CAQH CORE and X12 Webinar Series: Introduction to the 270/271 Transaction, Standard, & Operating Rules

July 11, 2022

1:00-2:00pm ET

Logistics

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  - A copy of the slides and the webinar recording will also be emailed to all attendees and registrants in the next 1-2 business days.
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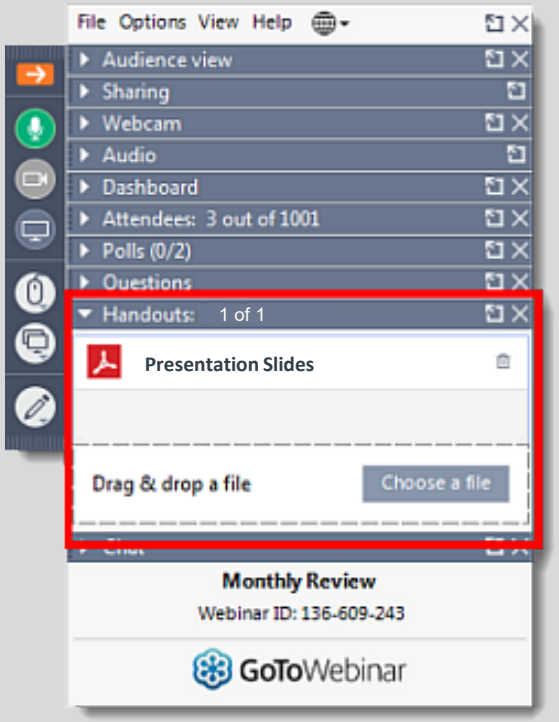

Thank You to Our Speakers

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CAQH CORE

Session Outline

- Introduction to the 270/271 Transaction Standard
- CAQH CORE Eligibility & Benefits Operating Rules
- Q & A

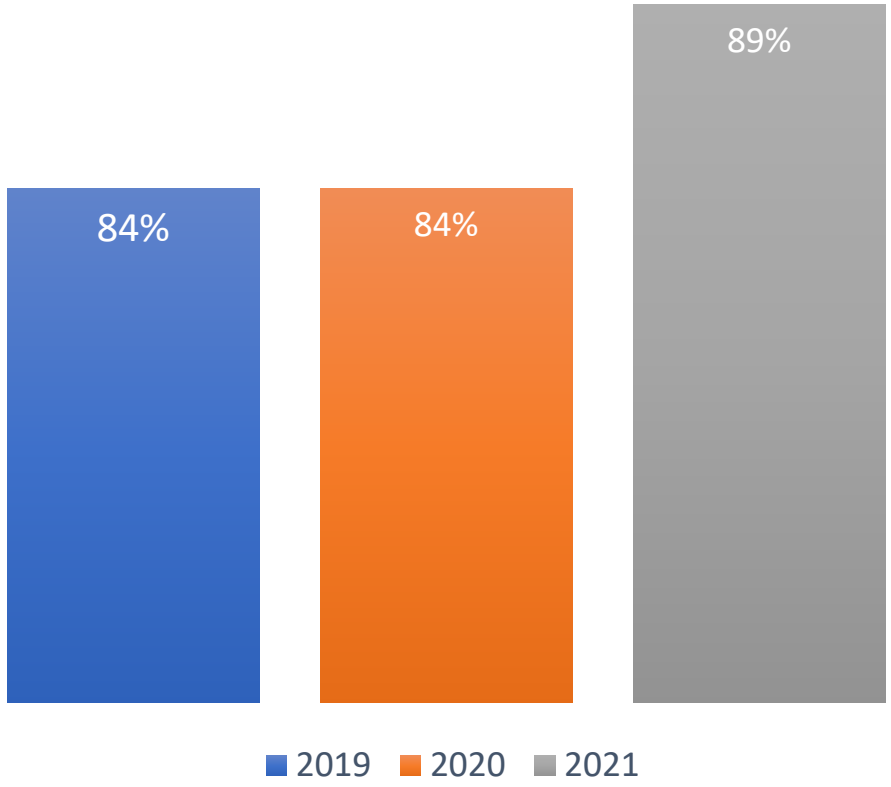
Health Plan Eligibility Benefit Inquiry and Response Level Set

