CORE Attributed Patient Roster (X12 v5010X318 834) Infrastructure Rule
Version APR.3.0

March 2024

Revision History for CAQH CORE Attributed Patient Roster (X12 v5010X318 834) Infrastructure Rule

Version	Revision	Description	Date
APR.1.0	Major	CAQH CORE Attributed Patient Roster (X12 v5010X318 834) Infrastructure Rule balloted and approved via the CORE Voting Process.	December 2020
APR.2.0	Major	• Substantive updates to system availability requirements to align with current business needs. • Additional non-substantive updates for clarity.	April 2022
APR.3.0	Major	• Substantive updates to establish Real-time Processing Mode requirements and accommodate additional Batch Processing Mode requirements. • Substantive updates to facilitate inclusion of disclosure of socio-demographic data collection, exchange and use into the transaction-specific companion guide. • Additional non-substantive updates for clarity.	March 2024

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1. Background Summary

1.1. CAQH CORE Overview

CORE is an industry-wide facilitator committed to the creation and adoption of healthcare operating rules that support standards, accelerate interoperability, and align administrative and clinical activities among providers, health plans and patients. Guided by over 100 participating organizations – including healthcare providers, health plans, government entities, vendors, associations, and standards development organizations – CORE Operating Rules drive a trusted, simple, and sustainable healthcare information exchange that evolves and aligns with market needs.[1]

To date, this cross-industry commitment has resulted in operating rules addressing many pain points of healthcare business transactions, including eligibility and benefits verification, claims and claims status, claim payment and remittance, health plan premium payment, enrollment and disenrollment, prior authorization, and aspects of value-based healthcare such as patient attribution data exchange and addressing social determinants of health (SDOH).

1.2. Industry Interest in Value-based Payments Focused Data Operating Rules

Value-based Payment models (VBP) are transformative to the healthcare landscape. Shifting reliance away from fee-for-service, volume-driven payment, VBP incentivizes good outcomes and the thoughtful utilization of services. Doing so drives efficiency – measured by both time and dollars – and increases the quality of care provided to attributed patient populations.

The move to value-driven models is accelerating, but continued reliance on a fee-for-service infrastructure paired with the need for stakeholders to accommodate new, innovative methodologies leads to administrative barriers that are often solved using manual workarounds. CORE and other key industry leaders recognize the need for standardization and uniformity to further support value-based payment programs and their aim to create more efficient and effective patient care.

CORE is an active contributor to the evolution, adoption, and simplification of VBP models. In 2018, CORE released the foundational report, All Together Now: Applying the Lessons of Fee-for-Service to Streamline Adoption of Value-based Payments, informed by industry partners who identified common barriers to VBP adoption, including, but not limited to:

- A lack of data uniformity.
- Challenges with patient attribution.
- Nascent technical interoperability.

This pioneering work led to the consensus-based development of a set of CORE Operating Rules addressing patient attribution, including this infrastructure rule. The set is:

- CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule vEB.1.0.
- CORE Attributed Patient Roster (X12 v5010X318 834) Data Content Rule.
- CORE Attributed Patient Roster (X12 v5010X318 834) Infrastructure Rule.

Underpinning the continued relevance and importance of patient attribution, the National Committee for Vital and Health Statistics (NCVHS), a federal advisory committee to the Department of Health and Human Services (HHS), sent a letter to the Secretary of HHS recommending several CORE Operating Rules for federal adoption, including the CORE Single Patient Attribution Operating Rule.[2] This marks the first time an operating rule directly addressing value-based payments was recommended for federal

[1] In 2012, CORE was designated by the Secretary of the Department of Health and Human Services (HHS) as the author for federally mandated operating rules under Section 1104 of the Patient Protection and Affordable Care Act (ACA). See Appendix §5.1 for more information.

[2] Letter submitted by NCVHS to HHS on June 30, 2023: https://ncvhs.hhs.gov/wp-content/uploads/2023/07/Recommendation-Letter-Updated-and-New-CAQH-CORE-Operating-Rules-June-30-2023_Redacted-508.pdf.

adoption by NCVHS. The Single Patient Attribution Rule is the foundation of which this rule builds upon.

