



AUC EXECUTIVE COMMITTEE AGENDA and Meeting Materials

Monday, November 2, 2015 8:30 a.m. – 10:30 a.m.

[HealthPartners-Bloomington](#)

8170 Building, 1W Walnut Room

*Teleconference and WebEx **OPTION***

Dial-in # **1-712-832-8300**, Access Code: 337213

[WebEx](#), Password: Exc2010!

Meeting Objectives:

- Update re. ACO Data Analytics Planning
- Other updates and planning

Meeting materials contents (following this cover page):

- I. Draft meeting agenda
- II. Discussion guide -- Old Business
- III. Discussion guide -- New Business

I. 11/02/15 Meeting Agenda

| Agenda item | Notes |
|--|-------|
| A. Meeting to order – Ann Hale | |
| B. Anti-trust statement | |
| C. Review of notes from the previous meeting | |
| D. Updates/Old business <ol style="list-style-type: none">1. Update -- TAG meeting to review Council of Health Plans' Home Health PA form2. Update – TAG to recommend standard data analytics for ACO providers3. TAG/SBAR update4. Rx PA form update | |
| E. New business <ol style="list-style-type: none">1. Eligibility TAG2. Medical Code TAG | |
| F. Other business | |
| G. Next meeting: December 7, 2015 8:30am - 10:30am <ol style="list-style-type: none">a. Health Partners 8170 Bldng, 6W - Lilac Room | |

II. Discussion Guide – Old Business

| Agenda item # | Agenda Item | Background, discussion | Notes/Next steps/Follow up |
|---------------|---|--|--|
| D1 | Next steps – form TAG to review Council of Health Plans’ Home Health PA form | <p>The Council discussed the development of the form at the last Operations meeting.</p> <p>In an email vote completed 9/17, the AUC agreed to create a temporary TAG to review the form. In creating the TAG, it was agreed to invite participation by the Minnesota Department of Human Service (DHS) and “county-based purchasing organizations.”</p> <p>The TAG met Oct. 23. One of the main issues that was to be clarified is whether the form was to be used for DHS FFS home health PA. It was clarified at the meeting that the form is not for use with DHS FFS. The rest of the meeting was spent revising and refining the form.</p> | The product from the Oct. 23 meeting will be reviewed by stakeholders. I believe there will be another meeting scheduled to finalize and approve the form. |
| D2 | Next steps – form TAG to recommend standard data analytics for ACO providers | <p>The ACO Data Analytics TAG above has been formed. The current list of members (17 as of 10-28-15) is attached. The first meeting will be held at the Minnesota Humanities Center 8:30-10:30 am, Thursday, Nov. 5.</p> | |
| D3 | TAG/SBAR update | <p>Acknowledgment TAG – last met August 17. Has completed revisions of Acknowledgment companion guides, which are being voted on Ops in an email vote due Sept. 30. Ops is also voting on revisions to two best practices, and the vote is also to be completed Sept. 30. No further meetings are planned at this time but will be needed in the future to review public comments on companion guide revisions.</p> <p><u>Update:</u> AUC-approved changes to companion guide</p> | |

II. Discussion Guide – Old Business

| Agenda item # | Agenda Item | Background, discussion | Notes/Next steps/Follow up |
|---------------|-------------|--|----------------------------|
| | | <p>forwarded to Commissioner’s office. When approved, we plan to publish a State Register notice of 30 day public comment period on November 23.</p> <p>Eligibility TAG – The Eligibility TAG met Oct. 28. It reviewed and approved the continuation of a current, statutorily allowed exception to the state’s e-transactions for entities not subject to HIPAA, for only the 270-271 transaction. We will be sending the exception and the TAG’s approved continuation of it to Ops, for a final review and vote. Today’s meeting was short (20 minutes) and we would like to discuss the TAG’s future meeting schedule and focus.</p> <p>Claims DD TAG – The TAG is next scheduled to meet Dec. 9.</p> <p>Medical Code TAG – The MCT met Oct. 8 and made final changes as part of annual companion guide maintenance to the 837P and 837I. We are preparing the guides for an Ops vote. We also discussed with the MCT several other items, which we can summarize at the Exec meeting.</p> <p>The TAG met again on Oct. 27 to review and discuss 2 dental-related SBARs submitted by DHS. The TAG concluded that the proposed U modifiers suggested by DHS were not needed (NPIs could be used) and that additional review and discussion was needed for an SBAR proposing coding for tele-dentistry services.</p> <p>EOB/Remit TAG – The TAG met Oct. 18 to review a proposed companion guide change related to exchange of workers’ comp remittances and payments. The proposed change was considerably shortened and approved at the meeting.</p> | |

