q.68, subdivision 2, that requires a medical determination in its resolution.

Sec. 4. Minnesota Statutes 1998, section 62M.02, subdivision 3, is amended to read:

Subd. 3. **ATTENDING DENTIST.** "Attending dentist" means the dentist with primary responsibility for the dental care provided to ~~a patient~~ an enrollee.

Sec. 5. Minnesota Statutes 1998, section 62M.02, subdivision 4, is amended to read:

Subd. 4. **ATTENDING ~~PHYSICIAN~~ HEALTH CARE PROFESSIONAL.** "Attending ~~physician~~ health care professional" means the ~~physician~~ health care professional providing care within the scope of their practice and with primary responsibility for the care provided to ~~a patient in a hospital or other health care facility~~ an enrollee. Attending health care professional shall include only physicians; chiropractors; dentists; mental health professionals as defined in section 245.462, subdivision 18, or section 245.4871, subdivision 27; podiatrists; and advanced practice nurses.

Sec. 6. Minnesota Statutes 1998, section 62M.02, subdivision 5, is amended to read:

Subd. 5. **CERTIFICATION.** "Certification" means a determination by a utilization review organization that an admission, extension of stay, or other health care service has been reviewed and that it, based on the information provided, meets the utilization review requirements of the applicable health plan and the health ~~carrier~~ plan company will then pay for the covered benefit, provided the preexisting limitation provisions, the general exclusion provisions, and any deductible, copayment, coinsurance, or other policy requirements have been met.

Sec. 7. Minnesota Statutes 1998, section 62M.02, subdivision 6, is amended to read:

Subd. 6. **CLAIMS ADMINISTRATOR.** "Claims administrator" means an entity that reviews and determines whether to pay claims to enrollees~~, physicians, hospitals, or others~~ or providers based on the contract provisions of the health plan contract. Claims administrators may include insurance companies licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended.

Sec. 8. Minnesota Statutes 1998, section 62M.02, subdivision 7, is amended to read:

Subd. 7. **CLAIMANT.** "Claimant" means the enrollee ~~or covered person~~ who files a claim for benefits or a provider of services who, pursuant to a contract with a claims administrator, files a claim on behalf of an enrollee or covered person.

Sec. 9. Minnesota Statutes 1998, section 62M.02, subdivision 9, is amended to read:

Subd. 9. **CONCURRENT REVIEW.** "Concurrent review" means utilization review conducted during ~~a patient's~~ an enrollee's hospital stay or course of treatment and has the same meaning as continued stay review.

Sec. 10. Minnesota Statutes 1998, section 62M.02, subdivision 10, is amended to read:

Subd. 10. **DISCHARGE PLANNING.** "Discharge planning" means the process that assesses ~~a patient's~~ an enrollee's need for treatment after hospitalization in order to help arrange for the necessary services and resources to effect an appropriate and timely discharge.

Sec. 11. Minnesota Statutes 1998, section 62M.02, subdivision 11, is amended to read:

Subd. 11. **ENROLLEE.** "Enrollee" means an individual ~~who has elected to contract for, or participate in, a health benefit plan for enrollee coverage or for dependent coverage~~ covered by a health benefit plan and includes an insured policyholder, subscriber, contract holder, member, covered person, or certificate holder.

Sec. 12. Minnesota Statutes 1998, section 62M.02, subdivision 12, is amended to read:

Subd. 12. **HEALTH BENEFIT PLAN.** "Health benefit plan" means a policy, contract, or certificate issued by a health ~~carrier to an employer or individual~~ plan company for the coverage of medical, dental, or hospital benefits. A health benefit plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) supplemental to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis;

(5) credit accident and health insurance issued under chapter 62B;

(6) blanket accident and sickness insurance as defined in section 62A.11;

(7) accident only coverage issued by a licensed and tested insurance agent; or

(8) workers' compensation.

Sec. 13. Minnesota Statutes 1998, section 62M.02, is amended by adding a subdivision to read:

Subd. 12a. **HEALTH PLAN COMPANY.** "Health plan company" means a health plan company as defined in section 62Q.01, subdivision 4, and includes an accountable provider network operating under chapter 62T.

Sec. 14. Minnesota Statutes 1998, section 62M.02, subdivision 17, is amended to read:

Subd. 17. **PROVIDER.** "Provider" means a licensed health care facility, physician, or other health care professional that delivers health care services to an enrollee ~~or covered person~~.

Sec. 15. Minnesota Statutes 1998, section 62M.02, subdivision 20, is amended to read:

Subd. 20. **UTILIZATION REVIEW.** "Utilization review" means the evaluation of the necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities, by a person or entity other than the attending ~~physician~~ health care professional, for the purpose of determining the medical necessity of the service or admission. Utilization review also includes review conducted after the admission of the enrollee. It includes situations where the enrollee is unconscious or otherwise unable to provide advance notification. Utilization review does not include ~~the imposition of a requirement that services be received by or upon referral from a participating provider~~ a referral or participation in a referral process by a participating provider unless the provider is acting as a utilization review organization.

