CAQH CORE

CAQH CORE Town Hall

September 14, 2021

Agenda

- CAQH CORE Overview & Industry Update
- Spotlight:
  - Advanced Explanation of Benefits Advisory Group
  - Infrastructure Operating Rule Update
- Current Rule Writing Efforts:
  - Attachments
  - Eligibility
- CAQH CORE Activities:
  - Rule Maintenance
  - Pilot Initiative
- Q&A

Logistics

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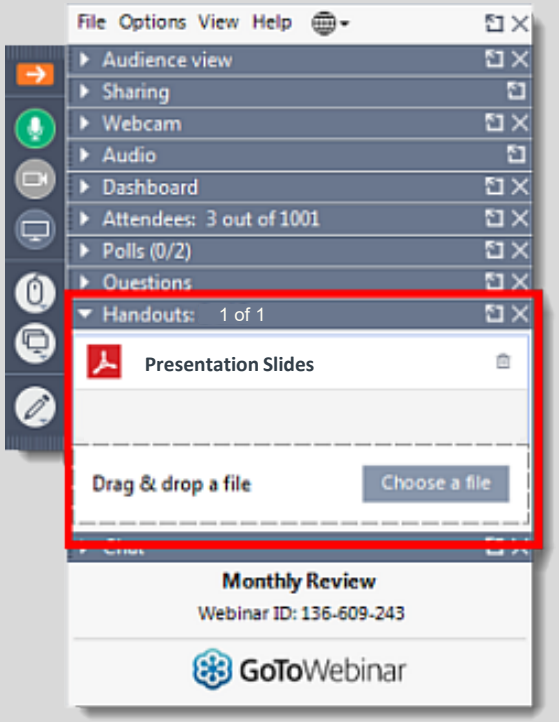


CAQH CORE

CAQH CORE
Overview & Industry Update

Erin Weber
Director, CAQH CORE

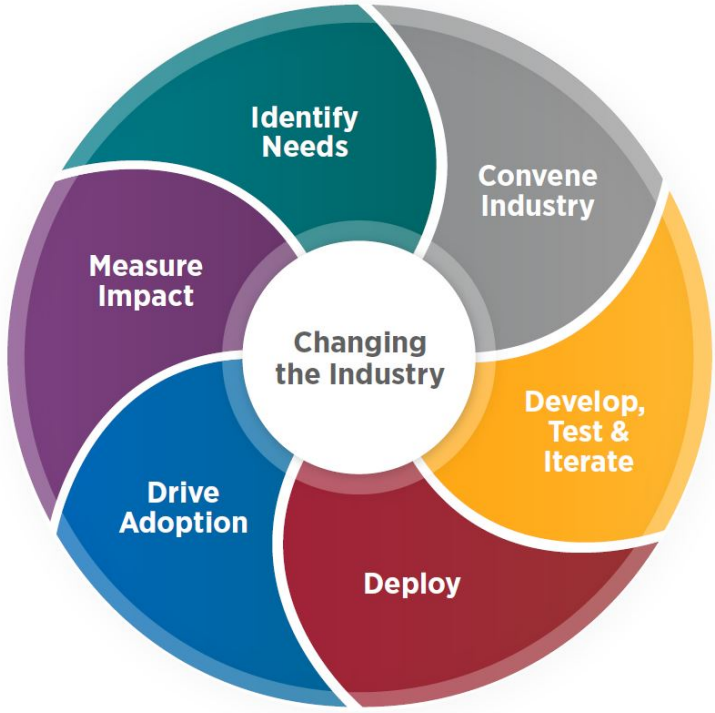
CAQH CORE Mission/Vision & Industry Role

Industry-led, CAQH CORE Participants include healthcare providers, health plans, vendors, government entities, associations and standard-setting organizations. Health plans participating in CAQH CORE represent **75 percent of the insured US population.**

MISSION Drive the creation and adoption of healthcare operating rules that **support standards**, **accelerate interoperability and align administrative and clinical activities** among providers, payers and consumers.

VISION An **industry-wide facilitator** of a trusted, simple and sustainable healthcare data exchange that evolves and aligns with market needs.

DESIGNATION CAQH CORE is the **national operating rule author to improve the efficiency, accuracy and effectiveness of industry-driven business transactions.** The Department of Health and Human Services (HHS) designated CAQH CORE as the author of national operating rules for the HIPAA-covered administrative transactions.



INDUSTRY ROLE **Develop business rules to help industry** effectively and efficiently use electronic standards while remaining technology- and standard-agnostic.

CAQH CORE BOARD **Multi-stakeholder.** Members include health plans, providers (some of which are appointed by associations such as the AHA, AMA, MGMA), vendors, and government entities. Advisors to the Board include SDOs (X12, HL7, NACHA, NCPDP) and WEDI.

