



**CORE Attributed Patient Roster (X12 v5010X318  
834) Data Content Rule  
Version APR.2.0  
March 2024**

**CAQH Committee on Operating Rules for Information Exchange (CORE)  
Attributed Patient Roster (X12 v5010X318 834) Data Content Rule vAPR.2.0**

**Revision History for CAQH CORE Attributed Patient Roster (X12 v5010X318 834) Data Content Rule**

<b>Version</b>	<b>Revision</b>	<b>Description</b>	<b>Date</b>
APR.1.0	Major	CAQH CORE Attributed Patient Roster (X12 v5010X318 834) Data Content Rule balloted and approved via the CAQH CORE Voting Process.	December 2020
APR.2.0	Major	<ul style="list-style-type: none"><li>• Substantive changes to facilitate the inclusion of collected socio-demographic information into the attributed patient roster.</li><li>• Other non-substantive updates for clarity.</li></ul>	March 2024

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## **1. Background**

### **1.1. CORE Overview**

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

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

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

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

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

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

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

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

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

Underpinning the continued relevance and importance of patient attribution, in 2023, the National Committee for Vital and Health Statistics (NCVHS), a federal advisory committee to the Department of Health and Human Services (HHS), sent a letter to the Secretary of HHS recommending several CORE Operating Rules for federal adoption, including the CORE Single Patient Attribution Operating Rule.<sup>2</sup> This marks the first time an operating rule directly addressing value-based payments was recommended for federal adoption by NCVHS. The Single Patient Attribution Rule is the foundation of which this rule builds upon.

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

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

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

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

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

## **2. Issues to Be Addressed and Business Requirement Justification**

### **2.1. Problem Space**

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

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

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

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

- Promoting the use of standardized data elements, including those identifying social characteristics, and provider attribution methodologies that identify providers at the individual level, as well as their relationships with 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.

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<sup>3</sup> Participant is defined in the CORE Framework for Semantic Interoperability in VBP. [Here](#).

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- Providing the simplest transport for providers to synchronize data with practice management systems and Electronic Health Records (EHRs), and to enable providers and health plans to validate individual enrollment at the point of care and population level enrollment in value-based payment programs.

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

Providers may not be aware of their patient’s attribution status 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 high-quality, person-centered care, a physician or other type of VBP Participant 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 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.

In 2023, CORE Participants decided to maintain the application of this rule, originally published in 2020, only to population-based VBP models but to update the data available to providers in the roster. As adoption and implementation of this operating rule grow, 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. In 2023, The Subgroup approved the addition of new socio-demographic data elements to empower Participants in identifying individual-level characteristics that could influence care.

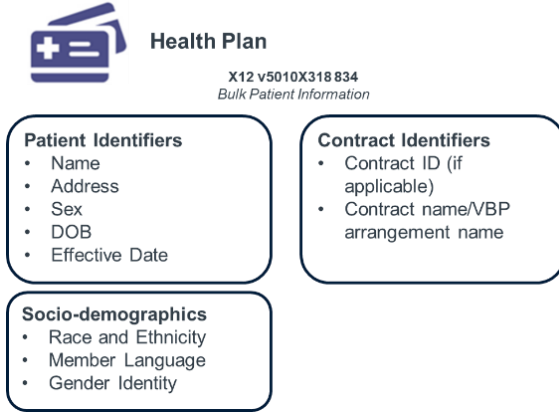
The collection of these elements is facilitated by the CORE Benefit Enrollment and Maintenance Data Content Rule (X12 005010X220 834) which requires health plans and their agents to collect socio-demographic information at the point of member enrollment or renewal into a health plan or maintenance of a member record.<sup>4</sup> When facilitating the collection of potentially sensitive socio-demographic information, special care must be taken to ensure its security and its accuracy in representing a member’s personal experience. Best practices for collection, identified by CORE Participants, are included in §2.3. of the associated CORE Benefit Enrollment and Maintenance Data Content Rule. That content is additionally available as a standalone document [here](#). CORE encourages implementers to reference these resources as they consider the exchange of this important, sensitive information.

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 CORE Attributed Patient Roster (X12 v5010X318 834) Data Content Rule brings consistency and reduces provider burden in processing various formats of proprietary rosters used today. 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.

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<sup>4</sup> [CORE Benefit Enrollment & Maintenance \(834\) Data Content Rule](#)

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In parallel with this operating rule, CORE Participants developed the CORE Attributed Patient Roster (X12 v5010X318 834) Infrastructure Rule which aligns with other CORE Infrastructure Rules. The 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 CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule.