In 2022, in recognition of the changing contexts in which VBP is implemented, CORE conducted an extensive environmental scan to understand how known barriers to the adoption of VBP have evolved and what new areas have emerged since the foundational work completed in 2018. These findings, detailed in the report, Unifying Value: Industry Opportunities to Streamline Value-based Payment Data Exchange, confirmed the relevance and influence of the operational areas identified in the 2018 – including patient attribution - and highlighted new challenges associated, including:

- Incorporation of methodologies to promote health equity and
- Growing administrative complexity of value-based payment models.

In 2023, CORE convened a Value-based Payment Subgroup to evaluate these opportunities further and assess the need for new or updated operating rules to de-burden and streamline the administration of VBP. Among the topics considered were updates to existing Attributed Patient Roster Operating Rules to incorporate socio-demographic information that can be leveraged by providers to sensitively and proactively address health inequities in their attributed patient populations.

2. Issues to be Addressed and Business Requirement Justification

2.1. Problem Space

In VBP models, Participants[3] are rewarded with incentive payments or penalized for the quality of patient care delivered to a specific population. These models look to support the quintuple aim: better care for individuals, better health for populations and a lower cost to health care while supporting provider well-being and advancing health equity.

A process called “attribution” matches individual patients in a population with providers. Attribution ultimately determines the patients for which a VBP Entity or Participant is responsible within a population. Attribution also serves as a basis for the analytic platforms that are used by VBP Entities and Participants to administer programs and monitor performance. Clear attribution information is essential to tie patient-specific details to model-specific metrics, such as total costs of care, outcomes, and distribution of shared savings/shared risk.

Providers participating in CORE research consistently identify attribution as an important opportunity area for improvement in the administration of VBP models. Providers are inhibited by the “black box” methodologies used by health plans to carry-out patient attribution, leading to confusion in how or why a patient has been assigned to them – particularly if a prior relationship is limited or non-existent. Though the VBP Entities who execute and administer contracts may have some insight into specific attribution methodologies, it is uncommon for this information to trickle down into provider-facing settings. As a result, providers feel that they are not receiving the data necessary to succeed in value-based payment models and proactively manage these patients’ health, which ultimately impact the physicians’ bottom line.

Clearly defined and accurate data are needed to attribute patients to providers. Identifying providers at the individual level, their relationships to other providers, (e.g., same group, same physical location, within network), and their specialty with respect to their patients (e.g., primary care physician, specialist by type) can improve the accuracy of patient attribution. Additionally, VBP models require a mechanism for sharing attribution data and, with it, insights about the socio-demographic characteristics of a population empowering providers to address health inequities at the point-of-care. Key issues and needs include:

[3] Participant is defined in the CAQH CORE Framework for Semantic Interoperability in VBP. Here.

- Promoting use of standardized data elements, including those identifying social characteristics, and provider attribution methodologies that identify providers at the individual level, as well as their relationships to other providers.
- Providing a clear way to identify members of a patient population associated with risk-based contracts.
- Ensuring attribution methodologies assign patients to providers that are directly within the providers' care and hold providers responsible only for services and costs within their control.
- Providing the simplest transport for providers to synchronize data with practice management systems and Electronic Health Records (EHRs), and to enable providers and health plans to validate individual enrollment at the point of care and population level enrollment in value-based payment programs.

When facilitating the collection of potentially sensitive socio-demographic information, special care must be taken to ensure its security and its accuracy in representing a members' personal experience. Best practices for collection, identified by CORE Participants, are recorded in §2.3 of the associated CORE Benefit Enrollment and Maintenance Data Content Rule. That content is additionally available as a standalone document here. CORE encourages implementers to reference these resources as they consider the exchange of this important, sensitive information.

