CORE Review Work Group

Call #2

October 31, 2024

CAQH CORE℠

October 31st

Introduction • Dashboard Reminder • Timeline Review	Tanner Fuchs, CORE
Straw Poll #1 Results • Support Levels • Comments	Donna Campbell, HCSC Margaret Schuler, Aspen Dental Pete Benziger, CORE Michael Phillips, CORE Bob Bowman, CORE
Next Steps	Donna Campbell, HCSC Pete Benziger, CORE

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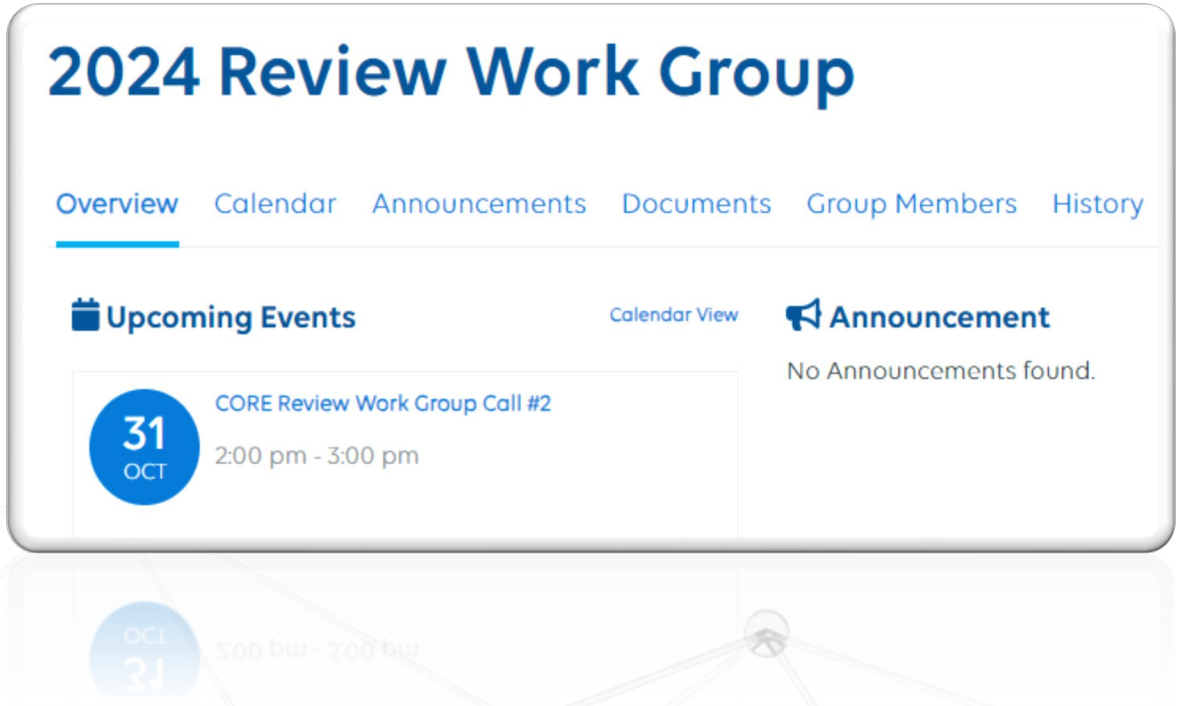
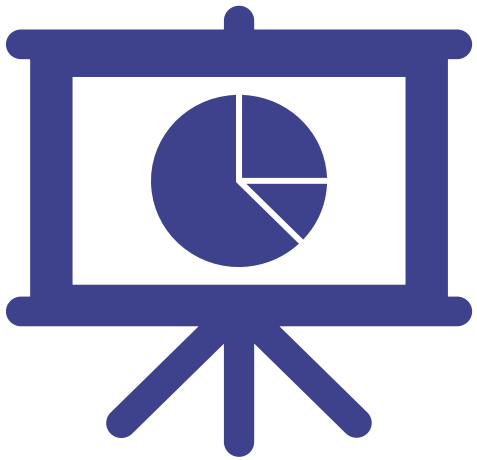
CORE Participant Dashboard



- **The dashboard is accessible only to CORE Participants.**
- Participants can view the work groups they are currently involved in and add themselves to new groups.
- Participants can view upcoming events, documents, announcements, and group member information.
- Email core@caqh.org if you need a login.

Review Work Group Timeline

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 the RWG 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



Straw Poll #1 Results

RWG Straw Poll #1 Responses

Total Number of Organizational Responses	20
Other Stakeholder Type Responses (includes SDOs)	**20%**
Provider/Provider Association Responses	**25%**
Vendor/Clearinghouse Responses	**15%**
Health Plan/Health Plan Association Responses	**30%**
Government Responses	**10%**

***Number of RWG Participating Organizations: 31**

Summary of Polled Requirements

Requirements Evaluated On RWG Straw Poll #1	
Question #	**Section A. General Update Requirements**
1-2	Electronic Policy Access of Required Information
3-4	Methodology for Tracking Required Eligibility & Benefit Service Type Codes and Categories of Service
	Section B. Medication Benefits
5-6	Specifying Formulary Accessibility and Alternative Information
7-10	Cross-Benefit Workflow Routing
	Section C. Dental Benefits
11-12	Triggering an Eligibility Inquiry
13-18	Specifying Dental Benefit Limitations (frequency, waiting period, and age limitations)
19-22	Cross-Benefit Workflow Routing
	Section D. Value-based Care
23-24	Indication and Coverage Information for Bundled Payment & Episode of Care Requirements

Straw Poll Comment Categorization

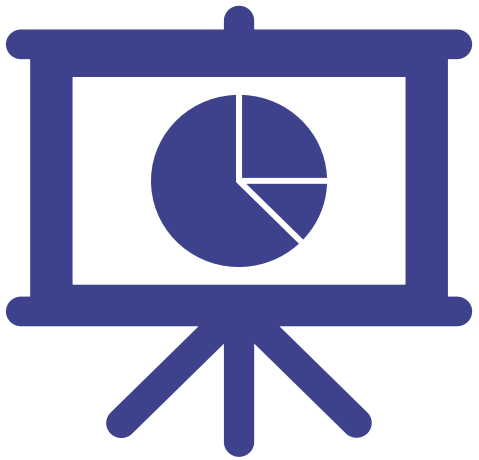
Comments received on the Review Work Group Straw Poll #1 were grouped into three categories:

1. **Substantive Comments:** May impact rule requirements; some comments require Work Group discussion on potential adjustments to the draft requirements.

