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New CAQH CORE Operating Rules to Improve Patient Attribution Data Sharing and Connectivity

February 16, 2021

2:30-3:30pm ET

Agenda

- New Operating Rules for Industry Implementation
  - Connectivity Rule vC4.0.0
  - Value-based Payment Attribution Rules Package Overview
- Conversation about Benefits of Implementation
- Q & A

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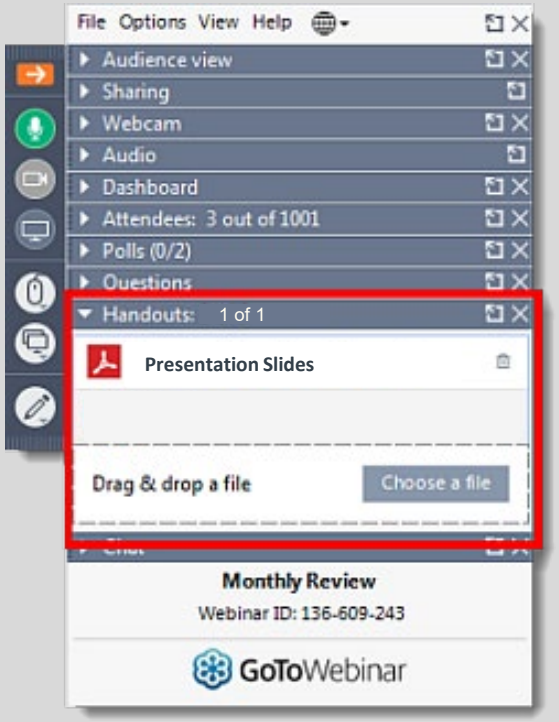


CAQH CORE

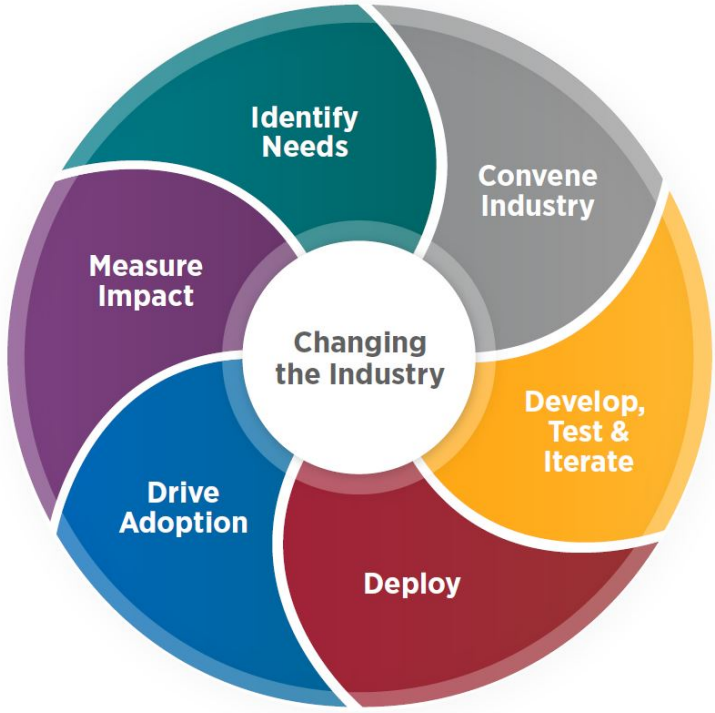
CAQH CORE Mission/Vision & Industry Role

Industry-led, CAQH CORE Participants include healthcare providers, health plans, vendors, government entities, associations and standard-setting organizations. Health plans participating in CAQH CORE represent **75 percent of the insured US population.**

MISSION Drive the creation and adoption of healthcare operating rules that **support standards**, **accelerate interoperability and align administrative and clinical activities** among providers, payers and consumers.

VISION An **industry-wide facilitator** of a trusted, simple and sustainable healthcare data exchange that evolves and aligns with market needs.

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



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

CAQH CORE BOARD **Multi-stakeholder.** Members include health plans, providers (some of which are appointed by associations such as the AHA, AMA, MGMA), vendors, and government entities. Advisors to the Board include SDOs (X12, HL7, NACHA, NCPDP) and WEDI.

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CAQH CORE Operating Rule Overview

Operating Rules Support the Full Continuum of the Healthcare Revenue Cycle

Rule Set	Infrastructure	Connectivity Rule Application	Data Content	Other
Eligibility & Benefits	Eligibility (270/271) Infrastructure Rule	Connectivity Rule vC1.0.0 Connectivity Rule vC2.0.0	Eligibility (270/271) Data Content Rule	Single Patient Attribution Data
Claim Status	Claim Status (276/277) Infrastructure Rule	Connectivity Rule vC2.0.0		
Payment & Remittance	Claim Payment/ Advice (835) Infrastructure Rule		EFT/ERA 835/CCD+ Data Content Rule	EFT/ERA Enrollment Data Rules
Prior Authorization & Referrals	Prior Authorization (278) Infrastructure Rule	Connectivity Rule vC3.0.0	Prior Authorization (278) Data Content Rule	Prior Auth Web Portal Rule
Health Care Claims	Health Care Claim (837) Infrastructure Rule			
Benefit Enrollment	Benefit Enrollment (834) Infrastructure Rule			
Premium Payment	Premium Payment (820) Infrastructure Rule			
Attributed Patient Roster	Attributed Patient Roster (834) Infrastructure Rule	Connectivity Rule vC4.0.0*	Attributed Patient Roster (834) Data Content Rule	

Rules in purple boxes are federally mandated.

*Connectivity Rule vC4.0.0 can be used to support all rule sets for CORE Certification.

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New CAQH CORE Operating Rules for Industry Implementation

- **Connectivity**
- Value-based Payments

Emily TenEyck
CAQH CORE Manager

CAQH CORE Connectivity Update

Aligning CAQH CORE Connectivity Requirements to Support Industry Advancement

CAQH CORE Vision for Connectivity: The CAQH CORE Connectivity Rules address connectivity and security of administrative data exchange and establish a **national base** guiding healthcare communication.

