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CAQH CORE Eligibility & Benefits Task Group (EBTG)

Call #2

Call Doc #1

May 26, 2021

2:00 – 3:30 PM ET

Agenda

Time	Agenda Item	Discussion Item or Action Required
2:00 PM	**1. Antitrust Guidelines**	*Discussion*
2:02 PM	**2. Roll Call and Administrative Items**	*Discussion*
2:05 PM	**3. Summary of 04/28/21 Task Group Call** • Level set. • Review CAQH CORE Eligibility & Benefits Data Content Operating Rule. • Review Eligibility & Benefits Opportunity Area Survey Results. • Agreed to Next Steps.	Action Required: • Approve 04/28/21 Call Summary
2:10 PM	**4. Task Group Timeline Level Set**	*Discussion*
2:15 PM	**5. Review Results of Feedback Form including:** • Respondent Breakdown, Priority Rank, and Percent Support for Opportunity Areas • Comments Received on Opportunity Areas and Potential Rule Options including questions requesting additional feedback. • Agree to adjustments, as necessary.	*Discussion*
3:20 PM	**6. Next Steps** • CAQH CORE Eligibility & Benefits Task Group (EBTG): o Participate in the next EBTG Call: **Wednesday, 6/23/21 at 2:00 PM ET**. o Complete EBTG Straw Poll #1 **by end of day Friday, 06/11/21**. • CAQH CORE Co-chair & staff: o Draft a summary for today's call. o Send EBTG Straw Poll #1 to Task Group Participants by, **Friday, 05/28/21**.	Action Required: • Agree to Next Steps

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Eligibility & Benefits Task Group– EBTG Call #1 Summary

Motion to Approve

CAQH Committee on Operating Rules for Information Exchange (CORE)
Eligibility & Benefits Task Group (EBTG)
Call #1 Summary: Wednesday, April 28, 2021, 2:00-3:30 pm ET Conference Call

This document contains:

- Agenda items and key discussion points.
- Decisions and actions to be taken.
- Next steps.
- Call attendance.

Agenda Item	*Key Discussion Points*	*Decisions and Actions*
1. Antitrust Guidelines	• Bob Bowman (CAQH CORE Director) opened the call and reviewed the Antitrust Guidelines, noting that they are published on the CAQH CORE Calendar along with the meeting materials. • Bob Bowman (CAQH CORE Director) introduced CAQH CORE staff supporting the Task Group and the Co-chairs, Donna Campbell (Health Care Service Corps), Nora Iluri (athenahealth), Megan Soccorso (Cigna), and Molly Reese (AMA).	*Discussion*
2. Roll Call and Administrative Items	• Bob Bowman (CAQH CORE Director) reviewed the call documents: o Doc #1: EBTG Call 1 Slide Deck 04.28.21. • Bob Bowman (CAQH CORE Director) reviewed the focus of the call, which was to: o Level set. o Review CAQH CORE Eligibility & Benefits Data Content Operating Rule. o Review Eligibility & Benefits Opportunity Area Survey Results. o Discuss Next Steps. • Taha Anjarwalla (CAQH CORE Senior Manager) facilitated roll call. [See call participant roster at the end of this meeting summary to view call attendees and affiliated organizations]. • **Summary of EBTG Discussion:** o No questions or comments were raised by the EBTG participants.	*Discussion*
3. Level Set (Doc #1)	• Megan Soccorso (Cigna) provided a summary of the Level Set. • **Summary of EBTG Discussion:** o No questions or comments were raised by the EBTG participants.	*Discussion*
4. Review CAQH CORE Eligibility & Benefits Data Content Operating Rule (Doc #1)	• Bob Bowman (CAQH CORE Director) and Taha Anjarwalla (CAQH CORE Senior Manager) provided an overview of the CAQH CORE Eligibility & Benefits Data Content Operating Rule. • **Summary of EBTG Discussion:** o Ada Sanchez (CMS) asked for if the prior authorization and certification opportunity area was related to the certification of the prior authorization or the transaction since they have a 278 that handles that	*Discussion*

Eligibility & Benefits Task Group Roadmap

Level Set for Today's Call

We are here

Task Group Call #1	Feedback Form	Task Group Call #2	Straw Poll #1	Task Group Call #3	Straw Poll #2	Task Group Call #4	Straw Poll #3	Task Group Call #5
Level Set review scope, environmental scan results, opportunity areas, rule options, task group schedule **Agree to Feedback Form**	**Opportunity Areas** Indicate level of support on opportunity areas and collect feedback on rule options/potential requirements.	**Review results of Feedback Form** Agree to opportunity areas and adjustments to defined rule options, if applicable **Agree to Straw Poll #1: Rule Options**	**Rule Options/ Potential Rule Requirements** Indicate level of support for Potential High-Level Rule Requirements	**Review results of Straw Poll #1** Agree to adjustments, if applicable **Agree to Straw Poll #2: Draft Rule Requirements**	**Rule Requirements** Support for draft rule requirements	**Review results of Straw Poll #2** Agree to adjustments, if applicable **Agree to Straw Poll #3: Draft Rule**	**Draft Rule** Support for draft rule, by rule section	**Review results of Straw Poll #3** Agree to adjustments, if applicable

Today

- **Review Results of Feedback Form including**:
  - Respondent priority, support, and feedback of Opportunity Areas for CAQH CORE Eligibility & Benefit Rule Update
  - Respondent support and feedback of Potential Rule Options for CAQH CORE Eligibility & Benefit Rule Update
- **Agree to adjustments** to the opportunity areas and/or potential rule options, as necessary.
- **Provide an overview** of Straw Poll #1.
- **Agree to Next Steps**.