CAQH CORE

CAQH CORE Operating Rule Overview

Published Rules to Date

Rule Set	Infrastructure	Connectivity Rule	Data Content	Other	In Development
Eligibility & Benefits	Eligibility (270/271) Infrastructure Rule*	Connectivity Rule vC1.0.0* Connectivity Rule vC2.0.0*	Eligibility (270/271) Data Content Rule*	Single Patient Attribution Data	**Eligibility (270/271) Data Content Update***
Claim Status	Claim Status (276/277) Infrastructure Rule*	Connectivity Rule vC2.0.0*			
Payment & Remittance	Claim Payment/ Advice (835) Infrastructure Rule*		EFT/ERA 835/CCD+ Data Content Rule*	EFT/ERA Enrollment Data Rules*	
Prior Authorization & Referrals	Prior Authorization (278) Infrastructure Rule	Connectivity Rule vC3.0.0	Prior Authorization (278) Data Content Rule	Prior Auth Web Portal Rule	**Attachment Rule(s) (Prior Authorization Use Case)**
Health Care Claims	Health Care Claim (837) Infrastructure Rule				**Attachment Rule(s) (Claims Use Case)**
Benefit Enrollment	Benefit Enrollment (834) Infrastructure Rule				
Premium Payment	Premium Payment (820) Infrastructure Rule				
Attributed Patient Roster	Attributed Patient Roster (834) Infrastructure Rule	Connectivity Rule vC4.0.0**	Attributed Patient Roster (834) Data Content Rule		

Rules in purple boxes are federally mandated.

*Connectivity Rule vC4.0.0 can be used to support all rule sets for CORE Certification.

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CAQH CORE Participating Organizations

Over 120 CAQH CORE Participating Organizations work together to develop and implement rules of the road that streamline the business of healthcare, across all components of the revenue cycle.

A Sample of Organizations that Participate in CAQH CORE

(See full list here)

CAQH CORE

CORE Certification

CORE Certification program was developed **by industry, for industry** by CAQH CORE Participating Organizations including health plans, providers, vendors, government agencies and associations.

CORE Certification program allows organizations to **certify on specific transactions** related to their products or solutions.

Many health plans **require** their vendors to be CORE-certified prior to contracting.

Recertification enables ongoing conformance when rule requirements are updated over time to align with market needs.

New Participating and CORE Certified Organizations

New Participating Organizations

Children's Healthcare of Atlanta

Mettle Solutions

CLAIM·MD

New CORE Certifications

alight

(834 Benefit Enrollment)

Healthcare IP

(270/271 Eligibility & Benefits)

(276/277 Health Care Claim Status)

CLAIM·MD

(270/271 Eligibility & Benefits)

Recent Recertifications

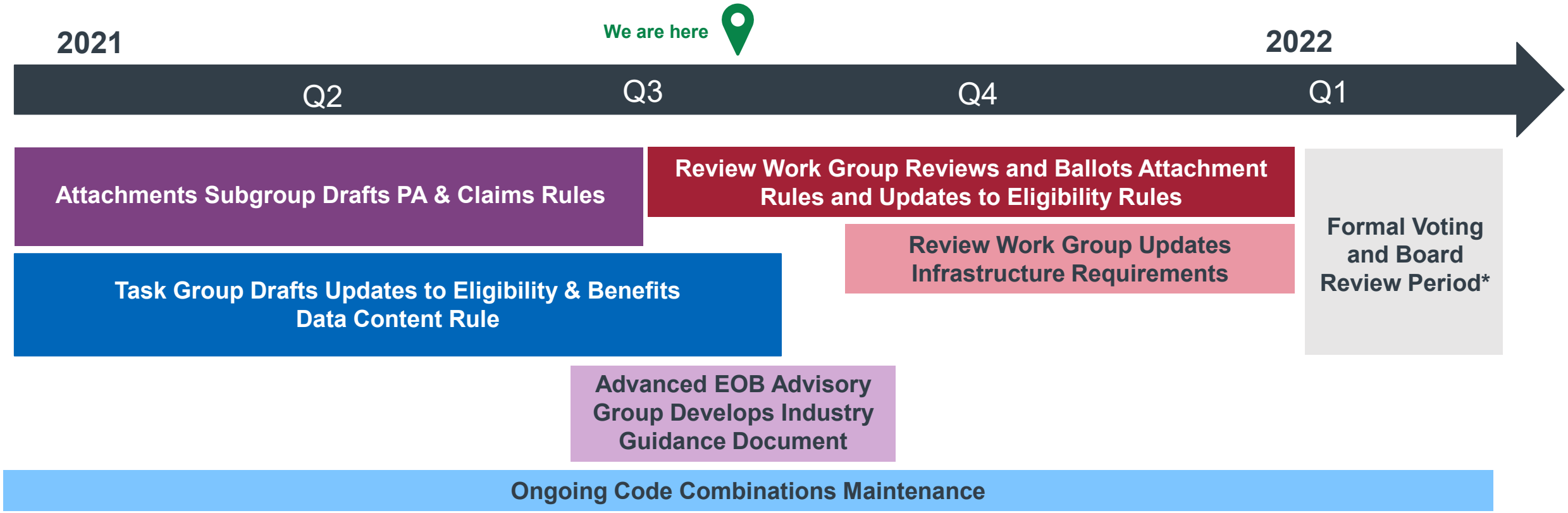
AULTCARE HEALTH PLANS

Horizon

Horizon Blue Cross Blue Shield of New Jersey

Welcome!