CAQH CORE Connectivity Rule vC4.0.0 Business Case:

- Aligns the CAQH CORE Connectivity Rule vC4.0.0 to support frameworks proposed in the **CMS and ONC interoperability rules,** including the use of REST and other API technology**.**
- Establishes a **Safe Harbor** that aligns with existing IT implementations and supports emerging approaches for exchanging data by **continuing to support SOAP** as an exchange method and **adding support for data exchanged using REST**.
- Supports the intersection of administrative and clinical data exchange by adding support for the attachments transaction and publishing a **single updated rule to include all transactions that are addressed in CAQH CORE Operating Rules**, including those in development.
- **Updates the national floor** guiding connectivity communication in the industry.

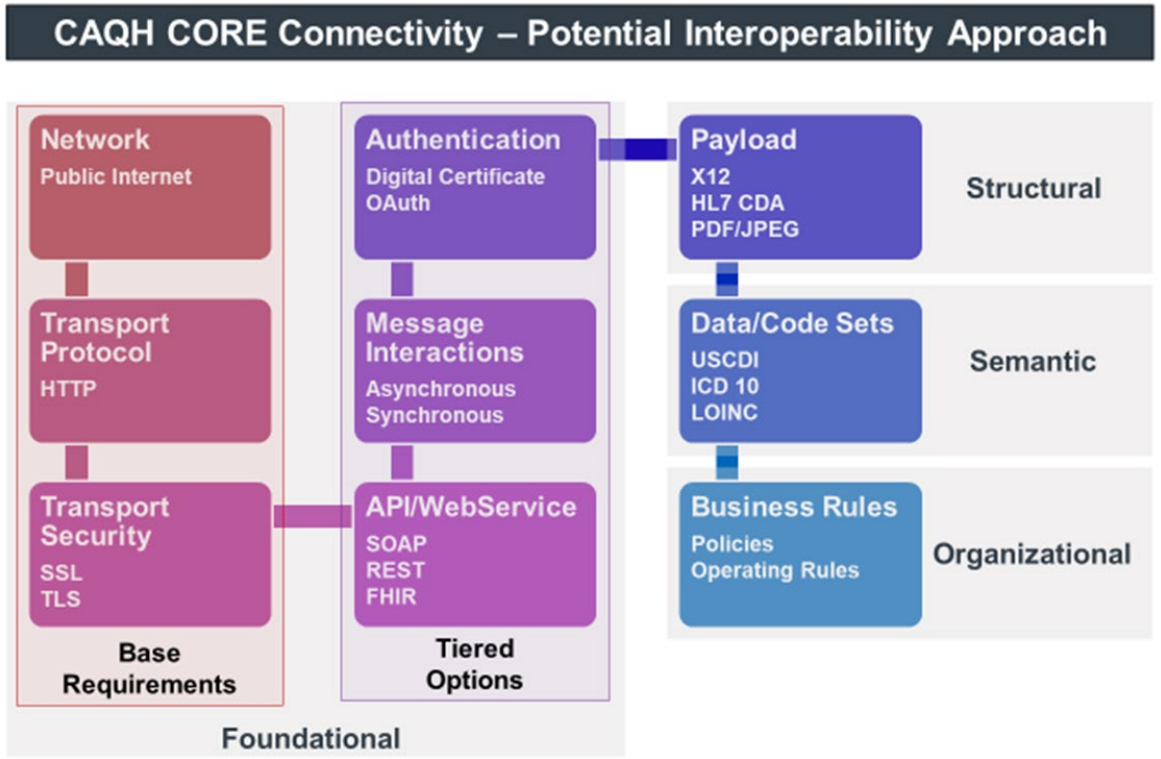
Future Connectivity Opportunities: Once a single Connectivity Rule is established across all CAQH CORE operating rule sets, CAQH CORE Participants will continue to update the rule to align with current interoperability, privacy and security standards.

CAQH CORE Connectivity Update

Aligning CAQH CORE Connectivity Requirements to Support Healthcare Interoperability

Key Updates to CORE Connectivity Requirements in vC4.0.0:

- Requires the use of **TLS v1.2 higher for security** over the public internet for increased and modernized security.
- Defines **authentication and authorization methods** to establish trust within an exchange including the addition of **OAuth 2.0** as an emerging authorization standard.
- Adds support and requirements pertaining to **REST APIs** including specifying **API endpoint naming conventions for X12 and non-X12 payload types** to ensure CORE Connectivity serves as a bridge between existing and emerging standards.
- Adds support for the exchange of **attachments transactions** to advance the intersection of clinical and administrative interoperability.



CAQH CORE Connectivity Rule vC4.0.0

- Updates to SOAP Requirements
- New REST Requirements

Summary of Key Updates to SOAP Requirements

Scope: The rule applies when trading partners exchange **any X12 transactions specified in CAQH CORE Operating Rules.** The scope for the SOAP and REST requirements are identical and therefore are only included once in the rule (Section 3).

Key Updates to SOAP Requirements			
#	**Connectivity Area**	**CORE Connectivity Rule vC3.1.0 SOAP Requirements**	**CAQH CORE Connectivity Rule vC4.0.0 SOAP Requirements**
1	Network	Public Internet	No Changes
2	Transport Protocol	HTTP/S	No Changes
3	Security	SSL 3.0 or TLS 1.1. or higher	TLS 1.2 or higher (remove SSL 3.0)
4	Message Protocol	SOAP + WSDL; XML	No Changes
5	Authentication	X.509 Digital Certificate	No Changes
6	Authorization	N/A	Add support for OAuth 2.0
7	Web Services: SOAP	Payload Types	Add support for X12 275 v6020
		Processing Modes: Real Time and Batch	No Changes
		Message Envelope Structure	No Changes
		Envelope Metadata	No Changes
		Communication of Errors and Status	No Changes

CAQH CORE Connectivity vC4.0.0 SOAP Requirements

Deep Dive: SOAP Authentication and Authorization Requirements

Authentication Requirement: The rule requires HIPAA-covered entities and their agents to support the use of X.509 Mutual Authentication over TLS 1.2 or higher when exchanging messages using SOAP.

