Review Work Group

Call #1

October 3, 2024

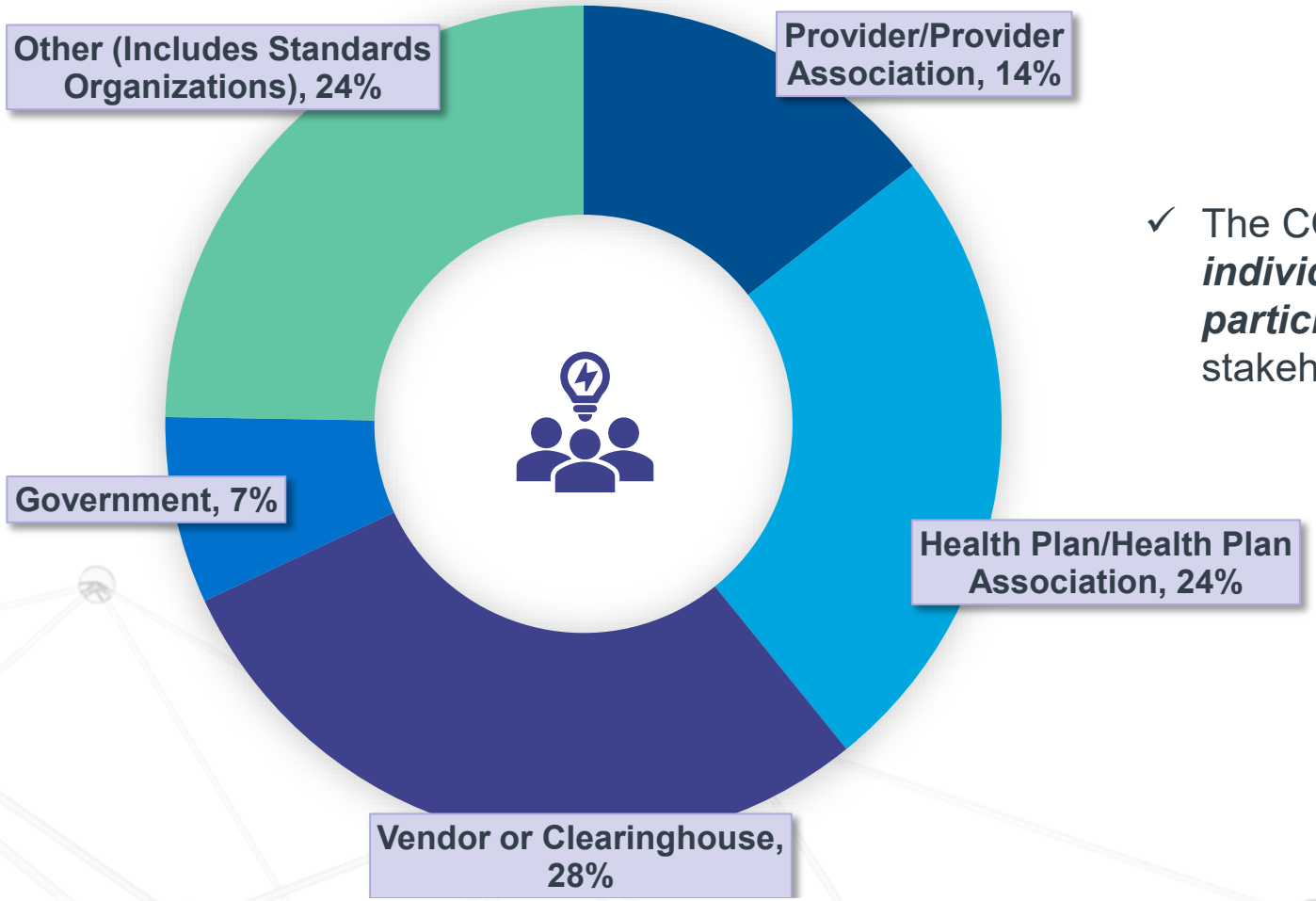
Eligibility & Benefits Data Content Rule Updates

Agenda

1. Review Work Group (RWG) Overview
2. Eligibility & Benefits Task Group (EBTG) Summary
3. Technical Requirements Overview
4. Next Steps

Review Work Group Overview

Review Work Group Stakeholder Breakdown



- ✓ The CORE Review Work Group (RWG) consists of ***51 individuals*** representing ***29 unique CORE participating organizations*** across a diverse set of stakeholder types.