2. **Points of Clarification:** Pertain to areas where more explanation for the Work Group is required; may require adjustments to the rule which do not change rule requirements.

3. **Non-substantive Comments:** Pertain to typographical/grammatical errors, wordsmithing, clarifying language, addition of references; do not impact rule requirements.

The Review Work Group will discuss substantive comments, points of clarification and co-chair and staff recommendations.



Section A. General Update Requirements

Question 1: Electronic Policy Access of Required Information

Question on Straw Poll	Support Level	Polling %
1. The Eligibility & Benefits Task Group approved a requirement to place policy information online in an easily accessible format and location. CORE often references this as "Electronic Policy Access of Required Information." Below is the draft requirement language to meet this goal (lines 820-822 of the draft rule): *Health plans and their agents must make these data requirements easily accessible to submitters of an eligibility and benefits inquiry, either on the plan website or in the transaction-specific companion guide.*	**Support as Written**	90%
	Support With Edits	5%
	Do Not Support This Function	5%

1. Support level totals may not perfectly align (e.g. add up to 100% exactly) due to rounding.

Question 2: Electronic Policy Access of Required Information Comments

#	Substantive	Co-chair and CORE Response
1.	A commenter requested clarification, stating it seems this requirement could be fulfilled by posting the information in sections 1.6 and 1.6.2.	**Agree**. Health plans and their agents are required to post ALL data requirements - not just those applying to the cross-benefit section - in the transaction specific companion guide or onto their website. The purpose of this requirement is to promote transparency and consistency in how the E&B transaction is conducted. CORE will edit the section to ensure the requirement and what it applies to is stated clearly.
#	**Point of Clarification**	**Co-chair and CORE Response**
2.	A respondent stated they are not prepared to support expanded procedure code requirements and suggests changing the language to "plan supported data requirements easily accessible to submitters."	The current version of the CORE Eligibility and Benefits Operating Rule (vEB.2.0) requires health plans and their agents to support select procedure codes, including CPT and HCPCS, for CORE-defined Categories of Service. This update requires the support of additional categories of service and procedure codes.

Question 3: Methodology for Tracking Required Eligibility & Benefit Service Type Codes and Categories of Service

Question on Straw Poll	Support Level	Polling %
3. The current Eligibility & Benefits Data Content Rule includes an appendix with a master table of Service Type Codes and health plan response requirements (see section *5.1. Eligibility & Benefits CORE Service Type Codes* in the current rule). The proposal separates the appendix and creates a unique, complementary document for this information. The intention is to make the information easier to access. Please indicate your organization's level of support for separating the Service Type Code table from the operating rule (see section *5.1. Eligibility & Benefits CORE Service Type Codes* in the current rule) and creating a unique, complementary document (see *DRAFT Appendix, Table 1* in the Participant Dashboard for an example of the proposed organization).	**Support as Written**	71%
	Support With Edits	24%
	Do Not Support This Function	6%

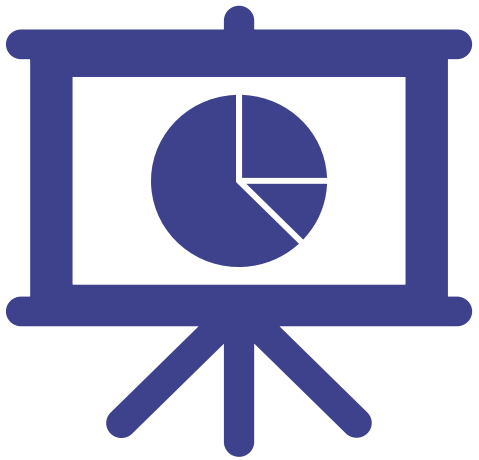
1. Support level totals may not perfectly align (e.g. add up to 100% exactly) due to rounding.

Question 4: Methodology for Tracking Required Eligibility & Benefit Service Type Codes and Categories of Service Comments

#	Point of Clarification	Co-chair and CORE Response
1.	A commenter requested additional context to support interpretation of the table be added to the rule; first, to clarify the purpose of the column "Service Type Codes Required for Remaining Coverage Benefits," and second, to clarify the meanings of "mandatory" and "discretionary" return of patient financial responsibility information.	First - the referenced column is in vEB.2.0's STC table and indicates the STCs for which remaining coverage benefits are required in the 271 response. Second - mandatory STCs must support return of patient financial information by a health plan and its agent. Discretionary STCs, as the name implies, can be supported at the discretion of the health plan and its agent. However, section 1.3.2.5 in vEB.2.0 of the rule outlines certain datapoints that are not discretionary. CORE will reference this detail in the final version of the appendix document.
2.	A commenter supported the separate document but does not agree that remaining coverage benefits should be returned for all the items with a designation of Service Type Code (STC).	The expansion of mandatory STCs for remaining benefits was discussed and agreed upon by the EBTG. If remaining benefits are not applicable to the STC inquiry, the information does not have to be returned. Supporting this exchange, however, enhances transparency and consistency in the conduct of the E&B transaction.

(Continued) Question 4: Methodology for Tracking Required Eligibility & Benefit Service Type Codes and Categories of Service Comments

#	Point of Clarification	Co-chair and CORE Response
3.	A commenter agreed with putting STCs in a separate document as long as they remain unmodified.	The STC codes included in the companion document remain unmodified from the STCs in the X12 270/271 TR3. The CORE Eligibility and Benefits Operating Rule designates STCs as mandatory or discretionary. For those labeled as mandatory, a health plan and its agent must return all benefit information in the X12 271 response, as applicable.
4.	Three organizations shared risks of separating the appendix and STC table from the E&B rule and presented alternative options.	The appendix will be directly linked to the updated E&B rule in an obvious manner to reduce any risk of confusion and simplify future updates.
5.	A commenter supports the external STC list, but questions why STCs 21, 22, 85, BA, BJ, BM, BP & BQ are not included on the list when they are indicated in the v5010 TR3.	Any STC code not included in the CORE Eligibility and Benefits Operating Rule was not supported for inclusion by CORE Participants during past rule development. The expansion of STCs was not considered as part of this rule development cycle. The STCs indicated by the commenter may be supported at the discretion of the health plan and its agents in line with the X12 v5010 TR3 requirements.