Sec. 16. Minnesota Statutes 1998, section 62M.02, subdivision 21, is amended to read:

Subd. 21. **UTILIZATION REVIEW ORGANIZATION.** "Utilization review organization" means an entity including but not limited to an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third party administrator licensed under section 60A.23, subdivision 8, which conducts utilization review and determines certification of an admission, extension of stay, or other health care

services for a Minnesota resident; or any entity performing utilization review that is affiliated with, under contract with, or conducting utilization review on behalf of, a business entity in this state.

Sec. 17. Minnesota Statutes 1998, section 62M.03, subdivision 1, is amended to read:

Subdivision 1. **LICENSED UTILIZATION REVIEW ORGANIZATION.** Beginning January 1, 1993, any organization that meets the definition of utilization review organization in section 62M.02, subdivision 21, must be licensed under chapter 60A, 62C, 62D, 62N, 62T, or 64B, or registered under this chapter and must comply with sections 62M.01 to 62M.16 and section 72A.201, subdivisions 8 and 8a. Each licensed community integrated service network or health maintenance organization that has an employed staff model of providing health care services shall comply with sections 62M.01 to 62M.16 and section 72A.201, subdivisions 8 and 8a, for any services provided by providers under contract.

Sec. 18. Minnesota Statutes 1998, section 62M.03, subdivision 3, is amended to read:

Subd. 3. **PENALTIES AND ENFORCEMENTS.** If a utilization review organization fails to comply with sections 62M.01 to 62M.16, the organization may not provide utilization review services for any Minnesota resident. The commissioner of commerce may issue a cease and desist order under section 45.027, subdivision 5, to enforce this provision. The cease and desist order is subject to appeal under chapter 14. A nonlicensed utilization review organization that fails to comply with the provisions of sections 62M.01 to 62M.16 is subject to all applicable penalty and enforcement provisions of section 72A.201. Each utilization review organization licensed under chapter 60A, 62C, 62D, 62N, 62T, or 64B shall comply with sections 62M.01 to 62M.16 as a condition of licensure.

Sec. 19. Minnesota Statutes 1998, section 62M.04, subdivision 1, is amended to read:

Subdivision 1. **RESPONSIBILITY FOR OBTAINING CERTIFICATION.** A health benefit plan that includes utilization review requirements must specify the process for notifying the utilization review organization in a timely manner and obtaining certification for health care services. Each health plan company must provide a clear and concise description of this process to an enrollee as part of the policy, subscriber contract, or certificate of coverage. In addition to the enrollee, the utilization review organization must allow any ~~licensed hospital, physician or the physician's~~ provider or provider's designee, or responsible patient representative, including a family member, to fulfill the obligations under the health plan.

A claims administrator that contracts directly with providers for the provision of health care services to enrollees may, through contract, require the provider to notify the review organization in a timely manner and obtain certification for health care services.

Sec. 20. Minnesota Statutes 1998, section 62M.04, subdivision 2, is amended to read:

Subd. 2. **INFORMATION UPON WHICH UTILIZATION REVIEW IS CONDUCTED.** If the utilization review organization is conducting routine prospective and

concurrent utilization review, utilization review organizations must collect only the information necessary to certify the admission, procedure of treatment, and length of stay.

(a) Utilization review organizations may request, but may not require~~, hospitals, physicians, or other~~ providers to supply numerically encoded diagnoses or procedures as part of the certification process.

(b) Utilization review organizations must not routinely request copies of medical records for all patients reviewed. In performing prospective and concurrent review, copies of the pertinent portion of the medical record should be required only when a difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay.

(c) Utilization review organizations may request copies of medical records retrospectively for a number of purposes, including auditing the services provided, quality assurance review, ensuring compliance with the terms of either the health benefit plan or the provider contract, and compliance with utilization review activities. Except for reviewing medical records associated with an appeal or with an investigation or audit of data discrepancies, ~~health care~~ providers must be reimbursed for the reasonable costs of duplicating records requested by the utilization review organization for retrospective review unless otherwise provided under the terms of the provider contract.

Sec. 21. Minnesota Statutes 1998, section 62M.04, subdivision 3, is amended to read:

Subd. 3. **DATA ELEMENTS.** Except as otherwise provided in sections 62M.01 to 62M.16, for purposes of certification a utilization review organization must limit its data requirements to the following elements:

(a) Patient information that includes the following:

(1) name;

(2) address;

(3) date of birth;

(4) sex;

(5) social security number or patient identification number;

(6) name of health ~~carrier~~ plan company or health plan; and

(7) plan identification number.

(b) Enrollee information that includes the following:

(1) name;

(2) address;

(3) social security number or employee identification number;

(4) relation to patient;

(5) employer;

(6) health benefit plan;

(7) group number or plan identification number; and

(8) availability of other coverage.

(c) Attending ~~physician or provider~~ health care professional information that includes the following:

(1) name;

(2) address;

(3) telephone numbers;

(4) degree and license;

(5) specialty or board certification status; and

(6) tax identification number or other identification number.

(d) Diagnosis and treatment information that includes the following:

(1) primary diagnosis with associated ICD or DSM coding, if available;

(2) secondary diagnosis with associated ICD or DSM coding, if available;

(3) tertiary diagnoses with associated ICD or DSM coding, if available;

(4) proposed procedures or treatments with ICD or associated CPT codes, if available;

(5) surgical assistant requirement;

(6) anesthesia requirement;

(7) proposed admission or service dates;

(8) proposed procedure date; and

(9) proposed length of stay.