Eligibility/Benefit Verification

- An inquiry from a provider to a health plan or from one health plan to another to **obtain eligibility, coverage or benefits associated with the plan** and a response from the health plan to the provider.
- In January 2009, HHS adopted **Version 5010 of the ASC X12N 270/271** for health plan eligibility benefit inquiry and response.
- As of January 1, 2013, HIPAA-covered entities were required to comply with **federally mandated operating rules for eligibility** for a health plan.

Source: CMS. "Health Plan Eligibility Benefit and Response"

Eligibility & Benefits Electronic Adoption by Year



Source: 2021 CAQH Index

WHAT'S HAPPENING AT X12

Eligibility and Benefits

DISCLAIMER

- This presentation is for informational purposes only
- The content is point-in-time information, subject to revision

TOPICS

1. About X12
2. Eligibility and Benefits
   - *Purpose and Scope*
   - *Benefits*
   - *Users*
   - *Workflow*
3. Wrap-Up

About X12

About X12

Purpose and Scope

Benefits

Users

Workflow

Wrap-Up

THE X12 ORGANIZATION

- X12 is a consensus-based ANSI-accredited National Standards Developer (ASD) focusing on the development and ongoing use of cross-industry interoperable data interchange standards
- X12's standards have proven reliable, efficient, & effective in supporting organizations and industries for 40+ years
- X12 maintains electronic messaging that supports finance, government, health care, insurance, supply chain, transportation, and other industries

