Health Policy Division, Center for Health Care Purchasing Improvement
PO Box 64882
St. Paul, MN 55164-0882
651-201-3573

Center for Health Care Purchasing Improvement (CHCPI) Annual Report

January - December 2013

Minnesota Department of Health

Report to the Minnesota Legislature

August 2014

Center for Health Care Purchasing Improvement (CHCPI)
Annual Report January - December 2013

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For more information, contact:
Health Policy Division, Center for Health Care Purchasing Improvement
Minnesota Department of Health
P.O. Box 648882
St. Paul, Minnesota 55164-0882

Phone: 651-201-3573
Fax: 651-201-3830

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MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, maintaining and improving the health of all Minnesotans

August 11, 2014
Office of the Governor
130 State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155

Dear Governor Dayton and Legislators:

This annual report of the Center for Health Care Purchasing Improvement (CHCPI) for the period January to December 2013 is being submitted to the Governor and Legislature as required by Minnesota Statutes, section 62J.63. The report summarizes CHCPI's operations, activities, and impacts in 2013 as well as preliminary planning considerations for 2014.

CHCPI works closely with the health care industry, and in particular, a voluntary stakeholder advisory group, the Minnesota Administrative Uniformity Committee (AUC) to bring about more standard, automated, efficient exchanges of health care business data such as claims (billings) and other common transactions. This administrative simplification initiative is vital to many health reforms and to reducing overall administrative costs and burdens throughout Minnesota's health care system.

Thank you for the opportunity to provide this update. For additional information, please contact the CHCPI Director, David K. Haugen, at 651-201-3573 or at david.haugen@state.mn.us.

Sincerely,

Edward P. Ehlinger, MD, MSPH

Commissioner

P.O. Box 64975

St. Paul, MN 55164-0975

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Center for Health Care Purchasing Improvement (CHCPI) Annual Report, January – December 2013

Executive Summary

Introduction and overview

CHCPI coordinates and oversees a statutory, statewide initiative to reduce the costs and burdens associated with exchanges of common health care business (administrative) transactions such as billings and remittances. The initiative is an important, integral part of broader health care reforms because the health care system is transaction-intensive and increasingly data driven. Achieving even modest efficiency gains through greater use of "e-billing" and "e-commerce" across a large volume of routine business activity will result in an estimated annual savings to the state's health care system of $40 million to $60 million.[i] Moreover, the accurate, efficient exchange of health care business data is foundational for achieving other health reform goals, including improving patient care and outcomes.

CHCPI works closely with the health care industry, and in particular, a voluntary stakeholder advisory group, the Minnesota Administrative Uniformity Committee (AUC), in developing and administering rules to promote more standard, automated, efficient exchanges of health care business data. In this capacity, CHCPI:

- provides staffing and support of planning, logistics, research and analysis of issues, group facilitation, implementation, and communications for the AUC and its associated work groups known as "Technical Advisory Groups (TAGs)," as well as for other ad hoc AUC task forces and committees;
- is responsible for technical assistance, enforcement, and coordination with other state agencies needed to ensure compliance with the rules; and
- serves as a participant in and liaison to federal and national health care administrative simplification efforts, and with other state agencies and other state's administrative simplification efforts.

2013 activities and accomplishments

As described in more detail in the body of this report, in 2013 CHCPI collaborated with the AUC and other state and national stakeholders and subject matter experts to:

- Lead rulemaking to revise and adopt six sets of state rules intended to ensure conformance with complementary federal requirements and use of best practices. As part of the rulemaking process, CHCPI planned, staffed, and facilitated more than 40 open public meetings and reviewed comments from public comment periods;
- Develop and publish data specifications required pursuant to Minnesota Statutes, section 62J.497, Subd. 5b for the automated, electronic exchange of "prescription drug prior authorization requests" between physicians ("prescribers") and payers;

- Conduct joint administrative simplification compliance reviews and follow-up with the Minnesota Department of Labor and Industry (DLI) regarding workers compensation-related medical claims and other business data that was not being exchanged electronically per state statute;
- Participate in national administrative simplification discussions and reviews, including presenting to the national Institute of Medicine's (IOM) "Value Incentives Learning Collaborative (VILC)" on "Minnesota's Collaborations To Reduce Health Care Business Transaction Costs And Burdens;"
- Initiate a new AUC TAG and began meeting with the AUC and industry stakeholders to review and implement recent federal rules for a new national Health Plan Identifier (HPID) to enumerate health plans and identify them in health care business transactions;
- Provide technical assistance in responding to an estimated more than 250 inquiries and questions. In addition, CHCPI collaborated with the AUC and industry stakeholders in developing best practices and medical coding clarifications to supplement state rules with additional clarification, specificity, and examples, for use throughout the industry;
- Submit a change request on behalf of the AUC to the national Accredited Standards Committee X12 (ASC X12) requesting continuation of the ability to report taxes such as Minnesota's health care provider tax (MinnesotaCare Tax) on standard health care billings (claims). The request was subsequently adopted, to be incorporated in subsequent national level standards;
- Develop and begin implementing new outreach and communications strategies. CHCPI began implementing the strategies with a new AUC newsletter and submission of proposals to present at national and statewide conferences in 2014, as well as additional follow-up planned for 2014;
- Work closely with the AUC in completing a thorough review of the 20 year old state "Health Care Administrative Simplification Act (ASA) of 1994" (Minnesota Statutes, sections 62J.50 – 62J.63) and to recommend changes needed to remove obsolete language and concepts during the 2014 legislative session to ensure that the ASA remain current and relevant.

Plans and next steps for 2014

CHCPI met with the AUC in December 2013 to discuss and make preliminary plans for 2014. The planning process identified a number of key needs and objectives for the coming year, including:

- Meeting CHCPI and the AUC's primary ongoing responsibilities for the development, administration, and refinement of rules for standard, electronic exchange of routine health care business transactions;
- Promoting preparedness and successful implementation of a federally mandated, much more detailed, robust new version of an international medical diagnoses coding system known as "ICD-10" by the required deadline of October 1, 2014;

- Developing and implementing customer satisfaction surveys and other tools to provide MDH with feedback to help assess its role, services, and resources in support of health care administrative simplification and the AUC, and to make any changes as needed;
- Creating a framework for the review and discussion of the administrative implications of rapidly emerging new forms of health care delivery and financing, such as payment for bundled services, Accountable Care Organizations (ACOs), pay for performance, and others;
- Continuing engagement in the development and implementation of administrative simplification transactions standards and federal operating rules mandated by the federal Patient Protection and Accountable Care Act (ACA), including in particular a new national Health Plan Identifier (HPID) for exchanges of electronic business data in which a health plan must be identified.
- Additional new projects and responsibilities, including technical assistance to aid those who must fulfill requirements in Minnesota Statutes, 62J.497 for the standard, electronic exchange of prescription drug prior authorizations by January 1, 2015.