- ✓ **Applies to** HIPAA-covered health plans, providers, and their agents
- ✓ **No change** from CAQH CORE Connectivity Rule vC3.1.0

Authorization Requirement: The rule requires HIPAA-covered health plans and their agents to support OAuth 2.0 Client Authorization over TLS 1.2 or higher. HIPAA-covered providers and their agents may *optionally* use OAuth 2.0 Client Authorization over TLS 1.2 or higher when exchanging messages using SOAP.

- ✓ **Applies to** HIPAA-covered health plans and their agents
- ✓ **Optionally Applies to** HIPAA-covered providers and their agents
- ✓ **New Requirement** in CAQH CORE Connectivity Rule vC4.0.0

CAQH CORE Connectivity Rule vC4.0.0

- Updates to SOAP Requirements
- New REST Requirements

CAQH CORE Connectivity vC4.0.0 REST Requirements

Summary of Key REST Requirements

Scope: The rule applies to REST requirements when trading partners exchange **any X12 transactions specified in CAQH CORE Operating Rules.** The scope for the SOAP and REST requirements are identical and therefore are only included once in the rule (Section 3).

NOTE: The updated rule remains payload agnostic, meaning that the SOAP and REST services are not aware of the content they are serving, and the rule may be applied to non-X12 payload types (e.g., HL7 C-CDA, .pdf, .doc, etc.).

Key REST Requirements

#	Connectivity Area	REST Standards and Requirements
1	**Network**	Public Internet
2	**Transport Protocol**	HTTP/S
3	**Security**	TLS 1.2 or higher
4	**Authentication**	X.509 Digital Certificate
5	**Authorization**	OAuth 2.0
6	**Web Services: REST**	Message Protocol
		Payload Types
		Versioning
		HTTP Methods
		Error Handling
		API Endpoints

REST standards and requirements **align with updated SOAP** standards and requirements

New REST Connectivity Requirements

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CAQH CORE Connectivity vC4.0.0 REST Requirements

Deep Dive: REST API Interface Format, Authentication and Authorization Requirements

REST API Format: The rule requires the use of **JavaScript Object Nation (JSON) for REST Interfaces** to reduce variations and enable greater interoperability in the market.

Authentication Requirement: The rule requires HIPAA-covered entities and their agents to support the use of X.509 Mutual Authentication over TLS 1.2 or higher when exchanging messages using REST.

- ✓ **Applies to** HIPAA-covered health plans, providers, and their agents
- ✓ **New Requirement** in CAQH CORE Connectivity Rule vC4.0.0
- ✓ **Mirrors** SOAP Authentication Requirement

Authorization Requirement: The rule requires HIPAA-covered entities and their agents to support OAuth 2.0 (mutual client based authorization) over TLS 1.2 or higher when exchanging messages using REST.

- ✓ **Applies to** HIPAA-covered health plans, providers, and their agents
- ✓ **New Requirement** in CAQH CORE Connectivity Rule vC4.0.0
- ✓ **Differs** from SOAP Authorization Requirement

CAQH CORE Connectivity vC4.0.0 REST Requirements

Deep Dive: REST Versioning Requirements

URI Versioning is explicit, enables version navigation and discovery, and simplifies version management.

1. **Versioning** for REST APIs should be **maintained via the URI Path.**

2. To communicate the use of the Safe Harbor method, **versioning for the CAQH CORE Connectivity Rule** should be maintained via the URI Path.

HTTP Method	Server	CAQH CORE Connectivity Rule	REST API Version
POST	https://www.acmehealthplan.com	/caqhcorevC4.0.0	/v1

The text highlighted in yellow refers to a modifiable variable for versioning management.

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CAQH CORE Connectivity vC4.0.0 REST Requirements

Deep Dive: Specifications for API Endpoint Naming Conventions (Normative)

1. The REST requirements specify that each X12 transaction set and non-X12 payload types point to a specific endpoint.

2. API Endpoints should follow a normative naming convention.

HTTP Method	Server	CAQH CORE Connectivity Rule	REST API Version	Endpoint Name
POST	https://www.acmehealthplan.com	/caqhcorevC4.0.0	/v1	/eligibility

The text highlighted in green below refers to a **modifiable endpoint variable** (green highlighted column) and can be interchanged with the appropriate endpoint, which is dependent on the specific transaction being exchanged.

#	Payload Type	Transaction Name	Endpoint Name (normative)
1	X12_270_005010X279A1	Health Care Eligibility Benefit Inquiry and Response	eligibility
2	X12_275_006020X314	Additional Information to Support Health Care Claim or Encounter	claimAttachment
3	X12_275_006020X316	Additional Information to Support Health Care Services Review	paAttachment
4	X12_276_005010X212E1_2_3	Health Care Claim Status Request and Response	claimStatus
5	X12_277_005010X213	Health Care Claim Request for Additional Information	claimStatusRFAI
6	X12_277_006020X313	Health Care Claim Request for Additional Information	claimStatusAI
7	X12_277_005010X214E1_2	Health Care Claim Acknowledgment	claimStatusCA
8	X12_278_005010X217E1_2	Health Care Services Review – Request and Response	servicesReview
9	X12_278_005010X215	Health Care Services Review – Inquiry and Response	servicesReviewIR
10	X12_278_005010X216E2	Health Care Services Review – Notification and Acknowledgment	servicesReviewNA
11	**X12_820_005010X218A1**	Payroll Deducted and Other Group Premium Payment for Insurance Products	payrollDeducted
12	**X12_834_005010X220A1**	Benefit Enrollment and Maintenance	benefitEnrollment
13	X12_834_005010X307	Health Insurance Exchange Enrollment	exchangeEnrollment
14	X12_834_005010X318	Plan Member Reporting	memberReporting
15	X12_835_005010X221	Health Care Claim Payment / Advice	remittanceAdvice
16	**X12_837_005010X223**A1_2	Health Care Claim – Institutional	claimInstitutional
17	**X12_837_005010X222**A1	Health Care Claim – Professional	claimProfessional
18	**X12_837_005010X224**A1_2	Health Care Claim – Dental	claimDental
19	X12_999_005010X231A1	Implementation Acknowledgement for Health Care Insurance	ackNack
20	X12_TA1_Response_00501X231A	Interchange Acknowledgment Segment	iaAckNack

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CAQH CORE Connectivity vC4.0.0 REST Requirements

Deep Dive: REST Metadata Parameter Fields, Descriptions, Intended Use and Values

1. The parameters specified in the tables below **pertain to the REST exchange only**.

2. These **parameters serve as a base** of what is required by the CORE REST Requirements. **Entities may include additional parameters**, as needed.

