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CAQH CORE Eligibility & Benefits Task Group (EBTG)

Call #4

Call Doc #1

August 4, 2021

2:00 – 3:30 PM ET

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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 06/23/21 Task Group Call** • Level set. • Review Straw Poll#1 Results and Comments. • Agreed to Next Steps.	Action Required: • Approve 06/23/21 Call Summary
2:10 PM	**4. Task Group Timeline Level Set**	*Discussion*
2:15 PM	**5. Review Results of Straw Poll #2 including:** • Respondent Breakdown, Percent Support for Draft Rule Requirements. • Comments Received on Draft Rule Requirements. • 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, 09/22/21 at 2:00 PM ET**. o Complete EBTG Straw Poll #1 **by end of day Thursday, 09/09/21**. • CAQH CORE Co-chair & staff: o Draft a summary for today's call. o Send EBTG Straw Poll #4 to Task Group Participants by, **Thursday, 08/26/21**.	Action Required: • Agree to Next Steps

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Eligibility & Benefits Task Group– EBTG Call #3 Summary

Motion to Approve

CAQH Committee on Operating Rules for Information Exchange (CORE)
Eligibility & Benefits Task Group (EBTG)
Call #3 Summary: Wednesday, June 23, 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	• Molly Reese (AMA) opened the call and reviewed the Antitrust Guidelines, noting that they are published on the CAQH CORE Calendar along with the meeting materials. • Molly Reese (AMA) introduced CAQH CORE staff supporting the Task Group and other the Co-chairs, Donna Campbell (Health Care Service Corps), Nora Iluri (athenahealth), and Megan Soccorso (Cigna).	*Discussion*
2. Roll Call and Administrative Items	• Molly Reese (AMA) reviewed the call documents: o Doc #1: EBTG Call 3 Slide Deck 06.23.21. o Doc #2: EBTG Call 2 Summary 05.26.21. • Molly Reese (AMA) reviewed the focus of the call, which was to: o Review results of Straw Poll #1. o Agree to adjustments, as necessary. o Provide an overview of Straw Poll #2. 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 EBTG participants.	*Discussion*
3. Summary of 05/26/21 EBTG Call #2 (Doc #2)	**Summary of 05/26/21 EBTG Call #2 (Doc #2).** o Review results of Feedback Form #1 o Agree to adjustments, as necessary. o Provide an overview of Straw Poll #1. o Discuss Next Steps. • Taha Anjarwalla (CAQH CORE Senior Manager) asked the group for motion to approve the call summary. • **Summary of ASG-CL Discussion:** o No questions or comments were raised by EBTG participants.	**Action Required:** • Approved 05/26/21 Call Summary (Doc #2) o Motion to approve by Chuck Veverka (Michigan Medicaid). Seconded by Pranav Shah (U.S. Department of Veterans Affairs).

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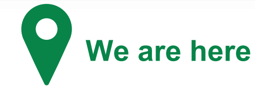
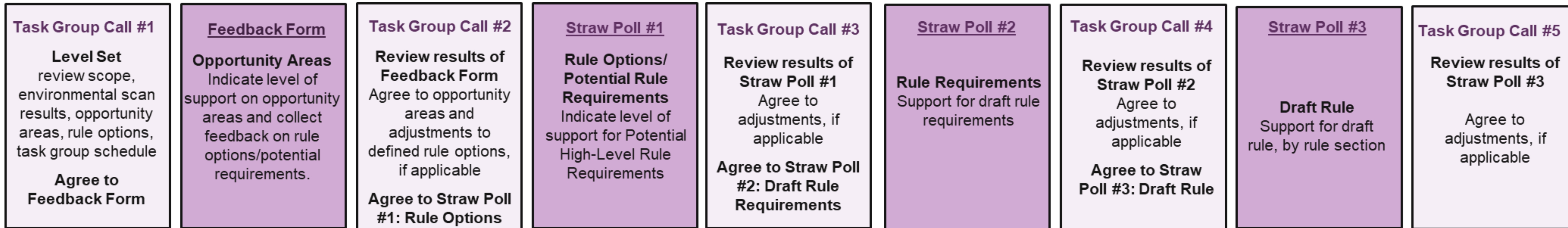
Eligibility & Benefits Task Group Roadmap

Level Set for Today's Call





Today

- **Review Results of Straw Poll #2 including**:
  - Respondent support and feedback on draft rule requirements for CAQH CORE Eligibility & Benefit Rule Update.
- **Agree to adjustments** to the draft rule requirements, as necessary.
- **Provide an overview** of Straw Poll #3.
- **Agree to Next Steps**.