II. Discussion Guide – Old Business

| Agenda item # | Agenda Item | Background, discussion | Notes/Next steps/Follow up |
|---------------|--------------------------|--|----------------------------|
| | | The TAG will be developing a best practice regarding the PLB segment. | |
| D4 | Rx PA form update | A few weeks ago we discussed changes to the single Rx PA form requested by DHS and agreed to several changes that seemed to have the least impact on scanning of the form. The changes are being made at this time. <u>Update:</u> See final version of form, along with an underline-strikeout version showing the changes, embedded at the end of this document . | |

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III. Discussion Guide – New Business

| Agenda item # | Agenda Item | Background, discussion | Notes/Next steps/Follow up |
|---------------|-------------|------------------------|----------------------------|
| | | | |
| | | | |

VI. Other business

VII. Next Exec Committee meeting

| | |
|--------------|--|
| Dec. 7, 2015 | HealthPartners-Bloomington 8170 Building, 1st Floor - Walnut Room |
|--------------|--|

ACO Data Analytics Membership as of 10-28-15

| | | |
|-----------|------------|-------------------------------------|
| Nancy | Martens | CentraCare |
| Chad | Heim | HealthPartners - Health Plan |
| Ann | Hale | HealthPartners - Health Plan |
| Abdi | Abdirahman | Fairview Health Services |
| Tina | Morey | Allina |
| Janet | Coenen | Blue Cross Blue Sheild of Minnesota |
| Margareth | Ranheim | PreferredOne |
| Patrice | Lingren | PreferredOne |
| Frank | Gilbertson | Hennepin County Medical Center |
| Joe | Schindler | Minnesota Hospital Association |
| Chuck | Anderson | North Memorial Health Care |
| Kellie | Roberts | Optum |
| Ruqayya | Shaik | Medica |
| Mesa | Lieser | PrimeWest |
| Mary | Winter | PrimeWest |
| Laurie | Darst | Mayo |
| Jerry | Sobolik | Mayo |

Revised Uniform Rx ePA form



redline ufefpaform
10-21-15.pdf



PA-form.pdf

Minnesota Uniform Form for Prescription Drug Prior Authorization (PA) Requests and Formulary Exceptions

INSTRUCTIONS

Important: Please read all instructions and information before completing the form.

Please do NOT send this form to a patient's employer or to the Minnesota Department of Health (MDH) or to the Minnesota Administrative Uniformity Committee (AUC).

Note: This version of the form (C-1.0) is current as of July 2010, and supersedes the following previous versions of Minnesota Department of Health forms for PA requests and formulary exceptions:

- Example Minnesota Prescription Drug Prior Authorization (PA) Request Form, version 1.0 2/15/10
- Minnesota Uniform Formulary Exception Form, version 1.0 September, 2009

This form will not change frequently. The form version number and most recent revision date are displayed in the lower right corner.

Overview:

The following form is made available by the Minnesota Department of Health (MDH) pursuant to statute, to facilitate exchanges of information between prescribers and patients' insurance carriers, HMOs, Pharmacy Benefits Managers (PBMs), or other payers* of prescription drug claims.

Intended use and requirements:

The form is intended primarily for use by prescribers, or those designated and authorized to act on behalf of prescribers, to:

1. Request an exception to a prescription drug formulary.

- Requests for formulary exceptions are requests to make nonformulary prescription drugs available to a patient as a formulary drug.
 - Laws 2010, chapter 336, section 4 requires that all health care providers must submit requests for formulary exceptions using the uniform form, and that all payers must accept this form from health care providers. No later than January 1, 2011, the uniform formulary exception form must be accessible and submitted by health care providers, and accepted and processed by group purchasers, through secure electronic transmissions. Note: A previous restriction in law that facsimile was not considered "secure electronic transmission" was removed in 2010.

2. Request a prior authorization (PA) for a prescription drug.

- Prescription drug prior authorization requests are requests for pre-approval from a payer for specified medications or quantities of medications.
 - Laws 2010, chapter 336, section 5 requires that by January 1, 2015, drug PA requests must be accessible and submitted by health care providers, and accepted by payers, electronically through secure electronic transmissions.

Additional Instructions:

- Prescribers, or their designees, use parts A-F as applicable. Payers making the form available on their websites may pre-populate section A. Payers use section G when responding to requests.
- Payers may request additional information or clarification needed to process formulary exceptions and PA requests.
- Payers may supply additional instructions or other relevant or legally required information with their response.
- Complete section F when submitting prescription drug PA requests to the Minnesota Department of Human Services.