Metadata	Description	Requirement	Values	Example
HTTP Request Metadata				
Accept	Media type(s) that is/are acceptable for the response.	Mandatory	application/json	**Accept**: application/json
Authorization	Authorization credentials for HTTP authorization.	Mandatory	A valid OAuth 2.0 token.	**Authorization**: Bearer [Access Token]
Content-Type	The Media type of the body of the request.	Mandatory	application/json	**Content-Type**: application /json
Date	The date and time at which the message was originated.	Mandatory	HTTP-date format[i]	**Date**: Tue, 23 Jun 2020 08:12:31 UTC
Host	The domain name of the server	Mandatory	server domain	**Host:** https://www.acmehealthplan.com

Metadata	Description	Requirement	Field Constraints or Value-sets	Example
HTTP Response Metadata				
Content-Type	The media type of the response content.	Mandatory	application/json	**Content-Type**: application/json
Date	The date and time at which the message was originated.	Mandatory	HTTP-date format	**Date**: Tue, 23 Jun 2020 08:12:31 UTC
Last Modified	The last modified date for the requested object.	Mandatory	HTTP-date format	**Date**: Tue, 23 Jun 2020 08:12:31 UTC
Status Code	The Status line in the HTTP response indicates whether the server responded to the request successfully, or if there was an error.	Situational: When a request is successful or fails, the resource server must responds using the appropriate HTTP status code.	Please see Section 4.3.6.1 for a definition of status and error codes.	**Status**: 401
WWW-Authenticate	Defines the authentication method that should be used to gain access to a resource.	Situational: If the protected resource request does not include authentication credentials or does not contain an access token that enables access to the protected resource, the resource server MUST include the HTTP WWW-Authenticate response header field	HTTP Bearer Authorization Scheme[i]	**WWW-Authenticate:** Bearer

CAQH CORE Connectivity vC4.0.0

Safe Harbor: Connectivity Supported by Stakeholder Type

Like previous CAQH CORE Connectivity Rules, this rule update is a **Safe Harbor** and the following conformance requirements will apply to stakeholders that choose to implement the CAQH CORE Connectivity Rule vC4.0.0 (which includes both SOAP and REST requirements):

1. **Health Plans or Clearinghouses (Server) must support <u>all</u> connectivity methods (SOAP <u>and</u> REST).**
2. **Providers or Vendors (Client) must support <u>at least one</u> connectivity method (SOAP <u>or</u> REST).**

NOTE: While trading partners may also choose to utilize another connectivity method that is mutually agreeable, **if the trading partner insists on using the CORE Safe Harbor, that request must be accommodated**.

Summary: Connectivity Rule vC4.0.0

The CAQH CORE Connectivity Rule vC4.0.0 is a single, uniform Connectivity Rule that support administrative and clinical data exchange. The rule updates and aligns CAQH CORE connectivity & security requirements to support REST and other API technology, building upon prior versions of CAQH CORE Connectivity.

1 Updates to CORE Connectivity vC3.1.0 SOAP Requirements:

- Add support for the exchange of **Attachments transactions**
- Specify **TLS 1.2 or higher** for security
- Add **OAuth 2.0** as an authorization standard

2 New REST Requirements:

- Support for **REST** style web resources for X12 and non-X12 exchanges.
- Use of **JSON** to exchange REST messages
- Support for specific **HTTP Methods (e.g., POST and GET)**
- Support for **REST API and CORE Connectivity Rule Versioning**
- Use of specific **HTTP Error/Status Codes** and specifications **for REST Error Handling**
- Specify **API Endpoint Naming Conventions**

Like previous CAQH CORE Connectivity Rules, v4.0.0 is a Safe Harbor and the following conformance requirements apply:

- **Health Plans or Clearinghouses (Server) must support <u>all</u> connectivity methods included in the rule (SOAP <u>and</u> REST).**
- **Providers or Vendors (Client) must support <u>at least one</u> connectivity method included in the rule (SOAP <u>or</u> REST).**

New CAQH CORE Operating Rules for Industry Implementation

- Connectivity
- **Value-based Payments**

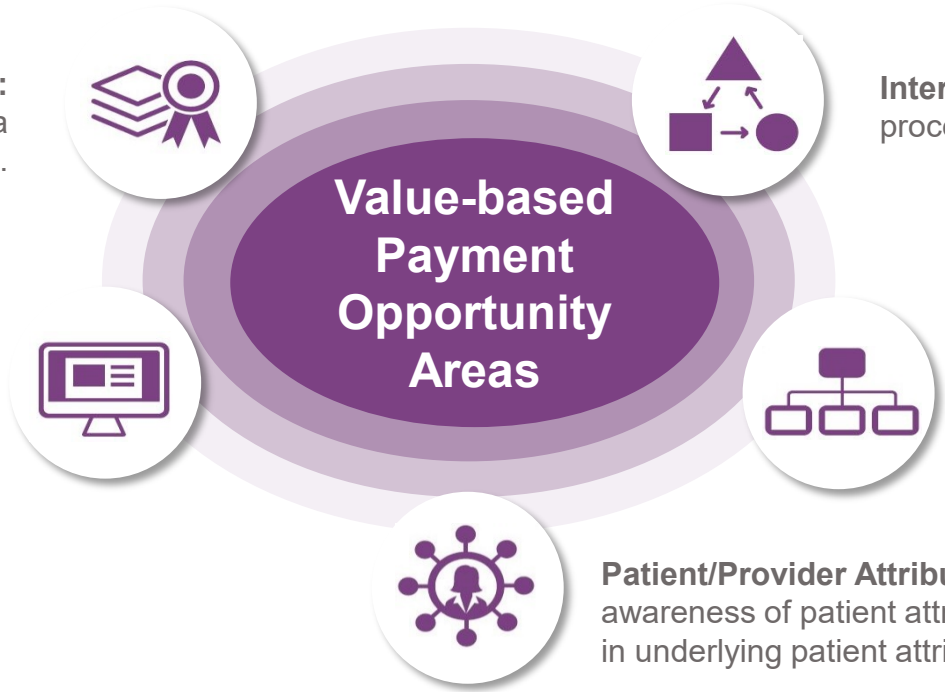
Helina Gebremariam
CAQH CORE Manager

Streamlining Adoption of Value-based Payments

CAQH CORE conducted over two years of research and identified five opportunity areas in the industry that could **smooth the implementation of value-based payments.** Stakeholders must act decisively and collaboratively to prevent value-based payment from confronting the administrative roadblocks once encountered in fee-for-service.