Upcoming

- **Straw Poll #1**
  - Indicate level of support and provide feedback on High-Level Potential Rule Requirements for CAQH CORE Eligibility & Benefit Rule Update.
- **EBTG Call #3**.

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Eligibility & Benefits Task Group Feedback Form Results

Megan Soccorso, *Cigna*
Bob Bowman, *CAQH CORE*
Taha Anjarwalla, *CAQH CORE*
Molly Reese, *American Medical Association*
Donna Campbell, *Health Care Service Corporation*
Nora Iluri, *athenahealth*

Eligibility & Benefits Task Group – Feedback Form

Feedback Form Background

Purpose of Feedback Form: To provide feedback on potential opportunity areas and rule options

Format:

- **Prioritization of Opportunity Areas:** Rank and weight opportunity areas in order of priority
- **Support for Opportunity Areas:** Indicate level of support for each opportunity area
- **Feedback on Potential Rule Options:** Provide feedback on potential rule options for each of opportunity area

Summary of Opportunity Areas:

1. **Telemedicine:** Address the emergent need to communicate telemedicine-specific eligibility and benefit information
2. **Service Type Codes:** Include adding additional SCT Codes beyond the current 52 CORE-required STC codes
3. **Tiered Benefits:** Provision of more granular level data for members of tiered benefit plans
4. **Procedure/Diagnosis Codes:** Ability to respond to eligibility and benefit requests at the procedure or diagnosis level
5. **Remaining Coverage Benefits:** Support the communication of the number of remaining visits/services left on a benefit
6. **Patient Data Sharing:** Leverage standard cost sharing transaction data from the X12 270/271 or FHIR Resources for patient data sharing applications
7. **Dental:** Support additional dental-specific eligibility and benefit requirements
8. **Prior Authorization:** ability to communicate if prior authorization or certification is required for a specific procedure or service

Eligibility & Benefits Task Group – Feedback Form

Respondent Breakdown

Respondent Breakdown: Responses were received from **27** respondents, representing **55%** of Task Group Participating Organizations.

Number of EBTG Participating Organizations	49
Total Number of EBTG Participating Organization Responses	**27 (55% of EBTG Entities)**
Number of Provider/Provider Association Responses	4 (15% of respondents)
Number of Health Plan/Health Plan Association Responses	9 (33% of respondents)
Number of Vendor/Clearinghouse Responses	8 (30% of respondents)
Number of Government Responses	2 (7% of respondents)
Number of 'Other' Responses (includes SDOs)	4 (15% of respondents)

Eligibility & Benefits Task Group – Feedback Form

Prioritization and Support for Each Opportunity Area

Rank of Opportunity Areas in Order of Priority For Rule Development (*1 is highest, 8 is lowest priority*):

#	Opportunity Area	Average Rank
1	Prior Authorization	3.5
2	Telemedicine	3.5
3	Procedure/Diagnosis Codes	3.9
4	Service Type Codes	3.9
5	Tiered Benefits	4.3
6	Remaining Coverage Benefits	4.3
7	Patient Data Sharing	6.2
8	Dental	6.4

Percent Support for Opportunity Areas to be Included in Rule Development:

#	Opportunity Area	Support/Partially Support	Oppose/Partially Oppose	Neither Support nor Oppose	Abstain
1	Service Type Codes	24 (89%)	0 (0%)	3 (11%)	0
2	Prior Authorization	23 (86%)	2 (7%)	2 (7%)	0
3	Telemedicine	23 (85%)	0 (0%)	4 (15%)	0
4	Tiered Benefits	21 (81%)	1 (4%)	4 (15%)	1
5	Remaining Coverage Benefits	22 (81%)	0 (0%)	5 (19%)	0
6	Procedure/Diagnosis Codes	21 (78%)	2 (7%)	4 (15%)	0
7	Patient Data Sharing	17 (68%)	3 (12%)	5 (20%)	2
8	Dental	14 (59%)	0 (0%)	10 (41%)	3

Note: Due to low support Dental will be dropped from rule development consideration.

Eligibility & Benefits Task Group – Feedback Form

Feedback on Potential Rule Options

#	Potential Rule Option	Support/ Partially Support	Oppose/ Partially Oppose	Neither Support nor Oppose	Abstain
1	Telemedicine 2: Follow RFI #1957	19 (70%)	3 (11%)	5 (19%)	0
2	Telemedicine 1: Uniform MSG Segment	19 (73%)	3 (12%)	4 (15%)	1
3	STC: Add Additional X12 v5010 270/271 STC Codes	21 (78%)	0 (0%)	6 (22%)	0
4	Remaining Coverage Benefits: Define Minimum Set	20 (77%)	2 (8%)	4 (15%)	1
5	Tiered Benefits: Uniform MSG Segment	17 (68%)	3 (12%)	5 (20%)	2
6	Tiered Benefits: Follow RFI #1767	20 (80%)	2 (8%)	3 (12%)	2
7	Procedure/Diagnosis Codes: Define Minimum Set	18 (67%)	3 (11%)	6 (22%)	0
8	Prior Authorization 1: EB11 for Service Type Level	21 (78%)	4 (15%)	2 (7%)	1
9	Prior Authorization 2: EB11 for Procedure or Diagnosis Code	19 (79%)	3 (13%)	2 (8%)	4
10	Patient Data Sharing: Define Minimum Set	15 (58%)	5 (19%)	6 (23%)	1

Eligibility & Benefits Task Group – Feedback Form

Comment Categorization

Comments received on the EBTG Feedback Form were grouped into three categories.

