CAQH CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule

vEB.1.0

Revision History for CAQH CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule

Version	Revision	Description	Date
EB.1.0	Major	CAQH CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule balloted and approved via the CAQH CORE Voting Process.	December 2020

Table of Contents

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 particular risk-based contracts.
- Ensuring attribution methodologies assign patients to providers 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 from practice management and EHRs, and to enable providers and payer organizations to synchronize, validate at the point of care and population level enrollment in value-based payment programs.

2.2. Business Requirements Justification and Focus of the CAQH CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule

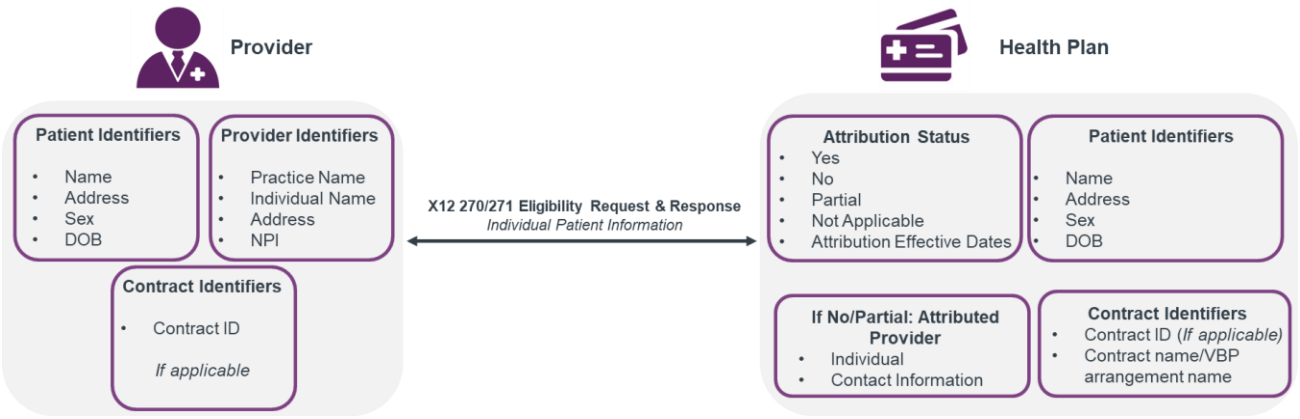
Providers are often unaware of their patient's attribution status within their value-based payment contracts at the point of service, leaving the provider unaware of care gaps and/or required encounter or service reporting until well after the patient visit. In order to assess financial exposure, make 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 single patient attribution status between a health plan and provider. The rule does not address the attribution methodology utilized by the health plan. Single Patient Attribution Data are the data necessary for a provider to understand if the specific patient 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 sharing single patient attribution status at the time of the patient eligibility check in response to a provider's request for information about a single patient. The minimum data elements and corresponding data element characteristics, (e.g., data element definition, name, length, type, associated codes, etc.) are identified in §3.5. See §6 Appendix for a mapping of all data elements to the HIPAA-mandated X12 005010X279A1 Eligibility Benefit Response (271) Implementation Guide. As the healthcare industry continues to shift from fee-for-service to a more value-based system, the industry will continue to 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. 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 also developed two complementary rules to address the exchange of attributed patient rosters at regular intervals between health plans and providers - the CAQH CORE Attributed Patient Roster (X12 005010X318 834) Data Content and Infrastructure Rules.

3. CAQH CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule: Requirements Scope

3.1. What the Rule Applies to

This CAQH CORE Operating Rule conforms with and builds upon the X12 005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271) Technical Report Type 3 (TR3) implementation guide (hereafter referred to as the X12 270/271) and specifies the minimum data content that a health plan and its agent must include in the X12 271 Response when a provider (or information receiver) submits a X12 270 Request to determine if the subscriber/dependent is attributed to the provider under any health plan/contracts with the health plan. The X12 271 Response must include the information the attribution status of Patient (Yes, No, Partial, or Invalid), and the effective dates of attribution status. 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.

This CAQH CORE Operating Rule builds upon and extends the CAQH CORE Operating Rules specified in §4.1 by adding constraints to the X12 271 Response content that a health plan and its agent must include in the X12 271 Response.

3.2. When the Rule Applies

This rule applies when:

- The individual is located in the health plan and its agent's eligibility system.

And

- A health plan and its agent conduct provider attribution status 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]

And

- A health plan and its agent receive a generic vX12 270 Request.