1. Percentages may not add up to 100% due to rounding. A complete roster can be found at the end of the Next Steps section.

Responsibilities of The RWG

- **Become familiar with CORE Operating Rules work and processes**

- **Attend and actively participate in calls.**
  - Read materials ahead of time whenever possible.
    - CORE staff assist Work Group Co-chairs with drafting call documents and ensure they are made available on the CORE Participant Dashboard.
    - Call summaries are created after each call and approved by the participants.
- **Participate in straw polls, ballots and cast votes, as appropriate.**
  - Participating organizations may have any number of participants in the Work Group, but each organization has only **one** vote on straw polls and ballots.
- **Work with your organization's subject matter experts (SMEs), as appropriate. SMEs should have:**
  - Knowledge of their organization's capabilities with respect to the Eligibility & Benefits transaction (X12N 005010X279A1; the X12 270/271).
  - Understanding of how the potential draft rules would impact their organization and the industry, both in terms of feasibility to implement and value.
- **Provide regular updates on the Review Work Group's progress to Executive Sponsors.**
  - SMEs should regularly update their Executive Sponsors on the Work Group's progress to ensure larger organization buy-in of the drafted operating rule requirements and commitment to implementation.

Two Review Work Group Meetings and Polls

Event	Topic	Targeted Date
✓ **Call for Participants**	Sign-up period to join the Review Work Group.	Thursday, September 12th – Thursday, September 26th
❑ **RWG Call #1**	Introduce the Review Work Group and review a summary of updated draft rule requirements.	Thursday, October 3rd
❑ **Straw Poll #1**	Indicate support/non-support for requirements scoped for further evaluation.	Monday, October 7th – Friday October 18th
❑ **RWG Call #2**	Review results of Straw Poll #1 and level-set on Ballot.	Thursday, October 31st
❑ **RWG Ballot**	Indicate support/non-support for draft rule.	Monday, November 4th – Friday, November 15th
❑ **CORE Participant Vote**	Approve draft rule to move to CORE Board Vote.	Monday, November 25th – December 20th

We are here

The Road to Rule Finalization

CORE Body	CORE Requirements for Operating Rules Approval
Level 1: Subgroups & Task Groups	Formal vote is not required, but consensus is assessed via straw poll and must be achieved prior to moving to the next level of voting.
Level 2: Work Groups	***We are here*** Work Groups require for a quorum that 60% of all organizational participants are voting. Simple majority vote (greater than 50%) by this quorum is needed to approve a rule.
Level 3: Full Voting Membership	Full CORE Voting Membership vote requires for a quorum that 60% of all Full CORE Voting Member organizations (i.e., CORE Participants that create, transmit, or use transactions) vote on the proposed rule at this stage. With a quorum, a 66.67% approval vote is needed to approve a rule.
Level 4: CORE Board	The CORE Board's normal voting procedures would apply. If the Board does not approve any proposed Operating Rule, the Board will issue a memorandum setting forth the reasons it did not approve the proposed Operating Rule and will ask the CORE Subgroups and Work Groups to revisit the proposed Operating Rule.

Eligibility & Benefits Task Group Summary

Opportunities Addressed in Rule Development

The updated rule enhances care coordination, empowers decision making, and improves the flow of information across medication eligibility, dental benefits, and value-based care use cases.

Medication Eligibility

Empowers informed decision-making for medications covered under the medical benefit to match patients with the most effective treatment options, resulting in better health outcomes and reduced care delays.

Dental Benefits

Enhances dental care coordination through granular benefit details, ensuring appropriate and timely services.