- **Substantive Comments** – May impact rule requirements; some comments require Task Group discussion on potential adjustments to the draft requirements.
- **Points of Clarification** – Pertain to areas where more explanation for the Task Group is required*; may* require adjustments to the rule which do not change rule requirements.
- **Non-substantive Comments** – Pertain to typographical/grammatical errors, wordsmithing, clarifying language, addition of references; do not impact rule requirements.

The EBTG will discuss substantive comments and points of clarification as well as CAQH CORE Co-chair and staff recommendations. Non-substantive and Dental comments were summarized in a separate document for offline review (*Doc 3 EBTG Feedback Form Non-Substantive and Dental Comments*). Task Group participants are encouraged to review this document as there were some minor adjustments for clarity, as recommended by task group feedback form comments.

Eligibility & Benefits Task Group – Feedback Form

General Comments Received

Points of Clarification	CAQH CORE Co-chair & Staff Response
1. **Several entities commented that many of the potential opportunity areas will be addressed with X12 v8010 270/271 when published. Further, some of these entities asked for clarification if operating rule development will be limited to X12 v5010 270/271 or will rules also apply to succeeding versions of the transaction.**	1. CAQH CORE Participants identified enhancing the existing CAQH CORE Eligibility & Benefit Data Content Rule as a priority topic for CAQH CORE to address to serve as a bridge between existing and upcoming versions of the X12 270/271 standard. As such, the CAQH CORE Eligibility & Benefit Data Content Rule Update is scoped to X12 v5010 270/271. Further, CAQH CORE has a detailed maintenance process to update CAQH CORE Operating Rule when new versions are made available (including X12 v8010 270/271) and when HHS designates them for mandate.

Eligibility & Benefits Task Group – Feedback Form

Comments Received on Telemedicine Rule Options

#	Potential Rule Option	Support/ Partially Support	Oppose/ Partially Oppose	Neither Support nor Oppose	Abstain
1	Telemedicine 2: Follow RFI #1957	19 (70%)	3 (11%)	5 (19%)	0

Substantive Comments

2. Six entities identified codifiable ways to communicate and return telemedicine benefits.

- One explained that the Place of Service = 02 can be used to indicate that place of service for a specific service type code is Telemedicine. For CMS the Place of Service code value 02 satisfies the need to indicate what service or benefit is available via telemedicine.
- Another recommended the use of Service Type Code 98 with Place of Service=02.
- Another entity expressed support for use of Place of Service to identify telemedicine.
- Another commented that although RFI #1957 states to use STC 3 for telemedicine, considerations should be made to accommodate additional scenarios for other service types that align to telemedicine benefits.
- Another stated that the use of STC 3 per RFI #1957 is only an example, so other STC values could be used in conjunction with the MSG segment.
- Another entity stated that codification allows for simplicity, clarity, and support automation processes.

CAQH CORE Co-chair & Staff Response

2. EBTG Discussion for additional feedback on this topic is needed.

X12 is drafting a new Request for Information (RFI) which addresses the codification of Telemedicine.

Points of Clarification

3. One entity commented that the task group should consider using the Telemedicine STC Code.

CAQH CORE Co-chair & Staff Response

3. The scope of the CAQH CORE Eligibility & Benefit Rule Update applies to the X12 v5010 270/271 transaction. Currently, the E37-Telemedince Service Type Code listed in the X12 External Code List is not applicable to the X12 v5010 270/271.

Eligibility & Benefits Task Group – Feedback Form

Comments Received on Telemedicine Rule Options

#	Potential Rule Option	Support/ Partially Support	Oppose/ Partially Oppose	Neither Support nor Oppose	Abstain
2	Telemedicine 1: Uniform MSG Segment	19 (73%)	3 (12%)	4 (15%)	1

Substantive Comments	CAQH CORE Co-chair & Staff Response
4. Four entities expressed concerns on the usage of the MSG segments when communicating telemedicine benefits. • One noted they support telemedicine as a general concept, but do not support the use of the MSG segment. • Another commented that they strongly support the adoption of operating rules to communicate telemedicine benefits; however, they would like to see a solution that does not rely on the MSG segment. • Another stated that an ideal operating rule would avoid relying on the use of the MSG segment and pursue structured ways for communicated telemedicine coverage. • Another explained that the MSG segment is free text and may be processed in different ways across provider organizations.	**4. EBTG Discussion for additional feedback on this topic is needed.**

Eligibility & Benefits Task Group – Feedback Form

Comments Received on Service Type Codes Rule Options

#	Potential Rule Option	Support/ Partially Support	Oppose/ Partially Oppose	Neither Support nor Oppose	Abstain
3	STC: Add Additional X12 v5010 270/271 STC Codes	21 (78%)	0 (0%)	6 (22%)	0