Upcoming

- **Straw Poll #3**
  - Indicate level of support and provide feedback on the DRAFT CAQH CORE Eligibility & Benefit Rule Update.
- **EBTG Call #5**.

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Eligibility & Benefits Task Group Straw Poll #2 Results

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Eligibility & Benefits Task Group – Straw Poll #2

Straw Poll #2 Background

Purpose of Straw Poll: To indicate level of support and provide feedback on draft rule requirements for the CAQH CORE Eligibility & Benefits Rule update.

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. **Remaining Coverage Benefits:** Support the communication of the number of remaining visits/services left on a benefit
4. **Procedure Codes:** Ability to respond to eligibility and benefit requests at the procedure level (e.g., CPT, HCPCS)
5. **Prior Authorization/Certification:** Ability to communicate if prior authorization/certification is required for a specific procedure or service
6. **Tiered Benefits:** Provision of more granular level data for members of tiered benefit plans

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Eligibility & Benefits Task Group – Straw Poll #2

Respondent Breakdown

Respondent Breakdown: Responses were received from **26** respondents, representing **63%** of Task Group Participating Organizations.

Number of EBTG Participating Organizations	41
Total Number of EBTG Participating Organization Responses	**26 (63% of EBTG Entities)**
Number of Provider/Provider Association Responses	3 (12% of respondents)
Number of Health Plan/Health Plan Association Responses	10 (38% of respondents)
Number of Vendor/Clearinghouse Responses	7 (27% of respondents)
Number of Government Responses	3 (12% of respondents)
Number of 'Other' Responses (includes SDOs)	3 (12% of respondents)

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Eligibility & Benefits Task Group – Straw Poll #2

Results Summary: Percent Support for Draft Rule Requirements

	Support/Partially Support	Partially Do Not Support/ Do Not Support	Abstain
1. **Telemedicine**: CMS POS 02 (TELEHEALTH) in III Segment within Data Element III02	18 (82%)	4 (18%)	4
2. **Remaining Coverage Benefits**: Maximum Benefit Subsection & Remaining Benefit Subsection	19 (86%)	3 (14%)	4
3. **Remaining Coverage Benefits**: Remaining Benefit with Date Limitations Subsection	16 (73%)	6 (27%)	4
4. **Procedure Codes**: Return Procedure Codes on 271	19 (79%)	5 (21%)	2
5. **Authorization/Certification**: Determination for STC Codes	20 (80%)	5 (20%)	1
6. **Authorization/Certification**: Determination for Procedure Codes	19 (79%)	5 (21%)	2
7. **Tiered Benefits**: Member Tiered Benefit Coverage	19 (86%)	3 (14%)	4
8. **Tiered Benefits**: Provider Tiered Benefit Reimbursement	18 (82%)	4 (18%)	4

All draft rule requirements received higher than 70% support.

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Eligibility & Benefits Task Group – Straw Poll #2

