CAQH CORE Attributed Patient Roster (X12 005010X318 834) Infrastructure Rule vAPR.1.0

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

Version	Revision	Description	Date
APR.1.0	Major	CAQH CORE Attributed Patient Roster (X12 005010X318 834) Infrastructure 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. 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 particular 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) Infrastructure Rule

The CAQH CORE Attributed Patient Roster (X12 005010X318 834) Infrastructure Rule addresses the X12 005010X318 Member Plan Reporting (834) transaction (hereafter referred to as the X12 v5010X318 834) to allow the industry to leverage its investment in the CAQH CORE Attributed Patient Roster (X12 005010X318 834) Data Content Rule as well as the X12 005010X231 Implementation Acknowledgment for Health Care Insurance (999) transaction and all associated errata (hereafter referred to as X12 v5010 999) for the exchange of patient rosters. Benefits to the industry from applying the CAQH 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 CAQH CORE Attributed Patient Roster (X12 005010X318 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 CAQH CORE Operating Rules, the CAQH 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 CAQH CORE infrastructure requirements to the X12 v5010X318 834 transaction will ensure alignment across administrative data exchanges.

The CAQH CORE Attributed Patient Roster (X12 005010X318 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 v5010 999 for Batch 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 development of the CAQH CORE Attributed Patient Roster (X12 005010X318 834) Infrastructure Rule, CAQH CORE used discussion, 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	
CAQH CORE Infrastructure Requirement Description	**Apply to CAQH CORE Benefit Enrollment Infrastructure Rule for the X12 v5010X318 834**
Processing Mode	N
Connectivity	Y
System Availability	Y
Real Time Processing Mode Response Time	N
Batch Processing Mode Response Time	N
Real Time Acknowledgements	N
Batch Acknowledgements	Y
Companion Guide	Y

As with all CAQH CORE Operating Rules, the CAQH CORE Attributed Patient Roster (X12 005010X318 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[2] make appropriate use of the standard acknowledgements, support the CAQH CORE Connectivity requirements, and use the CAQH CORE v5010 Master Companion Guide Template when publishing their X12 v5010X318 834 Companion Guide for the use of exchanging attributed patient rosters.

By applying these CAQH CORE infrastructure requirements to the conduct of the X12 v5010X318 834 transactions for exchanging patient rosters, this CAQH CORE Attributed Patient Roster (X12 005010X318 834) Infrastructure Rule helps provide the information that is necessary to electronically

[2] 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.

exchange patient rosters uniformly and consistently, reducing cost associated with proprietary transaction processes.

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

3.1 What the Rule Applies to

This CAQH CORE Attributed Patient Roster (X12 005010X318 834) Infrastructure Rule applies to the conduct of the X12 v5010X318 834 Plan Member Reporting transaction.

3.2 When the Rule Applies

This CAQH CORE Attributed Patient Roster (X12 005010X318 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.

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 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.[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 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.

3.6 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 CAQH CORE Operating Rules.
- The CAQH CORE Guiding Principles apply to this rule and all other rules.

[3] For data content requirements for use of the X12 v5010X318 834 transaction see the CAQH CORE Attributed Patient Roster (X12 005010X318 834) Data Content Rule.
[4] For infrastructure requirements for use of the HIPAA-mandated X12 005010X220 834 transaction see the CAQH CORE Benefit Enrollment (834) Infrastructure Rule.

- This rule is not a comprehensive companion document addressing any content requirements of the X12 v5010X318 834 transaction.
- 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.

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.

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 CAQH CORE Connectivity Safe Harbor requires the implementation of the CAQH CORE Connectivity Rule so that application vendors, providers, and health plans (or other information sources) can be assured the CAQH CORE Connectivity Rule will be supported by any trading partner.

4 CAQH CORE Attributed Patient Roster (X12 005010X318 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 CAQH CORE adopted version of the CAQH CORE Connectivity Rule (hereafter referred to as the CAQH CORE Connectivity Rule).

[5] https://www.merriam-webster.com/legal/safe%20harbor.

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 CAQH CORE Connectivity Rule is designed to provide a “safe harbor” that application vendors, providers and health plans (or other information sources) 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. CAQH 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.

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 processing of X12 v5010X318 384 and X12 v5010 999 transactions on certain nights and weekends. This rule requirement addresses these conflicting needs.

4.2.1 System Availability Requirements

System availability must be no less than 86 percent per calendar week. System is defined as all necessary components required to process an X12 v5010X318 834 and an X12 v5010 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.

4.2.2 Reporting Requirements

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.

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.

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.

No Response Required

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

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 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 v5010 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.

4.3.1 Use of the X12 999 Implementation Acknowledgement for Functional Group Acknowledgement

A receiver of a X12 v5010X318 834 transaction must return:

- A X12 v5010 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 a X12 v5010 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 v5010 999 Implementation Acknowledgement must report each error detected to the most specific level of detail supported by the X12 v5010 999 Implementation Acknowledgement.

4.4 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, CAQH CORE developed the CAQH CORE v5010 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 CAQH CORE believes that a standard template/common structure is desirable, it recognizes that different health plans may have different requirements. The CAQH CORE v5010 Master Companion Guide template gives health plans the flexibility to tailor the document to meet their needs.

4.4.2 Plan Member Reporting for Attributed Patient Roster Companion Guide Requirements

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 CAQH CORE v5010 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.

4.5 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.

6 Appendix

6.1 Appendix 1: Reference

X12 005010X231 Implementation Acknowledgement for Health Care Insurance (999) Technical Report Type 3 and associated errata.

X12 005010X318 Plan Member Reporting (834) Technical Report Type 3 Implementation Guide and associated errata.