Section B. Medication Eligibility Requirements

Question 5: Specifying Formulary Accessibility and Alternative Info.

Question on Straw Poll	Support Level	Polling %
5. The Eligibility & Benefits Task Group approved a requirement to communicate formulary alternatives for drugs inquired upon for medication covered under the medical benefit. Below is the proposed methodology and draft requirement language to meet this goal (lines 709-732 of the draft rule): *When the X12 v5010 270 includes a CORE-required procedure code for medication categories of service, and it is determined that a formulary alternative is available, the health plan, PBM, or its agent must return alternative formulary information in the X12 v5010 271 using the EB and REF Segments in Loop 2110C/2110D as follows:* *EB Segment: Return specific benefit information for the alternative drug per CORE rule requirements in §1.4.* *AND* *REF Segment:* *REF01 = ALS-Alternative List ID* *REF02 = <Alternative Drug Formulary ID>* *REF03 = <Title of Alternative List>* *If known, the health plan, PBM, or its agent must repeat the REF segments in Loop 2110C/D to communicate the drug formulary number as follows:* *REF Segment:* *REF01 = FO-Drug Formulary Number* *REF02 = <Drug Formulary Number>* *REF03 = <National Drug Code in 5-4-2 format for the drug in REF02>* *If known, the health plan, PBM, or its agent must repeat the REF segments in Loop 2110C/D to communicate coverage limitations as follows:* *REF Segment:* *REF01 = CLI-Coverage List ID* *REF02 = <Coverage List ID>* *REF03 = <Title of Coverage List>*	**Support as Written**	60%
	Support With Edits	0%
	Do Not Support This Function	40%

1. Support level totals may not perfectly align (e.g. add up to 100% exactly) due to rounding.

Question 6: Specifying Formulary Accessibility and Alternative Information Comments

#	Point of Clarification	Co-chair and CORE Response
1.	A commenter states that implementing formulary alternatives would require significant effort and investment.	EBTG Participants reached consensus for the inclusion of these requirements. In development, resources relative to industry benefit were considered and discussed. Participants are welcome to submit estimates to further quantify the impact of implementation.
2.	A commenter stated that the REF01 data element may only be used once per code value in the 2110C/D loops and cannot be repeated.	The draft CORE Operating Rule does not indicate how many times the 2110C/D loop must be returned or REF must be repeated to fulfill the requirements. Consistent with the TR3, the 2110C/D loops may be returned >1 times to accommodate multiple alternatives. Non-substantive language edits will be made to ensure this is clear without restating the contents of the TR3.
3.	A commenter pointed out that the NDC format must be presented in the transaction with no dashes. The commenter further goes on to say that even if this information is included, they cannot control provider behavior.	NDC codes are to be returned within the capability and format indicated in the v5010 TR3.

(Continued) Question 6: Specifying Formulary Accessibility and Alternative Information Comments

#	Point of Clarification	Co-chair and CORE Response
4.	A commenter expressed non-support for this requirement, highlighting that alternatives would be too large to send through the 271 REF segment; that the proposed requirement does not account for proposed 6-4-2 NDC formatting; that a health plan should not be responsible to return carved-out pharmacy benefits; and that the full clinical picture cannot be taken into account and we must be cautious that the payer not be seen as influencing clinical decision-making.	1. The draft language does not indicate how a health plan must fulfill this requirement, and health plans and their agents may choose to send one or multiple alternatives in the response in line with their policies and the capability of the transaction. 2. Language can be generalized to ensure the CORE Operating Rule is not impacted by necessary changes to the number of digits in the NDC codes. 3. A health plan and its agent is only responsible for the return of this information when it is known/available. If administered externally and unknown to the responsible health plan, then it would not have to be returned. With this understood, cross-benefit coverage is contemplated in the draft rule language to streamline how this information would be discovered and included. 4. It is not the role of the health plan and its agents to make treatment decisions. This requirement is in place to inform the provider of alternatives. Providers are expected to exercise best practice clinical decision-making to match the patient with the best treatment possible; even if this involves choosing higher cost treatments.

(Continued) Question 6: Specifying Formulary Accessibility and Alternative Information Comments

#	Point of Clarification	Co-chair and CORE Response
5.	A commenter considers this requirement cumbersome and may limit timely responses. Though ok with the first part of the requirement, they state other parts cause concern.	The commenter is invited to share, in detail, what parts are cumbersome or concerning. The CORE Operating Rule does not indicate how this requirement must be accomplished. It is expected that as health plans and their agents remediate their system, they will do so in a way that maintains timely and actionable responses.

Question 7: Cross-Benefit Workflow Routing

Question on Straw Poll	Support Level	Polling %
7. The Eligibility & Benefits Task Group **approved** a requirement for the instance where an eligibility inquiry submitter should be querying a patient's medical benefits, and not pharmacy benefits, or vice versa. The initially inquired upon health or pharmacy plan must return the appropriate plan information for the coverage inquiry. CORE named this process "Cross-Benefit Workflow Routing." Below is the draft requirement language to meet this goal for medication covered under the medical benefit (lines 783-803 of the draft rule): *This section specifies the required process for routing between benefit plans when an initial response indicates that coverage is not available by the inquired plan.* ○ *When a medication is covered under a different benefit plan (e.g., medical instead of pharmacy, or vice versa), the following requirements apply:* ▪ *A health plan, pharmacy benefit manager (PBM), or its agent (information source) must:* • *Indicate that the medication is not covered under the initial benefit.* • *AND* • *If known, identify and communicate the name of the benefit plan where coverage may exist (i.e. the name of the medical plan or the pharmacy plan) in the response using the appropriate standard (i.e. X12 v5010 271 for medical benefits, NCPDP Telecommunication Standard and the NCPDP Real-Time Prescription Benefit Standard for pharmacy benefits).* ▪ *A provider or its agent (information receiver) must:* • *Upon receipt of a non-covered response, use relevant information from the initial inquiry and response (e.g., procedure code, provider information, cross-benefit plan name, etc.) to trigger a cross-benefit inquiry and transmit it using the appropriate standard (X12 v5010 270 for medical benefit, NCPDP Telecommunication Standard and the NCPDP Real-Time Prescription Benefit Standard for pharmacy benefits).*	**Support as Written**	54%
	Support With Edits	15%
	Do Not Support This Function	31%