Results Summary: Service Type Codes

Mandatory STCs to Add to CORE-Required Service Type Code List for an Explicit Inquiry		
10 Blood Charges	63 Donor Procedures	BR Eye
11 Used Durable Medical Equipment	66 Pathology	BS Invasive Procedures
14 Renal Supplies in the Home	69 Maternity	BT Gynecological
15 Alternate Method Dialysis	70 Transplants	BU Obstetrical
16 Chronic Renal Disease CRD Equipment	71 Audiology Exam	BV Obstetrical Gynecological
17 Pre Admission Testing	72 Inhalation Therapy	BY Physician Visit Office Sick
23 Diagnostic Dental	75 Prosthetic Device	BZ Physician Visit Office Well
24 Periodontics	77 Otological Exam	C1 Coronary Care
25 Restorative	79 Allergy Testing	CB Private Duty Nursing Home
26 Endodontics	83 Infertility	CC Surgical Benefits Professional Physician
37 Dental Accident	87 Cancer	CD Surgical Benefits Facility
38 Orthodontics	95 Podiatry Nursing Home Visits	CL Screening laboratory
39 Prosthodontics	96 Professional Physician	CM Mammogram High Risk Patient
41 Routine Preventive Dental	97 Anesthesiologist	CN Mammogram Low Risk Patient
44 Home Health Visits	A1 Professional Physician Visit Nursing Home	DG Dermatology
49 Hospital Room and Board	A2 Professional Physician Visit Skilled Nursing Facility	DS Diabetic Supplies
56 Medically Related Transportation	AH Skilled Nursing Care Room and Board	GY Allergy
57 Air Transportation	AM Frames	ON Oncology
58 Cabulance	AN Routine Exam	PU Pulmonary
59 Licensed Ambulance	BK Orthopedic	RN Renal
60 General Benefits	BL Cardiac	TN Transitional Nursery Care
61 In vitro Fertilization	BN Gastrointestinal	

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Eligibility & Benefits Task Group – Straw Poll #2

Results Summary: Service Type Codes

Discretionary STCs to Add to CORE-Required Service Type Code List for an Explicit Inquiry		
19 Pneumonia Vaccine	A9 Rehabilitation	CE Mental Health Provider Inpatient
27 Maxillofacial Prosthetics	AA Rehabilitation Room and Board	CF Mental Health Provider Outpatient
28 Adjunctive Dental Services	AB Rehabilitation Inpatient	CG Mental Health Facility Inpatient
32 Plan Waiting Period	AC Rehabilitation Outpatient	CH Mental Health Facility Outpatient
34 Chiropractic Office Visits	AJ Alcoholism	CI Substance Abuse Facility Inpatient
36 Dental Crowns	AK Drug Addiction	CJ Substance Abuse Facility Outpatient
43 Home Health Prescriptions	AO Lenses	CK Screening X ray
46 Respite Care	AQ Nonmedically Necessary Physical	CO Flu Vaccination
54 Long Term Care	AR Experimental Drug Therapy	CP Eyewear and Eyewear Accessories
55 Major Medical	B1 Burn Care	CQ Case Management
64 Acupuncture	B2 Brand Name Prescription Drug Formulary	DM Durable Medical Equipment
67 Smoking Cessation	B3 Brand Name Prescription Drug Non Formulary	GF Generic Prescription Drug Formulary
74 Private Duty Nursing	BB Partial Hospitalization Psychiatric	GN Generic Prescription Drug Non Formulary
84 Abortion	BC Day Care Psychiatric	IC Intensive Care
89 Free Standing Prescription Drug	BD Cognitive Therapy	NI Neonatal Intensive Care
90 Mail Order Prescription Drug	BE Massage Therapy	PT Physical Therapy
91 Brand Name Prescription Drug	BF Pulmonary Rehabilitation	RT Residential Psychiatric Treatment
92 Generic Prescription Drug	BI Nursery	TC Transitional Care
94 Podiatry Office Visits	BW Mail Order Prescription Drug Brand Name	3 Consultation
A4 Psychiatric	BX Mail Order Prescription Drug Generic	9 Other Medical
A5 Psychiatric Room and Board	CA Private Duty Nursing Inpatient	

STC Codes Not Supported:

21 Third Surgical Option, 22 Social Work, BA Independent Medical Evaluation, BM Lymphatic, BP Endocrine, BQ Neurology, BJ Skin, 85 AIDS

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Eligibility & Benefits Task Group – Straw Poll #2

Results Summary: Remaining Coverage Benefits

Service Type Codes to be CORE-Required for the Return of Remaining Coverage Benefit Information via X12 v5010 270/271 Exchanges