(e) Clinical information that includes the following:

(1) support and documentation of appropriateness and level of service proposed; and

(2) identification of contact person for detailed clinical information.

(f) Facility information that includes the following:

(1) type;

(2) licensure and certification status and DRG exempt status;

(3) name;

(4) address;

(5) telephone number; and

(6) tax identification number or other identification number.

(g) Concurrent or continued stay review information that includes the following:

(1) additional days, services, or procedures proposed;

(2) reasons for extension, including clinical information sufficient for support of appropriateness and level of service proposed; and

(3) diagnosis status.

(h) For admissions to facilities other than acute medical or surgical hospitals, additional information that includes the following:

(1) history of present illness;

(2) patient treatment plan and goals;

(3) prognosis;

(4) staff qualifications; and

(5) 24–hour availability of staff.

Additional information may be required for other specific review functions such as discharge planning or catastrophic case management. Second opinion information may also be required, when applicable, to support benefit plan requirements.

Sec. 22. Minnesota Statutes 1998, section 62M.04, subdivision 4, is amended to read:

Subd. 4. **ADDITIONAL INFORMATION.** A utilization review organization may request information in addition to that described in subdivision 3 when there is significant lack of agreement between the utilization review organization and the ~~health care~~ provider regarding the appropriateness of certification during the review or appeal process. For purposes of this subdivision, "significant lack of agreement" means that the utilization review organization has:

(1) tentatively determined through its professional staff that a service cannot be certified;

(2) referred the case to a physician for review; and

(3) talked to or attempted to talk to the attending ~~physician~~ health care professional for further information.

Nothing in sections 62M.01 to 62M.16 prohibits a utilization review organization from requiring submission of data necessary to comply with the quality assurance and utilization review requirements of chapter 62D or other appropriate data or outcome analyses.

Sec. 23. Minnesota Statutes 1998, section 62M.05, is amended to read:

62M.05 **PROCEDURES FOR REVIEW DETERMINATION.**

Subdivision 1. **WRITTEN PROCEDURES.** A utilization review organization must have written procedures to ensure that reviews are conducted in accordance with the requirements of this chapter ~~and section 72A.201, subdivision 4a.~~

Subd. 2. **CONCURRENT REVIEW.** A utilization review organization may review ongoing inpatient stays based on the severity or complexity of the ~~patient's~~ enrollee's condition or on necessary treatment or discharge planning activities. Such review must not be consistently conducted on a daily basis.

Subd. 3. **NOTIFICATION OF DETERMINATIONS.** A utilization review organization must have written procedures for providing notification of its determinations on all certifications in accordance with ~~the following:~~ this section.

Subd. 3a. **STANDARD REVIEW DETERMINATION.** (a) Notwithstanding subdivision 3b, an initial determination on all requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision within ten business days of the request, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

(b) When an initial determination is made to certify, notification must be provided promptly by telephone to the provider. The utilization review organization shall send written notification to the ~~hospital, attending physician, or applicable service provider within ten business days of the determination in accordance with section 72A.201, subdivision 4a,~~ provider or shall maintain an audit trail of the determination and telephone notification. For purposes of this subdivision, "audit trail" includes documentation of the telephone notification, including the date; the name of the person spoken to; the enrollee ~~or patient~~; the service, procedure, or admission certified; and the date of the service, procedure, or admission. If the utilization review organization indicates certification by use of a number, the number must be called the "certification number."

~~(b)~~ (c) When ~~a~~ an initial determination is made not to certify ~~a hospital or surgical facility admission or extension of a hospital stay, or other service requiring review determination,~~ notification must be provided by telephone within one working day after making the ~~decision~~ determination to the attending ~~physician~~ health care professional and hospital ~~must be notified by telephone~~ and a written notification must be sent to the hospital, attending ~~physician~~ health care professional, and enrollee ~~or patient~~. The written notification must include the principal reason or reasons for the determination and the process for initiating an appeal of the determination. Upon request, the utilization review organization shall provide the ~~attending physician or~~ provider or enrollee with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service and identify the database, professional treatment parameter, or other basis for the criteria. Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the ~~attending physician~~ provider or enrollee.

(d) When an initial determination is made not to certify, the written notification must inform the enrollee and the attending health care professional of the right to submit an appeal to the internal appeal process described in section 62M.06 and the procedure for initiating the internal appeal.

Subd. 3b. **EXPEDITED REVIEW DETERMINATION.** (a) An expedited initial determination must be utilized if the attending health care professional believes that an expedited determination is warranted.

(b) Notification of an expedited initial determination to either certify or not to certify must be provided to the hospital, the attending health care professional, and the enrollee

as expeditiously as the enrollee's medical condition requires, but no later than 72 hours from the initial request. When an expedited initial determination is made not to certify, the utilization review organization must also notify the enrollee and the attending health care professional of the right to submit an appeal to the expedited internal appeal as described in section 62M.06 and the procedure for initiating an internal expedited appeal.