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Center for Health Care Purchasing Improvement (CHCPI)

Annual Report
January – December 2013

Introduction and Overview

This annual report of the Center for Health Care Purchasing Improvement (CHCPI) for the period January to December 2013 is being submitted to the Governor and Legislature as required by Minnesota Statutes, section 62J.63.

CHCPI is part of the Health Policy Division of the Minnesota Department of Health (MDH), and is authorized in MS §62J.63 to coordinate state efforts to reduce the costs and burdens associated with the exchange of routine health care business (administrative) transactions. This health reform goal – known as "administrative simplification" – is important because health care is a highly transaction-intensive enterprise, with millions of billings, payments, and other common business-related exchanges in Minnesota each year. For example, Minnesota's health plans reported processing nearly 69 million billings (claims) alone in 2013,[ii] a number that is projected to increase with a growing and aging population using more medical services. In addition, the Minnesota Department of Human Services (DHS), which oversees the state's Medical Assistance (Medicaid) program, processed nearly 32 million fee-for-service claims in 2013[iii] as well.

Despite the considerable volume of routine business exchanges and their expense, many transactions are often still manual, paper-based, and unnecessarily costly. In addition, improving the flow and accuracy of health care business data is integral to not only reducing health care administrative costs, but to also achieving other health reform goals, including improvements in care delivery and quality.

Minnesota Statutes, section 62J.536 was enacted in 2007 to accelerate the transition of health care business transactions to less costly, more automated, computer-to-computer electronic data interchange (EDI). The law requires that specified high-volume business communications must be exchanged electronically using a standard data content and format adopted into state rules by MDH. Achieving even small efficiency improvements from greater use of EDI-based "e-billing" and "e-commerce" is projected to save $40 to $60 million dollars annually across the state's health care system, permitting more of every health care dollar to be spent on patient care and health improvements.

CHCPI was selected in mid-2007 to manage the ongoing adoption and oversight of the administrative simplification rules, which apply to more than 60,000 health care providers in Minnesota and more than 2,000 insurance carriers and other health care payers and intermediaries nationwide. Minnesota's efforts operate in tandem with, and are complementary to, federal health care administrative simplification requirements and standards. These include federal transactions and code sets regulations adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as well as more recent provisions of the

federal Patient Protection and Accountable Care Act (ACA) designed to accelerate the adoption and use of EDI in health care business processes. As applicable federal regulations and national standards are adopted or changed, Minnesota's rules must also be reviewed and revised to ensure conformance with federal law and industry best practices.

CHCPI continues to lead and coordinate the state's health care administrative simplification initiative. In this capacity it plays several key roles and oversees a variety of activities outlined in more detail in this report.

CHCPI works closely in partnership with the health care industry and stakeholders, particularly the Minnesota Administrative Uniformity Committee (AUC), a large, voluntary organization of health care providers, payers, health care associations, and state agencies working together to reduce health care administrative costs and burdens. CHCPI coordinates and staffs the AUC committee of the whole as well as several AUC workgroups known as "Technical Advisory Groups" (TAGs) that bring together subject matter experts with interests and expertise in particular business transactions and topics. This division of labor is important to rulemaking to ensure that relevant experts and interested parties are aware of and involved in the process. It is also important to help identify and address any problems or questions in implementing and complying with the rules. Because of its substantial contributions and active partnership with the state, Governor Dayton proclaimed February 21, 2012, as "AUC Day" in Minnesota.

Appendix A provides additional background and detail regarding Minnesota's health care administrative simplification initiative. Appendix B lists the AUC member organizations. Appendix C summarizes relevant parts of the ACA and related health reforms.

CHCPI Key Activities and Accomplishments in 2013

In 2013 CHCPI played a variety of key roles while actively leading and coordinating:

- Rulemaking;
- Technical assistance;
- Compliance and Enforcement;
- Special legislated studies and tasks;
- Participation in national level health care administrative simplification; and
- Planning for next steps and phases.

Each of these activity areas are further summarized in the following sections.

Rulemaking

CHCPI collaborates extensively with the health care industry and the AUC as part of an ongoing process to create and maintain "rules of the road" needed for the secure, efficient exchange of health care business transactions. The rules are designed to assure that key business transactions crucial to all aspects of health care financial management and data reporting are exchanged electronically, according to well-defined, detailed standards for greatest efficiency, accuracy, and reliability.

The state's rules are intentionally designed to be aligned with, and to be used as "companions" to complementary federal regulations and national standards. The rules are therefore known as "Minnesota Uniform Companion Guides (MUCGs)."

In recent years, federal and national administrative simplification efforts have accelerated as a result of provisions of the ACA, additional federal requirements, and other national developments and market pressures. As a result, the state's rules (the MUCGs) must be periodically reviewed and updated as needed to conform with and appropriately supplement federal rules and national standards. In 2013 CHCPI led and coordinated an open, public rulemaking process to revise and update the MUCGs to assure that they remained accurate, relevant, and in conformance with federal requirements and changes at the national level.

As shown in table 1 below, CHCPI consulted with the AUC in overseeing the development and adoption of six sets of revised MUCG rules in 2013, pursuant to the process described in Minnesota Statutes, section 62J.59. As part of the process, CHCPI provided staff, logistics, planning, research, outreach, communications, and facilitation support for over 40 open public meetings of the AUC and relevant TAGs. The most recent versions of the MUCGs are available at http://www.health.state.mn.us/auc/guides.htm and http://www.health.state.mn.us/asa/rules.html.

Table 1. Summary of CHCPI recent rulemaking for standard health care transactions
(an illustration of the transactions below as part of a larger "health care revenue cycle" is presented as part of Appendix A following the body of this report.)

Health care transaction	Description/purpose	Most recent rule updates/revisions
Claims	Claims are bills submitted by health care providers to third party payers (insurers) for health care services and products. Separate, slightly different versions of the claim transaction are sent for professional (e.g., physician/clinic), institutional (e.g., hospital), and dental billings.	Revised, updated rules for Professional, Institutional, and Dental claims transactions were proposed in September 2013 and adopted in December 2013.
Eligibility Inquiry and Responses	This transaction is used by health care providers to inquire of third party payers regarding a patient's insurance coverage and benefits, in order to properly bill the third party payer and the patient. The response is used by the payer to respond to the eligibility inquiry.	Updated rules for the Eligibility Inquiry and Response transaction were also proposed in September 2013 and adopted in December 2013.
Remittance Advices	Remittance advice transactions, known formally within the industry as "Health Care Claim Payment/Advice" transactions, are sent by the payer to the health care provider to explain the disposition of a claim, including any adjustments to what is being paid and payment amounts.	Revised rules for the Health Care Claim Payment/Advice transaction were proposed in September 2013, and adopted December 2013.
Acknowl-edgments	Acknowledgments serve as receipts showing whether a transaction was received at a	Rule revisions and updates for a type of acknowledg-

Health care transaction	Description/purpose	Most recent rule updates/revisions
	destination point, and, depending on the type of acknowledgment, provide additional information that may be needed to identify and correct errors or mistakes in the transaction.	ment known formally as the "Health Care Claim Acknowledgment (277)" were developed and proposed in late 2012, and adopted in April 2013.