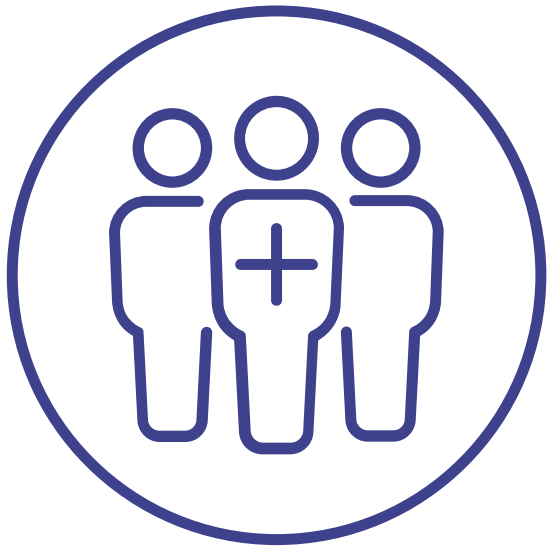
Value-based Care

Enables providers to understand patient participation in VBC models at the point of care, streamlining care coordination and optimizing financial and quality outcomes.

Rule updates were developed in collaboration with the American Dental Association (ADA), National Dental EDI Counsel (NDEDIC), and National Council for Prescription Drug Programs (NCPDP)

Summary of EBTG-Supported Requirements to Review

General Updates	Medication Eligibility	Dental Benefits	Value-Based Care
1. Electronic Policy Access of Required Information. 2. Methodology for tracking required Eligibility & Benefit Service Type Codes. 3. Expanded procedure codes. 4. Expanded Categories of Service (COS). 5. Expanded Service Type Codes (STCs).	6. Specifying Formulary Accessibility and Alternative Information. 7. Cross-Benefit Workflow Routing.	8. Specifying Dental Benefit Limitations. 9. Cross-Benefit Workflow Routing.	10. Bundled Payment & Episode of Care requirements.



Technical Requirements Overview

General Update Takeaways

Goals of the Requirements:

1. Support explicit, procedure code-level inquiries for the care that patients and providers seek information about.
2. The complementary document outlining STCs is accessible, clear, and formatted in a helpful manner for health plan developers.

Ask of RWG Participants:

- Review the proposed methodology for:
  - Accessing COS, procedure codes, and STCs that support procedure code-level inquiries.
  - Communicating health plan-specific policies.

Considerations:

- Will patients and providers benefit from proposed updates?
- What is the lift of remediation for health plans or vendors implementing the proposed updates?

General Updates At-a-Glance

Existing CORE Eligibility and Benefits Operating Rule Requirements

- ✓ Support explicit inquiry of procedure codes (CPT, HCPCS) for CORE-defined Categories of Service:
  1. Surgery
  2. Physical Therapy
  3. Occupational Therapy
  4. Imaging
- ✓ Tiered benefit structure
- ✓ Specification of maximum benefits
- ✓ Patient financial responsibility
- ✓ Prior authorization requirements
- ✓ Telehealth requirements
- ✓ Name normalization requirements
- ✓ Standardized error-reporting
- ✓ Discretionary and mandatory service-type codes

New General Requirements from the EBTG

Electronic Policy Access of Required Information

- Plan-specific policies are accessible online
- Machine-readable COS to procedure code mapping

Methodology for tracking required Eligibility & Benefit STCs

- Complementary document for STC tables

A complete list of proposed, updated procedure codes, COS, and STCs to support explicit inquiries is included in this presentation

Medication Eligibility Takeaways

Goals of the Requirements:

1. Information for medications covered under the medical benefit is available to providers upon request.
2. Formulary alternative information for medications covered under the medical benefit is available to providers upon request.
3. When drug coverage is unavailable under one benefit plan but may exist under a different plan, health plans and providers identify and communicate the proper coverage information.

Ask of RWG Participants:

- Review the proposed methodology for:
  - Indicating the formulary alternative for the requested drug.
  - Identifying the appropriate, existing insurance to submit an eligibility inquiry.

Considerations:

- Are the responsibilities of the health plan and inquiring provider in the inquiry and response process correct?
- Who are the different parties to collaborate with when implementing these requirements?