Subd. 4. **FAILURE TO PROVIDE NECESSARY INFORMATION.** A utilization review organization must have written procedures to address the failure of a ~~health care~~ provider~~, patient, or representative of either~~ or enrollee to provide the necessary information for review. If the ~~patient~~ enrollee or provider will not release the necessary information to the utilization review organization, the utilization review organization may deny certification in accordance with its own policy or the policy described in the health benefit plan.

Subd. 5. **NOTIFICATION TO CLAIMS ADMINISTRATOR.** If the utilization review organization and the claims administrator are separate entities, the utilization review organization must forward, electronically or in writing, a notification of certification or determination not to certify to the appropriate claims administrator for the health benefit plan.

Sec. 24. Minnesota Statutes 1998, section 62M.06, is amended to read:

62M.06 **APPEALS OF DETERMINATIONS NOT TO CERTIFY.**

Subdivision 1. **PROCEDURES FOR APPEAL.** A utilization review organization must have written procedures for appeals of determinations not to certify ~~an admission, procedure, service, or extension of stay~~. The right to appeal must be available to the enrollee ~~or designee~~ and to the attending ~~physician~~ health care professional. ~~The right of appeal must be communicated to the enrollee or designee or to the attending physician, whomever initiated the original certification request, at the time that the original determination is communicated.~~

Subd. 2. **EXPEDITED APPEAL.** (a) When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review, and the attending ~~physician~~ health care professional believes that the determination warrants ~~immediate~~ an expedited appeal, the utilization review organization must ensure that the enrollee and the attending ~~physician, enrollee, or designee has~~ health care professional have an opportunity to appeal the determination over the telephone on an expedited basis. In such an appeal, the utilization review organization must ensure reasonable access to its consulting physician or health care provider. ~~Expedited appeals that are not resolved may be resubmitted through the standard appeal process.~~

(b) The utilization review organization shall notify the enrollee and attending health care professional by telephone of its determination on the expedited appeal as expeditiously as the enrollee's medical condition requires, but no later than 72 hours after receiving the expedited appeal.

(c) If the determination not to certify is not reversed through the expedited appeal, the utilization review organization must include in its notification the right to submit the appeal to the external appeal process described in section 62Q.73 and the procedure for initiating the process. This information must be provided in writing to the enrollee and the attending health care professional as soon as practical.

Subd. 3. **STANDARD APPEAL.** The utilization review organization must establish procedures for appeals to be made either in writing or by telephone.

(a) ~~Each~~ A utilization review organization shall notify in writing the enrollee ~~or patient~~, attending ~~physician~~ health care professional, and claims administrator of its determination on the appeal ~~as soon as practical, but in no case later than 45 days after receiving the required documentation on the appeal~~ within 30 days upon receipt of the notice of appeal. If the utilization review organization cannot make a determination within 30 days due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to 14 additional days to notify the enrollee, attending health care professional, and claims administrator of its determination. If the utilization review organization takes any additional days beyond the initial 30-day period to make its determination, it must inform the enrollee, attending health care professional, and claims administrator, in advance, of the extension and the reasons for the extension.

(b) The documentation required by the utilization review organization may include copies of part or all of the medical record and a written statement from the attending health care ~~provider~~ professional.

(c) Prior to upholding the ~~original decision~~ initial determination not to certify for clinical reasons, the utilization review organization shall conduct a review of the documentation by a physician who did not make the ~~original~~ initial determination not to certify.

(d) The process established by a utilization review organization may include defining a period within which an appeal must be filed to be considered. The time period must be communicated to the ~~patient,~~ enrollee~~, or~~ and attending ~~physician~~ health care professional when the initial determination is made.

(e) An attending ~~physician~~ health care professional or enrollee who has been unsuccessful in an attempt to reverse a determination not to certify shall, consistent with section 72A.285, be provided the following:

(1) a complete summary of the review findings;

(2) qualifications of the reviewers, including any license, certification, or specialty designation; and

(3) the relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision.

(f) In cases of appeal to reverse a determination not to certify for clinical reasons, the utilization review organization must, upon request of the attending ~~physician~~ health care professional, ensure that a physician of the utilization review organization's choice in the same or a similar general specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonably available to review the case.

(g) If the initial determination is not reversed on appeal, the utilization review organization must include in its notification the right to submit the appeal to the external review process described in section 62Q.73 and the procedure for initiating the external process.

Subd. 4. **NOTIFICATION TO CLAIMS ADMINISTRATOR.** If the utilization review organization and the claims administrator are separate entities, the utilization re-

view organization must ~~forward~~ notify, either electronically or in writing, ~~a notification of certification or determination not to certify to~~ the appropriate claims administrator for the health benefit plan of any determination not to certify that is reversed on appeal.

Sec. 25. Minnesota Statutes 1998, section 62M.07, is amended to read:

62M.07 **PRIOR AUTHORIZATION OF SERVICES.**

(a) Utilization review organizations conducting prior authorization of services must have written standards that meet at a minimum the following requirements:

(1) written procedures and criteria used to determine whether care is appropriate, reasonable, or medically necessary;

(2) a system for providing prompt notification of its determinations to enrollees and providers and for notifying the provider, enrollee, or enrollee's designee of appeal procedures under clause (4);

(3) compliance with section ~~72A.201~~ 62M.05, ~~subdivision~~ 4a subdivisions 3a and 3b, regarding time frames for approving and disapproving prior authorization requests;

(4) written procedures for appeals of denials of prior authorization which specify the responsibilities of the enrollee and provider, and which meet the requirements of ~~section~~ sections 62M.06 and 72A.285, regarding release of summary review findings; and

(5) procedures to ensure confidentiality of patient–specific information, consistent with applicable law.