2021 Rule Development and Maintenance Timeline



*The CAQH CORE Board is expected to review and vote on the new Attachment Rules and updated Eligibility and Infrastructure Rules at its March 2022 meeting.

Current CAQH CORE Rule Development Initiatives

#	CAQH CORE Initiative	Focus	Objectives	Co-Chair(s)	Cadence
1	**Eligibility & Benefits Task Group**	Rule Development	Update the **Eligibility & Benefits Data Content Rule to address emerging industry needs** (such as support more STC codes, tiered benefits, procedure-level, # of remaining visits/services, telemedicine).	**Meg Soccorso** Cigna **Molly Reese** AMA **Nora Illuri** athenahealth **Donna Campbell** HCSC	Monthly, adjourning September 2021
2	**Attachments Subgroup (Prior Authorization Use Case)**	Rule Development	Develop operating rules to **improve automation of the exchange of attachments/additional documentation**; initial focus on prior authorization use case.	**Santo Carino** Epic **Bob Gross** Cleveland Clinic **Mahesh Siddanthi** Centene	**Concluded March 2021.** Draft Rules forwarded to Review Work Group
3	**Attachments Subgroup (Claims Use Case)**	Rule Development	Following the prior authorization use case, **continue developing operating rules to improve automation of the exchange of attachments/additional documentation** with a focus on claims attachments.	**Alkka Mukker** Change Healthcare **Christol Green** Anthem **Mahesh Siddanati** Centene **Michael Marchant** UC Davis Health	**Concluded June 2021**. Draft Rules forwarded to Review Work Group
4	**Review Work Group (RWG**	Rule Development	Following the conclusion of the Attachments Subgroups, the **RWG will further review and refine both Draft Attachments Operating Rule Sets** to ensure uniformity and cohesion across use cases. Additionally, the RWG will review the Draft Eligibility and Benefits Data Content Rule Update prior to the launch of the Final CAQH CORE Vote.	**Donna Campbell** HCSC **Mahesh Siddanati** Centene **Molly Malavey** AMA	Monthly, adjourning January 2022

Other CAQH CORE Initiatives

#	CAQH CORE Initiative	Focus	Objectives	Co-Chair(s)	Cadence
1	**Pilot & Measurement Initiative**	ROI; Opportunity Identification	**Prior Authorization (Ongoing).** Measure the impact of prior authorization data content and infrastructure operating rules and potential attachments operating rules on efficiency metrics, including impact on time, provider staff experience, and overall savings. **Quality Measures Reporting (Launching 2021).** Test the use of expanded code sets (e.g., LOINC or CPT II Codes) with healthcare claims to convey non-service-related clinical information, such as outcomes measures, to reduce physician reporting burden.	N/A	Ongoing
2	**Advanced Explanation of Benefits (EOB) Advisory Group**	Opportunity Identification	Guide CAQH CORE's work on price transparency with an immediate focus on the advanced EOB requirements in the No Surprises Act. The Advisory Group will have the goal of **developing a guidance document by the fall of 2021 to support the provider/payer exchange for advanced EOB**. The guidance may be considered for a future CAQH CORE Operating Rule.	N/A	**Launched August 2021**
3	**CORE Code Combinations Task Group**	Rule Maintenance	Ensure compliance with the **base standard code lists – CARCs and RARCs.** Conduct annual industry survey to collect suggestions for potential market-driven adjustments to code combinations.	**Lynn Franco,** UnitedHealth Group **Heather Morgan,** Aetna	Once every 2-3 months, for a total of 6 times a year

Federal Update

No Surprises Act

- No Surprises Act protects consumers from surprise medical bills. Section 111 of the Act requires health plans to provide an **Advanced EOB** for scheduled services one to three business days in advance.
- Observation: Need for workflow changes and standardized processes to meet the advanced EOB requirements without creating undue burden for patients, providers, and health plans.

CAQH CORE Comment Letter

CMS Published FAQ Guidance

No Surprises Act Interim Final Rule

Federal Advisory Committees

NCVHS

- NCVHS Subcommittee on Standards held a listening session to get industry feedback on healthcare standards development, adoption and implementation on August 25, 2021.

CAQH CORE Comment Letter

- **Next NCVHS Meeting** is on January 24-25, 2022.

The Office of the National Coordinator for Health Information Technology

- The HITAC identifies priorities for standards adoption and makes recommendations to the National Coordinator for Health Information Technology (National Coordinator). The HITAC will hold public meetings throughout 2021.
- **Next HITAC Meeting** is on October 13, 2021.

