CAQH CORE Attributed Patient Roster (005010X318 834) Data Content Rule

vAPR.1.0

Revision History for CAQH CORE Attributed Patient Roster (X12 005010X318 834) Data Content Rule

Version	Revision	Description	Date
APR.1.0	Major	AQH CORE Attributed Patient Roster (X12 005010X318 834) Data Content Rule balloted and approved via the CAQH CORE Voting Process.	December 2020

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1 Background Summary

1.1 CAQH CORE Overview

CAQH 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 130 participating organizations – including healthcare providers, health plans, government entities, vendors, associations and standards development organizations – CAQH 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 and prior authorization.

1.2 Industry Interest in Value-based Payments Attribution Data Operating Rules

Value-based payment models are transforming a sizable portion of the U.S. healthcare economy by aligning provider compensation with improvements in care and cost controls. However, innovation and experimentation are ongoing and operational challenges may create barriers to adoption. Processes and systems in place to administer fee-for-service payment models do not always support value-based payments. Consequently, a patchwork of proprietary approaches and workarounds is emerging. The resulting lack of uniformity and standardization has created additional administrative burden on providers as each provider may encounter dozens of proprietary workflows.

Without collaboration to minimize these variations, the current environment is ripe for repeating the scenario that emerged in the fee-for-service environment more than two decades ago. Much like the operational challenges being encountered today in value-based payments, initial adoption of electronic transactions for fee-for-service payment models was slow, complicated, and more costly due to a lack of common rules for uniform use.

CAQH CORE was originally created by the industry to address this challenge and is now applying lessons learned to help streamline administration of value-based payments. As the healthcare industry moves towards value-based care, stakeholders remain hampered by features of value-based payment models that do not align with current fee-for-service revenue cycle operational workflows, including the convergence of clinical and administrative data. CAQH CORE is working to strengthen the operational processes and systems supporting value-based payments.

In 2018, CAQH CORE published the report All Together Now: Applying the Lessons of Fee-for-Service to Streamline Adoption of Value-Based Payments, which analyzes operational challenges that may slow or add costs to the implementation of value-based payments. The research found that industry collaboration is needed to minimize variations and identified five operational opportunity areas that, if improved, would smooth implementation. These opportunity areas included: data quality and uniformity, interoperability, patient risk stratification, quality measurement and patient/provider attribution.

Building on the report findings, CAQH CORE launched a multi-stakeholder Advisory Group consisting of executive leaders representing health plans, providers, vendors, government entities and advisors. The group evaluated pain points caused by value-based payments across the traditional revenue cycle workflow, prioritizing a list of opportunity areas for streamlining administration of these arrangements including the exchange of patient/provider attribution information between health plans and providers.

[1] In 2012, CAQH 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 Issues to Be Addressed and Business Requirement Justification

2.1 Problem Space

In value-based payment models, providers are rewarded with incentive payments or penalized for the quality of patient care delivered to a specific population. These models look to support the triple aim: better care for individuals, better health for populations and a lower cost to health care. A process called "attribution" matches individual patients in a population with providers. Attribution ultimately determines the patients for which a provider (as an individual or as an organization) is responsible within a population. Subsequent analytics draw heavily on the attributed population's individual patient health data. For example, attribution forms the basis of analysis for metrics underpinning value-based payment, such as total costs of care, outcomes and distribution of shared savings/shared risk. Providers participating in CAQH CORE research were quick to identify attribution as an important opportunity area for improvement in value-based payment operations. While it is essential for providers to understand attribution models when they engage in value-based payment arrangements, many indicated that they encounter barriers when trying to understand how patients are attributed to them. Value-based payment contracts between health plans and providers may include information on the methodology for assigning patients to a population. However, clinicians providing care often do not have insight into those contracts and may not know why a patient is in their population, especially if it is a patient without a prior relationship. Furthermore, these providers may not know where else their patient has sought care. 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, value-based payment programs require a mechanism for sharing attribution data. Key issues and needs include:

- Promoting use of standardized data elements 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 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.