1. Support level totals may not perfectly align (e.g. add up to 100% exactly) due to rounding.

Question 8: Cross-Benefit Workflow Routing Comments

#	Substantive	Co-chair and CORE Response
1.	A commenter suggested additional specificity for this requirement. Notably, populating EB01 with "U" (loops 2110C/D) and putting the other plan ID in NM109 (loops 2120C/D). Without a specific payer ID, the commenter fears it would be too difficult for providers to figure out where to send the second request.	**For Discussion**. Given the newness of this requirement, it is expected it will be completed in various ways and that it is too early to decide on and codify a single best practice. CORE works with entities to understand implementation variation and will act to update rule requirements, as necessary.

(Continued) Question 8: Cross-Benefit Workflow Routing Comments

#	Point of Clarification	Co-chair and CORE Response
2.	A commenter asked if the draft language requires the use of non-mandated standards. The commenter referenced the NCPDP Real-time Prescription Benefit Standard.	The RTPB standard is mandated for use beginning 1/1/27 for Part D sponsor.[1] It is the expectation that where other standards exist and are implemented, either voluntary or mandated, that they will be used to support this workflow. CORE liaised with NCPDP to ensure consistency of references.
3.	A commenter stated that they support the return of alternatives using the transaction; however, if the provider requires specific information about medication coverage, they can use the member ID card to contact the PBM directly.	The intent of this requirement is to automate the return of cross-benefit coverage information. Despite requiring the submission of additional details using the transaction, it effectively avoids providers and their staff spending administrative time on phone calls. This workflow helps ensure a speedier, consistent process.

1. eRx-Standards-Final-Rule-v0-PR.pdf

(Continued) Question 8: Cross-Benefit Workflow Routing Comments

#	Point of Clarification	Co-chair and CORE Response
4.	A commenter believes that the requirements create new workflows for providers and do not fit cleanly into existing workflows. They also fear that an inability to meet these requirements - resulting from varying technical capabilities - would result in being labeled as non-compliant. The commenter further believes that the NCPDP RTB may be too immature to support this workflow.	These are the steps that providers must take if they would like automate inquiries for cross-benefit coverage. They are not required to undertake these steps, but industry scanning suggested they are beneficial to workflows. Inclusion of this requirement ensures that provider-facing health IT has the capability to support these functions and that health plans and their agents are capable of returning the required information. The NCPDP standards are capable of returning this information and implementation maturity is supported by federal mandate.
5.	Two commenters stated that they do not currently support necessary functionality to fulfill these requirements. This ranges from not returning pharmacy under the medical benefit to not support procedure codes.	It is expected that to meet these requirements, health plans and their agents must undertake system remediation. Participants are welcome to submit information about the impact of these requirements relative to the investment.

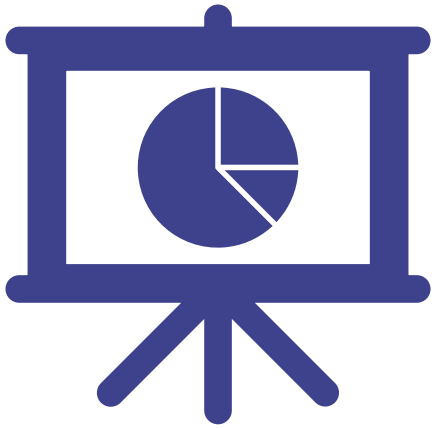
Question 9: Cross-Benefit Workflow Routing (Lines 817-819)

Question on Straw Poll	Support Level	Polling %
9. Below is the proposed requirement for Cross-Benefit Workflow Routing between medical and pharmacy benefits (lines 817-819 of the draft rule): *Providing information to manage cross-benefit coverage can be facilitated similarly to benefits associated with another entity, which is outlined in section 1.4.7.1 of the X12N 005010X279 TR3.* *Footnote:* *See RFI # 1618, 271 2110C/D EB05 Plan Name, for further guidance RFI # 1618: 271 2110C/D EB05 Plan Name | X12.*	**Support as Written**	75%
	Support With Edits	6%
	Do Not Support This Function	19%

1. Support level totals may not perfectly align (e.g. add up to 100% exactly) due to rounding.

Question 10: Cross-Benefit Workflow Routing Comments

#	Point of Clarification	Co-chair and CORE Response
1.	A commenter requested that the reference to section 1.4.7.1 mention specific items necessary to convey this information.	Participants should reference the included RFI for specific guidance.
2.	A commenter agreed with the inclusion of the referenced RFI.	The RFI provides an actionable solution to support this process. Reference in the CORE Operating Rules boosts support of the solution, lending to workflow consistency and standardization.
3.	Two commenters stated that they do not currently support necessary functionality to fulfill these requirements. This ranges from not returning pharmacy under the medical benefit to not supporting procedure codes.	It is expected that to meet these requirements, health plans and their agents must undertake system remediation. Participants are welcome to submit information about the impact of these requirements relative to the investment.