(b) No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of emergency confinement or emergency treatment. The enrollee or the enrollee's authorized representative may be required to notify the health plan company, claims administrator, or utilization review organization as soon after the beginning of the emergency confinement or emergency treatment as reasonably possible.

Sec. 26. Minnesota Statutes 1998, section 62M.09, subdivision 3, is amended to read:

Subd. 3. **PHYSICIAN REVIEWER INVOLVEMENT.** A physician must review all cases in which the utilization review organization has concluded that a determination not to certify for clinical reasons is appropriate. The physician should be reasonably available by telephone to discuss the determination with the attending ~~physician~~ health care professional. This subdivision does not apply to outpatient mental health or substance abuse services governed by subdivision 3a.

Sec. 27. Minnesota Statutes 1998, section 62M.10, subdivision 2, is amended to read:

Subd. 2. **REVIEWS DURING NORMAL BUSINESS HOURS.** A utilization review organization must conduct its telephone reviews, on–site reviews, and hospital communications during ~~hospitals' and physicians'~~ reasonable and normal business hours, unless otherwise mutually agreed.

Sec. 28. Minnesota Statutes 1998, section 62M.10, subdivision 5, is amended to read:

Subd. 5. **ORAL REQUESTS FOR INFORMATION.** Utilization review organizations shall orally inform, upon request, designated hospital personnel or the attend-

ing ~~physician~~ health care professional of the utilization review requirements of the specific health benefit plan and the general type of criteria used by the review agent. Utilization review organizations should also orally inform, upon request, ~~hospitals, physicians, and other health care professionals~~ a provider of the operational procedures in order to facilitate the review process.

Sec. 29. Minnesota Statutes 1998, section 62M.10, subdivision 7, is amended to read:

Subd. 7. **AVAILABILITY OF CRITERIA.** Upon request, a utilization review organization shall provide to an enrollee or to ~~an attending physician or~~ a provider the criteria used for a specific procedure to determine the necessity, appropriateness, and efficacy of that procedure and identify the database, professional treatment guideline, or other basis for the criteria.

Sec. 30. Minnesota Statutes 1998, section 62M.12, is amended to read:

62M.12 **PROHIBITION OF INAPPROPRIATE INCENTIVES.**

No individual who is performing utilization review may receive any financial incentive based on the number of denials of certifications made by such individual, provided that utilization review organizations may establish medically appropriate performance standards. This prohibition does not apply to financial incentives established between health ~~plans~~ plan companies and ~~their~~ providers.

Sec. 31. Minnesota Statutes 1998, section 62M.15, is amended to read:

62M.15 **APPLICABILITY OF OTHER CHAPTER REQUIREMENTS.**

The requirements of this chapter regarding the conduct of utilization review are in addition to any specific requirements contained in chapter 62A, 62C, 62D, 62Q, 62T, or 72A.

Sec. 32. Minnesota Statutes 1998, section 62Q.106, is amended to read:

62Q.106 **DISPUTE RESOLUTION BY COMMISSIONER.**

A complainant may at any time submit a complaint to the appropriate commissioner to investigate. After investigating a complaint, or reviewing a company's decision, the appropriate commissioner may order a remedy as authorized under ~~section 62Q.30 or~~ chapter 45, 60A, or 62D.

Sec. 33. Minnesota Statutes 1998, section 62Q.19, subdivision 5a, is amended to read:

Subd. 5a. **COOPERATION.** Each health plan company and essential community provider shall cooperate to facilitate the use of the essential community provider by the high risk and special needs populations. This includes cooperation on the submission and processing of claims, sharing of all pertinent records and data, including performance indicators and specific outcomes data, and the use of all dispute resolution methods ~~as defined in section 62Q.11, subdivision 1~~.

Sec. 34. **[62Q.68] DEFINITIONS.**

Subdivision 1. **APPLICATION.** For purposes of sections 62Q.68 to 62Q.72, the terms defined in this section have the meanings given them. For purposes of sections

62Q.69 and 62Q.70, the term "health plan company" does not include an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01 or a nonprofit health service plan corporation regulated under chapter 62C that only provides dental coverage or vision coverage.

Subd. 2. **COMPLAINT.** "Complaint" means any grievance against a health plan company that is not the subject of litigation and that has been submitted by a complainant to a health plan company regarding the provision of health services including, but not limited to, the scope of coverage for health care services; retrospective denials or limitations of payment for services; eligibility issues; denials, cancellations, or nonrenewals of coverage; administrative operations; and the quality, timeliness, and appropriateness of health care services rendered. If the complaint is from an applicant, the complaint must relate to the application. If the complaint is from a former enrollee, the complaint must relate to services received during the period of time the individual was an enrollee. Any grievance requiring a medical determination in its resolution must have the medical determination aspect of the complaint processed under the appeal procedure described in section 62M.06.

Subd. 3. **COMPLAINANT.** "Complainant" means an enrollee, applicant, or former enrollee, or anyone acting on behalf of an enrollee, applicant, or former enrollee who submits a complaint.