Substantive Comments	CAQH CORE Co-chair & Staff Response
5. Three entities commented their support for adding additional STC Codes to the CORE-required list. ▪ One stated to bridge the gap between v5010 and the next published version, CAQH CORE should require the support of all listed service type codes in the published v5010 TR3. Support meaning determination of coverage, utilization/limits (copay, deductible, coinsurance, out of pocket max) and authorization requirements. ▪ Another explained that the addition of more CORE-required STCs would help allow providers to receive more accurate information regarding coverage at the time of care. ▪ Another commented that they continue to have calls to provider servicing centers even when reporting out on an additional 20+ STCs beyond the current CORE-required STCs. They further noted, continuing to expand the list of STCs should help to reduce call volume. **Further, two additional entities commented that once X12 v8010 270/271 is published it will require payers to support all available STC Codes.**	**5. EBTG Discussion for additional feedback on this topic is needed.** Future versions of the X12 270/271 transaction will require all STCs to be supported via explicit inquiries. Through a future straw poll and EBTG calls, CAQH CORE can facilitate discussions to determine if all internal X12 v5010 270/271 STCs or a selected set of additional STCs should be supported as part of this rule update.

Eligibility & Benefits Task Group – Feedback Form

Comments Received on Service Type Codes Rule Options

#	Potential Rule Option	Support/ Partially Support	Oppose/ Partially Oppose	Neither Support nor Oppose	Abstain
3	STC: Add Additional X12 v5010 270/271 STC Codes	21 (78%)	0 (0%)	6 (22%)	0

Point of Clarification	CAQH CORE Co-chair & Staff Response
6. **One entity suggested that if procedure code look up is used, it will limit the need for using the STCs. They further indicated that more specificity can be identified using the CPT look up and will eliminate questions a provider may have.**	6. The goal of the CAQH CORE Rule Eligibility & Benefits Data Content Rule Update is to bridge existing system capabilities with evolving industry needs. There may be use cases where a procedure code may not be known, and providers will continue to use a service type code to determine eligibility and benefits.
7. **One entity noted that the addition of more CORE-required STCs should not serve as a replacement for pursuing operating rules at the level of procedure and diagnosis.**	7. The goal of the CAQH CORE Rule Eligibility & Benefits Data Content Rule Update is bridge existing system capabilities with evolving industry needs. By expanding the CORE-required Service Type Code List, providers would benefit from being able to receive coverage information for additional Service Types. Additionally, EBTG Participants will evaluate and provide feedback on options for developing operating rules pertaining to coverage requests and responses at the procedure/diagnosis code level.

Eligibility & Benefits Task Group – Feedback Form

Comments Received on Remaining Coverage Benefits Rule Options

#	Potential Rule Option	Support/ Partially Support	Oppose/ Partially Oppose	Neither Support nor Oppose	Abstain
4	Remaining Coverage Benefits: Define Minimum Set	20 (77%)	2 (8%)	4 (15%)	1

Points of Clarification	CAQH CORE Co-chair & Staff Response
8. **One entity had a comment pertaining to the timing of submission when obtaining remaining coverage benefits. They expressed concerns in instances where a claim may come through shortly after the eligibility transaction and changes the number of remaining visits. Further, they suggested the need to include a statement that although there may be remaining coverage at a point in time, it does not guarantee payment.**	8. EBTG Participants will have the opportunity on future calls and straw polls to give feedback on detailed rule options and operating rule requirements pertaining guarantee of payment when obtaining remaining coverage benefits. Further, this could also be addressed via provider contracts, trading partner agreements or companion documents, as this may be addressed through existing agreements.
9. **One entity indicated they do not always have accumulated data available as this information may be processed by third-party vendors/service providers.**	9. Rule requirements would identify scenarios when the operating rule would apply or not apply in the event where the specific benefit information is not available to the health plan or information source. Further, operating rules already specify categories for discretionary reporting for typical and customary “carve-out” benefits.

Eligibility & Benefits Task Group – Feedback Form

Comments Received on Tiered Benefits Rule Options

#	Potential Rule Option	Support/ Partially Support	Oppose/ Partially Oppose	Neither Support nor Oppose	Abstain
5	Tiered Benefits: Uniform MSG Segment	17 (68%)	3 (12%)	5 (20%)	2

Substantive Comments	CAQH CORE Co-chair & Staff Response
10. Five entities expressed concerns on the usage of the MSG segment when communicating Tiered Benefits. • One noted establishing uniform MSG segments for communicating Tiered Benefits may be challenging as content varies widely from Payer to Payer. • Another stated that it does not make sense to use MSG segments because it is not using a codified method of answering questions. • Another commented that tiered benefit information should be communicated in a way that is structured and not reliant on the MSG segment. • Another noted that MSG segment codes are an inefficient way of dealing with Tiered Benefits. • Another indicated that the MSG segment is free text and may be processed in different ways across provider systems and organizations.	**10. EBTG Discussion for additional feedback on this topic is needed.**

Eligibility & Benefits Task Group – Feedback Form

Comments Received on Tiered Benefits Rule Options

#	Potential Rule Option	Support/ Partially Support	Oppose/ Partially Oppose	Neither Support nor Oppose	Abstain
6	Tiered Benefits: Follow RFI #1767	20 (80%)	2 (8%)	3 (12%)	2