CAQH CORE

Spotlight

- **Advanced Explanation of Benefits Advisory Group**
- **Infrastructure Operating Rule Update**

Taha Anjarwalla
CAQH CORE Associate Director

CAQH CORE Advanced EOB Advisory Group Background

No Surprises Act, Advanced EOB, & Good Faith Estimate

The **No Surprises Act**, signed into law as part of the Consolidated Appropriations Act of 2021, addresses surprise medical billing at the federal level.

Section 111 of the Act requires health plans to provide an **Advanced EOB** for scheduled services one to three business days in advance, dependent on date of intended service/item, to give patients transparency into which providers are expected to provide treatment, the expected cost, and the network status of providers.

Section 112 requires health care providers and facilities to verify what type of coverage the patient is enrolled in and provide notification of a **Good Faith Estimate** of charges to the payer/patient at least three days in advance of service/item and no later than one day after scheduling the service.

Update: CMS Guidance on Advanced EOBs

CMS recently published new FAQ Guidance related to Advanced EOBs and other requirements of the No Surprises Act.

Issuance of regulations addressing the Good Faith Estimate prior to statutory effective date:

- HHS intends to issue regulations implementing good faith estimate requirements for individuals not enrolled in a health plan or coverage or who are not seeking to have a claim for the scheduled items or services submitted to the plan or coverage prior to the statutory effective date.
- HHS recognizes that compliance with implementing good faith estimates for individuals who are enrolled in a health plan or coverage and are seeking to have a claim for the scheduled items or services submitted to the plan or coverage is likely not possible by January 1, 2022. Until rulemaking is adopted, HHS will defer enforcement of this requirement.

Issuance of regulations addressing Advanced EOBs prior to effective date of January 1, 2022:

- HHS does not plan on issuing regulations prior to January 1, 2022, as compliance with this section is likely not possible by January 1, 2022.
- HHS intends to undertake notice and comment rulemaking in the future to implement this provision, including establishing appropriate data transfer standards. Until that time, enforcement of Advanced EOB requirements will be deferred. However, HHS will investigate whether interim solutions are feasible for insured consumers.

CAQH CORE is continuing to review the guidance which underscores the importance of the Advisory Group's work to develop industry consensus on how best to leverage uniform frameworks and industry standards to implement components of the Advanced EOB for consideration by industry stakeholders and regulators.

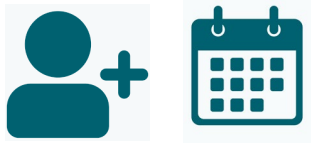
Advanced EOB & Good Faith Estimate Requirements

- **The Advanced EOB must be shared with the member/patient by mail or electronically, depending on the individual's preference, and include the following information:**
  - If a provider/facility is in- or out-of-network with respect to the item/service.
    - If the provider/facility is in-network, the contracted rate based on billing and diagnostic costs sent by the provider.
    - If the provider/facility is out-of-network, a description on how the individual can find contracted providers/facilities, if any.
  - A Good Faith Estimate of expected charges based on billing and diagnostic codes.
  - A Good Faith Estimate of the plan's payment responsibility and member's cost sharing responsibilities for the item/service.
  - A Good Faith Estimate of the amount the member has incurred toward meeting their financial responsibility limit (including deductibles and out-of-pocket maximums) under the plan.
  - Disclaimers that the coverage is subject to medical management requirements and that the estimates are subject to change.
  - Any other information health plans deem appropriate to include consistent with other requirements.

Advanced EOB Workflow

Scope for Advisory Group

1



Patient Schedules Appointment or Requests Cost Estimate

*Patient schedules a healthcare service appointment with a provider **OR** patient requests estimate for a healthcare item or service from provider.*

Applies to all healthcare items and services provided by providers and facilities.

2a

Provider Verifies Insurance with Health Plan

Provider verifies a patient's insurance coverage with health plan to determine eligibility and benefit information for the healthcare item or service.

2b

*If a patient is uninsured, the provider sends the patient an Advanced EOB disclosure on expected charges.**

3

Provider Sends Good Faith Estimate to Health Plan

Provider sends a Good Faith Estimate of expected charges for the healthcare service including billing, procedure and/or diagnostics codes to health plan at least three days in advanced of service and no later than one day after scheduling the service.

In-scope for the CAQH CORE Advanced EOB Advisory Group.

Out of Scope: Additional use cases will be considered in the future, such as provider/payer aggregation of Good Faith Estimates and Advanced EOB exchange.

4a

Health Plan Sends Advanced EOB to Member**

Health Plan sends member an Advanced EOB electronically or via mail that provides information on provider network status, covered costs, and out-of-pocket estimates.

4b

[Optional] Health Plan Sends a Copy of Advanced EOB to Provider

**** HHS intends to issue rules on the good faith estimate by the 2022 effective date for uninsured patients.***

*****Advanced EOB's must be issued within one business day after receiving Good Faith Estimate for services scheduled three to nine days before intended service date.***

*****Advanced EOB's must be issued within three business days after receiving Good Faith Estimate for serviced scheduled more than 10 days from intended service date.***

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CAQH CORE Advanced EOB Advisory Group

Implementation Approaches

Today, there are a variety of approaches the industry could implement to support Advanced EOB requirements. CAQH CORE is seeking to coalesce the industry towards a common approach to promote uniform implementations and to support interoperability.