Technical assistance

The state's rules provide an important legal and regulatory framework for health care administrative simplification and cost savings. However, additional information and technical assistance is often needed to comply with the rules and to realize the greatest benefits from administrative simplification. In 2013 CHCPI also played a key role in providing and coordinating technical assistance, education, information sharing, and communications to help health care providers, payers, and others understand the rules and to modernize and streamline health care business transactions.

CHCPI assists the industry and coordinates activities with other state agencies through a combination of AUC staffing and engagement, special projects or meetings, and responses to individual questions or requests for assistance. In this role, CHCPI also supports the AUC in developing and maintaining industry consensus best practices, medical coding clarifications, and other information and tools that do not have the force of law but are used voluntarily by the industry to bring about more efficient, standard exchanges of health care business data.

In 2013 CHCPI:

- Responded to over 250 individual requests from providers, payers, and others for information, clarification, referrals to other agencies or organizations, or other technical assistance. The assistance ranged from answering complex questions regarding the applicability of state law and rules, to providing directions for finding and using common forms, processes, website information, and other available resources;
- Staffed and facilitated AUC TAGs on the development and maintenance of best practices and related resources, used to clarify business transactions and/or to recommend billing and coding solutions for new and emerging medical services. As part of this ongoing effort, CHCPI coordinated:
  - Work with the AUC's Medical Code TAG on additions and updates to a "coding clarification grid" with information and recommendations for new, complex, and controversial medical coding issues. In 2013, CHCPI staffed and facilitated the Medical Code TAG in exploring and updating billing and coding recommendations for intensive management of obesity, special situations encountered in delivering evaluation and management services, telephone consultations between providers, and other issues.
  - Ongoing joint efforts between the Medical Code TAG, the Minnesota Department of Human Services (DHS), which is responsible for administering the state Medical Assistance (MA - Medicaid) program, and CHCPI, to address medical coding and billing

issues for a number of services to be covered by MA. For example, coding recommendations were developed for special new programs for: preventive care and case management for frequent users of hospital emergency rooms; help for those transitioning from institutional care settings to home and community settings; freestanding "birthing centers," services of recently established "community paramedics," a range of substance abuse and psychiatric services and other services.

- Contracted with a nonprofit consultant in mid-2013 and developed preliminary outreach and communications strategies to help prepare for and best address a rapidly changing health care administrative simplification environment. In particular, it was important to consider strategies to:
  - Help identify and address concerns regarding pockets of noncompliance with the state's e-billing requirements, particularly regarding the exchange of billings and related business transactions for workers' compensation-related medical care (see further information in the next section);
  - Help set priorities and direction with the AUC during a time of transition, from an initial emphasis on state rule development, to maintenance of the rules in the context of larger ACA-mandated national administrative simplification initiatives;
  - Balance MDH's role in providing technical assistance and ensuring compliance and appropriate oversight/regulation;
  - Advance the state's e-billing requirements, while at the same time being mindful that stakeholders faced a number of other important competing objectives and demands, including: state and federal requirements for the meaningful use of Electronic Health Records (EHRs); implementation of the ICD-10 coding system; adoption of health insurance exchanges and expansions of health coverage mandated by the ACA; and other significant, rapidly approaching transitions and deadlines.

  This work led to a preliminary report for further discussion with the AUC and others, emphasizing a variety of possible next steps dependent on budget and other factors, including:
  - Needs assessment(s) of AUC members, to calibrate goals, activities, information, tools, resources, and processes to best meet the needs;
  - Special workshops and educational forums on a variety of topics, both inside and outside the metro area;
  - Greater acknowledgment of the roles played by data exchange intermediaries and vendors such as clearinghouses, with a possible "vendor forum" to discuss the state's requirements, common obstacles to success, and possible options and solutions;
  - Brief recorded instructional recorded videos/webinars on MDH websites to provide new, more readily available, easily accessible, appropriately targeted and focused key information, tips, examples, etc.;
  - Participation and greater visibility as part of other related broader health care data forums and activities, such as the annual MDH "e-Health summit."

In 2013 CHCPI also began implementing a number of new communication and outreach efforts consistent with the strategies and needs above, starting with:

- Development and production of a new monthly newsletter to help keep the AUC and others informed and up to date regarding AUC activities, national issues and developments, and other information of interest; and
- Submission of proposals for presentations regarding Minnesota's implementation of e-billing requirements at the 2014 annual conference of the national Workgroup for Electronic Data Interchange (WEDI) and the 2014 statewide e-Health Summit.

CHCPI will continue refining and implementing its communications and technical assistance plans with the AUC and others in 2014.

Compliance and enforcement

CHCPI is responsible for compliance and enforcement of Minnesota Statutes, section 62J.536 and related rules requiring the standard, electronic exchange of health care administrative transactions. The law applies broadly to health care providers, group purchasers (payers), and to intermediaries facilitating the electronic exchange of transactions known as "clearinghouses." The law specifies that MDH:

- Will seek voluntary compliance to the extent practicable;
- Is authorized to investigate complaints of noncompliance;
- Will attempt to arrive at informal resolution of complaints;
- May impose civil monetary penalties of up $100 for each violation, not to exceed $25,000 for identical violations during a calendar year if the violation cannot be addressed by informal means; and
- May consider may consider certain aggravating or mitigating factors in imposing fines.

The backdrop for the compliance and enforcement process above is generally positive, if somewhat uneven. For example, since the passage of MS §62J.536 in 2007 and adoption of related rules, Minnesota has taken significant strides in automating health care claims. The Minnesota Council of Health Plans, an association of licensed, regional nonprofit health care organizations, reported that approximately 83% of medical claims were received electronically by Minnesota health plans in 2007; by 2013 approximately 98% of claims were received electronically.[iv] However, while the overall success in electronic claims is noteworthy, it obscures some continuing challenges, especially in the exchange of medical claims associated with workers' compensation cases as discussed below.

Special compliance focus on e-billing for workers' compensation

In 2013 CHCPI's primary and most visible compliance and enforcement efforts were undertaken jointly with the Minnesota Department of Labor and Industry (DLI), which administers the state's workers' compensation system, to explore and address concerns regarding compliance with the state's e-billing requirements for workers' compensation-related medical claims. The collaboration is important because MS §62J.536 applies to the exchange of billings and other transactions for medical care under the workers' compensation system. In addition, Minnesota

Statutes, section 176.135 also specifically references that workers' compensation medical claims must comply with MS §62J.536.