* Note: The term "payers" is used to avoid possible confusion. The electronic submission and acceptance requirements of Minnesota Statutes § 62J.497, subd. 4 and 5, apply to "group purchasers". The term "group purchaser" is defined in Minnesota Statutes § 62J.03, subd. 6 and can be considered more commonly as "payer".



Minnesota Uniform Form for Prescription Drug Prior Authorization (PA) Requests and Formulary Exceptions

Please do **NOT** send this form to a patient's employer or to the Minnesota Department of Health (MDH) or to the Minnesota Administrative Uniformity Committee (AUC).

See additional instructions and overview, [Instructions page](#).

Please check the appropriate box below (check only one box). This form is being used for:

Formulary Exception Prior Authorization (PA) Request Unsure/Unknown

A Destination This form is being submitted to: (Payers making this form available on their websites may pre-populate section A.)

Payer Name: _____

Payer Contact Name: _____
(IF AVAILABLE)

Payer Address: _____ City, State, ZIP: _____

Payer Phone: _____ Secure Fax: _____ Other: _____

B Patient Information

When filling Patient Health Plan ID number below, please note: If the patient has prescription benefits that are separate or "carved out" from the health plan benefits, provide the patient's prescription benefit card ID number (the "cardholder ID"). If the patient's prescription benefits are integrated with the health plan coverage (if there is no separate prescription benefit ID number), provide the patient's health plan ID number.

Patient Name: _____ DOB: _____
(LAST, FIRST, MI) (MM / DD / YYYY)

Patient Address: _____ City, State, ZIP: _____

Gender. Please Check Box: Male Female Unknown

Health Plan or Prescription Plan: _____ Patient Health Plan ID No.: _____
(OR PRESCRIPTION PLAN ID IF DIFFERENT THAN HEALTH PLAN ID)

C Prescriber Information

Prescriber Name: _____ NPI: _____ Specialty: _____
(LAST, FIRST, MI)

Prescriber Business Address: _____ City, State, Zip: _____

Prescriber Phone: _____ Prescriber Secure Fax: _____

Prescriber Point of Contact (POC) Name: _____ POC Phone: _____ POC Secure Fax: _____
(IF DIFFERENT THAN PRESCRIBER) (IF DIFFERENT THAN PRESCRIBER)

Clinic/Location/Facility Name: _____ Clinic/Location/Facility Contact Name: _____

Clinic/Location/Facility Phone: _____ Secure Clinic/Location/Facility Fax: _____

Clinic/Location/Facility Address: _____ City, State, ZIP: _____

D Prescription Drug Information (Medication information)

When completing this section and the following section (E), medication "strength" is usually expressed in milligrams, e.g., 30 mg, 15 mg/ml, etc. Medication "dosing schedule" is used to report how often the patient will take/use the medication, e.g., daily, four times per day, every four hours, as needed, etc.

Drug Being Requested: _____ Strength: _____
(REQUESTED DRUG NAME) (E.G., 30 MG, 15 MG/ML, ETC)

Dosing Schedule: _____ Date Therapy Initiated: _____

Duration of Therapy Expected: _____ Authorization Start Date: _____

Clinical Drug Trial Request? Yes No Is Dispense as Written (DAW) Specified? Yes No

(NOTE: THE MINNESOTA DEPT. OF HUMAN SERVICES DOES NOT COVER CLINICAL DRUG TRIALS.)

Rationale for DAW? _____

Is patient currently being treated with the drug requested? Yes No Date Started: _____

Minnesota Uniform Form for Prescription Drug Prior Authorization (PA) Requests and Formulary Exceptions

E Patient Clinical Information

Diagnosis Related to Medication Request: _____
(INCLUDE ICD-9 CODES WHEN AVAILABLE)

Drug Allergies: _____ Height: _____ Weight: _____
(IF RELEVANT TO THIS REQUEST) (IF RELEVANT TO THIS REQUEST) (IF RELEVANT TO THIS REQUEST)

PREVIOUS THERAPIES TRIED / FAILED (list name, date prescribed, etc., in boxes below. Note: Medication "strength" is usually expressed in milligrams, e.g., 30 mg, 15 mg/ml, etc. Medication "dosing schedule" is used to report how often the patient will take/use the medication, e.g., daily, four times per day, every four hours, as needed, etc.):

| Drug Name | Strength | Dosing Schedule | Date Prescribed | Date Stopped | Describe Adverse Reaction or Efficacy Failure |
|-----------|----------|-----------------|-----------------|--------------|---|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

RATIONALE FOR REQUEST (and also include any additional pertinent clinical information/comments regarding rationale): _____

F Pharmacy Information – For PA Requests to the Minnesota Department of Human Services (DHS)