Sec. 35. **[62Q.69] COMPLAINT RESOLUTION.**

Subdivision 1. **ESTABLISHMENT.** Each health plan company must establish and maintain an internal complaint resolution process that meets the requirements of this section to provide for the resolution of a complaint initiated by a complainant.

Subd. 2. **PROCEDURES FOR FILING A COMPLAINT.** (a) A complainant may submit a complaint to a health plan company either by telephone or in writing. If a complaint is submitted orally and the resolution of the complaint, as determined by the complainant, is partially or wholly adverse to the complainant, or the oral complaint is not resolved to the satisfaction of the complainant, by the health plan company within ten days of receiving the complaint, the health plan company must inform the complainant that the complaint may be submitted in writing. The health plan company must also offer to provide the complainant with any assistance needed to submit a written complaint, including an offer to complete the complaint form for a complaint that was previously submitted orally and promptly mail the completed form to the complainant for the complainant's signature. At the complainant's request, the health plan company must provide the assistance requested by the complainant. The complaint form must include the following information:

(1) the telephone number of the office of health care consumer assistance, advocacy, and information, and the health plan company member services or other departments or persons equipped to advise complainants on complaint resolution;

(2) the address to which the form must be sent;

(3) a description of the health plan company's internal complaint procedure and the applicable time limits; and

(4) the toll–free telephone number of either the commissioner of health or commerce and notification that the complainant has the right to submit the complaint at any time to the appropriate commissioner for investigation.

(b) Upon receipt of a written complaint, the health plan company must notify the complainant within ten business days that the complaint was received, unless the complaint is resolved to the satisfaction of the complainant within the ten business days.

(c) Each health plan company must provide, in the member handbook, subscriber contract, or certification of coverage, a clear and concise description of how to submit a complaint and a statement that, upon request, assistance in submitting a written complaint is available from the health plan company.

Subd. 3. **NOTIFICATION OF COMPLAINT DECISIONS.** (a) The health plan company must notify the complainant in writing of its decision and the reasons for it as soon as practical but in no case later than 30 days after receipt of a written complaint. If the health plan company cannot make a decision within 30 days due to circumstances outside the control of the health plan company, the health plan company may take up to 14 additional days to notify the complainant of its decision. If the health plan company takes any additional days beyond the initial 30–day period to make its decision, it must inform the complainant, in advance, of the extension and the reasons for the extension.

(b) If the decision is partially or wholly adverse to the complainant, the notification must inform the complainant of the right to appeal the decision to the health plan company's internal appeal process described in section 62Q.70 and the procedure for initiating an appeal.

(c) The notification must also inform the complainant of the right to submit the complaint at any time to either the commissioner of health or commerce for investigation and the toll–free telephone number of the appropriate commissioner.

Sec. 36. **[62Q.70] APPEAL OF THE COMPLAINT DECISION.**

Subdivision 1. **ESTABLISHMENT.** (a) Each health plan company shall establish an internal appeal process for reviewing a health plan company's decision regarding a complaint filed in accordance with section 62Q.69. The appeal process must meet the requirements of this section.

(b) The person or persons with authority to resolve or recommend the resolution of the internal appeal must not be solely the same person or persons who made the complaint decision under section 62Q.69.

(c) The internal appeal process must permit the receipt of testimony, correspondence, explanations, or other information from the complainant, staff persons, administrators, providers, or other persons as deemed necessary by the person or persons investigating or presiding over the appeal.

Subd. 2. **PROCEDURES FOR FILING AN APPEAL.** If a complainant notifies the health plan company of the complainant's desire to appeal the health plan company's decision regarding the complaint through the internal appeal process, the health plan company must provide the complainant the option for the appeal to occur either in writing or by hearing.

Subd. 3. **NOTIFICATION OF APPEAL DECISIONS.** (a) If a complainant appeals in writing, the health plan company must give the complainant written notice of the appeal decision and all key findings within 30 days of the health plan company's receipt of the complainant's written notice of appeal. If a complainant appeals by hearing, the

health plan company must give the complainant written notice of the appeal decision and all key findings within 45 days of the health plan company's receipt of the complainant's written notice of appeal.

(b) If the appeal decision is partially or wholly adverse to the complainant, the notice must advise the complainant of the right to submit the appeal decision to the external review process described in section 62Q.73 and the procedure for initiating the external process.

(c) Upon the request of the complainant, the health plan company must provide the complainant with a complete summary of the appeal decision.

Sec. 37. **[62Q.71] NOTICE TO ENROLLEES.**

Each health plan company shall provide to enrollees a clear and concise description of its complaint resolution procedure, if applicable under section 62Q.68, subdivision 1, and the procedure used for utilization review as defined under chapter 62M as part of the member handbook, subscriber contract, or certificate of coverage. If the health plan company does not issue a member handbook, the health plan company may provide the description in another written document. The description must specifically inform enrollees:

(1) how to submit a complaint to the health plan company;

(2) if the health plan includes utilization review requirements, how to notify the utilization review organization in a timely manner and how to obtain certification for health care services;

(3) how to request an appeal either through the procedures described in sections 62Q.69 and 62Q.70 or through the procedures described in chapter 62M;

(4) of the right to file a complaint with either the commissioner of health or commerce at any time during the complaint and appeal process;

(5) the toll–free telephone number of the appropriate commissioner;

(6) the telephone number of the office of consumer assistance, advocacy, and information; and

(7) of the right to obtain an external review under section 62Q.73 and a description of when and how that right may be exercised.