	Support	Do Not Support	Abstain
AF Speech Therapy	20 (95%)	2 (5%)	4
AD Occupational Therapy	20 (95%)	3 (5%)	4
PT Physical Therapy	21 (95%)	1 (5%)	3
33 Chiropractor	17 (89%)	2 (11%)	6
1AH Skilled Nursing Care - Room and Board	15 (79%)	4 (21%)	6
BG Cardiac Rehabilitation	13 (76%)	4 (24%)	8
AL Vision (Optometry)	12 (75%)	4 (25%)	9
34 Chiropractor Office Visits	13 (72%)	5 (28%)	7
AE Physical Medicine	12 (71%)	5 (29%)	8
A2 Professional (Physician) Visit	12 (71%)	5 (29%)	8
MH Mental Health	13 (68%)	6 (32%)	6
CP Eyewear and Eyewear Accessories	9 (60%)	6 (40%)	10

Task Group will move forward with STCs that received higher than 70% support.

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Eligibility & Benefits Task Group – Straw Poll #2

Results Summary: Categories of Service for Procedure Codes

Categories of Service Procedure Code Rule Should Apply			
	Support	Do Not Support	Abstain
Physical Therapy	15 (79%)	4 (21%)	6
Occupational Therapy	15 (79%)	4 (21%)	6
Imaging	12 (71%)	5 (29%)	8
Surgery	12 (71%)	5 (29%)	8
Laboratory	9 (60%)	6 (40%)	10
Cardiology	9 (56%)	7 (44%)	9
General Outpatient	9 (53%)	8 (47%)	8
Inpatient	9 (53%)	8 (47%)	8
Oncology	7 (47%)	8 (53%)	10

Task Group will move forward with Categories of Service that received higher than 70% support.

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Eligibility & Benefits Task Group – Straw Poll #2

Comment Categorization

Comments received on the EBTG Straw Poll #2 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 are summarized in a separate document for offline review (*Doc 3 EBTG Straw Poll #2 Non-Substantive Comments*). Task Group participants are encouraged to review this document.

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Eligibility & Benefits Task Group – Straw Poll #2

Comments Received on Telemedicine

	Support/Partially Support	Partially Do Not Support/ Do Not Support	Abstain
02 (TELEHEALTH) in Segment III within Data Element III02	18 (82%)	4 (18%)	4

Point of Clarification	EBTG Co-Chair and CAQH CORE Staff Response
1. Two entities had comments pertaining to the X12 Telemedicine RFIs: ▪ One entity indicated that the draft Telemedicine rule requirement conflicts with X12 RFIs 1957 and 2136. ▪ One entity noted that the situational rule for the III Segment in the 271 allows for the segment to be used to identify a benefit limitation or when the III Segment is also used in the 270 for eligibility determination.	X12 has drafted an RFI, Draft RFI #2486, which addresses the codification of Telemedicine to replace RFIs 1957 and 2136. While the RFI is still under review within the X12 RFI process, CAQH CORE can provide guidance to the industry by aligning operating rules to the draft RFI for addressing telemedicine in the X12 v5010 270/271. Further, on EBTG Straw Poll #1, 90% of organizations supported the approach of using a codifiable method, CMS Place of Service 02 TELEHEALTH, to communicate telemedicine benefit information via the X12 v5010 271 Response for a specific Service Type Code.
2. One entity stated that since EB02 coverage level is situational, requiring this data element when there is no difference based on coverage basis is unnecessary	The CAQH CORE Eligibility & Benefit Data Content Rule vEB1.0 requires the use of EB02 for specifying Family (FAM) or Individual (IND) for covered benefits. Thereby, these existing requirements are also applied to address Telemedicine. CAQH CORE Operating Rules have the capability to make a situational use element/code required to address specified business information needs.

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Eligibility & Benefits Task Group – Straw Poll #2