2.2 Business Requirement Justification and Focus of the CAQH CORE Attributed Patient Roster (X12 005010X318 834) Data Content Rule

Providers may not be aware of their patient's attribution status within their value-based payment contracts at the point of service, leaving the provider unaware of care gaps and/or required encounter or service reporting until well after the patient visit. In order to assess financial exposure, make appropriate operational decisions and provide the highest quality care, a physician should be able to access attribution information for a single patient in real time, as well as a roster of all attributed patients at regular intervals.

The purpose of this operating rule is to identify and standardize the data to be used for exchanging rosters of attributed patients between a health plan and provider. The rule does not address the attribution methodology utilized by the health plan. Patient Roster Attribution Data are the data necessary for a provider to understand which specific patients and specific services being performed are part of or subject to the terms of a value-based contract.

Participants of the CAQH CORE Value-based Payments Subgroup decided to draft this operating rule to apply only to a selection of value-based payment models. Given the complexity of patient attribution, the Subgroup decided to first draft operating rules to apply to the simplest types of attribution – those

applying to population-based models that cover the majority of patient services. Through adoption and implementation of this operating rule, CAQH CORE hopes to gather real world evidence to allow the expansion of this operating rule to include all types of value-based payment models, including bundled payments and quality measurement.

This rule addresses a health plan and its agent electronically sending patient rosters to their contracted providers at least once a month. The minimum data elements and corresponding data element characteristics (e.g., data element definition, name, use, etc.) are identified in §3.5. As the healthcare industry continues to shift from fee-for-service to a more value-based system, the industry will advance its understanding of the best methods to exchange attribution data. Aligning data content across the various approaches will be a critical component to enabling interoperability and supporting organizations at various stages of maturity in adopting standards and exchange mechanisms. The X12 834 transaction is used by health plans, state Medicaid agencies and managed care organizations but is relatively new for provider consumption. The Attributed Patient Roster (X12 005010X318 834) data content rule brings consistency and reduces provider burden in processing various formats of proprietary rosters used today. CAQH CORE continues to monitor industry adoption and other emerging industry efforts – including those led by HL7 and other organizations – by tracking usage and lessons learned to align data content needs among stakeholders.

In parallel with this operating rule, CAQH CORE Participants developed the CAQH CORE Attributed Patient Roster (X12 005010X318 834) Infrastructure Rule which aligns with other CAQH CORE infrastructure rules. The CAQH CORE Participants also developed a complementary rule to address the exchange of single patient attribution information between health plans and providers using the eligibility transaction - the CAQH CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule.

3 CAQH CORE Attributed Patient Roster (X12 005010X318 834) Data Content Rule: Requirements Scope

3.1 What the Rule Applies to

This CAQH CORE Operating Rule conforms with and builds upon the X12 005010X318 Member Plan Reporting (834) Technical Report Type 3 (TR3) Implementation Guide (hereafter referred to as the X12 v5010X318 834) and specifies the minimum content that a health plan and its agent must include when sending an X12 v5010X318 834 transaction to a provider (or information receiver) to provide a roster of subscribers/dependents attributed to a provider under a value-based health plan/contract. The X12 v5010X318 834 transaction must include patient identifying and demographic data, provider identifying information and effective dates of attribution. Attribution is defined by the health plan and is the assignment (or method of assignment) of a patient to a provider and the corresponding health plan and contract. The provider is held responsible by the health plan for the delivery of care to said patient and may be held responsible for the cost of care delivered as well.

3.2 When the Rule Applies

This rule applies when:

- This rule applies when a health plan and its agent make available to a provider a complete roster of patients attributed to a specific value-based contract.

And

- A health plan and its agent conduct provider attribution for the support of an overall value-based contract pertaining to most patient services (i.e. HCPLAN category three and four alternative payment models excluding episode and service specific models).[2]

3.3 When the Rule Does Not Apply

This rule does not apply when:

- A health plan and its agent conduct provider attribution for the support of value-based contracts associated with specific episodes or bundled payments.

Or

- A health plan and its agent conduct provider attribution only for the support of quality measurement.