Implementation Approaches

Proprietary Formats → *Web Portals* → *X12 Standards* → *HL7 FHIR*

Data Content Alignment (*Agnostic to Approach*)

- Good Faith Estimate Indicator
- Provider/Facility Information
- Patient Information
- Service Information

Development/ Implementation Complexity

Simple — **Complex**

Supports Interoperability

Low — **High**

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CAQH Advanced EOB Advisory Group

Goals and Scope

Goal: **Publish a guidance document** in October to share with regulators and industry stakeholders illustrating how industry can meet Advanced EOB requirements leveraging uniform frameworks and industry standards.

Scope: Develop a consensus-based approach for **how industry should implement connectivity protocols, messaging standards, and related data content to support provider to payer exchanges of Good Faith Estimates.**

Additional use cases for Advanced EOB requirements may be considered by the Advisory Group in the **future**:

- Provider/Payer Aggregation of Service Estimates
- Plan to Member Advanced EOB Exchange
- Plan to Provider Advanced EOB Exchange
- Comprehensive Advanced EOB Data Set

With further vetting via the CAQH CORE rule development process, **recommendations from the guidance document could be developed into operating rules in the future.**

Spotlight

- Advanced Explanation of Benefits Advisory Group
- **Infrastructure Operating Rule Update**

Erin Weber
CAQH CORE Director

Enhancements to Existing CAQH CORE Infrastructure Rules

Each set of CAQH CORE Operating Rules includes an infrastructure rule with requirements for processing mode, response time, system availability, connectivity, acknowledgements, and companion guides, by transaction.

- In response to feedback from CAQH CORE Participants and the CAQH CORE Board, the CAQH CORE Review Work Group (RWG) will address **updates to the existing CAQH CORE Infrastructure Operating Rule requirements** across all rule sets to align with evolving business needs and technology.
  - CAQH CORE launched a brief **Infrastructure Operating Rules Update Survey** in early September to further inform the scope of this work by gathering feedback from CAQH CORE Participating Organizations on updates to the system availability and response time requirements across all CAQH CORE Infrastructure Rules.
- The RWG will review the results in October and agree on specific adjustments as the first step in the formal CAQH CORE rule development and maintenance process.
  - The RWG may also consider changes to the infrastructure requirements beyond the areas included in the survey.
  - The RWG will meet monthly through the end of Q4 and a vote is expected in February 2022.

Summary of Impacted Operating Rule Sets

Rule Set	Infrastructure	Connectivity Rule	Data Content	Other	In Development
Eligibility & Benefits	Eligibility (270/271) Infrastructure Rule*	Connectivity Rule vC1.0.0* Connectivity Rule vC2.0.0*	Eligibility (270/271) Data Content Rule*	Single Patient Attribution Data	**Eligibility (270/271) Data Content Rule Update**
Claim Status	Claim Status (276/277) Infrastructure Rule*	Connectivity Rule vC2.0.0*			
Payment & Remittance	Claim Payment/ Advice (835) Infrastructure Rule*		EFT/ERA 835/CCD+ Data Content Rule*	EFT/ERA Enrollment Data Rules*	
Prior Authorization & Referrals	Prior Authorization (278) Infrastructure Rule	Connectivity Rule vC3.0.0	Prior Authorization (278) Data Content Rule	Prior Auth Web Portal Rule	**Attachment Rule(s) (Prior Authorization Use Case)**
Health Care Claims	Health Care Claim (837) Infrastructure Rule				**Attachment Rule(s) (Claims Use Case)**
Benefit Enrollment	Benefit Enrollment (834) Infrastructure Rule				
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Attributed Patient Roster	Attributed Patient Roster (834) Infrastructure Rule	Connectivity Rule vC4.0.0	Attributed Patient Roster (834) Data Content Rule		

Rules in purple boxes are federally mandated.

*Connectivity Rule vC4.0.0 can be used to support all rule sets for CORE Certification.

Current Rule Development Efforts

- **Attachments**
- **Eligibility**

Emily TenEyck
CAQH CORE Manager

CAQH CORE Attachments Initiative

Attachments refer to the exchange of patient-specific **medical information or supplemental documentation** to support an administrative healthcare transaction and are a **bridge between clinical and administrative data.**

- While attachments can be exchanged electronically, partially electronically and manually, exchanging medical documentation for prior authorization is **often highly manual** and a source of significant administrative burden.
- A range of **standards and specifications currently support the exchange of attachments** (e.g., X12 275, HL7 C-CDA, HL7 FHIR, SOAP, REST, etc.)
- **A HIPAA-mandated standard for attachments has not been named**, resulting in lack of industry direction on a uniform approach in the supporting clinical documentation requested by health plans.
- CAQH CORE launched its Attachments Subgroup in July 2020. The subgroup drafted requirements based on **opportunity areas identified in Attachments White Paper and prioritized by the CAQH CORE Attachments Advisory Group.**
- Draft requirements address the **Prior Authorization Attachments Use Case and Claims Attachments Use Case.** Both sets of attachments requirements (PA and Claims) are under review by a joint Review Work Group that launched August 2021.