Section C. Dental Benefits

Question 11: Triggering an Eligibility Inquiry

Question on Straw Poll	Support Level	Polling %
11. The Eligibility & Benefits Task Group approved a requirement to, in the event a health plan receives an inquiry about a dental procedure, communicate three types of information about dental procedures that are unique to dental benefit plans. The three types of information are: • Frequency limitations • Waiting period limitations • Age limitations Below is the draft requirement language to trigger an eligibility inquiry for a dental procedure (lines 674-677 of the draft rule): *When the X12 v5010 270 includes a CORE-required procedure code for a dental category of service, the information source (the health plan or contracted vendor) must return the dental benefit limitations as specified in §1.4.2.11.1 through §1.4.2.11.3.*	**Support as Written**	75%
	Support With Edits	6%
	Do Not Support This Function	19%

1. Support level totals may not perfectly align (e.g. add up to 100% exactly) due to rounding.

Question 12: Triggering an Eligibility Inquiry Comments

#	Substantive	Co-chair and CORE Response
1.	A commenter submitted that the 270 inquiry does not provide all data necessary for the payer to return dental coverage limitations at the procedure code level. The commenter also states that - in consideration of timely filing limits - return of limitation information may be superseded or invalidated by in-process claims or those received prior to the return of limitations.	**Agree.** Health plans and their agents can require specific information in the X12 270 explicit inquiry to facilitate the return of this information. Per the contents of this draft operating rule, this information must be publicly displayed on a website or in the transaction-specific companion guide. This extends to overlapping or timely claim requirements. It is understood that benefits returned are as accurate as possible at the time of the inquiry and that in-process claims, PA requirements, etc. may still impact benefits and care delivery.
2.	A commenter stated that this requires costly updates for a function that their dental providers are not requesting. They could support if the requirement was modified to only apply when the dental health plan is capable of returning this information.	**Disagree.** Industry scanning and consensus reached in the EBTG suggest friction originating from a relative lack of automation for eligibility verification in the dental industry. Some level of remediation is necessary to support requirements. Implementation must be approached uniformly, however, to limit industry variation.

(Continued) Question 12: Triggering an Eligibility Inquiry Comments

#	Point of Clarification	Co-chair and CORE Response
3.	A commenter stated that this requirement seems to apply to all dental procedure codes, regardless of if it is a covered benefit. If not a covered benefit, then limitations would not apply.	If the procedure code is a non-covered benefit and limitations do not apply, the information is not required for return. Note that all existing requirements of the vEB.2.0 rule still apply and providers would receive indication that this is a non-covered benefit in the X12 271 response.

Question 13: Returning Frequency Limitations

Question on Straw Poll	Support Level	Polling %
13. Draft requirement language to meet the goal of communicating frequency limitations (lines 678-689 of the draft rule). Please assume that the eligibility inquiry has appropriately triggered a response for a dental procedure: *A health plan and its agent must return frequency limitations for procedure codes that align with CORE-required dental categories of service, when applicable, using the EB and HSD Segment as follows:* ○ *EB Segment:* ▪ *EB01 = F-Limitations* ▪ *EB13 = <the Procedure Code the frequency limitation applies to>* ○ *HSD Segment[4]:* ▪ *HSD01 = <Applicable Quantity Qualifier>* ▪ *HSD02 = Quantity* ▪ *HSD05 = <Applicable Time Period Qualifier, see the appendix, Table 2 – CORE Recommended Time Period Qualifier Codes for recommended qualifiers>* ▪ *HSD06 = Number of Periods* *Footnote:* *4. When applicable, include HSD03= Unit or Basis for Measurement and HSD04= Sample Selection Modulus*	**Support as Written**	76%
	Support With Edits	6%
	Do Not Support This Function	18%

1. Support level totals may not perfectly align (e.g. add up to 100% exactly) due to rounding.

Question 14: Returning Frequency Limitations Comments

#	Point of Clarification	Co-chair and CORE Response
1.	A commenter recognized cases where dental plans limit procedure frequency across a set of CDT codes. For instance, if a patient has a claim for D5421, they may not qualify for another procedure in the same set, such as D5410. There are ways to specify ranges and individual codes in the standard, but not ways to indicate non-consecutive ranges. The commenter recommends adding a standard way to communicate these instances.	CORE liaises with X12 and can discuss this approach.
2.	A commenter stated that the three quantity identifiers do not adequately capture all possible limitations enacted by a health plan. Additionally, limitations conveyed during the eligibility verification do not communicate expectation of payment if services have already been billed/paid - including instances where already submitted claims may supersede the eligibility check. Lastly, required information on the explicit X12 270 inquiry is not contemplated in the rule.	The quantity qualifiers are recommended in the CORE Operating Rule. Health plans and their agents can use other qualifiers to match their policies. All other, existing requirements in the vEB.2.0 CORE Eligibility and Benefits Operating Rule apply to dental procedures. Therefore, the expectation is that if a benefit has been exhausted, this will be returned to the provider through the X12 271. Additionally, eligibility verification is not used to communicate payment. Payment is determined in the health care claim workflow after services have been delivered.

Question 15: Returning Waiting Period Limitations

Question on Straw Poll	Support Level	Polling %
15. Below is the proposed methodology and draft requirement language to meet the goal of communicating waiting period limitations (lines 690-698 of the draft rule). Please assume that the eligibility inquiry has appropriately triggered a response for a dental procedure: *A health plan and its agent must return waiting periods for procedure codes that align with CORE-required dental categories of service, when applicable, using the EB Segment as follows:* ○ *EB Segment:* ▪ *EB01 = F Limitation* ▪ *EB09 = <Applicable Quantity Qualifier for Waiting Period; see appendix, Table 3 – CORE Recommended Quantity Qualifier Codes for recommended qualifiers>[5]* ▪ *EB10 = Quantity (numeric value of waiting period)[6]* ▪ *EB13 = <the Procedure Code where the waiting period applies>* *Footnote:* *5. Use this code to identify the type of units that are being conveyed in the following data element (EB10)* *6. Use this number for the quantity value as qualified by the preceding data element (EB09)*	**Support as Written**	71%
	Support With Edits	6%
	Do Not Support This Function	24%

1. Support level totals may not perfectly align (e.g. add up to 100% exactly) due to rounding.

Question 16: Returning Waiting Period Limitations Comments

#	Substantive	Co-chair and CORE Response
1.	A commenter highlighted that the footnotes in this section are restatements of the X12 TR3 and should be removed.	**Agree**. These are restatements and will be removed from version presented for ballot.
#	**Point of Clarification**	**Co-chair and CORE Response**
2.	A commenter asked that "Waiting Period" be defined.	It is the "amount of time after purchasing a dental insurance plan that you must wait before you are eligible to receive benefits for treatment."[1]

1. https://www.deltadental.com/us/en/protect-my-smile/dental-insurance-101/dental-insurance-waiting-period.html#:~:text=A%20dental%20benefit%20waiting