2.2. Business Requirement Justification and Focus of the CORE Attributed Patient Roster (X12 v5010X318 834) Infrastructure Rule

The CORE Attributed Patient Roster (X12 v5010X318 834) Infrastructure Rule addresses the X12 v5010X318 Plan Member Reporting (834) transaction (hereafter referred to as the X12 v5010X318 834) to allow the industry to leverage its investment in the CORE Attributed Patient Roster (X12 v5010X318 834) Data Content Rule as well as the X12 v5010X231 Implementation Acknowledgment for Health Care Insurance (999) transaction and all associated errata (hereafter referred to as X12 v5010X231 999) for the exchange of patient rosters. Benefits to the industry from applying the CORE infrastructure requirements to the X12 v5010X318 834 include:

- Consistent infrastructure and service level agreements across administrative transactions.
- Increased consistency and automation across entities.
- Reduced administrative costs.
- More efficient processes.
- Enhanced revenue cycle management.

The inclusion of this CORE Attributed Patient Roster (X12 v5010X318 834) Infrastructure Rule continues to facilitate industry momentum to increase access to electronic administrative transactions, and will encourage all HIPAA-covered entities, business associates, intermediaries, and vendors to build on and extend the infrastructure they have established for other business transactions.

For each transaction addressed by the CORE Operating Rules, the CORE Participants developed foundational infrastructure rules addressing response times, appropriate Batch and Real Time acknowledgements, system availability, common companion guide formats, and a connectivity safe harbor.

By promoting consistent connectivity and infrastructure expectations between health plans and providers, manual processes are reduced, and electronic transaction usage increased. Applying the CORE infrastructure requirements to the X12 v5010X318 834 transaction ensures alignment across administrative data exchanges.

The CORE Attributed Patient Roster (X12 v5010X318 834) Infrastructure Rule is designed to bring consistency and improve the exchange of patient rosters. These infrastructure rules requirements include:

- Batch exchange of the X12 v5010X318 834 transactions at least monthly for patient rosters.
- The consistent use of the X12 v5010X231 999 for Batch and Real-time exchanges.
- Use of the public internet for connectivity.

- Use of a best practice template for format and flow of companion guides for entities that issue them.

During the 2020 development and 2023 update of the CORE Attributed Patient Roster (X12 v5010X318 834) Infrastructure Rule, CORE used discussions, research, and straw poll results to determine which infrastructure requirements should be applied to the exchange of the X12 v5010X318 834 transaction. The table below lists the infrastructure requirements incorporated into this rule in §4.

Infrastructure Requirements for the X12 v5010X318 834 Transaction	
CORE Infrastructure Requirement Description	**Apply to CAQH CORE Benefit Enrollment Infrastructure Rule for the X12 v5010X318 834**
Processing Mode	Y
Connectivity	Y
System Availability	Y
Real Time Processing Mode Response Time	Y
Batch Processing Mode Response Time	Y
Real Time Acknowledgements	Y
Batch Acknowledgements	Y
Companion Guide	Y

As with all CORE Operating Rules, the CORE Attributed Patient Roster (X12 v5010X318 834) Infrastructure Rule requirements are intended as a base or minimum set of requirements, and it is expected that many entities will go beyond these requirements as they work towards the goal of administrative interoperability. The rule requires that HIPAA-covered health plans or their agents[4] make appropriate use of the standard acknowledgements, support the CORE Connectivity requirements, and use the CORE Master Companion Guide Template when publishing their X12 v5010X318 834 companion guide for the use of exchanging attributed patient rosters.

By applying these CORE infrastructure requirements to the conduct of the X12 v5010X318 834 transactions for exchanging patient rosters, this CORE Attributed Patient Roster (X12 v5010X318 834) Infrastructure Rule helps provide the information that is necessary to electronically exchange patient rosters uniformly and consistently, reducing cost associated with proprietary transaction processes.

3. CORE Attributed Patient Roster (X12 v5010X318 834) Infrastructure Rule: Requirements Scope

3.1. What the Rule Applies to

This CORE Attributed Patient Roster (X12 v5010X318 834) Infrastructure Rule applies to the conduct of the X12 v5010X318 834 Plan Member Reporting transaction.

3.2. When the Rule Applies

This CORE Attributed Patient Roster (X12 v5010X318 834) Infrastructure Rule applies, when:

- A HIPAA-covered health plan and its agent uses, conducts, or processes the X12 v5010X318 834 transaction for the use of exchanging attributed patient rosters.
- A receiver of an attributed patient roster through the X12 v5010X318 834 acknowledges receipt using the X12 v5010X231 999 transaction.