This active collaboration between the two agencies started in mid-2012, when DLI responded to concerns regarding health care providers not submitting workers' compensation claims to payers electronically as required by Minnesota law, and brought the issue to the attention of MDH. CHCPI and DLI then collaborated in structured compliance reviews with several health care provider organizations, including face to face meetings with the organizations, and additional investigation and fact finding pursuant to guidelines in MS §62J.536. Pursuant to statute, CHCPI and DLI issued joint corrective action plans with several organizations in the fall of 2012 to take remedial action to become compliant and to informally resolve any violations.

CHCPI and DLI continued to monitor progress on the corrective action plans in 2013 and to provide technical assistance to assure compliance. With a few exceptions, all organizations under corrective action plans have reported making the progress required pursuant to their plans. In the case of the exceptions, we have met with the organizations involved for additional monitoring and continued follow-up to ensure compliance.

CHCPI also coordinated with DLI in the development and broad distribution of three bulletins for a wider workers' compensation audience both locally and nationally to respond to recurring questions and to clarify that:

- Minnesota's "e-billing" requirements do apply to workers' compensation payers and clearinghouses;
- requirements for ICD-10 and use of the most recent version of designated data standards apply to all payers, including workers' compensation insurers; and
- adherence to recently adopted federal operating rules for the reimbursement of health care providers via electronic funds transfer (EFT) is strongly encouraged.

The bulletins were: disseminated nationally via list serves and websites maintained by MDH and DLI; announced at MDH and DLI stakeholder and advisory group meetings; and were reported and discussed by recipients of the bulletins at several key national workers' compensation-related forums and meetings.

While the MDH-DLI joint enforcement above initially focused on health care providers, our follow-up investigations showed that providers were sometimes reporting being noncompliant as a result of their trading partners who were not providing information or taking actions needed to establish electronic connections, or who were themselves possibly not yet in compliance with the law. As a result, planning was initiated for any additional compliance reviews and follow-up with payers and other parties as needed in 2014. This additional information will also serve as a useful tool to test and corroborate self-reported compliance data and accounts of e-billing challenges received from providers.

In addition, while electronic claims are generally becoming nearly universal, preliminary assessments indicate that the rates of other important electronic transactions such as insurance eligibility and benefits verifications and acknowledgments have also improved but still remain less widely used. These exchanges are important for patient care, proper billing and payment, and to prevent costly delays and rework that may be needed to resolve errors or correct problems. In the same way that it is important to better understand and address the needs of

those who are not exchanging claims electronically, it will also be important to continue to better understand and address the factors contributing to lower rates of other electronic business transactions as part of planning 2014 priorities and follow-up.

Special legislated studies and tasks

Fulfillment of a statutory requirement for development of a companion guide with specifications for electronic prescription drug prior authorization requests

In 2013 CHCPI coordinated the development and publication of specifications for the automated, electronic exchange of a high volume health care business transaction known as "prescription drug prior authorization (PA) requests" that was required pursuant to Minnesota Statutes, section 62J.497, subd. 5 (b). In particular, the law required

> *(b) By January 1, 2014, the Minnesota Administrative Uniformity Committee shall develop the standard companion guide by which providers and group purchasers will exchange standard drug authorization requests using electronic data interchange standards, if available, with the goal of alignment with standards that are or will potentially be used nationally.*

In addition, the statute also required that

> *(c) No later than January 1, 2015, drug prior authorization requests must be accessible and submitted by health care providers, and accepted by group purchasers, electronically through secure electronic transmissions. Facsimile shall not be considered electronic transmission.*

The mandates above added to and reinforced a previous law that required MDH, in consultation with the AUC and the Minnesota e-Health Advisory Committee, to determine by 2010 "*how... best to standardize drug prior authorization request transactions between providers and group purchasers with the goal of maximizing administrative simplification and efficiency in preparation for electronic transmissions.*"

CHCPI, in consultation with the AUC and e-Health Advisory Committee, completed the 2010 study pursuant to statute. In its final report, CHCPI explained the nature and importance of prescription drug prior authorizations, noting that:

- *Prescription drug prior authorizations are required of prescribers, and in some cases pharmacies, by group purchasers (payers) in order that patients may receive particular prescription drugs;*
- *Prescription drugs requiring prior authorization make up only a small fraction of all prescribed medications. However, prior authorization is a "widely adopted method of drug utilization management" and the majority of prescribers submit PA requests. Both the number of drugs requiring prior authorization and the number of PAs have grown rapidly in recent years; and*
- *Despite its growing visibility and importance, the drug prior authorization process is often manual and nonstandard, creating administrative burdens and costs to health care providers and payers. It also may result in patients experiencing delays in getting prescriptions filled, or foregoing medications, leading to potentially adverse health impacts as well.*[v]

CHCPI's 2010 report noted that possible attributes of a "best" approach to standardize drug PA requests included "Extensive use of direct, computer-to-computer, automated electronic data interchange (EDI), based on well-established, widely-used national standards that are well suited to the drug PA transaction... ." However, the report also found that "an existing national standard for the electronic exchange of prior authorizations [in general] 'provides … limited support for prior authorization of drugs and is not widely used.'"[vi]

As a result, CHCPI recommended a short term "stop gap" strategy of "common, high-level, minimum specifications" to facilitate manual, direct data entry of PAs via website portals to be implemented by payers. This temporary, limited improvement over existing nonstandard faxing and telephoning of PAs was intended to help meet the need until a national standard for automated, computer to computer exchanges of drug PAs was available.[vii]

In 2010, the state's e-prescribing requirements (MS §62J.497, subd. 5 (b)) were also subsequently amended to acknowledge the need for a national prescription drug electronic PA standard as the basis for the required companion guide, much as the other companion guides discussed in this report are companions and supplements to national standards named in HIPAA regulations. The amended statute directed the AUC to develop the PA companion guide "using electronic data interchange standards, if available, with the goal of alignment with standards that are or will potentially be used nationally."

During the period 2010-2013 CHCPI monitored the development and testing of a possible national standard for automated, EDI-based prescription drug PAs. In 2013, the national prescription drug transactions standard setting body, the National Council for Prescription Drug Plans (NCPDP), adopted a national standard for the electronic exchange of PA requests and responses, known as the NCPDP SCRIPT Standard version 2013071 (hereinafter referred to as "SCRIPT 2013071").

With the emergence of this new national standard, CHCPI coordinated with the AUC and contracted with a consultant in April 2013 to develop the required companion guide pursuant to state statute. A special pharmacy technical advisory group (TAG) with participation of subject matter experts from the AUC, the industry, and NCPDP was convened and met four times from April – June 2013. The TAG reviewed the recently adopted SCRIPT 2013071 in detail and suggested several clarifications and elaborations which it submitted to NCPDP and which were also subsequently adopted by NCPDP.