Substantive Comments	CAQH CORE Co-chair & Staff Response
11. Three entities provided comments pertaining to tier determination and the type of information that should be included as part of the benefit information. • One entity commented that there are multiple ways payers are returning tiers. They indicated that one approach to address this issue should be that the tier the provider is in must be determined, like determining the age of a patient using DOB and not returning all levels of a benefit. Further, they stated if a health plan cannot be determined what tier the provider belongs in, all tiers should be returned. • Another entity explained that tiered structure would be more valuable if payers identified the appropriate benefit tier based on submitting provider NPI and identified this information on the X12 v5010 271 response. • Another entity expressed support for inclusion of provider network status, tier level, and % patient responsibility. They further noted that tiered benefit information should also clearly include any variations in benefits of patient responsibility based on procedure, diagnosis, or service type.	**11. EBTG Discussion for additional feedback on this topic is needed.**

Eligibility & Benefits Task Group – Feedback Form

Comments Received on Procedure/Diagnosis Codes Rule Options

#	Potential Rule Option	Support/ Partially Support	Oppose/ Partially Oppose	Neither Support nor Oppose	Abstain
7	Procedure/Diagnosis Codes: Define Minimum Set	18 (67%)	3 (11%)	6 (22%)	0

Substantive Comments	CAQH CORE Co-chair & Staff Response
12. Seven entities had varying comments pertaining to either the use of or connected use of procedure codes, diagnosis codes, and/or service type codes. ▪ One expressed that they would be supportive of procedure codes, but not necessarily diagnosis codes. ▪ One noted support for returning diagnosis codes on the response when a service type code or procedure code would only be available for the specific diagnoses. However, they would not be supportive of requiring a diagnosis on the inquiry. ▪ Another commented that Procedure and Diagnosis codes connected to Service Type Codes would be helpful. ▪ Another entity expressed that operating rules should require payers to support the same codes received on a request, not just return them on the response. ▪ Another stated that not all benefits for eligibility are defined at the procedure or diagnosis code level. They explained that additional back-end mapping would be required to conform to any code or code range specific item. ▪ Another noted that current procedure-specific requests by providers are met with general responses, which may not be accurate to a patient's actual eligibility and coverage details. They suggested that defining a set of procedure or diagnosis codes for the return of coverage benefit information would provide a level of granularity that would be beneficial to providers. ▪ Another suggested that diagnosis and procedure codes are not typically known at the time of eligibility and benefits verification. They explained that eligibility and benefits verification is done by front end staff before clinical staff sees the patient and provides a diagnosis and procedures to be done.	**12. EBTG Discussion for additional feedback on this topic is needed.**

Eligibility & Benefits Task Group – Feedback Form

Comments Received on Procedure/Diagnosis Codes Rule Options

Points of Clarification	CAQH CORE Co-chair & Staff Response
13. One entity asked for further clarification on which procedure and/or diagnosis codes are being considered for this opportunity area.	13. CAQH CORE is referring to the code sets included in the X12 v5010 270/271 such as: ▪ Current Procedural Terminology (CPT) Codes ▪ Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes ▪ International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) ▪ International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) ▪ American Dental Association (ADA) Current Dental Terminology (CDT) ▪ Home Infusion EDI Coalition (HIEC) Product/Service Code ▪ National Drug Codes (NDC) in 5-4-2 Format EBTG Participants will have the opportunity on future calls and straw polls to give feedback on which code sets should be included as part of the operating rule update.
14. One entity proposed that establishing categories of codes would be more accessible than establishing a "minimum set" of singular procedure/diagnosis codes.	14. EBTG Participants will have the opportunity on future calls and straw polls to identify an approach for how common code sets could be defined (e.g., minimum code set, categories of codes, top code list, etc.).
15. One entity suggested to add a PHI disclosure statement if diagnosis codes are exchanged within the X12 v5010 270/271.	15. EBTG Participants will have the opportunity on future calls and straw polls to give feedback on detailed rule options and operating rule requirements pertaining to Procedure/Diagnosis Codes.

Eligibility & Benefits Task Group – Feedback Form

Comments Received on Prior Authorization Rule Options

#	Potential Rule Option	Support/ Partially Support	Oppose/ Partially Oppose	Neither Support nor Oppose	Abstain
8	Prior Authorization 1: EB11 for Service Type Level	21 (78%)	4 (15%)	2 (7%)	1

Substantive Comments	CAQH CORE Co-chair & Staff Response
16. Two entities expressed concerns of using STCs to make determinations if prior authorization or certifications are required. • One entity indicated that this could not be done accurately on the X12 v5010 271 as there are too many variables that are looked at to make the decision such as benefit plan, age, gender, provider, attending provider, and various benefit limits. • Another expressed concerns in instances where some services, such as OB/GYN may or may not require prior authorization. In these events, the indication of PA=Y for this STC may not be accurate, while communication of prior authorization requirements at the procedure code level would be clear.	**16. EBTG Discussion for additional feedback on this topic is needed.** Operating rule requirements could require health plans to return a Yes or a No when authorization or certification is known for a service type to address variability. Further, operating rule requirements for authorization and certification determination could apply only to CORE-required STCs.