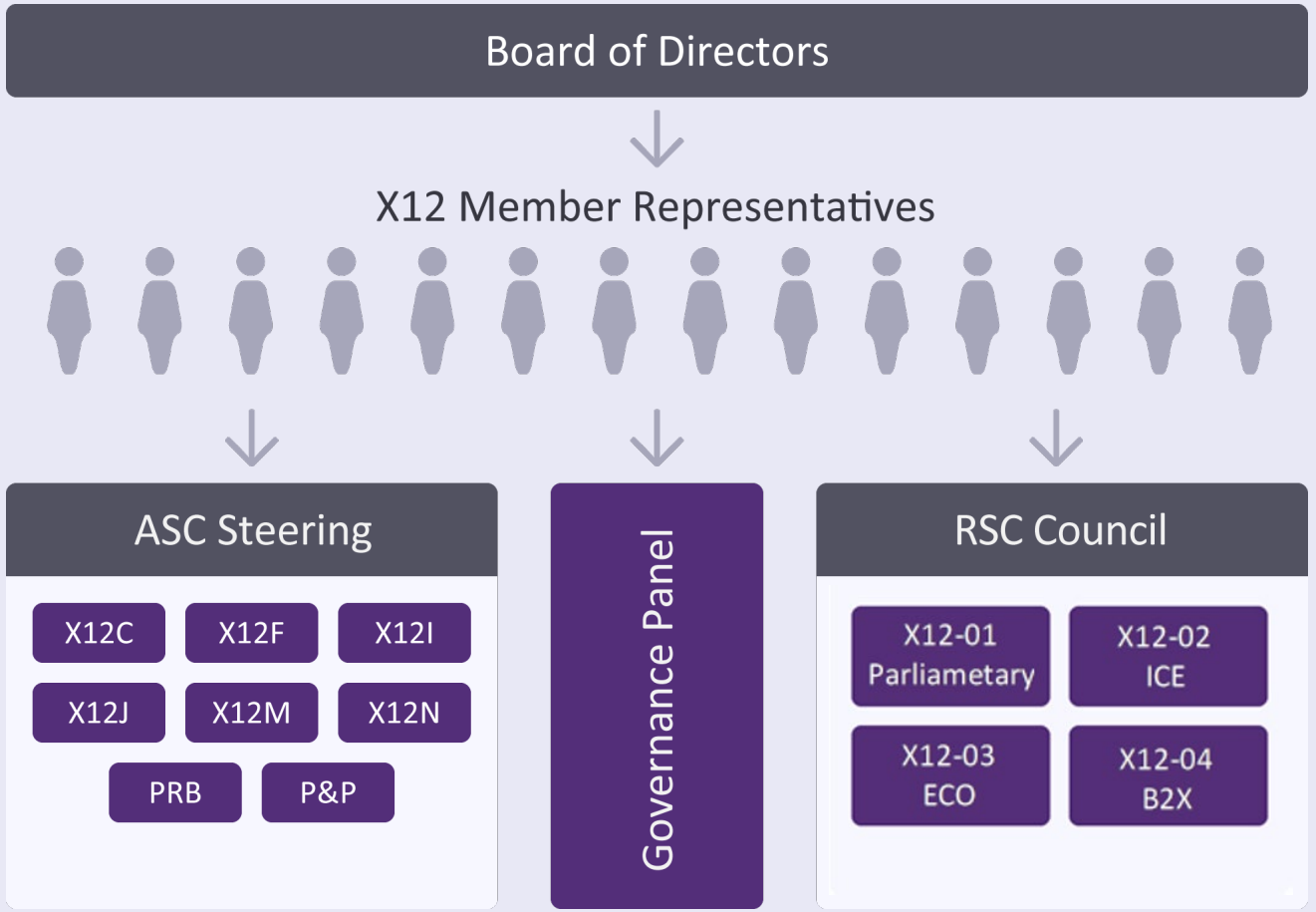
THE X12 ORGANIZATION

- X12 is comprised of a handful of staff, hundreds of members, and more than a thousand member representatives
- Members include corporations, associations, organizations, government entities, and individuals
- X12 standards are the workhorse standards for business to business exchanges
- Many partner-to-partner “standards” are developed based on X12’s intellectual property

X12 IMPLEMENTATION BASE

- Billions of transactions based on X12 standards are utilized daily across various industries including finance, government, health care, insurance, supply chain, transportation, and others
- Millions of entities around the world have an established infrastructure that supports X12 transactions, representing a significant investment in a stable and effective infrastructure
- The data exchanged in X12 transactions is well-defined and has been use-tested in production systems for over 40 years

X12 ORGANIZATIONAL STRUCTURE



THE X12 ORGANIZATION

- Most in health care are familiar with X12's Accredited Standards Committee (ASC)
  - *The ASC develops and maintains the EDI Standard and related implementation guides, including those mandated under HIPAA*
- Some are not as familiar with another X12 committee, the Registered Standards Committee (RSC)
  - *The RSC's External Code List Oversite (ECO) subcommittee develops and maintains X12's terminology, aka vocabulary, resources, excepting those defined within the EDI Standard*

X12 PRODUCTS

X12's product library includes

- *The EDI Standard which is comprised of hundreds of transactions and internal code lists*
- *Technical reports, including implementation guides, describing the business rules and data content for various uses of the EDI Standard*
- *External code lists, aka terminology or vocabulary resources*
- *Schema based on the EDI Standard and implementation guides*
- *Other offerings designed to assist implementers*

X12'S APPROACH

- Open-minded, with vision and insight related to data exchange in both current and developing technologies
- Responsive to business requirements presented by other organizations
- Collaborating enthusiastically with other SDOs, industry groups, government, and business-focused entities

Eligibility and Benefits

About X12

Purpose and Scope

Benefits

Users

Workflow

Wrap-Up

PURPOSE AND SCOPE

- The 005010X279A1 version (and beyond) implementation guide's purpose defines the requirements and guidance within the context of the Health Care Eligibility, Coverage, or Benefit Inquiry (270) and Health Care Eligibility, Coverage, or Benefit Information (271) transaction sets. These transactions specifically identify where and when data is included when conveying health care eligibility and benefit information. This paired transaction set is comprised of two transactions: the 270, which is used to request (inquire) information, and the 271, which is used to respond with coverage, eligibility, and benefit information.