NOTE: The HHS Unified Agenda announced that an **Attachments NPRM** may be published in 2021. The NPRM is expected to adopt standards for health care attachments transactions and electronic signature used with the transaction, among other standard and operating rule adoptions.

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Draft CAQH CORE Attachments Operating Rules

Benefits of Adoption

The Draft CAQH CORE Attachments Operating Rule requirements target key issues in the attachments process including, unnecessary back and forth between providers and health plans, manual follow-up by providers to ensure attachments were received and linked with the original submission, and inconsistent use of attachments standards. The requirements simplify the attachments workflow for prior authorization and claims submissions, thereby reducing burden and ensuring adoption of more automated approaches.

Benefits of Adoption

- Addresses attachments sent using the **X12 275 transaction** and additional documentation sent **without using the X12 275 transaction (e.g., FHIR Resources, HL7 C-CDA, .PDF, etc.)**, supporting the convergence of clinical and administrative data.
- Establishes **key infrastructure requirements** that align with existing CORE Infrastructure Rules and provide the necessary information to uniformly send electronic attachments.
- Requires **specific codes and reference data** to simplify reassociation of a claim or prior authorization to an attachment.
- Provides additional guidance to **communicate data and processing errors**, allowing for more specificity when providers adjust the submission due to errors.

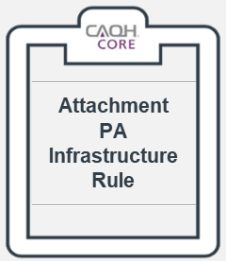
CAQH CORE Attachments Initiative – Prior Authorization Use Case

Draft Rule Requirements

Building off the Prior Authorization (PA) Operating Rules approved by the Board in May 2019, these Draft Attachments Operating Rules ensure infrastructure and data content meet business needs for submission and reassociation to reduce administrative burden.

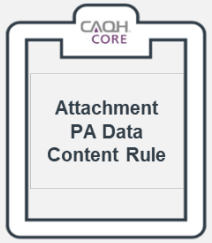
Scope: CAQH CORE Prior Authorization Attachment Operating Rule Requirements

Payload Formats include both the X12 275 and Non-X12 275 (HL7 C-CDA, FHIR, .pdf, etc.).



- ✓ **Electronic standard method for acknowledging** receipt of an X12 v6020X316 275 attachment and **maximum response times (Real-time**: 20 seconds **| Batch**: Two business days).
- ✓ **Minimums for document size and amount of data** that must be supported and accepted by systems (64MB).
- ✓ **Standard method and response time** for receiving system to return errors to the provider (X12 v6020 824).
- ✓ **System availability** must be no less than 86% per calendar week; health plans must publish downtimes.
- ✓ **Common format and flow of information** for implementation of attachment transactions in Companion Guides.

Note: *Draft rule requirements may be updated as part of the CAQH CORE Infrastructure Rule Update. The Review Work Group will address updates to the infrastructure rules to modernize requirements and ensure consistency.*



- ✓ **Reassociation** requirements for X12 275 and non-X12 275 payload formats including use of **Code EL**.
- ✓ **Consistent reference data** between the prior authorization Requests & associated attachment(s).

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CAQH CORE Attachments Initiative – Claims Use Case

Draft Rule Requirements

Building on the Health Care Claims Operating Rules, approved and published in September 2015, the Draft Attachments Claims Operating Rules ensure support for data content and infrastructure requirements, including specifying the capability of multiple electronic attachments to support a single claims submission.

Scope: CAQH CORE Claims Attachment Operating Rule Requirements

Payload Formats include both the X12 275 and Non-X12 275 (HL7 C-CDA, FHIR, .pdf, etc.).

- ✓ Builds upon the CAQH CORE Health Care Claims (837) Infrastructure Rule and aligns with the Draft Prior Authorization Attachment Infrastructure Requirements to include **support for real-time and batch response time, system availability, and companion guide requirements, etc**.
- ✓ Establishes **electronic policy access** requirements.
- ✓ Specifies **support for multiple electronic attachments** to support a single claim submission.

Note: *Draft rule requirements may be updated as part of the CAQH CORE Infrastructure Rule Update. The Review Work Group will address updates to the infrastructure rules to modernize requirements and ensure consistency.*

- ✓ **Aligns with the Draft Prior Authorization Attachment Data Content Requirements** to include support for specific codes to reassociate X12 275 attachments to X12 837 Claims submissions, including **Code EL**, and establishes common reference data used to connect X12 and non-X12 attachments with X12 837 Claim submissions.
- ✓ Requires health plans to use appropriate **LOINCs to request most specific additional information.**

Current Rule Writing Efforts

- Attachments
- **Eligibility**

Taha Anjarwalla
CAQH CORE Associate Director

CAQH CORE Eligibility & Benefits Data Content Rule

Overview of Existing Rule Requirements

The **CAQH CORE Eligibility & Benefits Data Content Rule** requires the submission and return of certain uniform data elements in real time for electronic eligibility, coverage, and benefit transactions.