3.3. When the Rule Does Not Apply

This rule does not require any entity to conduct, use or process the X12 v5010X318 834 transaction if

[4] One who agrees and is authorized to act on behalf of another, a principal, to legally bind an individual in particular business transactions with third parties pursuant to an agency relationship. Source: West's Encyclopedia of American Law, edition 2. Copyright 2008 The Gale Group, Inc. All rights reserved.

it currently does not do so or is not required by Federal or state regulation to do so.

3.4. What the Rule Does Not Require

This rule does not require use of a specific attribution methodology.

This rule does not address any data content requirements of the X12 v5010X318 834 transaction.[5]

This rule does not address requirements for the use of the X12 005010X307 834 transaction by the ACA Federal or state Health Information Exchanges (HIX).

This rule does not address requirements for the use of the HIPAA-mandated X12 005010X220 834 transaction.[6]

3.5. Maintenance of this Rule

Any substantive updates to the rule (i.e., change to rule requirements) are determined based on industry need as supported by the CORE Participants per the CORE Change and Maintenance Process.

3.6. Assumptions

A goal of this rule is to adhere to the principles of electronic data interchange (EDI) in assuring that transactions sent are accurately received and to facilitate the electronic exchange of patient attribution status.

The following assumptions apply to this rule:

- A successful communication connection has been established.
- This rule is a component of the larger set of CORE Operating Rules
- The CORE Guiding Principles apply to this rule and all other rules.
- This rule is not a comprehensive companion document addressing any content requirements of the X12 v5010X318 834 transaction.
- Compliance with all CORE Operating Rules is a minimum requirement; any entity is free to offer more than what is required in the rule.

3.7. Abbreviations and Definitions Used in This Rule

- **Batch (Batch Mode, Batch Processing Mode):** Batch Mode is when the initial (first) communications session is established and maintained open and active only for the time required to transfer a batch file of one or more transactions. A separate (second) communications session is later established and maintained open and active for the time required to acknowledge that the initial file was successfully received and/or to retrieve transaction responses.

  Batch Mode/Batch Processing Mode is also considered to be an asynchronous processing mode, whereby the associated messages are chronologically and procedurally decoupled. In a request-response interaction, the client agent can process the response at some indeterminate point in the future when its existence is discovered. Mechanisms to implement this capability may include polling, notification by receipt of another message, receipt of related responses (as when the request receiver "pushes" the corresponding responses back to the requestor), etc.

  Batch Mode/Batch Processing Mode is from the perspective of both the request initiator and the request responder. If a Batch (asynchronous) request is sent via intermediaries, then such intermediaries may, or may not, use Batch Processing Mode to further process the request.

- **Processing Mode:** Refers to when the payload of the connectivity message envelope is processed by the receiving system, i.e., in Real Time or in Batch Mode.

[5] For data content requirements for use of the X12 005010X318 834 transaction see the CORE Attributed Patient Roster (X12 005010X318 834) Data Content Rule.
[6] For infrastructure requirements for use of the HIPAA-mandated X12 005010X220 834 transaction see the CORE Benefit Enrollment (834) Infrastructure Rule.

- **Real Time (Real Time Mode, Real Time Processing Mode):** Real Time Mode is when an entity is required to send a transaction and receive a related response within a single communications session, which is established and maintained open and active until the required response is received by the entity initiating that session.

  Communication is complete when the session is closed.

  Real Time Mode/Real Time Processing Mode is also considered to be a synchronous processing mode.

  Real Time Mode/Real Time Processing Mode is from the perspective of both the request initiator and the request responder.

- **Safe Harbor:** A "Safe Harbor"[5] is generally defined as a statutory or regulatory provision that provides protection from a penalty or liability. In IT-related initiatives, a safe harbor describes a set of standards/guidelines that allow for an "adequate" level of assurance when business partners are transacting business electronically.

  The CORE Connectivity Safe Harbor requires the implementation of the CORE Connectivity Rule so that application vendors, providers, and health plans (or other their agents[5]) can be assured the CORE Connectivity will be supported by any trading partner.