BENEFITS

- Supports real-time and batch exchanges
- Supports multiple stakeholder types, such as payers, providers, vendors, clearinghouses
- Provides a vehicle to request and reflect membership eligibility and coverage statuses within an organization's system, and further provides a way to request and return benefit and contract details for a subscriber and/or dependent
- Sets basic requirements common to all requests and responses to alleviate the need for phone calls
- Provides the capability to return granular details with respect to benefit designs, such as (not limited to) coordination of benefits, primary care physician oversight, and prior authorization requirements

USERS

- Providers who need to determine eligibility status on their patients
- Providers who need to determine prior authorization requirements for services or benefits
- Vendors who need to determine coverage for certain categories of care (such as telemedicine)
- Vendors who are verifying coverage for coordination of benefits purposes
- Payers who need to verify prior coverage with previous payers for continuity of coverage
- Payers who respond to requests submitted by the aforementioned users
- Clearinghouses who will provide partnerships between providers, vendors and payers

WORKFLOW

Submitter (information Receiver) of a 270 identifies the information source to where the request will route

Receiver (Information Source) of the 270 may validate submitters authority to conduct exchange;
Receiver will search for the subscriber or dependent identified on the 270 and determine the eligibility and coverage status of the subscriber/dependent
Receiver will use information such as the dates of service, provider information, service type or procedure code, diagnosis code and/or place of service to determine whether the benefit or service for said specifics is a covered benefit within a plan that covers the subscriber or dependent

Receiver generates a 271 inclusive of the requirements set forth in the TR3, and any additional information defined by the receiver to provide a response to the submitter.

Wrap up

About X12

Purpose and Scope

Benefits

Users

Workflow

Wrap-Up

FEEDBACK. IDEAS. QUESTIONS

WE WANT TO HEAR IT ALL,

TELL US AT

X12.ORG/FEEDBACK

STAY CONNECTED

- Learn more about X12 and become a member at X12.org
- Stay informed by following X12
  - *@x12standards on Twitter*
  - *#X12 on LinkedIn*

CAQH CORE Eligibility & Benefits Operating Rules

Erin Weber
Vice President, 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.

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

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

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

More than 100 Participating Organizations Representing 75% of Insured Lives

Integrated Plan/Provider

- Highmark Health
- Kaiser Permanente
- Marshfield Clinic

Health Plans

- Aetna
- Ameritas Life Insurance Corp.
- Anthem Inc.
- AultCare
- Blue Cross and Blue Shield Association (BCBSA)
- Blue Cross Blue Shield of Michigan
- Blue Cross Blue Shield of North Carolina
- Blue Cross Blue Shield of Tennessee
- CareFirst BlueCross BlueShield
- Centene Corporation
- CIGNA
- Coventry Health Care
- Government Employees Health Association, Inc. (GEHA)
- Health Care Service Corp
- Highmark, Inc (Highmark Health)
- Health Net Inc. (Centene Corporation)
- Horizon Blue Cross Blue Shield of New Jersey
- Humana
- Medical Mutual of Ohio, Inc.
- Point32Health
- Security Health Plan of Wisconsin, Inc. (Marshfield Clinic)
- UnitedHealthGroup
- UnitedHealthcare

Government

- Arizona Health Care Cost Containment System
- California Department of Health Care Services
- Centers for Medicare and Medicaid Services (CMS)
- Federal Reserve Bank of Atlanta
- Florida Agency for Health Care Administration
- Health Plan of San Joaquin
- Michigan Department of Community Health
- Minnesota Department of Health
- Minnesota Department of Human Services
- Missouri HealthNet Division
- North Dakota Medicaid
- Oregon Department of Human Services
- Oregon Health Authority
- Pennsylvania Department of Public Welfare
- TRICARE
- United States Department of Treasury Financial Management
- United States Department of Veterans Affairs