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 infrastructure requirements of the X12 v5010X318 834 transaction.[3]

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.[4]

3.5 Applicable Loops & Data Elements

This rule addresses the use of the following specified loops, segments and data elements in the X12 v5010X318 834 transaction.

Table 1: Applicable Loops and Segments - Patient (Subscriber/Dependent) Identifying Data Elements

#	X12 Data Element Name	Applicable Loop and Segment in the X12 v5010X318 834	Use of Applicable Loop and Segment in the X12 v5010X318 834	CAQH CORE Operating Rule Supplemental Descriptions
1.	Enrollee Level Detail	Loop 2000 – INS01_1073 Yes/No	*Required Use*	Identify if member is subscriber or dependent
2.	Individual Relationship Code	Loop 2000 – INS02_1069	*Required Use*	Identify relationship of dependent to subscriber
3.	Maintenance Type Code	Loop 2000 – INS03_875	*Required Use*	Identifies Enrollment Status of Subscriber or Dependent
4.	Entity Identifier Code	Loop 2100A – NM101_98	*Required Use*	Identifies the attributed subscriber/dependent.
5.	Entity Type Qualifier	Loop 2100A – NM102_1065	*Required Use*	
6.	Last Name	Loop 2100A – NM103_1035	*Required Use*	
7.	First Name	Loop 2100A – NM104_1036	*Situational Use*	

[2] https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

[3] For infrastructure requirements for use of the X12 v5010X318 834 transaction see the CAQH CORE Attributed Patient Roster (X12 005010X318 834) Infrastructure Rule.

[4] For infrastructure requirements for use of the HIPAA-mandated X12 005010X220 834 transaction see the CAQH CORE Benefit Enrollment (834) Infrastructure Rule.

Table 1: Applicable Loops and Segments - Patient (Subscriber/Dependent) Identifying Data Elements				
#	**X12 Data Element Name**	**Applicable Loop and Segment in the X12 v5010X318 834**	**Use of Applicable Loop and Segment in the X12 v5010X318 834**	**CAQH CORE Operating Rule Supplemental Descriptions**
8.	Middle Name	Loop 2100A – NM105_1037	*Situational Use*	
9.	Name Prefix	Loop 2100A – NM106_1038	*Situational Use*	
10.	Identification Code Qualifier	Loop 2100A – NM108_66	*Required Use*	
11.	Identification Code	Loop 2100A – NM109_67	*Required Use*	
12.	Address Line 1	Loop 2100A – N301_166	*Required Use*	Identifies the primary address of the attributed subscriber/ dependent.
13.	Address Line 2	Loop 2100A – N302_166	*Situational Use*	
14.	City Name	Loop 2100A – N401_19	*Required Use*	
15.	State/Province	Loop 2100A – N402_156	*Situational Use*	
16.	ZIP Code/ Postal Code	Loop 2100A – N403_116	*Situational Use*	
17.	Country Code	Loop 2100A – N404_26	*Situational Use*	
18.	DMG Member Demographics	Loop 2100A – DMG01_02_03	*Required Use*	Enrollee Birth Date and Gender Code

Table 2: Applicable Loops and Segments – Value-Based Health Plan Coverage				
#	**X12 Data Element Name**	**Applicable Loop and Segment in the X12 v5010X318 834**	**Use of Applicable Loop and Segment in the X12 v5010X318 834**	**CAQH CORE Operating Rule Supplemental Descriptions**
1.	Maintenance Type Code	Loop 2300 – HD01_875	*Required Use*	Health Coverage
2.	Date/Time Qualifier	Loop 2300 – DTP01_374	*Required Use*	Effective dates of attribution for subscriber/dependent.[5]
3.	Date/Time Format	Loop 2300 – DTP02_1250	*Required Use*	
4.	Date/Time Period	Loop 2300 – DTP03_1251	*Required Use*	
5.	Reference Identification Qualifier	Loop 2300 – REF01_128	*Required Use*	Health Plan Coverage Policy Identifier Qualifier and Identifier
6.	Member Group or Policy Number	Loop 2300 – REF02_127	*Required Use*	

[5] Reference X12 005010X318 Member Plan Reporting (834) Technical Report Type 3 (TR3) Implementation Guide Loop ID 2300 Benefit Coverage which addresses the use of the DTP – Health Coverage Dates Segment. Due to various value-based payment programs and their attribution methodologies, different values for the DTP qualifier may be used; for example, *348 – Benefit Begin Date* and *349 – Benefit End* may be used to express appropriate dates of attribution, etc. Particulars of qualifier usage should be specified in a health plan companion guide.