- **Value-based Payment Terminology:** To understand concepts, terms, and methodologies used to navigate and administer value-based payment programs, CORE developed the CORE Framework for Semantic Interoperability in Value-based Payments.[7] Definitions included in the Framework apply to the terminology used in this operating rule and others containing references to value-based payment models. The CORE Attributed Patient Roster Infrastructure Rule vAPR.2.0.0. does not require the adoption of any term or concept included in The Framework.

4. CORE Attributed Patient Roster (X12 v5010X318 834) Infrastructure Rule: Rule Requirements

4.1. Plan Member Reporting for Attributed Patient Roster Connectivity Requirements

An entity must be able to support the most current published and CORE adopted version of the CORE Connectivity Rule (hereafter referred to as the CORE Connectivity Rule). This requirement addresses usage patterns for batch transactions, the exchange of security identifiers, and communications-level errors and acknowledgements. It does not attempt to define the specific content of the message exchanges beyond declaring that the X12 formats must be used between covered entities, and security information must be sent outside of the X12 payload.

The CORE Connectivity Rule is designed to provide a "safe harbor" that application vendors, providers, and health plans (or their agents) can be assured will be supported by any trading partner. All organizations must demonstrate the ability to implement connectivity as described in this section.

These requirements are not intended to require trading partners to remove existing connections that do not match the rule, nor is it intended to require that all trading partners must use this method for all new connections. CORE expects that in some technical circumstances, trading partners may agree to use different communication mechanism(s) and/or security requirements than that described by these requirements.

4.2. Plan Member Reporting for Attributed Patient Roster System Availability

Many health plans and their trading partners have a need to exchange attributed patient rosters outside of the typical business day and business hours. Additionally, health plans and their trading partners are now allocating staff resources to performing administrative and financial back-office activities on weekends and evenings. As a result, health plans and their trading partners have a business need to be able to conduct plan member reporting transactions at any time.

[7] CORE Framework for Semantic Interoperability in Value-based Payments

On the other hand, health plans have a business need to periodically take their plan member reporting processing and other systems offline to perform required system maintenance. This typically results in some systems not being available for timely delivery of X12 v5010X318 834 and retrieval of X12 v5010X231 999 transactions on certain nights and weekends. This rule requirement addresses these conflicting needs.

4.2.1. System Availability Requirements

4.2.1.1. Weekly System Availability Requirement

System availability must be no less than 90 percent per calendar week. System is defined as all necessary components required to process an X12 v5010X318 834 transaction and an X12 v5010X231 999 transaction. Calendar week is defined as 12:01 a.m. Sunday to 12:00 a.m. the following Sunday. This allows for a HIPAA-covered health plan and its agent to schedule system updates to take place within a maximum of 24 hours per calendar week for regularly scheduled downtime.

4.2.1.2. Quarterly System Availability Requirement

A HIPAA-covered health plan or its agent may choose to use an additional 24 hours of scheduled system downtime per calendar quarter. System is defined as all necessary components required to process an X12 v5010X318 834 transaction and an X12 v5010X231 999 transaction. This will allow a HIPAA-covered health plan or its agent to schedule additional downtime for substantive system migration. This additional allowance in a system downtime is in excess of the allowable weekly system downtime specified in §4.2.1.1.

4.2.2. Reporting Requirements

4.2.2.1. Scheduled Downtime

A HIPAA-covered health plan and its agent must publish its regularly scheduled system downtime in an appropriate manner (e.g., on websites or in Companion Guides) such that the HIPAA-covered health plan's trading partners can determine the health plan’s system availability so that staffing levels can be effectively managed.

4.2.2.2. Non-Routine Downtime

For non-routine downtime (e.g., system upgrade), a HIPAA-covered health plan and its agent must publish the schedule of non-routine downtime at least one week in advance.

4.2.2.3. Unscheduled Downtime

For unscheduled/emergency downtime (e.g., system crash), a HIPAA-covered health plan and its agent are required to provide information within one hour of realizing downtime is needed.

4.2.2.4. No Response Required

No response is required during scheduled, non-routine or unscheduled downtime(s).