Or

- A health plan and its agent receive an explicit X12 270 Request for a specific service type required in the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule.

3.3. When the Rule Does Not Apply

This rule does not apply when:

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

Or

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

3.4. What the Rule Does Not Require

This rule does not require any HIPAA-covered entity to modify its use and content of:

- Other loops and data elements that may be submitted in the X12 270 Request not addressed in this rule (see §3.5 and §4.1).

And

- Other loops and data elements that may be returned in the X12 271 Response not addressed in this rule (see §3.5 and §4.1).

This rule does not require health plans to use a specific attribution methodology.

3.5. Applicable Loops & Data Elements

This rule addresses the use of the following specified loops, segments and data elements in the X12 271 Response transaction.

Table 1: Applicable Loops and Segments

X12 Data Element Name	Applicable Loop and Segment in X12 271 Response	Use of Applicable Loop and Segment in X12 271 Response	CAQH CORE Operating Rule Description and Requirements
Date *"Effective Start and End Date for Attribution"*	Loop 2110C/Loop 2110D DTP01 = 356 Eligibility Begin/357 Eligibility End	*Situational Use*	Required when health plan identifies that subscriber and/or dependent is attributed to the provider. Return effective start and end dates of attribution.

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

Table 1: Applicable Loops and Segments			
X12 Data Element Name	**Applicable Loop and Segment in X12 271 Response**	**Use of Applicable Loop and Segment in X12 271 Response**	**CAQH CORE Operating Rule Description and Requirements**
	DTP02 = D8–Date Expressed in Format CCYYMMDD - DTP03 = the date applicable to the time period as specified in EB06		
Message Text *"Attribution Status"*	Loop 2110C/Loop 2110D MSG01	*Situational Use*	Required. Return one of the following messages: • ***Attribution Status - Yes*** Or • ***Attribution Status - No*** Or • ***Attribution Status - Partial*** Or • ***Attribution Status - Not Applicable***

3.6. Maintenance of This Rule

Any substantive updates to the rule (i.e., change to rule requirements) will be 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 Eligibility & Benefits (270/271) Operating Rules.
- The CAQH 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 270/271 Eligibility Inquiry and Response transactions.
- 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 Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule: Rule Requirements

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

This CAQH CORE Rule builds upon the following HIPAA-mandated CAQH CORE Operating Rules:

- CAQH CORE Eligibility & Benefits (270/271) Data Content Rule
- CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule

4.2. Identification of Subscriber/Dependent Attribution

A health plan and its agent must return explicit attribution status and effective dates of attribution as specified in Table 1 in §3.5 in the X12 271 for each of the CORE service type codes required by the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule submitted in a X12 270 Request. A health plan and its agent must develop and make available to the healthcare provider specific written instructions and guidance for the healthcare provider on its implementation of this operating rule and the following definitions of attribution and attribution status:

Table 2: Attribution Status Descriptions

Attribution Status	Definition
Attribution Status - Yes	*Patient is attributed to requesting provider.*
Attribution Status - No	*Patient is not attributed to requesting provider. If determined permissible by counsel, health plan and its agent should return the contract Single Patient Attribution Data including attributed provider information (e.g. provider name, NPI and address).*
Attribution Status - Partial	*Patient is attributed to more than one provider, including the requesting provider. If determined permissible by counsel, health plan and its agent should return the contract Single Patient Attribution Data including attributed provider information (e.g. provider name, NPI and address).*
Attribution Status - Not Applicable	*Patient attribution does not apply. Patient does not belong to a value-based care population.*

4.3. Attribution Basic Requirements for Receivers of the X12 271 Response

When receiving an X12 271 Response, a product extracting the data (e.g., a vendor's provider-facing system or solution) from the X12 271 Response for manual processing must make available to the end user:

- Exact text describing the message in the Loop 2110C/Loop 2110D MSG01 Segment included in the X12 271 Response, ensuring that the actual wording of the text displayed accurately represents the corresponding message including exact text in Attribution Status column as seen in Table 2: Attribution Status Definitions, without changing the meaning and intent of the description (i.e., *Attribution Status: Yes*; *Attribution Status: No*; *Attribution Status: Partial*; or *Attribution Status: Not Applicable*).

This requirement does not apply to an entity that is simply forwarding the X12 271 Response to another system for further processing.