Data Quality & Uniformity: Standardize identifiers, data elements, transactions and code sets.

Quality Measurement: Educate on need for consistent and actionable quality data while considering physician burden.



Interoperability: Define common process and technical expectations.

Patient Risk Stratification: Promote collaboration and transparency of risk stratification models.

Patient/Provider Attribution: Improve provider awareness of patient attribution and transparency in underlying patient attribution models.

CAQH CORE VISION FOR VBP | A common infrastructure that drives adoption of value-based payment models by reducing administrative burden, improving information exchange and enhancing transparency across clinical and administrative verticals.

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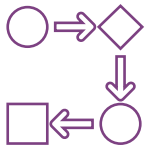
Value-based Payments Subgroup Initiative

Patient Attribution Challenge

Attribution matches individual patients in a population with providers, which ultimately determines the patients for which a provider (as an individual or as a group) is responsible. Attribution forms the basis of analysis for metrics underpinning VBP, such as total costs of care and quality measures.* While health plans supply attribution information on a regular basis, providers are often left with several questions:



Why are they in my population?

Who is on first?

Who else is involved?

Provider success under VBP models requires knowing the answers to all these questions,
but before asking these questions a provider needs to know the answer to the most important question:

IS THIS PATIENT IN MY ATTRIBUTED POPULATION?

*National Quality Forum, 2016

Value-based Payments Subgroup Initiative

Current State of Exchanging Patient Attribution Information

Patient schedules appointment with Provider.

Health Plan 1

Provider sends X12 270 Eligibility & Benefits Request

Health Plan replies with X12 270 Eligibility & Benefits Response

Health Plan 2

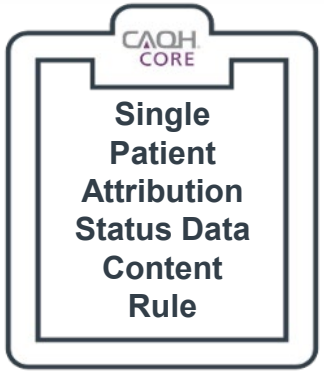
Provider submits healthcare claim for services rendered.

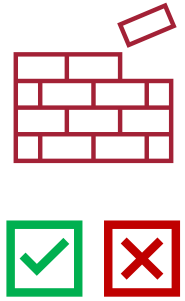
Provider does not meet necessary information and fails to fully satisfy terms of VBP contract.

Health Plan 3

Meanwhile, Provider receives patient rosters at inconsistent intervals from health plans using various formats.

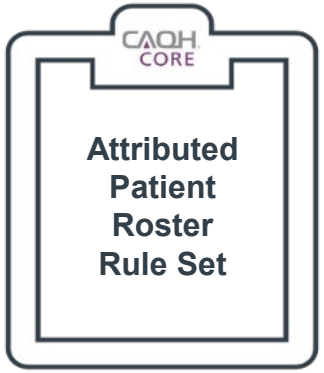
Value-based Payments Attribution Rules Package Overview





Builds upon the mandated CAQH CORE Eligibility & Benefits (270/271) Data Content and Infrastructure Rules.

Requires a health plan (or its agent) to return the **patient attribution status (yes/no/partial) and effective dates of attribution**.



Data content rule **standardizes the minimum data elements a health plan must return** to identify patients within the VBP population, including a VBP contract name and effective dates of attribution.

Infrastructure rule **standardizes expectations for exchange** and **requires health plans to send providers an updated attributed patient roster** (including updated dates of effective attribution) **at least once per month.**

CAQH CORE continues to monitor industry adoption and other emerging industry efforts – including those led by HL7 related to FHIR bulk data – by tracking usage and lessons learned to align data content needs among stakeholders.

Exchanging Attribution Status of a Single Patient

Building on Current CAQH CORE Operating Rules

The CAQH CORE Eligibility Operating Rules, which are federally mandated, set requirements for data content, infrastructure and connectivity when using the X12 270/271 transactions. The Draft CAQH CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule builds upon this set through **additional data content requirements for the return of patient attribution status for specific use cases.**

CAQH CORE Eligibility & Benefits Operating Rule Requirements for 271 Response

Data Content	
#	Rule Requirement
1.	Return of Health Plan Name
2.	Return of Patient Financial Responsibility (Including co-insurance, co-payment, deductibles and remaining deductibles)
3.	Return of Eligibility Dates
4.	Return of In/Out of Network Variances