4.2.2.5. Holiday Schedule

Each HIPAA-covered health plan and its agent establishes its own holiday schedule and publish it in accordance with the rule requirements above.

4.3. Plan Member Reporting for Attributed Patient Roster Real Time Processing Mode Response Time Requirements

Maximum response time for the receipt of an X12 v5010X231 999 transaction from the time of submission or receipt of an X12 v5010X318 834 must be 20 seconds when processing in Real Time

Processing Mode.

Each HIPAA-covered entity or its agent must support this *maximum* response time requirement to ensure that at least 90 percent of all required responses are returned within the specified maximum response time as measured within a calendar month.

Each HIPAA-covered entity or its agent must capture, log, audit, match, and report the date (YYYYMMDD), time (HHMMSS) and control numbers from its own internal systems and the corresponding data received from its trading partners.

The recommended maximum response time between each participant in the transaction routing path is 4 seconds or less per hop as long as the 20-second total roundtrip *maximum* requirement is met.

Each HIPAA-covered entity or its agent must support these response time requirements in this section and other CORE Operating Rules regardless of the connectivity mode and methods used between trading partners.

The goal of this requirement is to adhere to the principles of EDI in assuring that transactions sent are accurately received and to facilitate correction of errors in Functional Groups of X12 v5010X318 834 transactions.

This requirement assumes a successful communication connection has been established.

4.4. Plan Member Reporting for Attributed Patient Roster Real Time Processing Mode Acknowledgement Requirements

These requirements for use of acknowledgements for Real Time Processing mode places parallel responsibilities on both receivers of the X12 v5010X318 834 and senders of the X12 v5010X318 834 for sending and accepting X12 v5010X231 999 acknowledgements. The goal of this approach is to adhere to the principles of EDI in assuring that transactions sent are accurately received and to facilitate health plan correction of errors in their outbound transactions.

The rule assumes a successful communication connection has been established.

4.5. Plan Member Reporting for Attributed Patient Roster Batch Processing Mode Response Time Requirements

Maximum response time for availability of X12 v5010X231 999 transaction when processing an X12 v5010X318 834 transaction submitted in Batch Processing Mode by 9:00 pm Eastern Time of a business day by a health plan or its agent must be no later than 7:00 am Eastern Time the third business day following submission.

A business day consists of the 24 hours commencing with 12:00 am (Midnight or 0000 hours) of each designated day through 11:59 pm (2359 hours) of that same designated day. he actual calendar day(s) constituting business days are defined by and at the discretion of each HIPAA-covered health plan or its agent

Each HIPAA-covered entity or its agent must support this *maximum* response time requirement to ensure that at least 90 percent of all required responses are returned within the specified maximum response time as measured within a calendar month.

Each HIPAA-covered entity or its agent must capture, log, audit, match, and report the date (YYYYMMDD), time (HHMMSS) and control numbers from its own internal systems and the corresponding data received from its trading partners.

Each HIPAA-covered entity or its agent must support these response time requirements in this section and other CORE Operating Rules regardless of the connectivity mode and methods used between trading partners.

The goal of this requirement is to adhere to the principles of EDI in assuring that transactions sent are accurately received and to facilitate correction of errors in Functional Groups of X12 v5010X318 834 transactions.

This requirement assumes a successful communication connection has been established.

4.6. Plan Member Reporting for Attributed Patient Roster Batch Processing Mode Acknowledgement Requirements

These requirements for use of acknowledgements for Batch Mode places parallel responsibilities on both receivers of the X12 v5010X318 834 and senders of the X12 v5010X318 834 for sending and accepting X12 v5010X231 999 acknowledgements. The goal of this approach is to adhere to the principles of EDI in assuring that transactions sent are accurately received and to facilitate health plan correction of errors in their outbound transactions.

The rule assumes a successful communication connection has been established.

4.6.1. Use of the X12 999 Implementation Acknowledgement for Functional Group Acknowledgement

A receiver of an X12 v5010X318 834 transaction must return:

- An X12 v5010X231 999 Implementation Acknowledgement for each Functional Group of X12 v5010X318 834 transactions to indicate that the Functional Group was either accepted, accepted with errors or rejected.