Medication Eligibility Opportunity At-a-Glance

Existing CORE Eligibility and Benefits Operating Rule Requirements

- ✓ Support explicit inquiry of procedure codes (CPT, HCPCS) for CORE-defined Categories of Service:
  1. Surgery
  2. Physical Therapy
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- ✓ Tiered benefit structure
- ✓ Specification of maximum benefits
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New Medication Eligibility Requirements from the EBTG

To Support Explicit Medication Inquiries:

Expanded Code Sets:

1. HCPCS (including J-Codes)
2. National Drug Codes (NDC)
3. CPT

Expanded Categories of Service:

1. Chemotherapy
2. Injectables
3. Infusions
4. Oncology
5. Pain Management
6. Biologics
7. Compound drugs
8. Inhalations
9. Nephrology
10. Immunosuppressives
11. Antibiotics
12. Hormone Therapy
13. Antiemetics

Specifying Formulary Accessibility and Alternative Information:

- Drug formulary alternative indicator

Cross-Benefit Workflow Routing:

- Non-coverage indicator
- Return existing plan information
- Resubmit inquiry with updated information

1) 2 additional STCs approved for remaining coverage benefits

Dental Benefits Takeaways

Goals of the Requirements:

1. In addition to currently-required information, dental benefit-specific information is available to providers upon request.
2. When dental coverage is unavailable under one benefit plan but may exist under a different plan, health plans and providers identify and communicate the proper coverage information.

Ask of RWG Participants:

- Review the proposed methodology for:
  - Specifying dental benefit limitations, including:
    - Frequency limitations
    - Waiting periods
    - Age limitations
  - Identifying the appropriate, existing insurance to submit an eligibility inquiry.

Considerations:

- Who are the different parties to collaborate with when implementing these requirements?
- Will a health or dental plan have enough information to process the eligibility inquiry?

Dental Benefits Opportunity At-a-Glance

Existing CORE Eligibility and Benefits Operating Rule Requirements

- ✓ Support explicit inquiry of procedure codes (CPT, HCPCS) for CORE-defined Categories of Service:
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- ✓ Tiered benefit structure
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- ✓ Prior authorization requirements
- ✓ Telehealth requirements
- ✓ Name normalization requirements
- ✓ Standardized error-reporting
- ✓ Discretionary and mandatory service-type codes

New Dental Requirements from the EBTG

To Support Explicit Dental Inquiries:

Expanded Code Sets:

1. Current Dental Terminology (CDT)
2. HCPCS
3. CPT

Expanded Categories of Service

1. Oral and Maxillofacial Surgery
2. Implant Services
3. Diagnostic
4. Endodontics
5. Fixed Prosthetics
6. Orthodontics
7. Periodontics
8. Radiology
9. Preventative
10. Prosthodontics
11. Restorative
12. Specialty Procedures

Specifying Dental Benefit Limitations:

- Frequency indicator
- Waiting period indicator
- Age limitation indicator

Cross-Benefit Workflow Routing:

- Non-coverage indicator
- Return existing plan information
- Resubmit inquiry with updated information

1) 18 additional STCs approved for remaining coverage benefits

Value-based Care Takeaways

Goals of the Requirements:

1. Clearly share when an encounter may be aligned with the terms of a value-based program, allowing providers to easily fulfill non-care related contractual requirements.
2. Allow providers to request detailed benefit information by leveraging relevant diagnostic and procedure codes.

Proposed requirements must be approved "all or nothing" by the RWG

Ask of RWG Participants:

- Review the proposed approach for indicating that an inquiry may be tied to a value-based bundled payment/episode of care by providing the following information:
  - Indicating that queried service is an 'episode'.
  - Providing bundled payment amounts (target prices).
  - Showing the period, in days, an episode lasts.
  - Returning VBC program details using standard text.

Considerations:

- What other information would need to be delivered via the 271 Response to convey to the provider that the services are part of a VBC contract?