Comments Received on Telemedicine

Point of Clarification	EBTG Co-Chair and CAQH CORE Staff Response
4. Two entities noted that communication of telemedicine benefits at the STC level would be insufficient in cases where not all procedure codes within a STC are covered by telemedicine.	The goal of the CAQH CORE Rule Eligibility & Benefits Data Content Rule Update is to bridge existing system capabilities with evolving industry needs. As such, the draft rule requirement is scoped to apply only when a service type code is covered by telemedicine.
5. One entity recommended that EB03 be used for the STC representing the specific benefit in question for Telemedicine. For example, if a payer has general Telemedicine benefits to report, then recommend the use STC 03 = 1; otherwise, specific STC can be paired with III02 = 02.	Based off feedback received on prior calls, feedback forms, and straw polls there was alignment that telehealth benefits could apply to a variety of service type codes. As such, the draft rule requirement enables flexibility while providing specificity as to which service types are available for telemedicine.
6. One entity noted that the use of multiple EB segments to communicate differences in telemedicine benefits for both in- and out-of-network providers will cause confusion and could flood providers with unnecessary information, adding burden. The entity expressed that the rule requirements should clarify that if the provider is out-of-network, then the plan should return only the applicable out-of-network telemedicine benefits.	The in/out of network rule requirements would apply only when there are variances in telemedicine benefits between in and out of network. CAQH CORE can provide guidance within the operating rule on best practices pertaining to the return of information on the X12 271 response relevant to what is being requested via an explicit X12 270 inquiry.

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Eligibility & Benefits Task Group – Straw Poll #2

Comments Received on Service Type Codes

Point of Clarification	EBTG Co-Chair and CAQH CORE Staff Response
7. One entity expressed that this rule requirement should cover all Service Type Codes, especially since the next version of X12 270/271 transaction standard includes a requirement that plans support all STCs and adding additional STCs requires relatively minimal implementation effort by industry.	Through a consensus-based process via EBTG Straw Poll #1 it was identified that 62% of respondents were in support of requiring a select group of STCs to become CORE-required for an explicit inquiry. In comparison, only 33% of respondents were in support of requiring all STCs listed in the X12 v5010 270/271 TR3 to become CORE-required for an explicit inquiry.

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Eligibility & Benefits Task Group – Straw Poll #2

Comments Received on Remaining Coverage Benefits

	Support/Partially Support	Partially Do Not Support/ Do Not Support	Abstain
2. Maximum Benefit Subsection & Remaining Benefit Subsection	19 (86%)	3 (14%)	4
3. Remaining Benefit with Date Limitations Subsection	16 (73%)	6 (27%)	4

Substantive Comment	EBTG Co-Chair and CAQH CORE Staff Response
8. Two entities expressed concern of the use of EB06 22 Service Year for the Maximum and Remaining Benefit rule requirements. ▪ One entity indicated they do not necessarily support "service year" as some policies may allow per episode, calendar year or contract year. ▪ Another entity communicated that a service year may be the member's next enrollment period, should they enroll. As such, this would report future benefits for a member who may not have such future benefits if they do not re-enroll for continued coverage.	**Agree to Adjust.** Adjust draft rule requirement to allow the use of additional applicable time qualifier code relevant to the maximum benefit limitation.
9. One entity expressed support for draft Maximum and Remaining Benefit rule requirements, except for the specific ordering of the EB Loops.	**Agree to Adjust.** Adjust draft rule requirement to remove references to first and second occurrences. However, require that the EB Segment specifying maximum benefit limitations for a STC must occur before the EB Segment specifying remaining benefit limitations for the same STC.

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Eligibility & Benefits Task Group – Straw Poll #2

Comments Received on Remaining Coverage Benefits

Point of Clarification	EBTG Co-Chair and CAQH CORE Staff Response
10. One entity indicated that the inclusion of the patient's remaining deductible in the X12 v5010 271 response should be discretionary, based on the capabilities of the Payer's system.	The CAQH CORE Eligibility & Benefit Data Content Rule vEB1.0 requires the return of patient financial responsibility for base and remaining deductibles for CORE-required STCs and provides the following guidance: ▪ The benefit-specific remaining deductible returned is for the current time period only, i.e., as of the date of the v5010 271. When the v5010 270 is for a time period other than the current time period, no benefits specific remaining deductible is returned. ▪ Returning the benefit-specific remaining deductible is required except for those service types specified as exceptions for discretionary reporting.
11. Two entities had comments pertaining to the draft Remaining Benefits with Date Limitations rule requirement. ▪ One entity asked for clarification on what “next eligible date” means. ▪ Another entity stated they do not have the capability to know a future date.	The draft rule requirement addresses situations when benefits are limited by a date. The next eligible date refers to the next date that the specified benefit can be rendered by the provider and would be covered by the health plan. Further, the CAQH CORE Eligibility & Benefit Data Content Rule vEB1.0 states that the X12 v5010 270 may request a benefit coverage date 12 months in the past or up to the end of the current month. If the inquiry is outside of this date range and the health plan (or information source) does not support eligibility inquiries outside of this date range, the v5010 271 must include the AAA segment with code “62” Date of Service Not Within Allowable Inquiry Period in the AAA03-901 Reject Reason Code data element.