Points of Clarification	CAQH CORE Co-chair & Staff Response
17. Two entities expressed that the use of the Authorization or Certification Indicator is based off a situational rule and noted that payers should have the discretion to support Yes, No, or Unknown in any combination.	17. The goal of this opportunity area is to communicate whether prior authorization is or is not required for a specific procedure and/or service. A CAQH CORE Operating Rule would go above and beyond the situational rule by requiring the return of either Yes or No.

Eligibility & Benefits Task Group – Feedback Form

Comments Received on Prior Authorization Rule Options

#	Potential Rule Option	Support/ Partially Support	Oppose/ Partially Oppose	Neither Support nor Oppose	Abstain
9	Prior Authorization 2: EB11 for Procedure or Diagnosis Code	19 (79%)	3 (13%)	2 (8%)	4

Substantive Comments	CAQH CORE Co-chair & Staff Response
18. Four entities provided comments on the use of procedure and/or diagnosis code via the X12 v5010 270 and/or 271 for determining if authorization or certification is required. • One noted that using procedure/diagnosis codes X12 v5010 271 would provide a bridge to begin pushing the industry towards supporting procedure codes holistically. They indicated that prior authorization requirements should be returned on the X12 v5010 271 when they are required for payer defined procedure codes. Further, they stated once that can be accomplished, payers can begin supporting on the 270 the same procedure codes. They also noted that diagnosis codes may play a role if it's known, but at the time of a 270/271 a diagnosis may not have been made. • Another stated that procedure-specific requests should be met with procedure-specific responses to provide providers and patients with specific coverage and prior authorization requirements at the point of care. • Another commented on being able to have the option to submit either STC or procedure code for prior authorization determination. • Another noted that diagnosis or procedure code(s) may not be sole determinants of prior authorization requirement.	**18. EBTG Discussion for additional feedback on this topic is needed.** Operating rule requirements could require health plans to return a Yes or a No when authorization or certification is known for a procedure/diagnosis code. Further, operating rule requirements for authorization and certification determination could only apply to procedure/diagnosis categories or codes that become CORE-required via EBTG feedback.

Eligibility & Benefits Task Group – Feedback Form

Comments Received on Prior Authorization Rule Options

#	Potential Rule Option	Support/ Partially Support	Oppose/ Partially Oppose	Neither Support nor Oppose	Abstain
9	Prior Authorization 2: EB11 for Procedure or Diagnosis Code	19 (79%)	3 (13%)	2 (8%)	4

Points of Clarification	CAQH CORE Co-chair & Staff Response
19. One entity asked for clarification how this opportunity area and rule option aligns with industry initiatives such as Da Vinci.	19. The application of this rule option would enable providers to leverage the HIPAA-mandated X12 v5010 270/271 for authorization or certification determination, helping to serve a bridge between existing and emerging standards, thus supplementing and supporting initiatives such as Da Vinci.

Eligibility & Benefits Task Group – Feedback Form

Comments Received on Additional Opportunity Areas

	Substantive Comments	CAQH CORE Co-chair & Staff Response
20.	**NPI:** One entity suggested that payers should be required to return information on the X12 v5010 271 regarding the network status of the provider (In or Out) based on the NPI submitted on the X12 v5010 270. They further explained that many providers do not know which benefit amount to collect from a patient based on the in and out of network benefits being returned.	**For CAQH CORE EBTG Discussion.** CAQH CORE will solicit feedback from the EBTG on this topic on future straw polls and calls.
21.	**AAA Reporting Codes:** One entity noted that many submitters of the X12 v5010 270 do not want a 999 for reporting errors, so they return a 271 Response using the AAA03=42 (Unable to Respond at Current Time) is received from the payer. They further explain that because the 999 is not HIPAA-adopted, they cannot require the submitter to accept a 999. As a result, they stated there is no way to indicate the nature of this error and is seeking a solution to this issue.	**For CAQH CORE EBTG Discussion.** CAQH CORE will solicit feedback from the EBTG on this topic on future straw polls and calls.

Eligibility & Benefits Task Group – Feedback Form

Comments Received on Additional Opportunity Areas

	Points of Clarification		CAQH CORE Co-chair & Staff Response
22.	**Coordination of Benefits:** One entity noted that rule options such as primary and secondary benefit structure and procedures/diagnosis codes could be addressed for the coordination of benefits.	22.	EBTG Participants will have the opportunity on future calls and straw polls to give feedback if coordination of benefits should be included as part of the operating rule update.
23.	**National Drug Codes:** One entity expressed that it would be i beneficial if operating rules could support National Drug Codes (NDC). They explained that this could avoid unnecessary and/or high-cost prescription scripts if a payer or PBM can determine the cost of the prescription at the time the provider is writing the script.	23.	EBTG Participants will have the opportunity on future calls and straw polls to give feedback on which code sets should be included as part of the operating rule update.

Eligibility & Benefits Task Group – Feedback Form

Comments Received on Patient Data Sharing

#	Potential Rule Option	Support/ Partially Support	Oppose/ Partially Oppose	Neither Support nor Oppose	Abstain
10	Patient Data Sharing: Define Minimum Set	15 (58%)	5 (19%)	6 (23%)	1

Points of Clarification

24. Two entities asked for further information on the rule option and one asked for further clarification if the Patient Data Sharing takes the No Surprises Act of the 2021 Consolidated Appropriations Act into consideration.

- One stated that there is not information on how the data will be shared between health plan and member.
- Another asked for details on what data elements would a minimum data set include.