The TAG found that the SCRIPT 2013071 was sufficiently detailed that no additional explanatory documentation as necessary. Consequently, it recommended that the AUC companion guide incorporate by reference the relevant parts of the SCRIPT 2013071 pertaining to prior authorizations, and that they serve as the detailed specifications for exchanging PAs. The full AUC approved the TAG's recommendation and forwarded it to MDH, which adopted it via an announcement in the State Register and posted it for downloading and use at Rx ePA companion guide in September 2013.

Review of the Health Care Administrative Simplification Act of 1994 for outdated language

It is important to review statutes and rules to ensure that they remain relevant and are as clear and unambiguous as possible. In 2013, CHCPI worked closely with the AUC's Legislative TAG over several months to review the nearly twenty-year-old state "Health Care

Administrative Simplification Act (ASA) of 1994" (Minnesota Statutes, sections 62J.50 – 62J.63) for archaic or unclear language and concepts.

The ASA includes a variety of health care administrative simplification provisions that were relevant and important when first enacted in 1994. However, many of them have become obsolete, incorrect, or no longer clear as a result of changes in federal and state law, industry developments, and other changes. The AUC-CHCPI review was completed in the fall of 2013, and CHCPI recommended to MDH a number of technical revisions to the ASA to be considered during the Minnesota 2014 legislative session.

Participation in national-level health care administrative simplification

CHCPI monitors and participates in national-level health care administrative simplification in order to: be informed of potential changes affecting Minnesota's efforts; share information regarding Minnesota's efforts and experience with the broadest range of stakeholders and experts; and contribute to national discussions, problem solving, and innovations. CHCPI remains engaged nationally through: membership and participation in a number of well-recognized standards setting and advisory groups; partnerships with the AUC and state agencies to submit comments regarding federal rules, national standards, and other requests for comments and testimony; networking and contacts with other state and national groups; and outreach and communications through a large list-serve, website postings, and other communications. As part of this process, CHCPI regularly shares developments at the national level with the AUC and other stakeholders; contributes information, updates, and perspectives to the national process; and remains informed of and engaged in national and federal regulations and standard setting affecting Minnesota.

CHCPI was honored to be selected to present to the national Institute of Medicine (IOM) in October 2013 on "Minnesota's Collaborations To Reduce Health Care Business Transaction Costs And Burdens." The IOM is the health arm of the National Academy of Science and undertakes studies mandated by Congress or requested by federal agencies and independent organizations. It also convenes a series of forums and other activities, to facilitate discussion and cross-disciplinary thinking in a variety of fields.

CHCPI's presentation was made under the auspices of one of the IOM ongoing forums, the Value Incentives Learning Collaborative to address health costs and value. The purpose of the presentation was to provide a case study example of one approach being implemented to address health care administrative costs, and its lessons and impacts to date, as part of a backdrop of broader, ongoing discussions to improve the value of health care delivery. The presentation highlighted Minnesota's first-in-the-nation mandates for the electronic exchange of common health care business transactions, it's collaborations with the AUC, and initial estimated system-wide cost savings as well as challenges and obstacles.

Plans and next steps for 2014

CHCPI met with the AUC in December 2013 to discuss and make preliminary plans for 2014. The planning process identified a number of key needs and objectives for the coming year, including:

- Meeting CHCPI and the AUC's primary ongoing responsibilities for the development, administration, and refinement of rules for standard, electronic exchange of routine health care business transactions;
- Promoting preparedness and successful transition to a federally mandated, much more detailed, robust new version of an international medical diagnoses classification system known as "ICD-10" by the required deadline of October 1, 2014.
- Developing and implementing customer satisfaction surveys and other tools to provide MDH with feedback to help assess its role, services, and resources in support of health care administrative simplification and the AUC;
- Creating a framework for the review and discussion of the administrative implications of rapidly emerging new forms of health care delivery and financing, such as payment for bundled services, Accountable Care Organizations (ACOs), pay for performance, and others;
- Continuing engagement with and implementation of administrative simplification transactions standards and federal operating rules mandated by the federal Patient Protection and Accountable Care Act (ACA), including in particular a new national Health Plan Identifier (HPID) for exchanges of electronic business data in which a health plan must be identified.
- Additional new projects and responsibilities, including technical assistance to aid those who must fulfill requirements in Minnesota Statutes, 62J.497 for the standard, electronic exchange of prescription drug prior authorizations by January 1, 2016.

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Health Policy Division, Center for Health Care Purchasing Improvement
PO Box 64882
St. Paul, MN 55164-0882
651-201- 5000
www.health.state.mn.us

Minnesota's Health Care Administrative Simplification Initiative

Overview

As described below, the Minnesota Department of Health (MDH) is responsible for developing, implementing, and administering state requirements[1] to reduce the costs and burdens of exchanging common, high-volume health care business (administrative) transactions. The initiative is projected to reduce overall administrative costs in Minnesota's health care system by an estimated $40 million to $60 million.[2] In addition, achieving more standard, electronic exchanges of health care administrative transactions is important to meeting other goals for the accurate, efficient flow of data for health care performance measurement and improved patient care.

Background

Large volumes of routine administrative transactions

Health care delivery and payment is a transaction-intensive enterprise that is sometimes represented by a revenue cycle similar to the one illustrated on the right. The illustration summarizes in a simplified diagram several, but not all, of the key steps and transactions in the health care billing and payment process.

As illustrated, the process starts with enrollment in an insurance plan, and continues through successive steps of:

- determining patient eligibility for health insurance coverage and benefits prior to or at the point of health care service;
- obtaining any necessary prior authorizations and referrals necessary for patient care;
- submission of claims (billings) to insurers for care and services provided, as well as inquiries regarding the status of claims; and
- payment and delivery of the corresponding remittance advice to the provider.

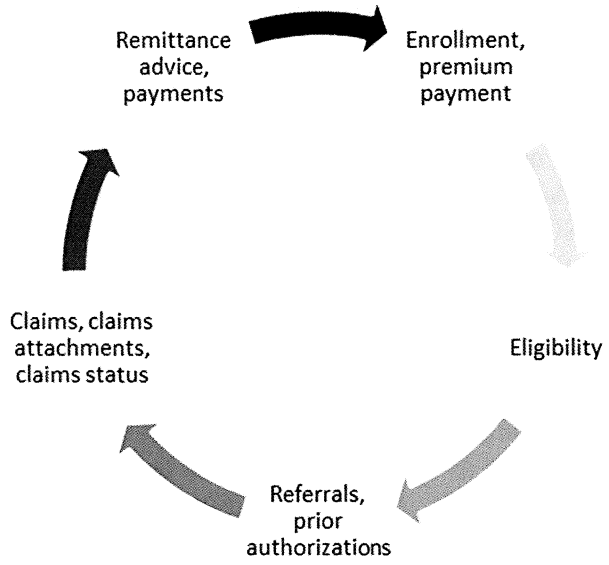

Figure 1 - Example Health Care Revenue Cycle

The volume of transactions exchanged throughout the revenue cycle is staggering. Nationally, health care payers process more than five billion medical claims (billings) annually.[3] In Minnesota alone, the state's health plans processed nearly 69 million health care claims in 2013.[4] Moreover, providers, payers, and venders exchange millions of other business communications, including eligibility inquiries and responses, authorizations, payments, and acknowledgments.