Question 17: Returning Age Limitations

Question on Straw Poll	Support Level	Polling %
17. Below is the proposed methodology and draft language to meet the goal of communicating age limitations (lines 699-708 of the draft rule). Please assume that the eligibility inquiry has appropriately triggered a response for a dental procedure: *A health plan and its agent must return age limitations for procedure codes that align with CORE-required dental categories of service, when applicable, using the EB Segment as follows:* ○ *EB Segment:* ▪ *EB01 = F Limitation* ▪ *EB09 = <Applicable Quantity Qualifier for Age Limitations: S7 – Age, High Value or S8 – Age, Low Value; see appendix, Table 3 – CORE Recommended Quantity Qualifier Codes for recommended qualifiers>* ▪ *EB10 = Quantity (numeric value of age limit)* ▪ *EB13 = <the Procedure Code where the age limit applies>*	**Support as Written**	69%
	Support With Edits	13%
	Do Not Support This Function	19%

1. Support level totals may not perfectly align (e.g. add up to 100% exactly) due to rounding.

Question 18: Returning Age Limitations Comments

#	Point of Clarification	Co-chair and CORE Response
1.	A commenter shared instances of dental payers sending high age limits for dependents in loop 2110C. Child dependents may have a high age limit of 18, whereas students may have a high age limit up to 26. The commenter suggested explicitly stating how these high limits should be communicated.	CORE liaises with X12 and can discuss / facilitate this approach.
2.	A commenter is concerned that high and low age limits are not adequate to communicate age-limited benefits - particularly if benefits are in force or expire prior to or after a specific "year" (e.g., 22 years old and 6 months).	The recommended quantity identifiers are sufficient to communicate both years and months. For instance, 22 years and 8 months is the equivalent of 272 months, which can then be converted into a more colloquial understanding.

Question 19: Cross-Benefit Workflow Routing

Question on Straw Poll	Support Level	Polling %
19. The Eligibility & Benefits Task Group approved developing a requirement for the instance where an eligibility inquiry submitter should be querying a patient's medical benefits, and not dental benefits, or vice versa. The initially inquired upon health or dental plan must communicate the appropriate plan information for the coverage inquiry. CORE named this process "Cross-Benefit Workflow Routing." Below is the draft requirement language to meet this goal for dental benefits (lines 784-786, 804-816 of the draft rule): *This section specifies the required process for routing between benefit plans when an initial response indicates that coverage is not available by the inquired plan…* ○ *When a dental benefit is covered under a different benefit plan (e.g., medical instead of dental, or vice versa), the following requirements apply:* ▪ *A health plan or its agent (information source) must:* • *Indicate that the dental benefit is not covered under the initial benefit.* • *AND* • *If known, identify and communicate the name of the benefit plan where coverage may exist and under which the benefit would be covered (i.e. the name of the medical plan or dental plan) in the response using the X12 v5010 271.* ▪ *A provider or its agent (information receiver) must:* • *Upon receipt a non-covered response, use relevant information from the initial inquiry and response (e.g., procedure code, provider information, cross benefit plan name) to trigger a cross-benefit inquiry, and transmit it using the X12 v5010 270 Request.*	**Support as Written**	53%
	Support With Edits	7%
	Do Not Support This Function	40%

1. Support level totals may not perfectly align (e.g. add up to 100% exactly) due to rounding.

Question 20: Cross-Benefit Workflow Routing Comments

#	Substantive	Co-chair and CORE Response
1.	A commenter reiterated points stating that without an attendant payer ID for the other plan, providers may face a burden in figuring out who to send the information to. The commenter suggests explicitly how this may be accomplished.	**For Discussion**. Given the newness of this requirement, it is expected it will be completed in various ways and that it is too early to decide on and codify a single best practice. CORE works with entities to understand implementation variation and will act to update rule requirements if necessary.

(Continued) Question 20: Cross-Benefit Workflow Routing Comments

#	Point of Clarification	Co-chair and CORE Response
2.	Three commenters stated this would require extensive coding updates in their system and that they do not currently support this level of functionality.	A level of system remediation is expected for adopting these requirements. Participants are welcome to submit estimates of the impact relative to benefit to inform implementation value.
3.	Similar to the medication requirements, a commenter is concerned that a provider's inability to meet these requirements - resulting from varying technical capabilities - would result in them being labeled as non-compliant.	These are the steps that providers must take if they would like automate inquiries for cross-benefit coverage. They are not required to undertake these steps, but industry scanning suggested they are beneficial to workflows. Inclusion of this requirement ensures that provider facing health IT has the capability to support these functions and that health plans and their agents are capable of returning the required information.
4.	A commenter said that, unlike pharmacy benefits which are handled through a PBM, the health plan rarely knows a member's dental plan choice and the entities with the clearest picture are either the employer or broker.	A level of system remediation is implied and expected for this requirement. Also important to understand that this information is only required to be returned 'if known.' This requirement would allow for a phased implementation wherein infrastructures can be established that support a wider return.

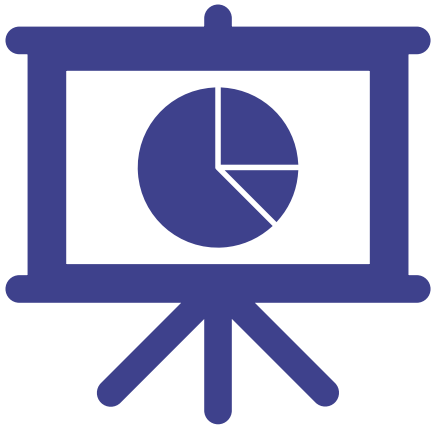
Question 21: Cross-Benefit Workflow Routing Cont.