Value-based Care Opportunity At-a-Glance

Existing CORE Eligibility and Benefits Operating Rule Requirements

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New Value-based Care Requirements from the EBTG

To Support Explicit Inquiries Including for VBC:

Expanded Code Sets:	*Expanded Categories of Service:*
1. ICD-10-PCS	1. Internal Medicine 2. Primary Care 3. Maternal Health 4. Renal Care

Bundled Payment & Episode of Care:

- Indication that coverage for a service aligns to a bundled payment/episode of care VBC contract.
- Contracted target price which participant financial performance is measured against.
- Amount of time/duration in days an episode lasts (e.g., 90 days following service delivery).
- Detailed information about the episode using standard text.

Code Set Updates At-a-Glance

New Requirements from EBTG

Expansion of the Procedure Codes, COS, and STCs to Support Explicit Eligibility Inquiries Includes:

Procedure Code Sets:

1. HCPCS (including J-Codes)
2. National Drug Codes (NDC)
3. Current Dental Terminology (CDT)
4. ICD-10-PCS

Categories of Service:

1. Chemotherapy
2. Injectables
3. Infusions
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8. Inhalations
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10. Immunosuppressives
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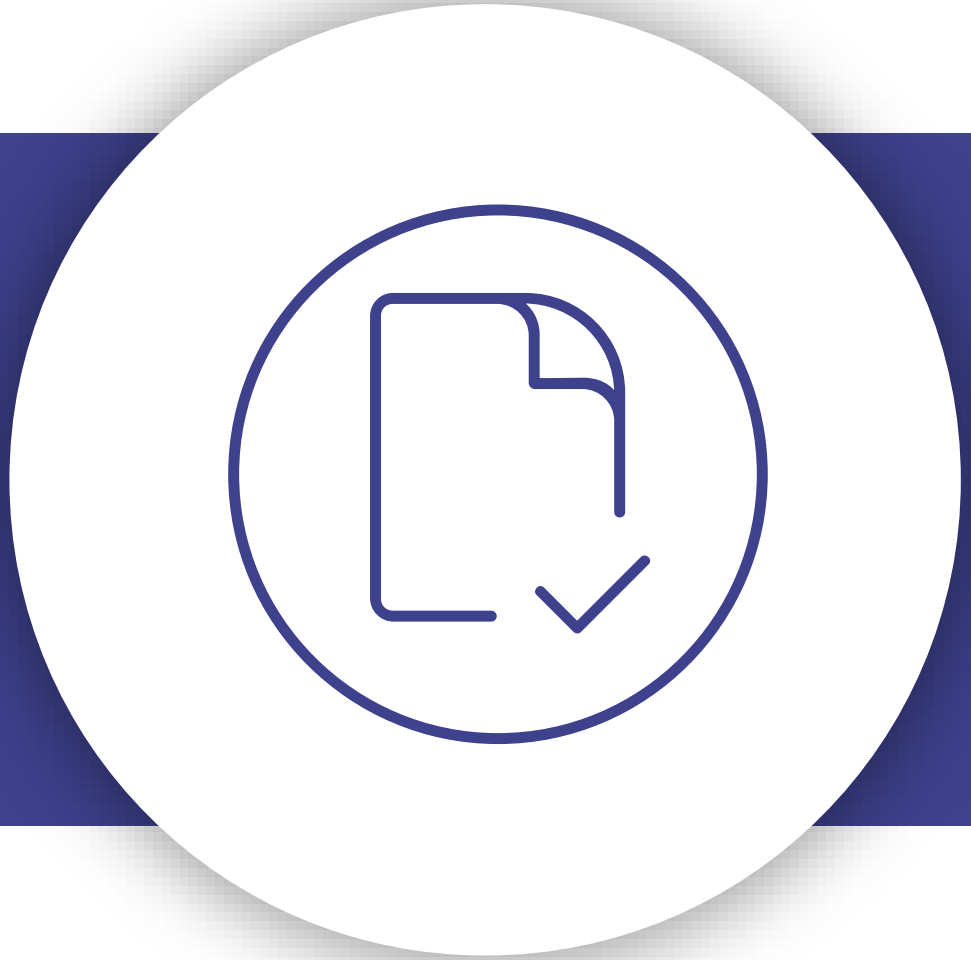
12. Hormone Therapy
13. Antiemetics
14. Oral and Maxillofacial Surgery
15. Implant Services
16. Diagnostic
17. Endodontics
18. Fixed Prosthetics
19. Orthodontics
20. Periodontics
21. Radiology
22. Preventative
23. Prosthodontics
24. Restorative
25. Specialty Procedures
26. Internal Medicine
27. Primary Care
28. Maternal Health
29. Renal Care