Unnecessary costs and burdens

Despite the large volume of these common administrative transactions, the health care industry has often lagged behind other sectors of the

economy in its use of standard, automated electronic data interchange (EDI) to conduct routine business.[5] The result is continued use of outdated paper and nonstandard electronic formats that are much less efficient. Because of the high volume of these transactions, even small inefficiencies add up significantly and quickly as unnecessary costs and burdens across the health care system.

Federal HIPAA administrative simplification

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 and related rules are intended in part to address the problems above by accelerating health care's adoption of more efficient EDI for business purposes. For example, HIPAA required that health care payers accept certain electronic transactions from providers, and that the transactions adhere to standards and code sets developed by several specified national organizations. In addition, the federal Administrative Simplification Compliance Act (ASCA) requires most health care providers to submit their initial bills to Medicare electronically.

These regulations provided an important framework for quicker, less burdensome, more accurate communications of large amounts of industry business data. However, the HIPAA regulations were often not as specific and detailed as needed, resulting in variability and ambiguity in how data were to be exchanged.

In response, and to the extent allowed by law, health care payers often published their own additional data exchange specifications, known as "companion guides." These guides are used in conjunction with national data rules and standards, and together provide the detailed instructions needed to electronically exchange data. While the proliferation of many individual, idiosyncratic companion guides was permitted under HIPAA, it eroded the regulations' effectiveness as a single, common standard for effectively and efficiently automating data flows.

Minnesota's three-pronged approach to health care administrative simplification

Minnesota Statutes, section 62J.536, was enacted in 2007 to address the problem of "nonstandard standards" created by the proliferation of individual companion guides, as well as other barriers to administrative simplification. The statute effectively addresses three sources of unnecessary health care administrative costs and burdens as described below.

Problem: *Many routine, high volume health care business transactions are still exchanged on paper.*

Many health care transactions are still exchanged on paper, which national studies have shown to be about twice as expensive to process as electronic transactions.[6]

Solution: Minnesota requires that four high volume health care business transactions be exchanged electronically via a single, standard form of HIPAA-compatible EDI including:

- *Eligibility verification* – submitted by a provider to a payer to confirm a patient's medical insurance coverage and benefits to facilitate proper billing;
- *Claims* – bills submitted by providers for payment for care and services;
- *Remittance advices* – submitted by payers to providers to explain any adjustments to bills and corresponding payments; and,
- *Acknowledgments* – receipts indicating that one party has received an exchange submitted by another party.

Problem: *A proliferation of "companion guides" to federal HIPAA transaction standards has resulted in variable, unnecessarily costly transactions.*

HIPAA standards for the electronic exchange of health care business transactions are often not sufficiently detailed to be used independently of other instructions or specifications known as "companion guides." Many payers have issued their own companion guides with requirements for data exchange that supplement the HIPAA standards. Requiring many different ways of sending the same business transaction (e.g., billings or "claims") to different recipients (e.g., payers)

creates unnecessary administrative burdens and costs.

Solution: Minnesota required the adoption into rule of a single uniform companion guide for each of the transactions above that must be exchanged electronically. The guides comply with HIPAA and provide additional data content specificity where needed. They must be used by health care providers providing services for a fee in Minnesota, by all payers licensed or doing business in the state, and by clearinghouses when exchanging acknowledgments for claims and remittance transactions and in order to ensure compliant transactions on the part of their customers.

In addition, as part of the overall standardization emphasis, Minnesota requires the exchange of standard, electronic acknowledgments, which are not yet required by HIPAA. Acknowledgments are important to determining whether transactions reached their destinations, and to identify errors or problems so that they can be addressed most effectively and efficiently.

Per state statute, MDH consults with the Minnesota Administrative Uniformity Committee (AUC) on the Minnesota Uniform Companion Guide rules. The AUC is a large, voluntary stakeholder advisory group comprised of health care provider, payer, and association organizations, as well as several state agencies. MDH also consults with the AUC in developing and publishing best practices, coding recommendations, responses to questions, and other information and recommendation. While these materials are not adopted into rule with the force of law, their use is highly encouraged as a further means of promoting the exchange of standard health care business data.

In recognition of the AUC's efforts and accomplishments, Minnesota Governor Mark Dayton declared February 21, 2012 as "Administrative Uniformity Committee Day" throughout the state.

Problem: *HIPAA data exchange requirements do not apply to all health care payers and providers.*

HIPAA health care transactions and code sets rules do not apply to workers' compensation, property-casualty, and auto carriers. Consequently, many transactions with these payers are often now conducted on paper or using nonstandard exchanges that are less efficient and more costly. Similarly, while the federal ASCA requires that most initial claims for reimbursement under Medicare be submitted electronically, there are exceptions for small providers.

Solution: Minnesota's requirements for the standard, electronic exchange of claims, remittance advices, and acknowledgments apply to payers not subject to HIPAA. In addition, Minnesota's regulations apply to all health care providers as defined in state statute.

More recent federal and state health care administrative simplification initiatives

Minnesota's rulemaking has been undertaken against a backdrop of the most sweeping national health care administrative simplification in over a decade. For example, in 2009 the federal Department of Health and Human Services (HHS) adopted rules requiring new versions of the transaction standards adopted under HIPAA, effective January 1, 2012. In addition, section 1104 of the Patient Protection and Affordable Care Act (ACA) requires the Secretary of HHS to adopt a series of operating rules and standards over a five year period to further standardize and automate a number of high volume health care business transactions.

MDH continues to work closely with the AUC and stakeholders to implement and administer Minnesota's health care administrative requirements in tandem with the federal regulations. It collaborates in particular with the AUC at this time to: help facilitate single, state-wide responses to proposed federal requirements; update and harmonize Minnesota rules with federal regulations; and to share the state's lessons learned and experience in administrative simplification as part of other national standards setting activities.

Example initial impacts

Under Minnesota's health care administrative simplification initiative:

- The percent of health care claims submitted electronically to Minnesota health plans increased from 83% (2007) to 98% (2013).[7] This is important because one national actuarial firm estimates that paper claims cost an average $3.73 more per claim than electronic claims.[8]
- Automation and standardization of eligibility and billing is reducing the need for phone-based follow-up and questions between providers and payers, helping reduce an estimated $15.5 million - $22 million annual expense statewide for the calls.[9]
- The Minnesota Department of Human Services (DHS) administers the state's publicly funded health care programs such as Medical Assistance (Medicaid) and pays more than one million fee-for-service health care claims annually. DHS reported in 2010 that:
    - It is receiving more electronic, automated claims and fewer needing manual review;
    - As a result of greater automation and streamlining, it was able to reduce its staff for claims processing from 41 to 16 persons, and to reallocate the 25 staff that previously worked in claims to new, higher priorities.
    - In addition, greater claims processing automation allowed DHS to discontinue a software maintenance contract and a post office box for paper claims, and reduced other overhead costs.
- Other providers and payers have also reported that reductions in health care administrative burdens costs will permit reallocation of critical information technology and operational resources to other high priority uses, including improving the flow of clinical health care data, where even greater savings and improvements in patient care are anticipated long term.