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Eligibility & Benefits Task Group – Straw Poll #2

Comments Received on Procedure Codes

	Support/Partially Support	Partially Do Not Support/ Do Not Support	Abstain
4. Return Procedure Codes on 271	19 (79%)	5 (21%)	2

Substantive Comment	EBTG Co-Chair and CAQH CORE Staff Response
12. One entity recommended to add additional rule requirements to support a “catch all’ response using the MSG segment and 2120 Loop to provide information that cannot be codified and possibly not able to be supported; as there are so many procedure codes and modifiers that if those are required to be supported, it may require additional "disclaimer-like" language to identify that the eligibility for the service is dependent on diagnosis, place of service and other limitations that may exist per contract for medical necessity.	**For Task Group discussion.**

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Eligibility & Benefits Task Group – Straw Poll #2

Comments Received on Procedure Codes

Point of Clarification	EBTG Co-Chair and CAQH CORE Staff Response
13. Four entities requested additional clarification or had concerns on the concept of grouping procedure codes (CPT or HCPCS) into CORE-required categories of services. ▪ One entity requested for further explanation and definition on the meaning of Categories of Service. ▪ Another entity asked for clarification on the intent of CORE-required categories of service as it relates to the X12 v5010 271 responses. They noted the following scenario: if a provider is wanting to submit one CPT code and if the intent is for the payer to return all CPT's that fall within a category as the CPT submitted the response would be enormous. ▪ Another entity stated that depending upon the list of required categories service, the matching to procedure codes could be challenge and may require a maintenance process. ▪ Another entity expressed that there would be ambiguity surrounding which CPT and HCPCS codes would fall or not fall within designated CORE-required categories of service leading to unintended loopholes in implementation.	Categories of Service refer to the business grouping of healthcare services or benefits. Service type codes, procedure codes, revenue codes, and diagnosis codes can all be grouped into categories of service. The approach of classifying procedure codes via categories of service was used when drafting the CAQH CORE Prior Authorization Data Content Rule. The categories of service requirements are placed on health plans to process a limited set of use cases for when a particular CPT or HCPCS code falls into a set of categories identified in the rule. When those CPT or HCPCS codes fall outside these categories of service the rule requirements do not apply. The rule requirements would be analogous to how the existing CAQH CORE Eligibility & Benefits (270/271) Data Content Rule addresses requirements for STCs. For example, if a health plan receives an explicit procedure code inquiry, and the procedure code falls into a CORE-required Category of Service, the health plan must return a response for the procedure code explicitly received. Given the magnitude of CPT and HCPCS codes it would not be feasible for CAQH CORE to develop and maintain such a grouping listing at this time. Allowing the industry to make feasible progress in building logic into their eligibility & benefit systems for an initial set procedure-code based inquires will help inform future rule development.
14. One entity asked for additional information for the following scenario on what the level of reply should be, procedure code or STC for the following scenario based on the rule requirement: "When the procedure code(s) received in the X12 v5010 270 Request transaction cannot be placed by the health plan and its agent into any of the above types of service categories, the health plan and its agent should attempt to evaluate and respond appropriately to the request."	The draft rule requirement represents a floor not a ceiling in terms of how a health plan should respond when a procedure code inquiry is received in the event a code falls outside the CORE-required categories of service. However, entities are strongly encouraged to evaluate and respond at the procedure level.