25. Five entities expressed concerns related to developing patient data sharing operating rules.

- One explained that operating rules should be limited to transactions between health plan and provider.
- Another noted that operating rules could conflict with CMS/ONC Interoperability Rule.
- Another commented that it is too early to establish operating rules as patient data sharing is based on an emerging standard (FHIR) that is not HIPAA adopted.
- Another indicated that it is neither timely nor prudent to create operating rules surrounding patient data sharing of eligibility and benefit information.
- Another stated that that patient data sharing is not the purpose of the X12 270/271 transaction, as the transaction needs information about the provider to determine coverage applicability.

CAQH CORE Co-chair & Staff Response

24. The method of how data should be shared would be determined via the CAQH CORE Rule Development Process via feedback from CAQH CORE Participating Organizations. Establishing a minimum data set would define what eligibility and benefit data elements would be required to be returned within a consumer-facing application (e.g., health plan name, coverage dates, eligible to see the provider, in-network vs out of network, co-pay amount, deductible remaining, etc.)

CAQH CORE would engage in further research and consensus-building via participant surveys and discussions to ensure future operating rules pertaining to patient data sharing are aligned to the No Surprises Act of the 2021 Consolidated Appropriations Act.

25. EBTG Participants will have the opportunity on future calls and straw polls to give feedback if patient data sharing should be included as part of the current rule update or be considered for evaluation in a future CAQH CORE development initiative.

Eligibility & Benefits Task Group Next Steps

Nora Iluri, *athenahealth*

Eligibility & Benefits Task Group Straw Poll #1

Straw Poll Objective: Indicate each EBTG Participating Organization's level of support, indicate implementation complexity, and provide feedback on Potential High-Level Rule Requirements for CAQH CORE Eligibility & Benefit Rule Update

Straw Poll Overview:

- **Potential High-Level Rule Requirements:** Respondents will be asked to indicate support and provide feedback on Potential High-Level Rule Requirements for CAQH CORE Eligibility & Benefit Rule Update, by opportunity area.
- **Implementation Complexity:** Respondents will be asked to provide feedback on the complexity of implementation (low, medium, or high) for each Potential High-Level Rule Requirement.

NOTE: Respondents will have the opportunity to leave comments along with each of their responses.

Additional Guidance:

- The form is to be completed by CAQH CORE EBTG Participants only; **please coordinate to submit only one response for your organization.**
- Responses must be submitted **via the online submission form by Friday, 06/11/21 end of day**.
- Questions should be directed to Kaitlin Powers, CORE Associate, at kpowers@caqh.org.
- **NOTE**: In accordance with CAQH CORE policy, all responses will be kept strictly confidential and will be reported in aggregate at stakeholder level.

Eligibility & Benefits Task Group

Next Steps

Eligibility & Benefits Task Group Participants

- Complete Straw Poll #1 by **Friday, 06/11/21.**
- Participate in the next CAQH CORE EBTG Call on **Wednesday, 06/23/21 at 2:00 PM ET.**

CAQH CORE Staff & Co-chairs

- Draft a summary for today's call.
- Send Straw Poll #1 to EBTG Participants by **Friday, 05/28/21.**
- Analyze Straw Poll #1 feedback and prepare results for **Wednesday, 06/23/21** call.

Contact CORE@caqh.org with any questions.

Appendix A

Additional Reference Materials

Today's Call Documents

Document Name
Doc 1: EBTG Call 2 Deck 05.26.21 Doc 2: EBTG Call 1 Summary 04.28.21

CORE Staff	Email Address
Bob Bowman, *Director, CORE*	rbowman@caqh.org
Taha Anjarwalla, *Senior Manager, CORE*	tanjarwalla@caqh.org
Kaitlin Powers, *Associate, CORE*	kpowers@caqh.org

Eligibility & Benefits Task Group

Activity Schedule

Task Group Schedule	Task Group Activity
Wednesday, 04/28/21 2:00 pm to 3:30 pm ET	**EBTG Call #1** ▪ Review scope, environmental scan results, opportunity areas, rule options, and task group schedule ▪ Agree to Feedback Form
04/30/21 – 05/17/21	**EBTG Feedback Form** ▪ Indicate level of support on opportunity areas ▪ Collect feedback on rule options/potential requirements
Wednesday, 05/26/21 2:00 pm to 3:30 pm ET	**EBTG Call #2** ▪ Review results from feedback form ▪ Agree to opportunity areas and adjustments to define rule options, if applicable ▪ Agree to Straw Poll #1: Rule Options
05/28/21 – 06/11/21	**EBTG Straw Poll #1: Rule Options** ▪ Indicate level of support for potential high level rule requirements
Wednesday, 06/23/21 2:00 pm to 3:30 pm ET	**EBTG Call #3** ▪ Review results of Straw Poll #1 ▪ Agree to adjustments, if applicable ▪ Agree to Straw Poll #2: Draft Rule Requirements
06/28/21 – 07/12/21	**EBTG Straw Poll #2: Draft Rule Requirements** ▪ Indicate level of support for rule requirements
Wednesday, 08/04/21 2:00 pm to 3:30 pm ET	**EBTG Call #4** ▪ Review results of Straw Poll #2 ▪ Agree to adjustments, if applicable ▪ Agree to Straw Poll #3: Draft Rule
08/06/21 – 08/20/21	**EBTG Straw Poll #3: Draft Rule** ▪ Support for draft rule, by rule section
Wednesday, 09/01/21 2:00 pm to 3:30 pm ET	**EBTG Call #5** ▪ Review results of Straw Poll #3 ▪ Agree to adjustments, if applicable