Endnotes

1. Minnesota Statutes, section 62J.536 and related rules.
2. Minnesota Department of Health, Center for Health Care Purchasing Improvement (CHCPI). (February 2011). Preliminary unpublished estimate of potential Minnesota health care administrative cost reductions with implementation of requirements for the standard, electronic exchange of health care administrative transactions.
3. Centers for Medicare and Medicaid Services (CMS). HCPCS – General Information: Overview, HCPCS Background Information. Retrieved from website: http://www.cms.gov/MedHCPCSGenInfo/
4. Minnesota Council of Health Plans. (2014). Personal communication.
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6. Milliman Technology and Operations Solutions. (2006). Electronic Transaction Savings Opportunities for Physician Practices. Retrieved from website: http://www.emdeon.com/resourcepdfs/MillimanEDIBenefits.pdf.
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8. John L. Phelan, Ph.D.. Electronic Transactions Between Payors and Providers: Pathways to Administrative Cost Reductions in Health Insurance. Milliman Client Report. (May 6, 2010). Retrieved from website: http://www.navinet.net/files/navinet/Milliman_report.pdf.
9. 2006 Administrative Simplification Project Project Documentation. (Working document.) 2006.

Appendix B: Minnesota Administrative Uniformity Committee (AUC) Member Organizations

The Minnesota Department of Health (MDH) works closely with a large, voluntary stakeholder organization, the Minnesota Administrative Uniformity Committee (AUC), in the development and administration of state requirements for the standard, electronic exchange of health care administrative transactions. A list of AUC member organizations is provided below.

AUC member organizations:

- Aetna
- Aging Services of Minnesota
- Allina Health System
- American Association of Healthcare Administrative Management (AAHAM)
- Blue Cross Blue Shield of Minnesota
- Care Providers of Minnesota
- CentraCare Health System
- Children's Hospitals and Clinics
- CVS Pharmacy
- Delta Dental Plan of MN
- Essentia Health
- Fairview Health Services
- HealthEast
- HealthEZ
- HealthPartners
- HealthPartners Medical Group and Regions Hospital
- Hennepin County Medical Center Hennepin Faculty Associates
- Mayo Clinic
- Medica Health Plan
- Metropolitan Health Plan
- Minnesota Chiropractic Association
- Minnesota Council of Health Plans
- Minnesota Dental Association
- Minnesota Department of Health
- Minnesota Department of Human Services
- Minnesota Department of Labor and Industry
- Minnesota Hospital Association
- Minnesota Medical Association
- Minnesota Medical Group Management Association
- Minnesota Pharmacist Association
- Noridian - Medicare Part A
- Olmsted Medical Center
- Park Nicollet Health Services
- PreferredOne
- PrimeWest Health
- Sanford Health
- Sanford Health Plan
- Silverscript
- St. Luke's
- UCare Minnesota
- UnitedHealth Group
- University of Minnesota Physicians
- Wisconsin Physicians Service Insurance Corporation

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Appendix C: Section 1104 of the Federal Patient Protection and Affordable Care Act (ACA) and Related Health Reforms

Minnesota Statutes, section 62J.536 requires the standard, electronic exchange of several high volume, common health care business transactions to reduce health care administrative costs and to improve the accuracy and timeliness of business data. The statute builds upon and also requires compliance with federal health care administrative simplification regulations.

As the federal regulations are adopted or modified, Minnesota's requirements must be reviewed and updated as necessary. At the same time, it is important to work with the Minnesota industry to create broader awareness and understanding of the changes, and to communicate lessons and Minnesota perspectives as part of national level policy making.

This state-federal relationship has become more visible and important recently with the 2010 enactment of section 1104 of the ACA. The law requires the Secretary of the U.S. Department of Health and Human Services (HHS) to develop and implement a variety of "operating rules" and data exchange standards over five years to simplify and automate a number of frequently exchanged health care business transactions. Operating rules are intended to supplement transactions standards and specifications adopted under federal Health Insurance Portability and Accountability Act (HIPAA) regulations, and are defined as "the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications."[1]

The tables and chart below show the timelines for completing the ACA rules and other related ACA milestones. In addition, they also summarize other important state and federal health care electronic data interchange (EDI) initiatives, including efforts to accelerate the flow of standard, electronic patient clinical data through adoption of incentives for "meaningful use" of Electronic Health Records (EHRs). These incentives were part of federal legislation and rules enacted in 2009-2010 under the Health Information Technology for Economic and Clinical Health (HITECH) Act, a part of the broader American Recovery and Reinvestment Act (ARRA). Efforts to improve the exchange and use of patient clinical data will likely have to compete for similar, limited health information technology (HIT) resources and expertise that are also needed to meet the state's administrative simplification goals and requirements. CHCPI is monitoring and coordinating with the state's patient clinical data exchange activity as part of its planning and oversight for administrative simplification. A summary chart below includes key ACA and HITECH milestones, as well also additional Minnesota-specific requirements for the implementation of interoperable EHRs, to be considered as part of overall administrative simplification planning and priority setting.

Table 1 below lists common health care business transactions that will become more uniform and more efficient under the ACA's operating rule requirements. It also lists the dates by which health plans must certify that they are compliant with the operating rules. Because of the lead times needed to implement and test computer system changes, efforts to meet the required compliance deadlines must be undertaken well in advance of the certification date. The asterisked items indicate transactions for which Minnesota also has established standard data

[1] Department of Health and Human Services. *Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions*. Federal Register Volume 76, Issue 131 (July 8, 2011). Retrieved from website: http://www.gpo.gov/fdsys/pkg/FR-2011-07-08/pdf/2011-16834.pdf .

content rules pursuant to MS § 62J.536, which will need to be reviewed and harmonized with the ACA operating rule requirements.