Question on Straw Poll	Support Level	Polling %
21. Below is the proposed Cross-Benefit Workflow Routing requirement between medical and dental benefits (lines 817-819 of the draft rule). **Of note, it is the same proposed methodology as Cross-Benefit Workflow Routing requirements between medical and pharmacy benefits from question 9:** *Providing information to manage cross-benefit coverage can be facilitated similarly to benefits associated with another entity, which is outlined in section 1.4.7.1 of the X12N 005010X279 TR3.* *Footnote:* *See RFI # 1618, 271 2110C/D EB05 Plan Name, for further guidance RFI # 1618: 271 2110C/D EB05 Plan Name | X12.*	**Support as Written**	65%
	Support With Edits	6%
	Do Not Support This Function	24%

1. Support level totals may not perfectly align (e.g. add up to 100% exactly) due to rounding.

Question 22: Cross-Benefit Workflow Cont. Comments

#	Substantive	Co-chair and CORE Response
1.	A commenter agreed with the inclusion of the referenced RFI.	**Agree**. The RFI provides an actionable solution to support this process. Reference in the CORE Operating Rules boosts support of the solution, lending to workflow consistency and standardization.
#	**Point of Clarification**	**Co-chair and CORE Response**
2.	A commenter requested that the reference to section 1.4.7.1 mention specific items necessary to convey this information.	Participants should reference the included RFI for specific guidance.

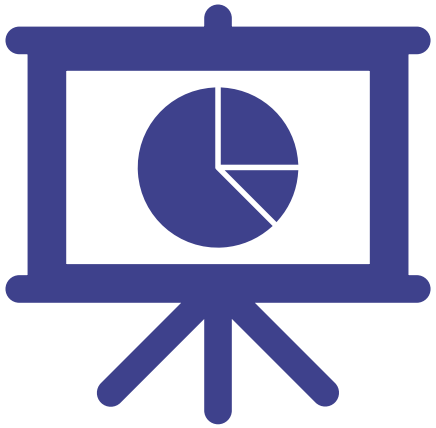


Section D. Value-based Care

Question 23: Indication and Coverage Information for Bundled Payment & Episode of Care

Question on Straw Poll	Support Level	Polling %
23. The Eligibility and Benefits Task Group supported a methodology to communicate information that can benefit providers managing patients in episode of care / bundled payment value-based care arrangements. The EBTG requested the methodology be re-presented to the RWG for final approval. The six data elements (EB01, EB06, EB07, EB09, EB10, & MSG01) must be evaluated in aggregate to ensure the X12 271 response to an explicit X12 270 inquiry maintains meaning and value to the receiver. Below is the proposed methodology and draft requirement language for communicating bundled payment and episode of care information (lines 733-749 of the draft rule): *When the X12 v5010 270 includes a procedure code aligned to any of CORE-required category of service shown in table 1.4.2.3 (medical, dental, or medication), and the procedure code is a "trigger" that initiates an episode of care consistent with the requirements of an in-force value-based contract[7], a health plan or its agent must return the following on the X12 v5010 271:* ○ *EB01 = 1 – Active Coverage* ○ *EB06 = 26 – Episode* ○ *EB07 = Episode of Care Dollar Amount[8]* ○ *EB09 = DY – Days* ○ *EB10 = Number of Days the Episode Lasts* ○ *MSG01 = Description of the Episode of Care Contract. Entries must begin with "MSG*EpisodeofCareDetail"[9]* *To avoid fragmentation and assist with interpretation, all data elements must be sent in a single occurrence of the EB segment. The MSG segment must be returned in the same EB loop.* *A health plan and its agent are not required to return this information when the submitter of the explicit X12 v5010 270 inquiry is not eligible to trigger episodes of care or is otherwise not accountable for performance in the associated value-based contract.* *Footnote:* *7. For the purposes of these requirements, episode of care value-based care models align to the definition included on page 6 of the CORE Framework for Semantic Interoperability in Value-based Payments, with a specific focus on HCP-LAN Categories 3a and 3b.* *8. When available, the health plan and its agent must return the unadjusted bundled payment that is used to calculate financial performance consistent with the requirements of the executed value-based contract. A definition of bundled payment is included on page 13 of the CORE Framework for Semantic Interoperability in Value-based Payments.* *9. A health plan and its agent must return the MSG01 beginning with the indicated language. It is at the discretion of the health plan and its agent what information to return after the required language is entered. CORE will work with industry to understand use and make recommendations for future refinement as greater implementation experience is gained.*	**Support as Written**	50%
	Support With Edits	14%
	Do Not Support This Function	36%

1. Support level totals may not perfectly align (e.g. add up to 100% exactly) due to rounding.



Section E. Additional Comments

Question 25: Additional Relevant Comments Provided

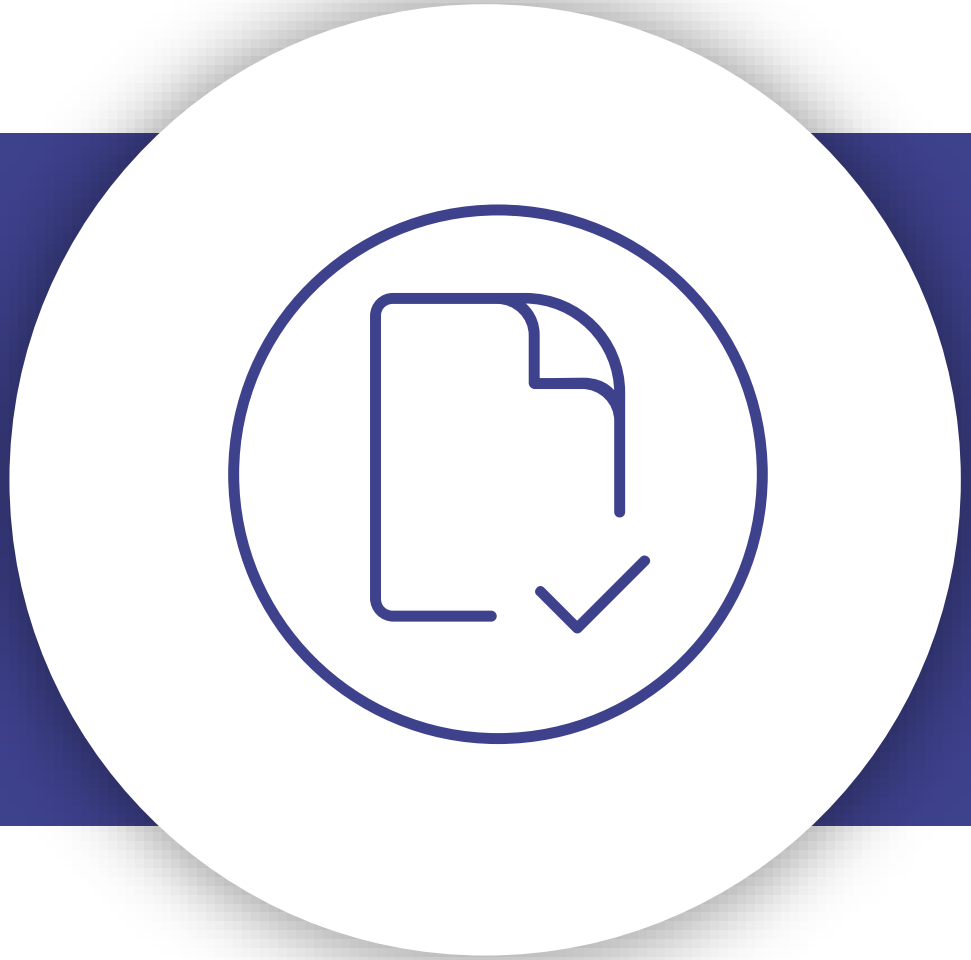
#	Point of Clarification	Co-chair and CORE Response
1.	A commenter supported this requirement if additional code changes are made.	No additional, net-new codes were proposed.
2.	Two commenters stated this would require extensive coding updates in their system and that they do not currently support this level of functionality.	A level of system remediation is expected for adopting these requirements. Participants are welcome to submit estimates of the impact relative to benefit to inform implementation value.