Providers

- American College of Physicians
- American Hospital Association (AHA)
- American Medical Association (AMA)
- Children's Healthcare of Atlanta Inc
- Cleveland Clinic
- Greater New York Hospital Association (GNYHA)
- Healthcare Financial Management Association
- Laboratory Corporation of America
- Mayo Clinic
- Medical Group Management Association (MGMA)
- Montefiore Medical Center
- New Mexico Cancer Center
- OhioHealth
- Ortho NorthEast (ONE)
- St. Jospeh's Health
- Virginia Mason Medical Center

Vendors & Clearinghouses

- AIM Specialty Health
- athenahealth
- Availity, LLC
- Aver
- Cedar Inc
- Cerner/Healthcare Data Exchange
- Change Healthcare
- ClaimMD
- Cognizant
- Conduent
- CSRA
- DXC Technology
- Edifecs
- Epic
- Experian
- Healthedge Software Inc
- HEALTHeNET
- HMS
- Infocrossing LLC
- InstaMed
- NantHealth NaviNet
- NextGen Healthcare Information Systems, Inc.
- Olive AI
- OptumInsight
- PaySpan
- PNC Bank
- PriorAuthNow
- SS&C Health
- The SSI Group, Inc.
- TIBCO Software, Inc.
- TrialCard
- TriZetto Corporation, A Cognizant Company
- Utah Health Information Network (UHIN)
- Virence Health (athenahealth)
- Wells Fargo

Other

- Accenture
- ASC X12
- Cognosante
- Healthcare Business Management Association
- HL7
- Mettle Solutions
- NACHA The Electronic Payments Association
- NASW Risk Retention Group, Inc.
- National Association of Health Data Organizations (NAHDO)
- National Committee for Quality Assurance (NCQA)
- National Council for Prescription Drug Programs (NCPDP)
- New England HealthCare Exchange Network (NEHEN)
- Ohio Hospital Association
- Private Sector Technology Group
- Tata Consultancy Services Ltd
- Utilization Review Accreditation Commission
- WEDI

CAQH CORE

What are Operating Rules?

Operating Rules are the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications.

01

CAQH CORE is the HHS-designated Operating Rule Author for all HIPAA-covered transactions.

02

Developed to facilitate administrative interoperability by building upon recognized standards and ensuring benefit for each critical stakeholder.

03

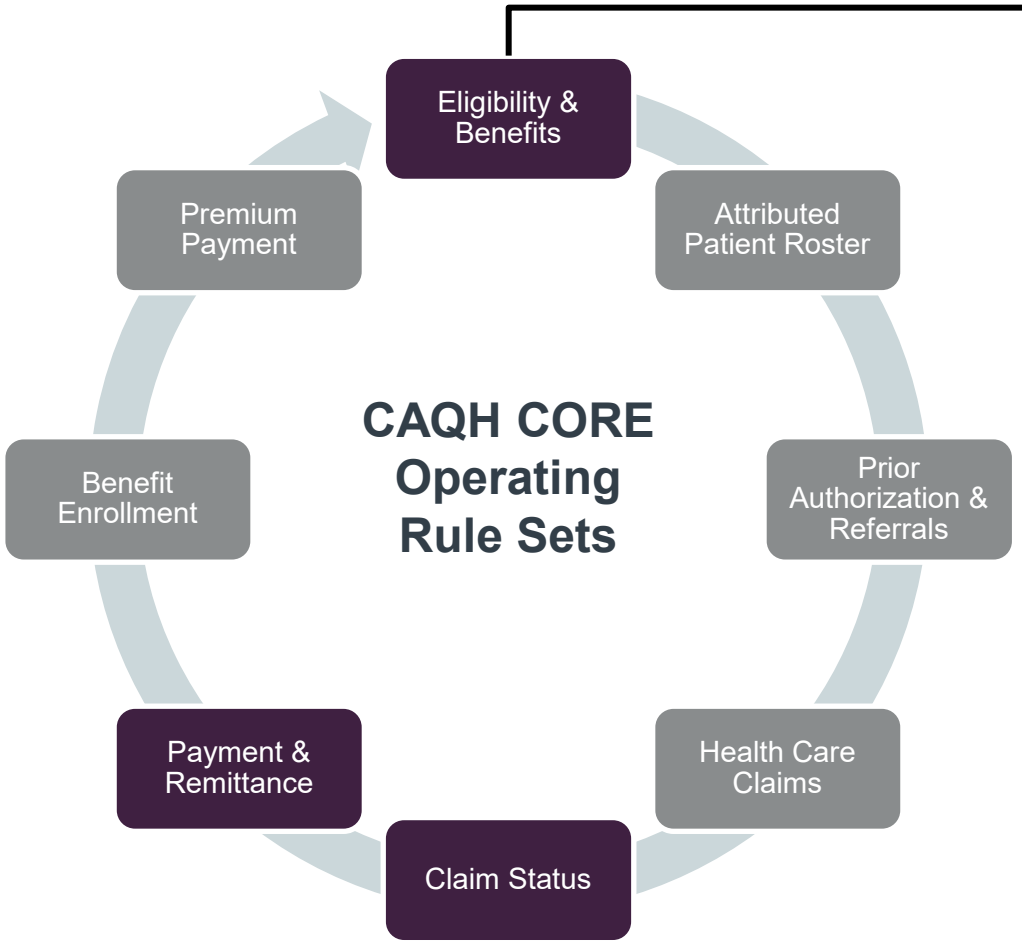
Complement and support healthcare industry and other standards – *they do not repeat or conflict with standards.*