Pharmacy Name: _____ National Provider Identifier: _____ Pharmacy Phone: _____

Pharmacy Address: _____ City, State, Zip: _____

NDC Number for Prescription Drug Being Requested: _____ Pharmacy Fax: _____

G Request Determination (may be completed by payers and sent to providers)

Date Request Received by Payer: _____ Date of Decision: _____

Payer Responder/Contact Name: _____ Payer Respondent/Contact Phone and/or Email: _____

Request Approved/Denied: Approved Denied Pharmacy Authorization/Reference No.: _____
(IF APPLICABLE TO PAYER)

Comments Regarding Decision: _____
(INCLUDE EFFECTIVE AND END DATES OF DECISION IF APPLICABLE)

Additional Information or Instructions

Note: Group purchasers may supply additional instructions or other relevant or legally required information with their response. Examples of additional information might include: Appeals rights and processes; other notifications; other information required for legal or clarification purposes. _____

CONFIDENTIALITY NOTICE: The information in this form is confidential and intended for the use of the recipient. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance of the contents of this communication is strictly prohibited. If you have received this form in error please immediately notify the sender to arrange for its return. Thank you for your assistance.



MINNESOTA UNIFORM FORM FOR PRESCRIPTION DRUG PRIOR AUTHORIZATION (PA) REQUESTS AND FORMULARY EXCEPTIONS

INSTRUCTIONS

Important: Please read all instructions and information before completing the form.

Please do NOT send this form to a patient's employer or to the Minnesota Department of Health (MDH) or to the Minnesota Administrative Uniformity Committee (AUC).

Note: This version of the form (C-2.0) is current as of October 2015, and supersedes previous versions of Minnesota Department of Health forms for PA requests and formulary exceptions.

This form will not change frequently. The form version number and most recent revision date are displayed in the lower right corner.

Overview:

The following form is made available by the Minnesota Department of Health (MDH) pursuant to statute, to facilitate exchanges of information between prescribers and patients' insurance carriers, HMOs, Pharmacy Benefits Managers (PBMs), or other payers* of prescription drug claims.

Intended use and requirements:

The form is intended primarily for use by prescribers, or those designated and authorized to act on behalf of prescribers, to:

1. Request an exception to a prescription drug formulary.

- Requests for formulary exceptions are requests to make nonformulary prescription drugs available to a patient as a formulary drug.
 - Minnesota Statutes, section 62J.497, Subd. 4 requires that all health care providers must submit requests for formulary exceptions using the uniform form, and that all payers must accept this form from health care providers. No later than January 1, 2011, the uniform formulary exception form must be accessible and submitted by health care providers, and accepted and processed by group purchasers, through secure electronic transmissions. Note: A previous restriction in law that facsimile was not considered "secure electronic transmission" was removed in 2010.

2. Request a prior authorization (PA) for a prescription drug.

- Prescription drug prior authorization requests are requests for pre-approval from a payer for specified medications or quantities of medications.
 - Minnesota Statutes, section 62J.497, subd. 5 requires that by January 1, 2016, drug PA requests must be accessible and submitted by health care providers, and accepted by payers, electronically using the NCPDP SCRIPT Standard version 2013101.

Additional Instructions:

- Prescribers, or their designees, use parts A-F as applicable. Payers making the form available on their websites may pre-populate section A. Payers use section G when responding to requests.
- Payers may request additional information or clarification needed to process formulary exceptions and PA requests.
- Payers may supply additional instructions or other relevant or legally required information with their response.
- **Complete section F when submitting prescription drug PA requests to the Minnesota Department of Human Services.**

* Note: The term "payers" is used to avoid possible confusion. The electronic submission and acceptance requirements of Minnesota Statutes § 62J.497, subd. 4 and 5, apply to "group purchasers". The term "group purchaser" is defined in Minnesota Statutes § 62J.03, subd. 6 and can be considered more commonly as "payer".



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Please do NOT send this form to a patient's employer or to the Minnesota Department of Health (MDH) or to the Minnesota Administrative Uniformity Committee (AUC).

See additional instructions and overview, Instructions page.

Please check the appropriate box below. This form is being used for:

Formulary Exception Prior Authorization (PA) Request Unsure/Unknown

A | Destination This form is being submitted to: (Payers making this form available on their websites may pre-populate section A.)

Payer Name: _____ Payer Contact Name (IF AVAILABLE): _____
 Payer Address: _____ City, State, Zip: _____
 Payer Phone: _____ Secure Fax: _____ Other: _____

B | Patient Information

When filling Patient Health Plan ID number below, please note: If the patient has prescription benefits that are separate or "carved out" from the health plan benefits, provide the patient's prescription benefit card ID number (the "cardholder ID"). If the patient's prescription benefits are integrated with the health plan coverage (if there is no separate prescription benefit ID number), provide the patient's health plan ID number.