(Continued) Question 25: Additional Relevant Comments Provided

#	Point of Clarification	Co-chair and CORE Response
3.	A commenter highlighted that the TR3, at a minimum, requires a health plan to respond to a X12 270 inquiry with whether the beneficiary has coverage. Requiring responses to procedure-level inquiries would require future versions, as well as required data elements in the X12 270 explicit inquiry, that support the generation of a 271 response.	CORE Operating Rules are mandated for use with the X12 270/271. Requirements of the operating rules go beyond the minimum requirements in the TR3. Additionally, an updated version of the CORE Eligibility and Benefits Operating Rules is awaiting the release of an IFR. This version would require health plans to support explicit, procedure-level inquiries for CPT and HCPCS codes. The draft requirements under consideration only serve to expand and increase the utility of these existing requirements and support provider need for detailed benefits of their patients. It is the responsibility of the health plan to clearly communicate what data is required in the X12 270 inquiry to support the return of the X12 271.

(Continued) Question 25: Additional Relevant Comments Provided

#	Point of Clarification	Co-chair and CORE Response
4.	Two commenters stated that they do not currently support necessary functionality to fulfill these requirements. This ranges from not returning pharmacy under the medical benefit to not support procedure codes.	It is expected that to meet these requirements, health plans and their agents must undertake system remediation. Participants are welcome to submit information about the impact of these requirements relative to the investment.
5.	A commenter stated that this would require system remediation to accomplish.	It is understood that some level of system remediation is necessary to meet these requirements. Once published, the CORE Operating Rules are available alongside implementation guides. CORE Certification is available to guide entities through implementation, identifying what areas need to be remediated to meet requirements.
6.	A commenter wants to understand adoption timelines.	If approved by the RWG, CORE Voting Participants and the CORE Board the rule is immediately available for voluntary implementation. Entities certified in the eligibility transaction have until their next recertification (occurs once every 3 years) to conform with the requirements. If adopted federally, entities have until 28 months following an interim final rule to comply.



Next Steps

Next Steps

Timeline

Event	Topic	Targeted Dates
✓ **Call for Participants**	Sign-up period to join the Review Work Group; EBTG participants auto enrolled into Review Work	Thursday, September 12th – Thursday, September 26th
✓ **RWG Call #1**	Introduce 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

Next Steps

Review Work Group Ballot

- The RWG Ballot allows each RWG Participating Organization to **indicate their support for the new draft operating rule and updated requirement**.
- The RWG Ballot includes an opportunity for organizations to **provide early assessments of implementation and impact** of the new and updated requirements.

RWG Ballot Requirements	
Quorum	*At least* **60%**
Approval	*At least* **50%**

Draft Eligibility & Benefits Data Content Operating Rule

Updated operating rule inclusive of data content requirements for:

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 Dental Benefit Limitations.

CORE Operating Rule Implementation Impact Assessment

Goal: Assess the expected impact of new/updated rules on business processes, resources, and operations for healthcare stakeholders.

Benefit: Provides valuable data for stakeholders and regulators to make informed decisions from understanding the business case and value of rule adoption.

Impact Assessment Categories:

- **Resource Assessment** : Evaluating resource allocation (people, IT, operations, maintenance) relative prior operating rule implementation projects.
- **Implementation Timeframe:** Estimating time required for full rule implementation, excluding federal mandate waiting periods.
- **Impact Analysis**: Assessing the impact on operating costs, customer satisfaction, administrative burden, workflow automation, and provider/health plan communication.
- **Post-Implementation Impact Timeframe:** Projecting the time to seeing impacts post-implementation

Sample Resource Assessment Question

	Much Fewer Resources	Fewer Resources	Average Resources	More Resources	Many More Resources
People (total FTEs)	○	○	○	○	○
New IT Infrastructure (new software or hardware investment)	○	○	○	○	○
Business Operations Support (updated education, live training, workflow updates, etc.)	○	○	○	○	○
Maintenance Costs (resources needed to sustain changes)	○	○	○	○	○
Other (required to indicate in comments)	○	○	○	○	○

Next Steps

Action Items

#	Item	Description
1.	*Complete RWG Ballot*	– Complete RWG Ballot: Submission period open from **November 4th, 2024 – November 15th, 2024.** – In accordance with CORE policy, **all responses will be kept strictly confidential** and will be reported in aggregate at the stakeholder level.
2.	*Save the Date*	– Full CORE Voting Membership Ballot **launching Monday, November 25th – Friday December 20th**

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
Amy King	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

Appendix

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
4. Oncology
5. Pain Management
6. Biologics
7. Compound drugs
8. Inhalations
9. Nephrology
10. Immunosuppressives
11. Antibiotics
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