04

Operating rules are also created and implemented in other industries such as finance.

CAQH CORE Operating Rules Support Key Revenue Cycle Functions

Three Rule Sets Adopted Under HIPAA



Certain requirements within these rule sets are federally mandated.

Eligibility & Benefits Rule Set Components:

- Eligibility & Benefits (270/271) **Infrastructure** Rule
- Eligibility & Benefits (270/271) **Data Content** Rule
- Eligibility & Benefits (270/271) Single Patient Attribution **Data Content** Rule*
- **Connectivity** Rules

*Developed in 2020 by the CAQH CORE Participants, the Single Patient Attribution Data Content Rule is not federally mandated.

Operating Rules Include Infrastructure and Data Content Requirements

Infrastructure

- **Infrastructure rules** apply across transactions – establishing basic expectations on how the US data exchange "system" works; e.g., ability to track response times across all trading partners.
- *Infrastructure rules can be used with any version of a standard.*

Data Content

- **Data content rules** support the exchange of valuable data that allow stakeholders to access information needed to manage an identified process; rules can address ongoing maintenance, setting expectation of evolution.
- *Content rules support further use of base standards whenever possible.*

CAQH CORE Eligibility & Benefits Rule Set Overview

Requirements Facilitate the Secure and Timely Exchange of Critical Eligibility Information

INFRASTRUCTURE	DATA CONTENT	
CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule vEB.2.0	**CAQH CORE Eligibility & Benefits (270/271) Data Content Rule vEB.2.0**	**CAQH CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule vEB.1.0**
• Connectivity • Real Time Acknowledgements • Batch Acknowledgements • Real Time Response Times • Batch Response Times • System Availability • Companion Guide	• Electronic Delivery of Patient Financial and Benefit Information • Normalizing Patient Last Name • AAA Error Code Reporting	• Explicit Attribution Status • Effective Dates of Attribution • Requirements for Receivers to Display Attribution Information

A Closer Look: CAQH CORE Eligibility & Benefits Data Content Rule

Overview of Federally Mandated 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 **52 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.

2022 Eligibility & Benefits Data Content Rule Update

Responding to Evolving Industry Needs

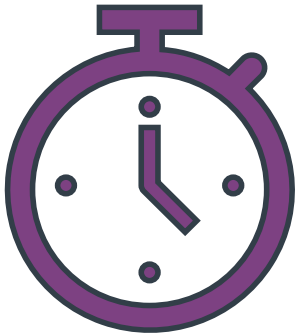
CAQH estimates the industry has **saved over $55 billion in cumulative savings** associated with incremental improvements in standards and operating rule automation since CAQH CORE Operating Rules were federally mandated in 2013. As the industry evolves, operating rules will be updated to address new business needs.