Table 3: Applicable Loops and Segments – Attributed Provider Identifying Information				
#	X12 Data Element Name	Applicable Loop and Segment in the X12 v5010X318 834	Use of Applicable Loop and Segment in the X12 v5010X318 834	CAQH CORE Operating Rule Supplemental Descriptions
1.	Provider Information	Loop 2310 – LX01_554	*Required Use*	Information about the primary care provider for the Subscriber or Dependent
2.	Entity ID Code	Loop 2310 – NM101_98 *Required Use*	*Required Use*	Identifies the of provider attributed to the member.
3.	Entity Type Qualifier	Loop 2310 – NM102_1065 *Required Use*	*Required Use*	
4.	Last Name or Organization Name	Loop 2310 – NM103_1035 *Situational Use*	*Situational Use*	
5.	First Name	Loop 2310 – NM104_1036 *Situational Use*	*Situational Use*	
6.	Middle Name	Loop 2310 – NM105_1037 *Situational Use*	*Situational Use*	
8.	Name Suffix	Loop 2310 – NM107_1039 *Situational Use*	*Situational Use*	
9.	Identifier Qualifier	Loop 2310 – NM108_66 *Situational Use*	*Situational Use*	
10.	Identifier	Loop 2310 – NM109_67 *Situational Use*	*Situational Use*	
12.	Address Line 1	Loop 2310 – N301_166	*Required Use*	
13.	Address Line 2	Loop 2310 – N302_166	*Situational Use*	
14.	City	Loop 2310 – N401_19	*Required Use*	
15.	State/Province	Loop 2310 - N402_156	*Situational Use*	
16.	ZIP Code/Postal Code	Loop 2310 – N403_116	*Situational Use*	
17.	Country Code	Loop 2310 – N404_26	*Situational Use*	

3.6 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 CAQH CORE Participants per the CAQH CORE Change and Maintenance Process.

3.7 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 CAQH CORE Operating Rules.
- The CAQH CORE Guiding Principles apply to this rule and all other rules.
- Compliance with all CAQH CORE Operating Rules is a minimum requirement; any entity is free to offer more than what is required in the rule.

4 CAQH CORE Attributed Patient Roster (X12 005010X318 834) Data Content Rule: Rule Requirements

4.1 Basic Requirements for Providers, Information Receivers, Health Plans & their Agents

This rule requires a health plan and its agent administering a value-based health plan to electronically deliver a current roster of patients covered by the VBP contract using the X12 v5010X318 834 transaction to

- Identify the provider receiving the roster in Loop 1000B – Receiver Name

And

- Identify the Subscribers and Dependents covered by the value-based health plan as specified in Table 1: Applicable Loops and Segments – Patient (Subscriber/Dependent) Identifying Data Elements

And

- Identify the details of the value-based health plan as specified in Table 2: Applicable Loops and Segments – Value-Based Health Plan Coverage

And

- Identify the attributed provider as specified in Table 3: Applicable Loops and Segments – Attributed Provider Identifying Information

4.2 Identification of Health Plan Contract

A health plan and its agent must return the appropriate Health Plan Coverage information for each Subscriber and Dependent as specified in Table 2: Applicable Loops and Segments – Value-Based Health Plan Coverage segments and data elements.[6]

4.3 Identification of Attributed Provider for Subscriber/Dependent

A health plan and its agent must return the appropriate Attributed Provider Information for each Subscriber and Dependent as specified in the Table 3: Applicable Loops and Segments – Attributed Provider Identifying Information segments and data elements.

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.

[6] Reference Footnote 5 for detail.