- Support requests for benefit information **at least 12 months into the past and up to the end of the current month**.
- Inclusion of the following in response to both generic and explicit inquires:
  - Patient financials for **co–insurance**, **co–payment, and base and remaining deductibles**.
  - Return any **in-network** and **out-of-network** variances in financial responsibility; both amounts are returned.
  - **Name of the health plan** covering the individual.
- Return of CORE-required eligibility & benefits data for **51 specific Service Type Codes**.
- Requires health plans and providers to uniquely identify patients (subscribers, members, beneficiaries) for the purpose of ascertaining the eligibility of the patient for health plan benefits via **last name normalization**
- Defines a standard way for health plans to report errors in the event they are not able to respond to a provider with eligibility information for the requested patient or subscriber through **AAA error code reporting requirements**.
- Vendors must be able to **detect and extract all data elements** to which the data content rule applies as returned by the health plan in the X12 271 response.

CAQH CORE Eligibility & Benefits Data Content Rule Update

Scope

The **Draft CAQH CORE Eligibility & Benefits Data Content Rule Update** enhances the exchange of eligibility information between health plans and providers through requirements including providing financial information, especially co-insurance, co-payment, deductible, remaining deductible amounts, and coverage information for a set of service types in real time.

- In Fall 2020, CAQH CORE participants identified the eligibility and benefits business process as an area for CAQH CORE to prioritize for operating rule development in 2021 given evolving business needs since rule was first developed.

- In Spring 2021, CAQH CORE launched a Task Group to evaluate opportunity areas for operating rule enhancement for the CAQH CORE Eligibility & Benefits Data Content Rule. The Task Group evaluated numerous opportunity areas and drafted operating rules for the following 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

NOTE: The CAQH CORE Eligibility & Benefits Task Group is currently reviewing and refining these updated requirements prior to sending to the Review Work Group. While in the review process, draft rule requirements are subject to change.

Next Step for Attachments & Eligibility:

CAQH CORE Review Work Group Review

The CAQH CORE Review Work Group (RWG) launched in August to further review and refine **both Draft CAQH CORE Attachments Operating Rule Sets** to ensure uniformity and cohesion across the prior authorization and claims use cases. Additionally, the RWG will review updates to the **CAQH CORE Eligibility & Benefits Data Content Rule** and update key requirements included in the existing **CAQH CORE Infrastructure Operating Rules.**

Updated and Newly Drafted Operating Rules for RWG Review

1. NEW: Draft CAQH CORE Attachments (275/278) Prior Authorization Operating Rules

- Draft CAQH CORE Attachments (275/278) Prior Authorization Infrastructure Rule
- Draft CAQH CORE Attachments (275/278) Prior Authorization Data Content Rule

2. NEW: Draft CAQH CORE Attachments (275/837) Health Care Claims Operating Rules

- Draft CAQH CORE Attachments (275/837) Health Care Claims Infrastructure Rule
- Draft CAQH CORE Attachments (275/837) Health Care Claims Data Content Rule

3. UPDATE: Draft CAQH CORE Eligibility & Benefits Data Content Rule

- Draft CAQH CORE Eligibility & Benefits Data Content Rule Update

4. UPDATE: Draft CAQH CORE Infrastructure Rules Update

- Requirements under consideration for the update will depend on Infrastructure Survey results*

**CAQH CORE Participant Infrastructure Update Survey launched 9/1/21.*

CAQH CORE Activities

- **Rule Maintenance**
- **Pilot Initiative**

Marianna Singh
CAQH CORE Senior Associate

CAQH CORE EFT/ERA Enrollment Data Sets Maintenance

Section 3.4 of the CAQH CORE EFT/ERA Enrollment Data Operating Rules requires a policy and process to review the Enrollment Data Sets. Since 2014, reviews of the Enrollment Data Sets have been conducted annually, with **limited in-scope submissions** from industry. To date, **no substantive adjustments have been made** to the Data Sets.

Maintenance Goal	▪ Address emerging, new, or changing industry business needs to the CAQH CORE EFT & ERA Enrollment Data Sets through an ongoing review process.
Updated: Review Process	▪ Given the Enrollment Data Sets have continued to meet industry's need over the years, CAQH CORE Participants voted to transition the EFT/ERA Maintenance Process to a **"rolling submission process"** whereby adjustments can be submitted at any point in time. ▪ If CAQH CORE receives **substantive submissions** and/or **critical needs are identified**, the Task Group will convene.
Updated: Review Requirements	▪ **Substantive submissions**: More than one of the same, in-scope submissions that meet the Enrollment Data Evaluation Criteria for Ongoing Maintenance. ▪ **Critical need**: Any adjustments necessary to resolve an issue prohibiting implementation of the current Enrollment Data Set for multiple implementers and/or to address regulatory requirement.