Sec. 38. **[62Q.72] RECORDKEEPING; REPORTING.**

Subdivision 1. **RECORDKEEPING.** Each health plan company shall maintain records of all enrollee complaints and their resolutions. These records shall be retained for five years and shall be made available to the appropriate commissioner upon request. An insurance company licensed under chapter 60A may instead comply with section 72A.20, subdivision 30.

Subd. 2. **REPORTING.** Each health plan company shall submit to the appropriate commissioner, as part of the company's annual filing, data on the number and type of complaints that are not resolved within 30 days, or 30 business days as provided under section 72A.201, subdivision 4, clause (3), for insurance companies licensed under chapter 60A. The commissioner shall also make this information available to the public upon request.

Sec. 39. **[62Q.73] EXTERNAL REVIEW OF ADVERSE DETERMINATIONS.**

Subdivision 1. **DEFINITION.** For purposes of this section, adverse determination means:

(1) a complaint decision relating to a health care service or claim that has been appealed in accordance with section 62Q.70 and the appeal decision is partially or wholly adverse to the complainant;

(2) any initial determination not to certify that has been appealed in accordance with section 62M.06 and the appeal did not reverse the initial determination not to certify; or

(3) a decision relating to a health care service made by a health plan company licensed under chapter 60A that denies the service on the basis that the service was not medically necessary.

An adverse determination does not include complaints relating to fraudulent marketing practices or agent misrepresentation.

Subd. 2. **EXCEPTION.** (a) This section does not apply to governmental programs except as permitted under paragraph (b). For purposes of this subdivision, "governmental programs" means the prepaid medical assistance program, the MinnesotaCare program, the prepaid general assistance medical care program, and the federal Medicare program.

(b) In the course of a recipient's appeal of a medical determination to the commissioner of human services under section 256.045, the recipient may request an expert medical opinion be arranged by the external review entity under contract to provide independent external reviews under this section. If such a request is made, the cost of the review shall be paid by the commissioner of human services. Any medical opinion obtained under this paragraph shall only be used by a state human services referee as evidence in the recipient's appeal to the commissioner of human services under section 256.045.

(c) Nothing in this subdivision shall be construed to limit or restrict the appeal rights provided in section 256.045 for governmental program recipients.

Subd. 3. **RIGHT TO EXTERNAL REVIEW.** (a) Any enrollee or anyone acting on behalf of an enrollee who has received an adverse determination may submit a written request for an external review of the adverse determination, if applicable under section 62Q.68, subdivision 1, or 62M.06, to the commissioner of health if the request involves a health plan company regulated by that commissioner or to the commissioner of commerce if the request involves a health plan company regulated by that commissioner. The written request must be accompanied by a filing fee of $25. The fee may be waived by the commissioner of health or commerce in cases of financial hardship.

(b) Nothing in this section requires the commissioner of health or commerce to independently investigate an adverse determination referred for independent external review.

(c) If an enrollee requests an external review, the health plan company must participate in the external review. The cost of the external review in excess of the filing fee described in paragraph (a) shall be borne by the health plan company.

Subd. 4. **CONTRACT.** Pursuant to a request for proposal, the commissioner of administration, in consultation with the commissioners of health and commerce, shall contract with an organization or business entity to provide independent external reviews of all adverse determinations submitted for external review. The contract shall ensure that the fees for services rendered in connection with the reviews be reasonable.

Subd. 5. **CRITERIA.** (a) The request for proposal must require that the entity demonstrate:

(1) no conflicts of interest in that it is not owned, a subsidiary of, or affiliated with a health plan company or utilization review organization;

(2) an expertise in dispute resolution;

(3) an expertise in health related law;

(4) an ability to conduct reviews using a variety of alternative dispute resolution procedures depending upon the nature of the dispute;

(5) an ability to provide data to the commissioners of health and commerce on reviews conducted; and

(6) an ability to ensure confidentiality of medical records and other enrollee information.

(b) The commissioner of administration shall take into consideration, in awarding the contract according to subdivision 4, any national accreditation standards that pertain to an external review entity.

Subd. 6. **PROCESS.** (a) Upon receiving a request for an external review, the external review entity must provide immediate notice of the review to the enrollee and to the health plan company. Within ten business days of receiving notice of the review the health plan company and the enrollee must provide the external review entity with any information that they wish to be considered. Each party shall be provided an opportunity to present its version of the facts and arguments. An enrollee may be assisted or represented by a person of the enrollee's choice.

(b) As part of the external review process, any aspect of an external review involving a medical determination must be performed by a health care professional with expertise in the medical issue being reviewed.

(c) An external review shall be made as soon as practical but in no case later than 40 days after receiving the request for an external review and must promptly send written notice of the decision and the reasons for it to the enrollee, the health plan company, and to the commissioner who is responsible for regulating the health plan company.