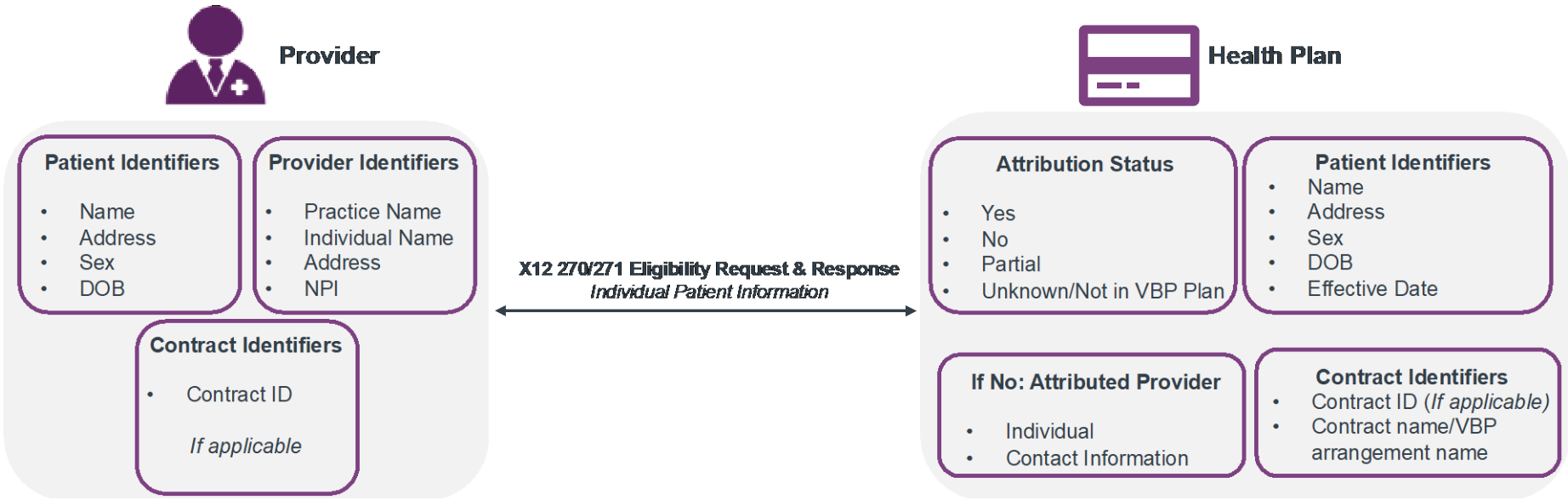
Infrastructure	
#	Rule Requirement
1.	Use of v5010 999 and 271 for Acknowledgements (Batch and Real Time)
2.	Standard Flow and Format of Companion Guides
3.	Overnight Batch Response Requirement
4.	20-second Real Time Response Requirement
5.	Minimum 86% System Availability Requirement

Connectivity	
#	Rule Requirement
1.	HTTP/S Transport Method
2.	Standard Flow and Format of Companion Guides
3.	SOAP and Digital Certificates and Clinical/Administrative Alignment

Exchanging Attribution Status of a Single Patient

Using the X12 270/271 Transactions

The Eligibility Benefit & Verification Transaction is the most common administrative transaction conducted between a provider and a health plan. The Draft CAQH CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule builds on existing mandated eligibility operating rules to **provide the attribution status of a single patient through expanded data content returned in an Eligibility & Verification Response.**



With an industry adoption rate of 84% for eligibility inquiries, the X12 270/271 transactions create a consistent pathway for providers to receive a single patient's attribution status. Use of these transactions will also help bridge the gap by meeting providers' needs now as the industry continues to pilot and test new and emerging standards and technology.

Source: 2020 CAQH Index

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Exchanging Attribution Status of a Single Patient

When Rules Requirements Apply

The CAQH CORE Participants decided to limit the scope of this data content operating rule to only VBP models that cover most patient services. The Subgroup agreed that a limited scope applying to the simplest VBP models would enable more rapid adoption and implementation of the operating rule, while allowing more mature organizations to pilot expanded use cases which could serve as real world evidence for further rule development.

Rule Requirements Apply When:

- The individual is located in the health plan's (or information source's) eligibility system **AND**
- A health plan conducts 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)* **AND**
- A health plan (or information source) receives a generic v5010 270 **OR** A health plan (or information source) receives an explicit v5010 270 for a specific service type required in the CAQH CORE Eligibility& Benefits (270/271) Data Content Rules.**

Rule Requirements *Do Not* Apply When:

- A health plan conducts provider attribution status for the support of value-based contracts associated with specific episodes or bundled payments **OR** provider attribution status for the support of quality measurement.

*Category Three APM: Based on an FFS architecture, while providing mechanisms for the effective management of a set of procedures, an episode of care, or all health services provided for individuals. To accomplish this, Category Three payments are based on cost (and occasionally utilization) performance against a target, irrespective of how the financial or utilization benchmark is established, updated, or adjusted. ; Category Four APM: Involve prospective, population-based payments, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care; https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

**There are 50+ service type codes required by the Phase I - II Eligibility Rules that can be found here. Examples include medical care, hospital-inpatient, hospital-outpatient, home health care etc.

Exchanging Attribution Status of a Single Patient

Rule Requirements

The Draft CAQH CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule consists of **four rule requirements** which enable the return of patient attribution information in the X12 271 Response.

Rule Requirement 4.1: ***Basic Requirements for Providers, Information Receivers, Health Plans & their Agents***

- Requires conformance with current Eligibility & Benefits Operating Rule Set..

Rule Requirement 4.2: ***Identification of Subscriber/Dependent Attribution***

- Requires return of explicit attribution status and effective dates of attribution 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.
- Requires a health plan and its agent to 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:

Rule Requirement 4.3: ***Attribution Basic Requirements for Receivers of the X12 271 Response***

- Requires a product extracting the data from the X12 271 Response for manual processing to make available to the end user the exact wording of the text included in the MSG segment.

Exchanging Attributed Patient Rosters

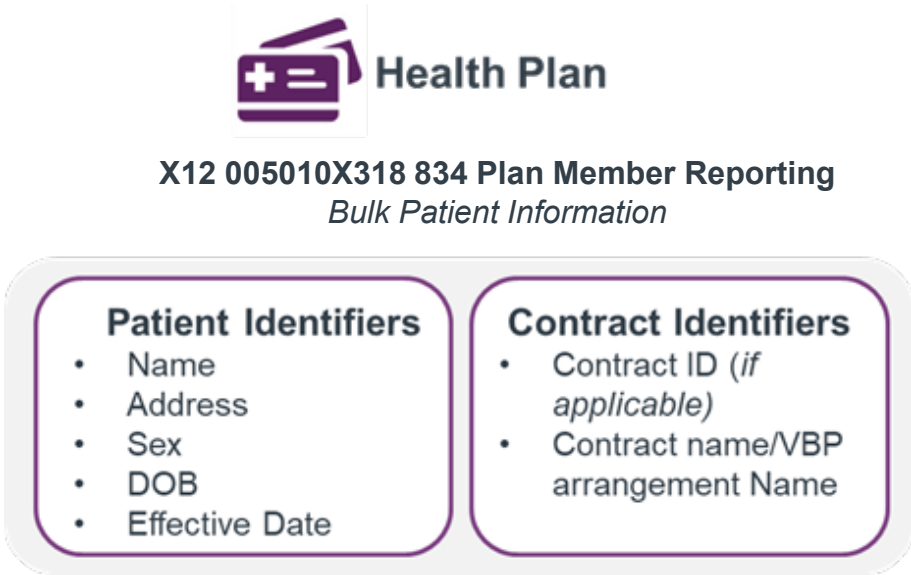
Using the X12 00510X318 834 Transaction

The Attributed Patient Roster Rule Set defines data content and infrastructure requirements for health plans to supply providers with regular patient roster updates in a standard electronic format. This bulk data exchange will replace cumbersome excel file downloads from FTP sites and allow for more seamless integration into the provider's existing workflow.