The updated process will conserve industry resources to address the most pressing issues while enabling critical updates to the Enrollment Data Sets, as needed.

Prior Authorization Pilot & Measurement Initiative: Phase II

Vision: Partner with industry organizations to measure the impact of existing and new CAQH CORE prior authorization operating rules and corresponding standards on organizations' efficiency metrics.

Organization Highlight

Cleveland Clinic | PriorAuthNow | CAQH (CORE & Explorations)

Phase I

- **Understanding of Workflows & Technical Specification**
  Timeframe: Mid Feb through Mid-June 2020
- **Provider staff satisfaction and experience survey**
  Timeframe: Mid Feb through Mid June 2020
- **Webinar – Prior Authorization Automation Case Study**
  Timeframe: August 17, 2020 (watch here)

Phase II

- **Cross-Sectional Comparison Analysis**
  Timeframe: June 2020 to Feb 2021
  Categories of Service: Diagnostic Imaging
- **Metrics reported by Time and Volume**
- **Upcoming Webinar – Part II**
  Timeframe: October 14, 2021

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Polling Question 1

What business processes would you like to see CAQH CORE prioritize in 2021? (Select All That Apply)

- Advanced EOB/Price Transparency
- Value-based Payments
- Patient Data Sharing
- Healthcare Claims
- Claim Status
- Healthcare Payment & Remittance

Polling Question 2

Are there additional topics you would like CAQH CORE to prioritize in 2022? (Select All That Apply)

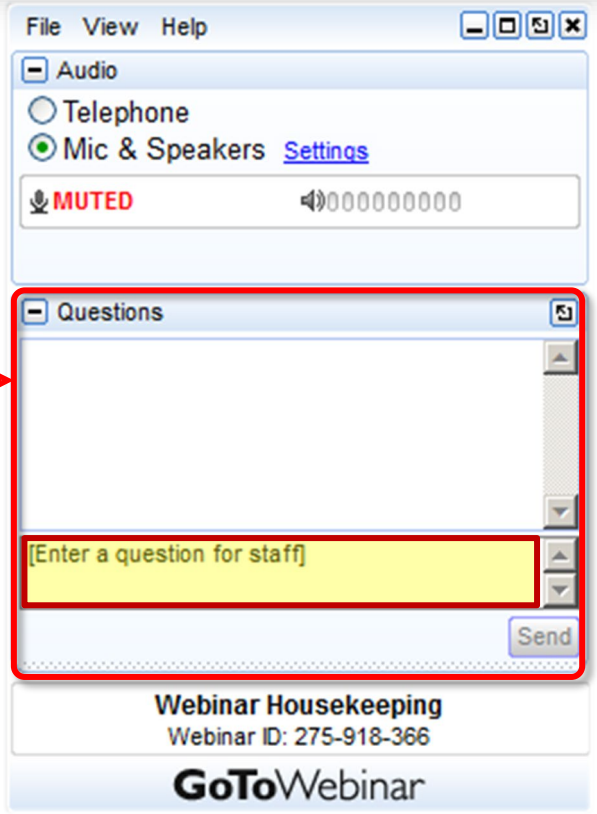
- Telehealth
- Certification/Accreditation
- Pilot/Testing
- Roadmap to Support Industry Interoperability

Audience Q&A

Please submit your questions

Enter your question into the “Questions” pane in the lower right-hand corner of your screen.

You can also submit questions at any time to CORE@caqh.org



Download a copy of today’s presentation slides at caqh.org/core/events

- Navigate to the Resources section for today’s event to find a PDF version of today’s presentation slides.
- The slides and webinar recording will be emailed to all attendees and registrants in the next 1-2 business days.

CAQH CORE

Upcoming CAQH CORE Education Sessions and Events

NACHA & CAQH CORE Webinar Series, Part 2: How Operating Rules Can Improve Dental Practice Financials

October 7, 2021 | 2-3 pm EST

Prior Authorization Automation Case Study Webinar with Cleveland Clinic, PriorAuthNow & CAQH CORE

October 14, 2021 | 1-2 pm EST

Healthcare administration is rapidly changing.

Join Us

Collaborate across stakeholder types to develop operating rules.

Present on CAQH CORE education sessions.

Engage with the decision makers that comprise 75% of the industry.

Represent your organization in work groups.

Influence the direction of health IT policy

Drive the creation of operating rules to accelerate interoperability

Click **here** for more information on joining CAQH CORE as well as a complete list of Participating Organizations.

CAQH CORE

Thank you for joining us!

@CAQH

Website: www.CAQH.org/CORE

Email: CORE@CAQH.org

The CAQH CORE Mission

Drive the creation and adoption of healthcare operating rules that support standards, accelerate interoperability and align administrative and clinical activities among providers, payers and consumers.