Subd. 7. **STANDARDS OF REVIEW.** (a) For an external review of any issue in an adverse determination that does not require a medical necessity determination, the external review must be based on whether the adverse determination was in compliance with the enrollee's health benefit plan.

(b) For an external review of any issue in an adverse determination by a health plan company licensed under chapter 62D that requires a medical necessity determination, the external review must determine whether the adverse determination was consistent with

the definition of medically necessary care in Minnesota Rules, part 4685.0100, subpart 9b.

(c) For an external review of any issue in an adverse determination by a health plan company, other than a health plan company licensed under chapter 62D, that requires a medical necessity determination, the external review must determine whether the adverse determination was consistent with the definition of medically necessary care in section 62Q.53, subdivision 2.

Subd. 8. **EFFECTS OF EXTERNAL REVIEW.** A decision rendered under this section shall be nonbinding on the enrollee and binding on the health plan company. The health plan company may seek judicial review of the decision on the grounds that the decision was arbitrary and capricious or involved an abuse of discretion.

Subd. 9. **IMMUNITY FROM CIVIL LIABILITY.** A person who participates in an external review by investigating, reviewing materials, providing technical expertise, or rendering a decision shall not be civilly liable for any action that is taken in good faith, that is within the scope of the person's duties, and that does not constitute willful or reckless misconduct.

Subd. 10. **DATA REPORTING.** The commissioners shall make available to the public, upon request, summary data on the decisions rendered under this section, including the number of reviews heard and decided and the final outcomes. Any data released to the public must not individually identify the enrollee initiating the request for external review.

Sec. 40. Minnesota Statutes 1998, section 62T.04, is amended to read:

62T.04 **COMPLAINT SYSTEM.**

Accountable provider networks must establish and maintain an enrollee complaint system as required under ~~section 62Q.105~~ sections 62Q.68 to 62Q.72. The accountable provider network may contract with the health care purchasing alliance or a vendor for operation of this system.

Sec. 41. Minnesota Statutes 1998, section 72A.201, subdivision 4a, is amended to read:

Subd. 4a. **STANDARDS FOR PREAUTHORIZATION APPROVAL.** If a policy of accident and sickness insurance or a subscriber contract requires preauthorization approval for any nonemergency services or benefits, the decision to approve or disapprove the requested services or benefits must be ~~communicated to the insured or the insured's health care provider within ten business days of the preauthorization request provided that all information reasonably necessary to make a decision on the request has been made available to the insurer~~ processed in accordance with section 62M.07.

Sec. 42. Minnesota Statutes 1998, section 256B.692, subdivision 2, is amended to read:

Subd. 2. **DUTIES OF THE COMMISSIONER OF HEALTH.** Notwithstanding chapters 62D and 62N, a county that elects to purchase medical assistance and general assistance medical care in return for a fixed sum without regard to the frequency or extent of services furnished to any particular enrollee is not required to obtain a certificate of

authority under chapter 62D or 62N. A county that elects to purchase medical assistance and general assistance medical care services under this section must satisfy the commissioner of health that the requirements of chapter 62D, applicable to health maintenance organizations, or chapter 62N, applicable to community integrated service networks, will be met. A county must also assure the commissioner of health that the requirements of sections 62J.041; 62J.48; 62J.71 to 62J.73; 62M.01 to 62M.16; all applicable provisions of chapter 62Q, including sections 62Q.07; 62Q.075; ~~62Q.105;~~ 62Q.1055; 62Q.106; ~~62Q.11;~~ 62Q.12; 62Q.135; 62Q.14; 62Q.145; 62Q.19; 62Q.23, paragraph (c); ~~62Q.30;~~ 62Q.43; 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.64; 62Q.68 to 62Q.72; and 72A.201 will be met. All enforcement and rulemaking powers available under chapters 62D, 62J, 62M, 62N, and 62Q are hereby granted to the commissioner of health with respect to counties that purchase medical assistance and general assistance medical care services under this section.

Sec. 43. **REPEALER.**

(a) Minnesota Statutes 1998, section 62D.11, subdivisions 1b and 2, are repealed.

(b) Minnesota Statutes 1998, sections 62Q.105; 62Q.11; and 62Q.30, are repealed.

(c) Minnesota Rules, parts 4685.0100, subparts 4 and 4a; and 4685.1700, are repealed.

(d) Minnesota Rules, part 4685.1010, subpart 3, is repealed.

Sec. 44. **EFFECTIVE DATE.**

Sections 1, 3 to 42, and 43, paragraphs (a) and (c), are effective April 1, 2000, and apply to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization.

Section 43, paragraph (b), is effective July 1, 1999.

Sections 2 and 43, paragraph (d), are effective January 1, 2000, and apply to contracts issued or renewed on or after that date.

Presented to the governor May 24, 1999

Signed by the governor May 25, 1999, 11:50 a.m.

CHAPTER 240—H.F.No. 2205

An act relating to capital improvements; authorizing spending for public purposes; authorizing spending to acquire and to better public land and buildings and other public improvements of a capital nature; authorizing certain improvements and transfers between accounts; making technical corrections; amending earlier authorizations; reauthorizing certain projects; authorizing and reauthorizing sale of state bonds; providing for storage and retention of certain documents; authorizing certain easements; providing for certain port authority leases or management contracts; re-