- Of the three versions of the X12 834 Benefit Enrollment transaction, the CAQH CORE Participants chose to develop operating rules for the **X12 005010X318 834 Plan Member Reporting** transaction as it was designed to support the transfer of member information both directly to providers and through intermediaries such as clearinghouses and value-added networks.

- The Attributed Patient Roster Rule Set specifies the loops, segments, and data elements to be used in the X12 v5010X318 834 transaction to send a providers a current list of attributed patients.

- Using a standard data set across all health plans reduces implementation costs and provider burden across the industry.



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Exchanging Attributed Patient Rosters

When Rules Requirements Apply

As with the attribution data for a single patient, the CAQH CORE Participants decided to draft this operating rule to apply only to the simplest types of attribution – those applying to population-based models that cover most 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.

Rule Requirements Apply 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 conducts 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).*

Rule Requirements *Do Not* Apply When:

- A health plan conducts provider attribution status for the support of value-based contracts associated with specific episodes or bundled payments **OR** provider attribution status for the support of quality measurement.

*Category Three APM: Based on an FFS architecture, while providing mechanisms for the effective management of a set of procedures, an episode of care, or all health services provided for individuals. To accomplish this, Category three payments are based on cost (and occasionally utilization) performance against a target, irrespective of how the financial or utilization benchmark is established, updated, or adjusted. ; Category Four APM: Involve prospective, population-based payments, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care; https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

**There are 50+ service type codes required by the Phase I - II Eligibility Rules and can be found here. Examples include medical care, hospital-inpatient, hospital-outpatient, home health care etc.

Exchanging Attributed Patient Rosters

Data Content Rule Requirements

The Draft CAQH CORE Attributed Patient Roster (0050510X318 834) Data Content Rule consists of **three rule requirements.**

Rule Requirement 4.1: ***Basic Requirements for Providers, Information Receivers, Health Plans & their Agents***

- Requires conformance with current published and adopted CAQH CORE Connectivity Rule.
- Requires a health plan or its agent delivering a current roster of patients covered by the VBP contract using the X12 v5010X318 834 transaction to
  - Identify the provider receiving the roster
  - Identify the Subscribers and Dependents covered by the value-based health plan

Rule Requirement 4.2: ***Identification of Health Plan Contract***

- Requires a health plan or its agent delivering a current roster of patients covered by the VBP contract using the X12 v5010X318 834 transaction to identify the details of the value-based health plan.

Rule Requirement 4.3: ***Identification of Attributed Provider for Subscriber/Dependent***

- Requires a health plan or its agent delivering a current roster of patients covered by the VBP contract using the X12 v5010X318 834 transaction to return the appropriate Attributed Provider Information for each Subscriber and Dependent.

Exchanging Attributed Patient Rosters

Drafting an Infrastructure Rule for the X12 00510X318 834 Transaction

While CAQH CORE does offer an infrastructure rule for the X12 005010X220 834 Benefit Enrollment Transaction, the differences in the directionality of the transaction from the X318 834 Plan Member Reporting transaction required a new infrastructure rule specific to this use case.

Benefit Enrollment (X12 005010X220 834) Transaction

Transaction is a one way "push" from an employer to a health plan, therefore infrastructure requirements sit on both sides of the transaction – both for the sender and recipient.

Attributed Patient Roster (X12 005010X318 834) Transaction

Transaction is a one way "push" from a health plan to a provider where the provider then picks up the transaction from a mailbox. Therefore, infrastructure requirements sit only on the transaction sender and not the recipient.

This small but important difference makes the Attributed Patient Roster transaction more like the Electronic Remittance Advice (835) transaction. This required updates to the rule language to reflect that only batch processing applies as it is a transaction "pick-up" and that there are no rule requirements on the transaction recipient.

Exchanging Attributed Patient Rosters

Infrastructure Rule Requirements

The Draft CAQH CORE Attributed Patient Roster (0050510X318 834) Infrastructure Rule generally aligns with all other CAQH CORE Infrastructure Rules.

The CAQH CORE Participants also drafted a monthly exchange requirement, specifying a minimum frequency for health plans to make updated rosters available.

#	Rule Requirement	Requirement Description
1.	**Connectivity**	Requires conformance with the most current version of the CAQH CORE Connectivity Rule
2.	**System Availability**	Requires health plans and their agents to adhere to 86% system availability per calendar week and specifies reporting requirements
3.	**Acknowledgements**	Requires receivers to return X12 v5010 999 Implementation Acknowledgement
4.	**Companion Guide**	Published companion guides must follow CAQH CORE v5010 Master Companion Guide Template
5.	**NEW for Attribution: Monthly Exchange Requirement**	Requires health plans and their agents to make an updated patient roster available via the X12 v5010X318 834 transaction at least once per month. Updated patient rosters must also include updated effective dates of attribution where applicable.