Patient Name (LAST, FIRST, MI): _____ DOB: _____ Gender: _____
 Patient Address: _____ City, State, Zip: _____
 Health Plan or Prescription Plan: _____ Patient Health Plan ID Number: _____
 (OR PRESCRIPTION PLAN ID IF DIFFERENT THAN HEALTH PLAN ID)

C | Prescriber Information

Prescriber Name (LAST, FIRST, MI): _____ NPI: _____ Specialty: _____
 Prescriber Business Address: _____ City, State, Zip: _____
 Health Plan or Prescription Plan: _____ Patient Health Plan ID Number: _____
 Prescriber Phone: _____ Prescriber Secure Fax: _____
 Prescriber Point of Contact (POC) Name: _____ POC Phone: _____ POC Secure Fax: _____
 (IF DIFFERENT THAN PRESCRIBER) (IF DIFFERENT THAN PRESCRIBER)
 Clinic/Location/Facility Name: _____ Clinic/Location/Facility Contact Name: _____
 Clinic/Location/Facility Phone: _____ Secure Clinic/Location/Facility Fax: _____
 Clinic/Location/Facility Address: _____ City, State, Zip: _____

"X" DEA number (buprenorphine prescriber status number, always preceded by "x," issued per the Drug Addiction Treatment Act of 2000 (Data 2000)): _____

D | Prescription Drug Information (Medication information)

When completing this section and the following section (E), medication "strength" is usually expressed in milligrams, e.g., 30mg, 15mg/ml, etc. Medication "dosing schedule" is used to report how often the patient will take/use the medication, e.g, daily, four times per day, every four hours, as needed, etc. If request is for a Minnesota Department of Human Services recipient, please also fill out Section F.

Drug Being Requested: _____ Strength: _____
 (REQUESTED DRUG NAME) (E.G., 30 MG, 15 MG/ML, ETC)
 Dosing Schedule: _____ Date Therapy Initiated: _____
 Duration of Therapy Expected: _____ Authorization Start Date: _____
 Clinical Drug Trial Request? _____ Is Dispense as Written (DAW) Specified? _____
 (NOTE: THE MINNESOTA DEPT. OF HUMAN SERVICES DOES NOT COVER CLINICAL DRUG TRIALS)
 Rationale for DAW? _____
 Is patient currently being treated with the drug requested? _____ Date Started: _____



E | Patient Clinical Information

Diagnosis Related to Medication Request: _____
(INCLUDE APPROPRIATE ICD-10 CODES WHEN AVAILABLE)

Drug Allergies: _____ Height: _____ Weight: _____
(IF RELEVANT TO THIS REQUEST) (IF RELEVANT TO THIS REQUEST) (IF RELEVANT TO THIS REQUEST)

PREVIOUS THERAPIES TRIED / FAILED (list name, date prescribed, etc., in boxes below. Note: Medication "strength" is usually expressed in milligrams, e.g., 30 mg, 15 mg/ml, etc. Medication "dosing schedule" is used to report how often the patient will take/use the medication, e.g., daily, four times per day, every four hours, as needed, etc.):

| Drug Name | Strength | Dosing Schedule | Date Prescribed | Date Stopped | Describe Adverse Reaction or Efficacy Failure |
|-----------|----------|-----------------|-----------------|--------------|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

RATIONALE FOR REQUEST (and also include any additional pertinent clinical information/comments regarding rationale):

F | Pharmacy Information

Pharmacy Name: _____ NPI: _____ Pharmacy Phone: _____
 Pharmacy Address: _____ City, State, Zip: _____
 NDC Number for Prescription Drug Being Requested: _____ Pharmacy Fax: _____

G | Request Determination (may be completed by payers and sent to providers)

Date Request Received by Payer: _____ Date of Decision: _____
 Payer Responder/Contact Name: _____ Payer Respondent/Contact Phone: _____
 Payer Respondent/Contact Email: _____ Request Approved/Denied: _____
 Pharmacy Authorization/Reference Number: _____
(IF APPLICABLE TO PAYER)

Comments Regarding Decision: (INCLUDE EFFECTIVE AND END DATES OF DECISION IF APPLICABLE)

Additional Information or Instructions

Note: Group purchasers may supply additional instructions or other relevant or legally required information with their response. Examples of additional information might include: Appeals rights and processes; other notifications; other information required for legal or clarification purposes.

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