What do the updated eligibility requirements add?

1. Allow health plans and providers to readily identify which services or benefits are covered, **reducing the time and effort spent verifying information.**
2. Include more **granular information** related to telemedicine, prior authorization, remaining coverage benefits, procedure-level information, and tiered benefits to service type and procedure codes.
3. Access to information prior to or at the time of service in real time will result in **more accurate pricing and billing practices.**

Call to Action

Become Involved in Streamlining Healthcare Data Exchange



Participate in Ongoing Pilot/ROI Assessment:

CAQH CORE continues to work With industry partners to measure the impact of current and potential future operating rules and corresponding standards on organizations' efficiency metrics.

Become CORE Certified:

Demonstrate conformance and commitment to streamlining administrative data exchange.

Engage with us as a CAQH CORE Participant:

Collaborate with decision makers that comprise 75% of the industry to drive creation of operating rules and accelerate interoperability.

Email CORE@caqh.org for more information.

Data Collection for 10th Annual CAQH Index Has Launched

Annual Benchmark Report Tracking Industry Progress

Despite high adoption, eligibility and benefits has the highest cost savings opportunity across the industry with $9.8 billion due to the high volume of transactions.

The CAQH Index tracks industry progress in the ongoing transition from manual to electronic administrative transactions. 2022 data collection is underway.

Email explorations@caqh.org for more information on how to participate in this year's data collection effort.

CAQH CORE

Polling Question

What topic would be of most interest for the next webinar in the series?

- Panel Discussion on 270/271 (Eligibility Benefit Inquiry and Response) transaction
- Technical webinar on the 278 (Healthcare Services Review and Response) transaction
- Beginner webinar on the 837 (Health Care Claim) transaction
- Technical webinar on 837 (Health Care Claim) transaction
- Panel Discussion on 837 (Health Care Claim) transaction

Audience Q&A

Please submit your questions

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

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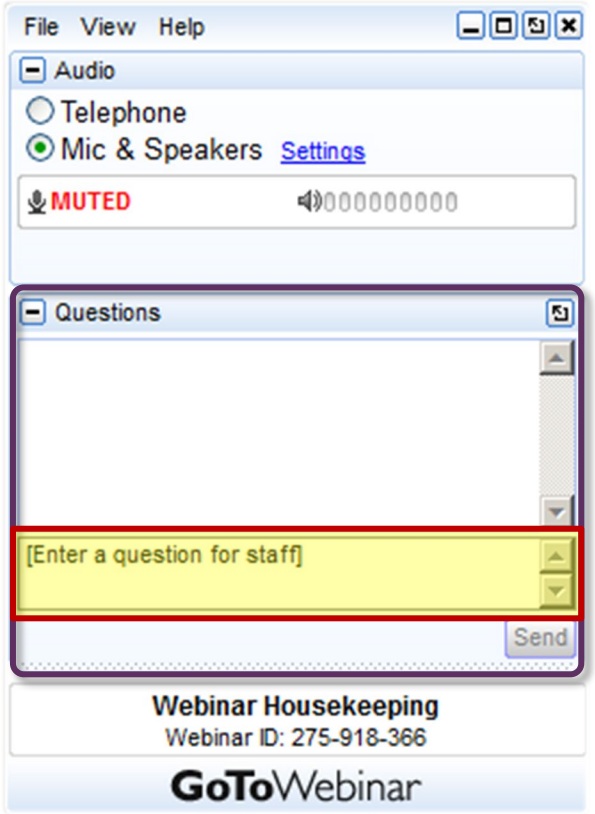

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Presentation Resources

- Webinar Recording
- Presentation Slides

Thank you for joining us!

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