Value-based Payments Subgroup Initiative

Impact of Draft Rules

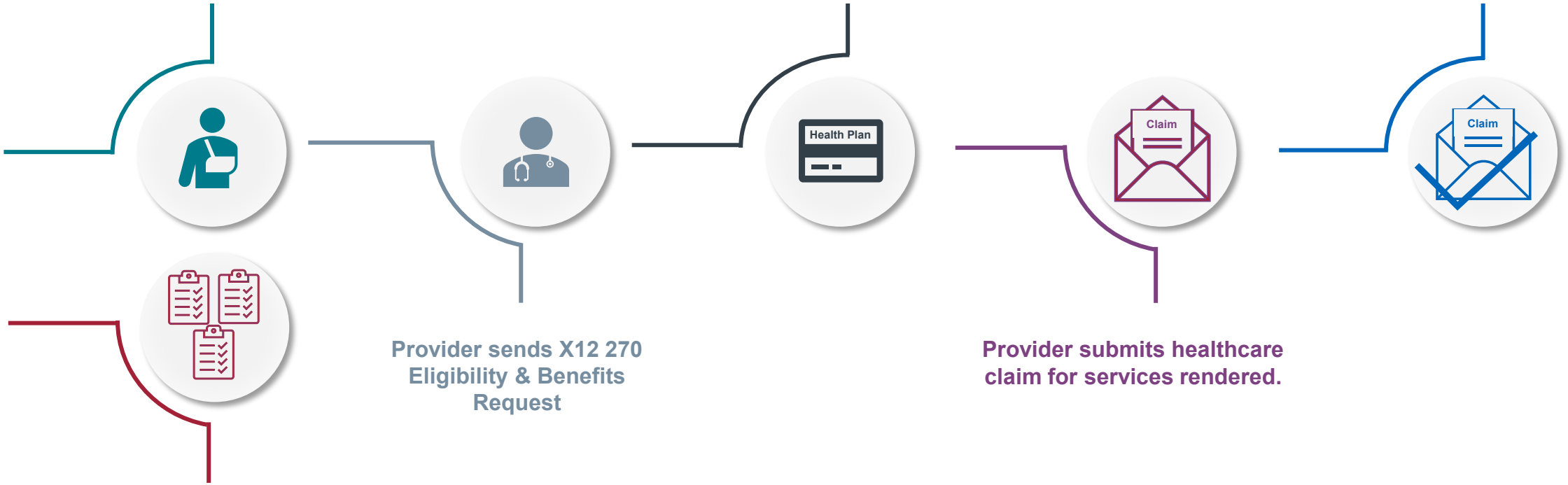
Patient schedules appointment with Provider.

Provider sends X12 270 Eligibility & Benefits Request

Health Plan replies with X12 270 Eligibility & Benefits Response conforming to the Single Patient Attribution Status Data Content Rule.

Provider submits healthcare claim for services rendered.

Health Plan adjudicates claims payment at end of fiscal year.



Provider receives monthly patient rosters via a standard format from health plans in conformance with Attributed Patient Roster Rule Set.

Uniform format enables data to be easily integrated into the provider system.

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Conversation on CAQH CORE Operating Rule Implementation Benefits

Conversation with CAQH CORE

Robert Bowman

Director, CAQH CORE

Emily TenEyck

Manager, CAQH CORE

Helina Gebremariam

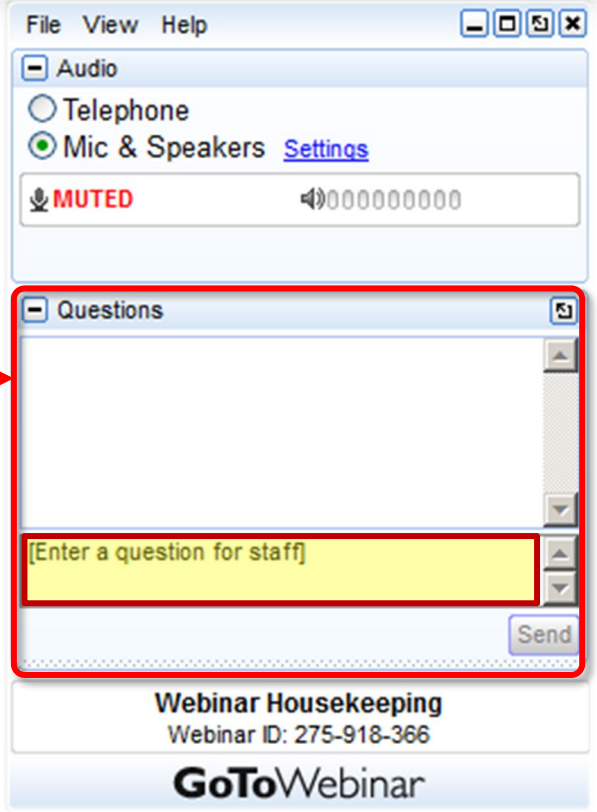
Manager, CAQH CORE

Audience Q&A

Please submit your questions

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

You can also submit questions at any time to CORE@caqh.org



Download a copy of today’s presentation slides at caqh.org/core/events

- Navigate to the Resources section for today’s event to find a PDF version of today’s presentation slides.
- The slides and webinar recording will be emailed to all attendees and registrants in the next 1-2 business days.

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Key Takeaways

New CAQH CORE Operating Rules:

- **Address changes in technology and payment models** that are shaping the future of healthcare.
- Establish industry foundation for **sharing of patient attribution information and exchanging data**.

Patient Attribution Rules

- Uniform expectations for the necessary data to **support the electronic exchange of attribution data between health plans and providers**, and the frequency by which it is shared for individual patients or for a roster of patients.

CAQH CORE Connectivity

- CAQH CORE Connectivity Rule establishes a national standard for how healthcare entities exchange data. The latest version has been updated to **support protocols including REpresentational State Transfer (REST) and application programming interfaces (APIs).**

These new Operating Rules will be ready for industry implementation later this year.

Upcoming CAQH CORE Education Sessions and Events

Training Session on Annual Industry Opportunity to Make Changes to CORE Code Combinations – 2021 Market-based Review

February 23, 2021 2:00-3:00 PM EST

Healthcare Payments Innovations Conference

March 9-10, 2021

HIPAA Summit

March 22-25, 2021

Healthcare administration is rapidly changing.

Join Us

Collaborate across stakeholder types to develop operating rules.

Present on CAQH CORE education sessions.

Engage with the decision makers that comprise 75% of the industry.

Represent your organization in work groups.

Influence the direction of health IT policy

Drive the creation of operating rules to accelerate interoperability

Click **here** for more information on joining CAQH CORE as well as a complete list of Participating Organizations.

CAQH CORE

Thank you for joining us!

 @CAQH

Website: www.CAQH.org/CORE

Email: CORE@CAQH.org

The CAQH CORE Mission

Drive the creation and adoption of healthcare operating rules that support standards, accelerate interoperability and align administrative and clinical activities among providers, payers and consumers.