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Eligibility & Benefits Task Group – Straw Poll #2

Comments Received on Authorization/Certification

	Support/Partially Support	Partially Do Not Support/ Do Not Support	Abstain
5. Determination for STC Codes	20 (80%)	5 (20%)	1
6. Determination for Procedure Codes	19 (79%)	5 (21%)	2

	Point of Clarification	EBTG Co-Chair and CAQH CORE Staff Response
15.	One entity asked for further information on whether the requirement "differ for in- and out-of-network, two occurrences" also indicates within the response which differentiator is being addressed for that EB12, in-network or out-of-network.	The in/out of network rule requirements would apply only when there are variances in authorization/certification determination between in and out of network. The EB12 indicator would be used to communicate in-network or out-of-network.
16.	Two entities expressed concerns on the draft Authorization/ Certification Determination for Service Type Codes rule requirement. ▪ One entity stated this rule requirement would cause more burden and confusion than it would resolve, as service type codes are not sufficiently specific to communicate whether authorization/certification is needed. ▪ Another entity indicated that a payer cannot return an authorization or certification requirement just using an STC alone.	The draft rule requirement aims to address scenarios where all benefits covered by an STC would either require or not require authorization/ certification. Further, CAQH CORE has drafted rule requirements to support authorization/certification determination for procedure codes. If other variables are needed to determine if authorization is required and those variables are not sent in the X12 270 Request, those situations would fall outside the scope of operating rule.
17.	Two entities provided comments pertaining to the draft Authorization/Certification Determination for Procedure Codes rule requirement. ▪ One entity noted that a health plan cannot return an authorization or certification requirement using "Categories of Service." ▪ Another entity stated that they would not be supportive of the rule requirement if it relies on a category concept. However, the entity would be supportive if the rule requirements support a CPT based inquiry with the same CPT in the response.	The categories of service requirements are placed on health plans to process a limited set of use cases for when a particular CPT or HCPCS code falls into a set of categories identified in the rule. When those CPT or HCPCS codes fall outside these categories of service the rule requirements do not apply. The draft rule requirement is supportive of individual procedure-code based inquiries and responses. For example, if a health plan receives an explicit procedure code inquiry, and the procedure code falls into a CORE-required Category of Service, the health plan must return a response for the procedure code explicitly received.

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Eligibility & Benefits Task Group – Straw Poll #2

Comments Received on Tiered Benefits

	Support/Partially Support	Partially Do Not Support/ Do Not Support	Abstain
7. Member Tiered Benefit Coverage	19 (86%)	3 (14%)	4
8. Provider Tiered Benefit Reimbursement	18 (82%)	4 (18%)	4

	Point of Clarification	EBTG Co-Chair and CAQH CORE Staff Response
18.	One entity recommended that the rule requirement be adjusted to convey that determining and returning the appropriate tier is first and foremost expected, but if a specific tier cannot be determined, all tires must be returned. Further, the entity stated rule requirements should address the MSG usage when a health plan does not indicate a specific tier, and how a provider could make a tier determination.	**Adjust for clarity.** CAQH CORE Co-chairs and Staff will adjust the draft rule requirement to clarify that health plans should use MSG Segment to communicate how a provider could make a tier determination in occurrences when all tiers are returned.
19.	One entity stated that since EB02 coverage level is situational, requiring this data element when there is no difference based on coverage basis is unnecessary.	The current version of the CAQH CORE Eligibility & Benefit Data Content Rule requires the use of EB02 for specifying Family (FAM) or Individual (IND) for covered benefits. CAQH CORE Operating Rules have the capability to make a situational use element/code required to address specified business information needs.
20.	One entity noted that for tiered benefits, inclusion of a patients remaining deductible in the X12 v5010 271 response should be discretionary. Further, the entity also expressed that forecasting the next available date would be a challenge, due to the complexity inherent in daily enrollment changes, and daily changes in beneficiary financial resources.	The existing CAQH CORE Eligibility & Benefits Data Content Rule requires the return of patient financial responsibility for base and remaining deductibles for CORE-required STCs. These rule requirements would apply to CORE-required STCs that are determined to be tiered benefits. Further, the next eligible date would be required to return, as applicable, only when a tiered benefit would be limited by a date.