Table 1. Standards and operating rule compliance dates for covered transactions

Transaction (An asterisk indicates that Minnesota requirements also apply)	Federal Operating Rules/Standard Certification Date (Health Plans must be certified as in compliance)
Eligibility* Transmits inquiries and responses regarding the applicable insurance coverage and benefits of a benefit plan enrollee to aid correct billing	December 31, 2013
Claim status Transmits inquires and response regarding the status of a health care claim (billing)	
Electronic funds transfer Transmits the electronic exchange of funds to pay medical claims	
Payment/advice* Transmits payment and payment processing information and explanations of amounts paid	
Claims* Transmits a request to obtain payment, or transmission of encounter information for the purpose of reporting health care	December 31, 2015
Enrollment/disenrollment in a health plan Transmits subscriber enrollment information to a health plan to establish or terminate insurance coverage	
Health plan premium payments Transmits health insurance premium payment and payment information	
Referral certification/authorization Transmits requests for an authorization and/or referral for health care	
Claims attachments Transmits supplemental health information needed to support a specific health care claim	
Health plan identifier Transmits an identification number to identify a health plan	November 7, 2016

Sources: Centers for Medicare & Medicaid Services websites for "Operating Rules for HIPAA Transactions" (http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/OperatingRulesforHIPAATransactions.html) and "Health Plan Identifier" (http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html)

Table 2 shows additional important health information technology (HIT) deadlines in federal and Minnesota regulations, including deadlines for the adoption of a new disease classification system ("ICD-10"), and incentives to bring about the "meaningful use" of electronic health records (EHRs).

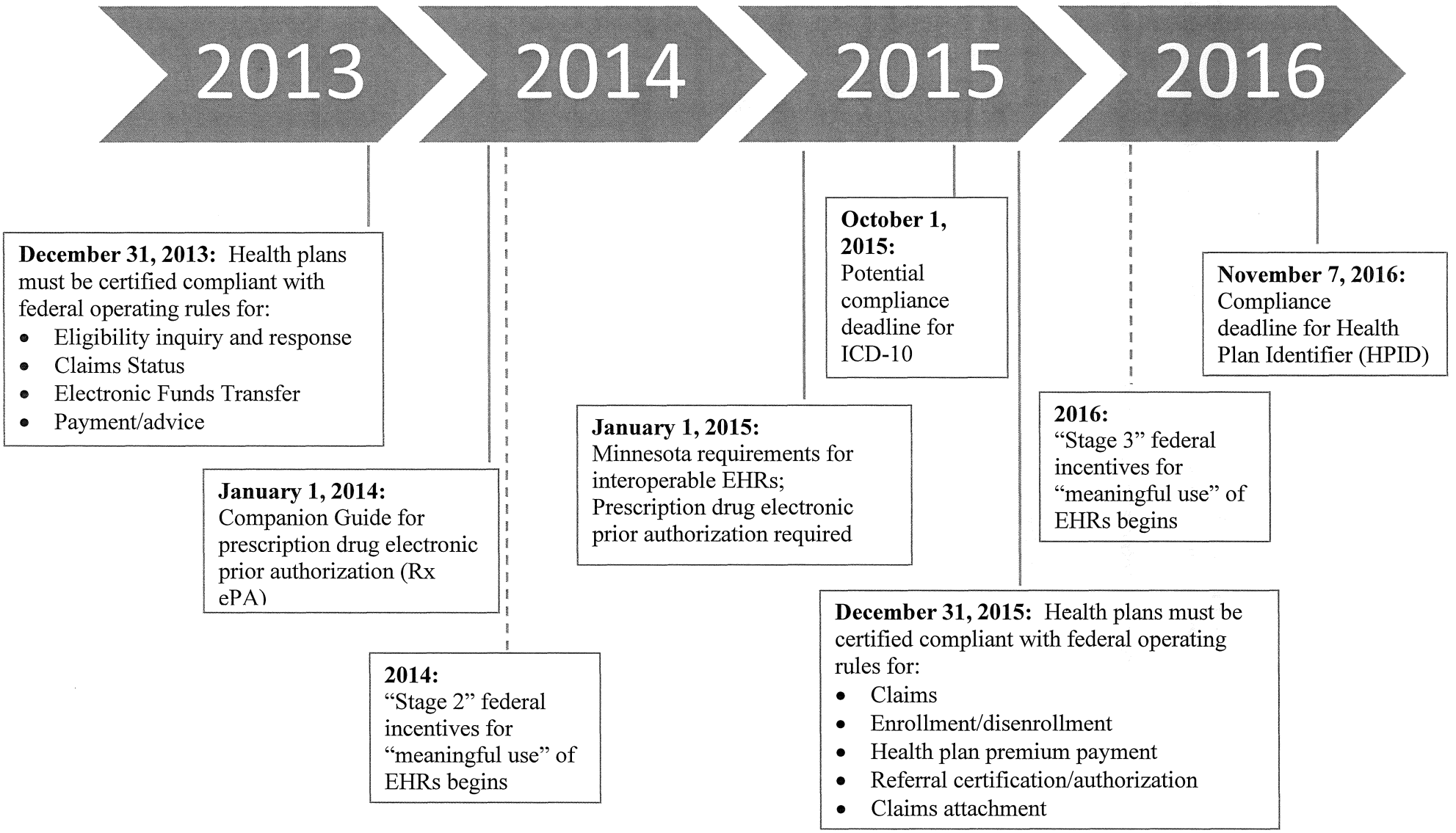
Table 2. Summary of selected additional federal and state HIT regulation deadlines

Category/transaction	Effective dates
ICD-10 (International Classification of Diseases, 10th revision)	October 1, 2015* (*A 10/1/2014 deadline was delayed as a result of a 2014 federal law to at least 10/1/2015.)
Incentives for Meaningful Use of Electronic Health Records (Incentives are planned in three stages. Stage 1 began in 2011. Incentives for Stages 2 and 3, requiring more advanced types of meaningful use, start in 2014 and 2016)	Stage 2: 2014 Stage 3: 2016
Minnesota requirements: *Adoption of interoperable EHRs*	January 1, 2015

Sources: HealthIT.gov websites on "Meaningful Use" (http://www.healthit.gov/policy-researchers-implementers/meaningful-use); CMS websites on ICD-10 (http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10); Minnesota Statutes, section 62J.495 Electronic Health Record Technology (https://www.revisor.mn.gov/statutes/?id=62J.495)

Chart 1 below shows the timelines for Tables 1-2 in a single illustration.

Chart 1. Patient Protection and Affordable Care Act (ACA) Section 1104 Administrative Simplification and other selected federal/state health care data exchange initiatives



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Endnotes

[i] Minnesota Department of Health, Center for Health Care Purchasing Improvement (CHCPI). (February 2011). Preliminary unpublished estimate of potential Minnesota health care administrative cost reductions with implementation of requirements for the standard, electronic exchange of health care administrative transactions.

[ii] Minnesota Council of Health Plans. (2014). *Personal communication.*

[iii] Minnesota Department of Human Services. (2014). *Personal communication.*

[iv] Minnesota Council of Health Plans. (2014). *Personal communication.*

[v] Minnesota Department of Health. (2010). *Electronic Drug Prior Authorization Standardization and Transmission: Report to the Minnesota Legislature, 2010.* Retrieved from website: http://www.health.state.mn.us/asa/rxpa021510rpt.pdf.

[vi] Idid.

[vii] Ibid.