5. Conformance Requirements

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

6. APPENDIX

The purpose of the Appendix is to provide additional background on the CAQH CORE Eligibility & Benefits Operating Rules. It is non-normative information and in a case of conflict, the actual rule language applies.

6.1. Recommended Applicable Loops and Segments for Data Returned in X12 271 Response

Table 3 includes the full list of recommended applicable loops and segments in the X12 271 Response for use along with this rule to exchange the attribution status of a single patient.

Table 3: Expanded List of Applicable Loops and Segments

#	X12 Data Element Name	Applicable Loop and Segment in X12 271 Response	Use of Applicable Loop and Segment in X12 271 Response
Provider Identifying Information			
1.	Entity ID Code	Loop 2120C/Loop 2120D NM101	*Required Use*
2.	Entity Type Qualifier	Loop 2120C/Loop 2120D NM102	*Required Use*
3.	Last Name or Organization Name	Loop 2120C/Loop 2120D NM103	*Situational Use*
4.	First Name	NM104	*Situational Use*
5.	Middle Name	NM105	*Situational Use*
6.	Name Suffix	NM107	*Situational Use*
7.	Address Line 1	N301	*Situational Use*
8.	Address Line 2	N302	*Situational Use*
9.	City	N401	*Situational Use*
10.	State/Province	N402	*Situational Use*
11.	ZIP Code/Postal Code	N403	*Situational Use*
12.	Country Code	N404	*Situational Use*
13.	Identifier Qualifier	NM108	*Situational Use*
14.	Identifier	NM109	*Situational Use*
15.	Provider Code	Loop 2120C/2120D PRV01	*Situational Use*
16.	Reference identification qualifier	Loop 2120C/2120D PRV02	*Situational Use*
17.	Reference identification	Loop 2120C/2120D PRV03	*Situational Use*
Health Plan Information Data Elementa			
18.	Information Source Contact Information	Loop 2100A PER01-02-03-04-05-06-07-08	*Situational Use*
Patient (Subscriber/Dependent) Identifying Data Elements			
19.	Last Name	Loop 2100C/Loop2100D NM101-02-03	*Situational Use*
20.	First Name	NM104	*Situational Use*
21.	Middle Name	NM105	*Situational Use*

Table 3: Expanded List of Applicable Loops and Segments			
#	X12 Data Element Name	Applicable Loop and Segment in X12 271 Response	Use of Applicable Loop and Segment in X12 271 Response
22.	Name Suffix	NM107	*Situational Use*
23.	Address Line 1	N301	*Situational Use*
24.	Address Line 2	N302	*Situational Use*
25.	City	N401	*Situational Use*
26.	State/Province	N402	*Situational Use*
27.	ZIP Code/ Postal Code	N403	*Situational Use*
28.	Country Code	N404	*Situational Use*
29.	Subscriber Identifier Qualifier	Loop 2100C NM108 *Situational Use*	*Situational Use*
30.	Subscriber Identifier	Loop 2100C NM109	*Situational Use*
31.	Dependent	Loop2100D	*Situational Use*
32.	Date of Birth	Loop 2100C/Loop 2100D DMG01-02	*Situational Use*
33.	Gender	Loop 2100C/Loop 2100D DMG03	*Situational Use*

6.2. Operating Rule Mandates

Section 1104 of the Affordable Care Act (ACA) contains an industry mandate for the use of operating rules to support implementation of the HIPAA standards. Using successful, yet voluntary, national industry efforts as a guide, Section 1104 defines operating rules as "the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications" (ACA, Section 1104). CAQH CORE is designated by the Secretary of the Department of Health and Human Services (HHS) as the author for federally mandated operating rules.[3]

The ACA outlines three sets of healthcare industry operating rules to be approved by HHS and then implemented by the industry. The first set of ACA-mandated operating rules includes eligibility and benefits inquiry and response transactions. All HIPAA-covered entities were required by Federal law to adopt the CAQH CORE Eligibility & Benefits (270/271) Infrastructure and Data Content Operating Rules and the CAQH CORE Claims Status (276/277) Infrastructure Operating Rule by January 1, 2013, excepting requirements pertaining to the use of Acknowledgements.[4] HHS will determine if additional CAQH CORE Eligibility & Benefits Operating Rules, including this Single Patient Attribution Data Content Rule, will be included in any regulatory mandates.

[3] https://www.caqh.org/sites/default/files/core/hhs-response-to-ncvhs-12122009.pdf
[4] https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Operating-Rules/OperatingRulesOverview.html