Service Type Codes:

1. 88 – Pharmacy
2. AR – Experimental Drug Therapy
3. 4 – Diagnostic X-Ray
4. 38 – Orthodontics
5. 24 – Periodontics
6. 41 – Routine Preventive Dental
7. 26 – Endodontics
8. 36 – Dental Crowns
9. 40 – Oral Surgery
10. 23 – Diagnostic Dental
11. 25 – Restorative
12. 27 – Maxillofacial Prosthetics
13. 8 – Surgical Assistance
14. 37 – Dental Accident
15. 35 – Dental Care
16. 39 – Prosthodontics
17. 86 – Emergency Services
18. 28 – Adjunctive Dental Services
19. 7 – Anesthesia
20. 51 – Hospital – Emergency Accident



Next Steps

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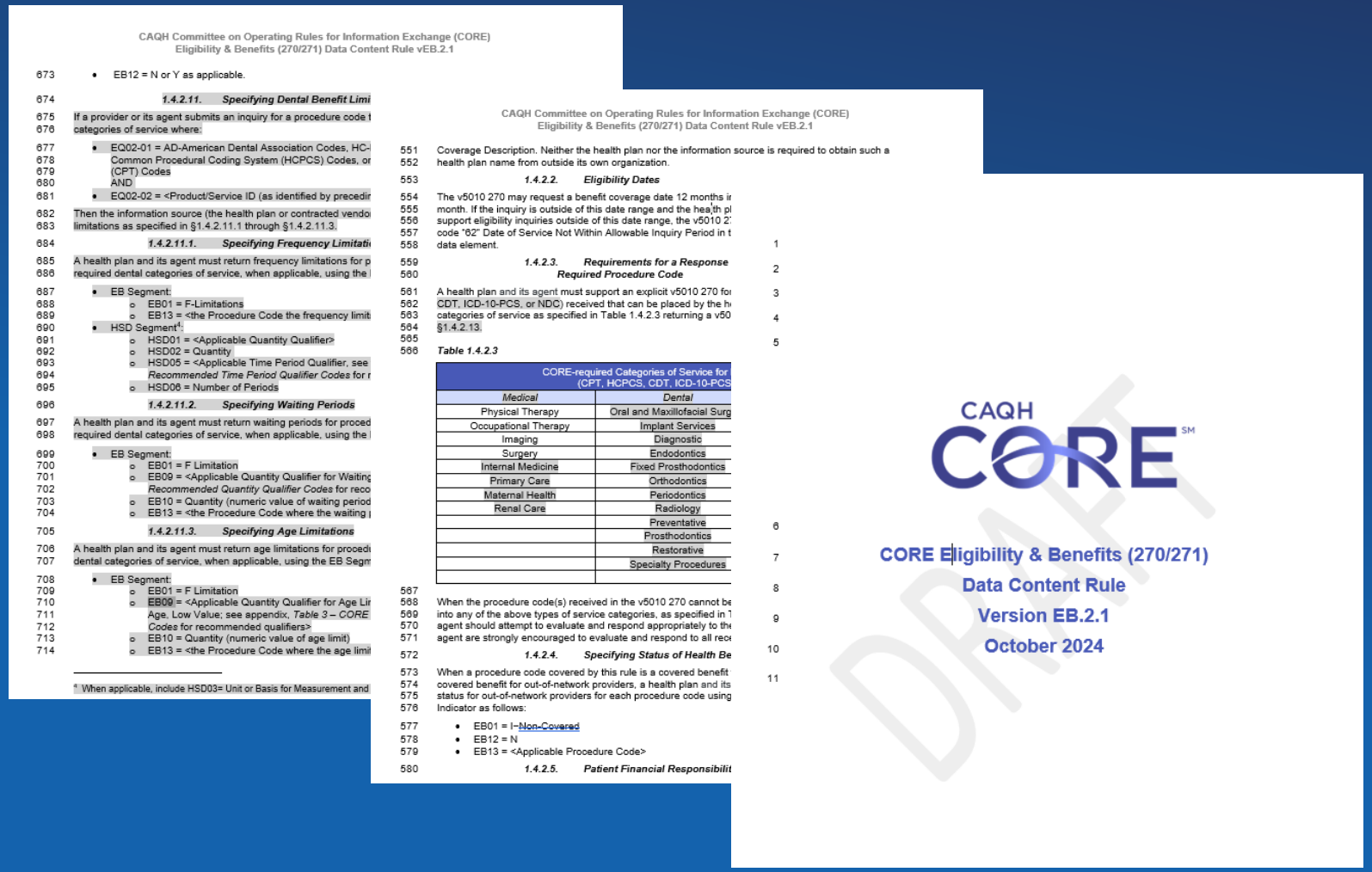
Draft Operating Rule Format