AND

- To specify for each included X12 v5010X318 834 Transaction Set that the Transaction Set was either accepted, accepted with errors or rejected.

A health plan must be able to accept and process an X12 v5010X231 999 for a Functional Group of X12 v5010X318 834 transactions.

When a Functional Group of X12 v5010X318 834 transactions is either accepted with errors or rejected, the X12 v5010X231 999 Implementation Acknowledgement must report each error detected to the most specific level of detail supported by the X12 v5010X231 999 Implementation Acknowledgement.

4.7. Plan Member Reporting for Attributed Patient Roster Companion Guide

A HIPAA-covered health plan and its agent have the option of creating a “companion guide” that describes the specifics of how it implements the X12 transactions. The companion guide is in addition to and supplements the corresponding X12 TR3 Implementation Guide.

Historically, HIPAA-covered health plans and their agents have independently created companion guides that vary in format and structure. Such variance can be confusing to trading partners who must review numerous companion guides along with the X12 TR3 Implementation Guides. To address this issue, CORE developed the CORE Master Companion Guide Template for health plans and their agents. Using this template, health plans and their agents can ensure that the structure of their Companion Guide is similar to other health plan documents, making it easier for its trading partners to find information quickly as they consult each health plan document on these important industry EDI transactions.

Developed with input from multiple health plans, system vendors, provider representatives, and health care/HIPAA industry experts, this template organizes information into several simple sections – General Information (Sections 1-9) and Transaction-Specific Information (Section 10) – accompanied by an Appendix. Note that the Companion Guide template is presented in the form of an example from the viewpoint of a fictitious Acme Health Plan.

Although CORE believes that a standard template/common structure is desirable, it recognizes that different health plans may have different requirements. The CORE Master Companion Guide Template gives health plans the flexibility to tailor the document to meet their needs.

4.7.1. Requirements to Follow the Format and Flow of the CAQH CORE Companion Guide Template for HIPAA Transactions

If a HIPAA-covered entity and its agent publishes a companion guide covering the X12 v5010X318 834 transaction for the use of exchanging attributed patient rosters, the companion guide must follow the format/flow as defined in the CORE Master Companion Guide Template for HIPAA transactions.

NOTE: This rule does not require any entity to modify any other existing companion guides that cover other HIPAA-mandated transaction implementation guides.

4.7.2. Requirements to Include Language Disclosing Collection, Exchange, Processing, and Use of Socio-Demographic Information Collected at Enrollment or Renewal

Consistent with the implementation of requirements in the CORE Benefit Enrollment and Maintenance Data Content Operating Rule, a health plan and its agent must create language disclosing the purpose and use associated with the collection, exchange, and processing of socio-demographic information at member enrollment, renewal, or maintenance. It is required that this information is presented unaltered to members at enrollment, renewal, or maintenance to inform their decision to share potentially sensitive demographic information.

The information indicated for exchange through the X12 v5010X318 834 is facilitated using the CORE Benefit Enrollment and Maintenance Data Content Rule. Although the information is collected according the to the requirements of the referenced rule and, as such, members are provided the disclosure language – in the interest of full transparency and maximizing opportunities for member consent, if a health plan or its agent publishes a Companion Guide covering the X12 v5010X318 834 transaction, the generated disclosure language must be included in the Companion Guide Appendix and appropriately appear in the table of contents to allow for ease of access. This requirement is purposefully redundant to augment disclosure and consent processes.

4.8. Minimum Monthly Requirement to Send Roster

A CORE-certified health plan and its agent must send or make available for pick-up an updated patient roster via the X12 v5010X318 834 transaction to those providers for whom a value-based contract is in effect *at least* once per month. An updated roster removes patients no longer attributed to provider and adds new patients attributed to the provider since last transaction with effective dates of attribution included and new effective dates for attributed patients where applicable. The timing of the receipt of the X12 v5010X318 834 transaction by the provider is to be determined by trading partner agreement to support the business needs of both parties.

5. Conformance Requirements

Conformance with this rule is considered achieved when all the required detailed step-by-step test scripts specified in the CORE Certification Test Suite are successfully passed.