Eligibility & Benefits Task Group
Roster

	Name	Organization
1	Merri-Lee Stine	Aetna
2	Nancy Senato	Aetna
3	Terrence Cunningham	American Hospital Association (AHA)
4	Celine Lefebvre	American Medical Association (AMA)
5	Heather McComas	American Medical Association (AMA)
6	Robert Otten	American Medical Association (AMA)
7	Molly Reese	American Medical Association (AMA)
8	Tyler Scheid	American Medical Association (AMA)
9	Kristina Steece	Ameritas
10	Kena Gwinn	Anthem Inc.
11	Nora Iluri	Athenahealth
12	Steffi Silva	Availity, Inc.
13	Gail Kocher	Blue Cross and Blue Shield Association (BCBSA)
14	Cindy Monarch	Blue Cross Blue Shield of Michigan
15	Shweta Talwar	Blue Cross Blue Shield of Michigan
16	Amy Turney	Blue Cross Blue Shield of Michigan
17	Sudheer Tummala	Blue Cross Blue Shield of North Carolina
18	Susan Langford	Blue Cross Blue Shield of Tennessee
19	Brian Poteet	Blue Cross Blue Shield of Tennessee
20	Mahesh Siddanati	Centene
21	Camille Haywood	Centers for Medicare and Medicaid Services (CMS)
22	Ada Sanchez	Centers for Medicare and Medicaid Services (CMS)
23	Rupinder Singh	Centers for Medicare and Medicaid Services (CMS)
24	Kathy Anderson	Change Healthcare
25	Colton Casteel	Change Healthcare
26	Karen Lamb	Change Healthcare
27	Deborah McCachern	Change Healthcare
28	Terry Thompson	Change Healthcare
29	Chuck Wilhelm	Change Healthcare
30	Maciej Wroblewski	Change Healthcare
31	Megan Soccorso	CIGNA

	Name	Organization
32	Shilesh Nair	CSRA
33	Sergiu Rata	Edifecs
34	Nate Donaldson	Epic
35	Billie Jo Churchill	Harvard Pilgrim
36	Sarah Farr	Harvard Pilgrim
37	Rhonda Starkey	Harvard Pilgrim
38	Donna Campbell	Health Care Service Corp
39	Maggie Brown	HealthEdge
40	Michael Hostetler	HMS
41	Ron Singh	HMS
42	Beth Wilcox	HMS
43	Jason Woodford	HMS
44	Sandra Jamison	Humana
45	Steve Clark	Kaiser Permanente
46	BJ Venhuizen	Mayo Clinic
47	Jean Oby	Medical Mutual of Ohio, Inc.
48	Jameelah O'Neal	Medical Mutual of Ohio, Inc.
49	Drew Voytal	MGMA
50	Margaret Weiker	National Council for Prescription Drug Programs (NCPDP)
51	Jackie Lopez	NextGen Healthcare Information Systems, Inc.
52	William Campbell	OneHealthPort
53	Althea Robinson	Tata Consulting Services
54	Tracey Tillman	The SSI Group, Inc.
55	Danielle Couch	TriZetto Corporation, A Cognizant Company
56	Katherine Knapp	United States Department of Veterans Affairs
57	Pranav Shah	United States Department of Veterans Affairs
58	Kiran Kalluri	Unitedhealthcare
59	Brent Backhaus	Verata
60	Robert Tennant	WEDI
61	Jason Birgenheier	Wells Fargo

Eligibility & Benefits Task Group Participants

Expectations & Responsibilities

- **Become familiar with CAQH CORE's Eligibility & Benefits work and processes, including:**
  - CAQH CORE New Operating Rule Structure.
  - CAQH CORE Eligibility & Benefits Data Content Operating Rule, Eligibility & Benefits Infrastructure Operating Rule, Single Patient Attribution Data Content Rule, Connectivity Rule, Mandated Operating Rules, as well as others.
  - CAQH CORE Guiding Principles, Board Evaluation Criteria, and Voting Process.

- **Attend and actively participate in calls.**
  - Read materials ahead of time whenever possible.
    - CAQH CORE staff assist Task Group Co-chairs with drafting call documents and ensure they are made available on the CAQH CORE Participant Dashboard.
    - Call summaries are created after each call and approved by the participants.

- **Work with your organization's subject matter experts (SMEs), as appropriate. SMEs should have:**
  - Knowledge of their organization's capabilities and processes with respect to exchanging eligibility and benefits information.
  - Understanding of how the potential draft CAQH CORE Eligibility & Benefits Data Content Rule update would impact their organization and the industry, both in terms of feasibility to implement and value.

- **Provide regular updates on Task Group's progress to Executive Sponsors.**
  - SMEs should regularly update their Executive Sponsors on the Task Group's progress to ensure larger organization buy-in of the drafted eligibility and benefits operating rule requirements and commitment to implementation.
- **Participate in feedback forms/straw polls and cast votes, as appropriate.**
  - Participating organizations may have any number of participants in the Task Group, but each organization has only one vote on feedback forms, straw polls, and ballots.