CAQH Committee on Operating Rules for Information Exchange (CORE)
Eligibility & Benefits (270/271) Data Content Rule vEB.2.1

673 • EB12 = N or Y as applicable.

674 ***1.4.2.11. Specifying Dental Benefit Limi***

675 If a provider or its agent submits an inquiry for a procedure code t
676 categories of service where:

677 • EQ02-01 = AD-American Dental Association Codes, HC-
678 Common Procedural Coding System (HCPCS) Codes, or
679 (CPT) Codes
680 AND
681 • EQ02-02 = <Product/Service ID (as identified by precedir

682 Then the information source (the health plan or contracted vendo
683 limitations as specified in §1.4.2.11.1 through §1.4.2.11.3.

684 ***1.4.2.11.1. Specifying Frequency Limitati***

685 A health plan and its agent must return frequency limitations for p
686 required dental categories of service, when applicable, using the

687 • EB Segment:
688 o EB01 = F-Limitations
689 o EB13 = <the Procedure Code the frequency limit
690 • HSD Segment[1]:
691 o HSD01 = <Applicable Quantity Qualifier>
692 o HSD02 = Quantity
693 o HSD05 = <Applicable Time Period Qualifier, see
694 *Recommended Time Period Qualifier Codes* for r
695 o HSD06 = Number of Periods

696 ***1.4.2.11.2. Specifying Waiting Periods***

697 A health plan and its agent must return waiting periods for proced
698 required dental categories of service, when applicable, using the

699 • EB Segment:
700 o EB01 = F Limitation
701 o EB09 = <Applicable Quantity Qualifier for Waiting
702 *Recommended Quantity Qualifier Codes* for reco
703 o EB10 = Quantity (numeric value of waiting period
704 o EB13 = <the Procedure Code where the waiting

705 ***1.4.2.11.3. Specifying Age Limitations***

706 A health plan and its agent must return age limitations for proced
707 dental categories of service, when applicable, using the EB Segm

708 • EB Segment:
709 o EB01 = F Limitation
710 o EB09 = <Applicable Quantity Qualifier for Age Lir
711 Age, Low Value; see appendix, *Table 3 – CORE*
712 *Codes* for recommended qualifiers>
713 o EB10 = Quantity (numeric value of age limit)
714 o EB13 = <the Procedure Code where the age limi

[1] When applicable, include HSD03= Unit or Basis for Measurement and

CAQH Committee on Operating Rules for Information Exchange (CORE)
Eligibility & Benefits (270/271) Data Content Rule vEB.2.1

551 Coverage Description. Neither the health plan nor the information source is required to obtain such a
552 health plan name from outside its own organization.