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Eligibility & Benefits Task Group – Straw Poll #2

Comments Received on Tiered Benefits

	Point of Clarification	EBTG Co-Chair and CAQH CORE Staff Response
21.	Two entities asked for further clarification on the draft Member Tier Benefit rule requirement. ▪ One entity requested additional clarification on how the MSG segment identifying the Tiered Benefits relates to CORE-required data content specified in the draft rule requirement. Further, this entity requested to view examples of how tiered benefit information would be exchanged via draft rule requirement. ▪ Another entity sought clarification asking if the draft requirement is implicating multiple MSG segments across multiple loops. The entity noted that tiered benefit structures are complex and that operating rules should pursue the most structured and codifiable approach as possible.	In reference to how required tiered benefit information should communicated, it is recommended that operating rule implementers follow guidance from X12 RFI #1767. As the X12 v5010 270/271 does not currently address tiered benefits, implementers may have to use a combination of codifiable approaches and the MSG segment.
22.	One entity stated that when conveying tiered benefits, a simple in-network, out-of-network, exclusive/preferred will not suffice as in some plans there can be more than one in-network with different financials.	CAQH CORE Staff and Task Group Co-Chairs recognize that there are many complexities with tiered benefits and that the X12 v5010 270/271 transaction may not be able to communicate all variations via codifiable methods. As such, the draft rule requirement requires health plans to return all benefit tiers when a patient benefit tier cannot be determined for a provider.
23.	One entity commented that operating rules for tiered benefits should ensure that only information relevant to the requesting provider should be returned.	CAQH CORE can provide guidance within the operating rule on best practices pertaining to the return of information on a X12 271 response relevant to what is being requested via an explicit X12 270 inquiry.

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Eligibility & Benefits Task Group Next Steps

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Eligibility & Benefits Task Group Straw Poll #3

Straw Poll Objective: Indicate each EBTG Participating Organization's level of support and provide feedback on the DRAFT CAQH CORE Eligibility & Benefit Rule Update by section.

Straw Poll Overview:

- **Draft Rule:** Respondents will be asked to indicate support and provide feedback on the DRAFT CAQH CORE Eligibility & Benefit Rule Update, by section.

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 Wednesday, 09/09/21 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.

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Eligibility & Benefits Task Group

Next Steps

Eligibility & Benefits Task Group Participants

- Complete Straw Poll #3 by **Thursday, 09/09/21.**
- Participate in the next CAQH CORE EBTG Call on **Wednesday, 09/22/21 at 2:00 PM ET.**

CAQH CORE Staff & Co-chairs

- Draft a summary for today's call.
- Send Straw Poll #3 to EBTG Participants by **Thursday, 08/26/21.**
- Analyze Straw Poll #3 feedback and prepare results for **Wednesday, 09/22/21** call.

Contact CORE@caqh.org with any questions.

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Appendix A

Additional Reference Materials

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Today's Call Documents

Document Name
Doc 1: EBTG Call 4 Deck 08.04.21 Doc 2: EBTG Call 2 Summary 06.23.21

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

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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 rule options and 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
07/08/21 – 07/22/21	**EBTG Straw Poll #2: Draft Rule Requirements** ▪ Indicate level of support for draft 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
08/26/21 – 09/09/21	**EBTG Straw Poll #3: Draft Rule** ▪ Support for draft rule, by rule section
Wednesday, 09/22/21 2:00 pm to 3:30 pm ET	**EBTG Call #5** ▪ Review results of Straw Poll #3 ▪ Agree to adjustments, if applicable

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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	Diana Fuller	State of Michigan Medicaid
54	Chuck Veverka	State of Michigan Medicaid
55	Althea Robinson	Tata Consulting Services
56	Tracey Tillman	The SSI Group, Inc.
57	Danielle Couch	TriZetto Corporation, A Cognizant Company
58	Katherine Knapp	United States Department of Veterans Affairs
59	Pranav Shah	United States Department of Veterans Affairs
60	Kiran Kalluri	Unitedhealthcare
61	Brent Backhaus	Verata
62	Robert Tennant	WEDI

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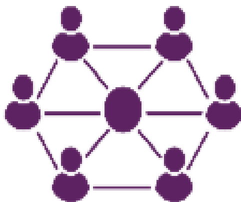
Eligibility & Benefits Task Group Participants

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.

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