553 ***1.4.2.2. Eligibility Dates***

554 The v5010 270 may request a benefit coverage date 12 months i
555 month. If the inquiry is outside of this date range and the hea th pl
556 support eligibility inquiries outside of this date range, the v5010 2
557 code "62" Date of Service Not Within Allowable Inquiry Period in t
558 data element.

559 ***1.4.2.3. Requirements for a Response***
560 ***Required Procedure Code***

561 A health plan and its agent must support an explicit v5010 270 fo
562 CDT, ICD-10-PCS, or NDC) received that can be placed by the h
563 categories of service as specified in Table 1.4.2.3 returning a v50
564 §1.4.2.13.
565
566 ***Table 1.4.2.3***

CORE-required Categories of Service for (CPT, HCPCS, CDT, ICD-10-PCS	
Medical	*Dental*
Physical Therapy	Oral and Maxillofacial Surg
Occupational Therapy	Implant Services
Imaging	Diagnostic
Surgery	Endodontics
Internal Medicine	Fixed Prosthodontics
Primary Care	Orthodontics
Maternal Health	Periodontics
Renal Care	Radiology
	Preventative
	Prosthodontics
	Restorative
	Specialty Procedures

567
568 When the procedure code(s) received in the v5010 270 cannot be
569 into any of the above types of service categories, as specified in T
570 agent should attempt to evaluate and respond appropriately to the
571 agent are strongly encouraged to evaluate and respond to all rece

572 ***1.4.2.4. Specifying Status of Health Be***

573 When a procedure code covered by this rule is a covered benefit
574 covered benefit for out-of-network providers, a health plan and its
575 status for out-of-network providers for each procedure code using
576 Indicator as follows:

577 • EB01 = I–Non-Covered
578 • EB12 = N
579 • EB13 = <Applicable Procedure Code>

580 ***1.4.2.5. Patient Financial Responsibilit***

CAQH CORE℠

CORE Eligibility & Benefits (270/271)
Data Content Rule
Version EB.2.1
October 2024

DRAFT

- ***Grey highlights indicate NEW content***
- ***Line numbers included for ease of reference***

Next Steps

RWG Roster

Name	Organization
Nancy Senato	Aetna
Rebekah Fiehn	American Dental Association
Heather McComas	American Medical Association
Tyler Scheid	American Medical Association
Emma Andelson	American Medical Association
Paul Chupp	Ameritas
Noah Mastel	Ameritas
Noami Miao	athenahealth
Evi Russo	athenahealth
Leah Barber	Availity
Kimberly Konyshak	Availity
Sharon Nichols	Availity
Cindy Monarch	BCBS Michigan
Sudheer Tummala	BCBS North Carolina
Gail Kocher	Blue Cross Blue Shield Association

Name	Organization
Meredith Ray	Cigna
Kristin Tahai	Cigna
Ana Isabella	Cigna
Rupinder Singh	CMS
Lorraine Doo	CMS
Paula Smith	CMS
Charlene Parks	CMS
Angelo Pardo	CMS
Daniel Saunders	Cognosante
Rob Sikorski	DaVita
Gloria Beazley	DaVita
BreAnne Davenport	DaVita
Kristin Leasiolagi	DaVita
Kena Gwinn	Elevance Health
Olga Khabinskay	HBMA
Maggie Brown	HealthEdge
Christopher Gracon	Healthenet
Sima Gandhi	Lassie
Suzanne Droste	Mayo Clinic

Name	Organization
Charles Veverka	Michigan Medicaid
Nancy Hyde	Michigan Medicaid
Diana Fuller	Michigan Medicaid
Charles Hawley	NAHDO
Margaret Weiker	NCPDP
Sandra Garnand	NCPDP
Kristina Steece	NDEDIC
Tonia Bateman	New Mexico Cancer Center
Marina Collins	Optum
Lorna Bradley	Sekhmet Advisors
Shannon Kennedy	Sekhmet Advisors
Nick Radov	Stedi, Inc.
Althea Robinson	TCS
Tammy Vicari	TCS
Maria Lagoutis	UHC
Jason Large	UHC
Sonya May	UHC