**3. CAQH CORE Attributed Patient Roster (X12 v5010X318 834) Data Content Rule: Requirements Scope**

**3.1. What the Rule Applies to**

This CORE Operating Rule conforms with and builds upon the X12 v5010X318 Plan Member 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 socio-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:

- 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 a population health contract encompassing most services delivered to a patient during a performance year (e.g., consistent with HCP LAN category three and four alternative payment models excluding episode and service specific models).<sup>5</sup>

**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.

<sup>5</sup> <https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>

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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.<sup>6</sup>
- 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.<sup>7</sup>

**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. Some of the information presented in Table 1 through Table 3 can be collected and processed consistent with the requirements of the CORE Benefit Enrollment and Maintenance Data Content Rule that facilitates the X12 v5010X220 834 transaction. Where appropriate, notes have been added to the data elements that can be collected and processed using the CORE Benefit Enrollment and Maintenance Data Content Rule.

<b>Table 1: Applicable Loops and Segments - Patient (Subscriber/Dependent) Identifying Data Elements</b>					
<b>#</b>	<b>X12 Data Element Name</b>	<b>Applicable Loop and Segment in the X12 v5010X318 834</b>	<b>Use of Applicable Loop and Segment in the X12 v5010X318 834</b>	<b>X12 Description</b>	<b>Data Facilitated for Collection by Related CORE Data Content Rules</b>
1.	Enrollee Level Details	Loop 2000 – INS01_1073 Yes/No	<i>Required Use</i>	Code indicating a Yes or No condition or response. <b>Semantic:</b> INS01 indicates status of the insured. A "Y" value indicates the insured is a subscriber; an "N" value indicates the insured is a dependent.	
2.	Individual Relationship Code	Loop 2000 – INS02_1069	<i>Required Use</i>	Code indicating the relationship between two individuals or entities. Value must be '18' for subscriber. For dependents the value identifies their relationship to the subscriber.	
3.	Maintenance Type Code	Loop 2000 – INS03_875	<i>Required Use</i>	Code identifying the specific type of item maintenance.	

<sup>6</sup> For infrastructure requirements for use of the X12 v5010X318 834 transaction see the CORE Attributed Patient Roster (X12 v5010X318 834) Infrastructure Rule.

<sup>7</sup> For infrastructure requirements for use of the HIPAA-mandated X12 v5010X220 834 transaction see the CORE Benefit Enrollment (834) Infrastructure Rule.



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#	X12 Data Element Name	Applicable Loop and Segment in the X12 v5010X318 834	Use of Applicable Loop and Segment in the X12 v5010X318 834	X12 Description	Data Facilitated for Collection by Related CORE Data Content Rules
4.	Entity Identifier Code	Loop 2100A – NM101_98	<i>Required Use</i>	Code identifying an organization entity, a physical location, property or an individual.	
5.	Entity Type Qualifier	Loop 2100A – NM102_1065	<i>Required Use</i>	Code identifying the type of entity.  <b>Semantic:</b> NM102 qualifies NM103.	
6.	Last Name	Loop 2100A – NM103_1035	<i>Required Use</i>	Individual last name or organizational name.	
7.	First Name	Loop 2100A – NM104_1036	<i>Situational Use</i>	Individual first name.	
8.	Middle Name	Loop 2100A – NM105_1037	<i>Situational Use</i>	Individual middle name or initial.	
9.	Name Prefix	Loop 2100A – NM106_1038	<i>Situational Use</i>	Prefix to individual name.	
10.	Identification Code Qualifier	Loop 2100A – NM108_66	<i>Required Use</i>	Code specifying the system/method of code structure used for Identification Code (67).	
11.	Identification Code	Loop 2100A – NM109_67	<i>Required Use</i>	Code identifying a party or other code.	
12.	Address Line 1	Loop 2100A – N301_166	<i>Required Use</i>	Address information.	
13.	Address Line 2	Loop 2100A – N302_166	<i>Situational Use</i>	Address information.	
14.	City Name	Loop 2100A – N401_19	<i>Required Use</i>	Free-form text for city name.	
15.	State/Province	Loop 2100A – N402_156	<i>Situational Use</i>	Code specifying the Standard State/Province as defined by appropriate government agency.	
16.	ZIP Code/ Postal Code	Loop 2100A – N403_116	<i>Situational Use</i>	Code specifying international postal zone code excluding punctuation and blanks (zip code for U.S.)	
17.	Country Code	Loop 2100A – N404_26	<i>Situational Use</i>	Code identifying the country.	
18.	Date Time Period Format Qualifier	Loop 2100A – DMG01_1250	<i>Required Use</i>	Code indicating the date format, time format, or date and time format.	

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#	X12 Data Element Name	Applicable Loop and Segment in the X12 v5010X318 834	Use of Applicable Loop and Segment in the X12 v5010X318 834	X12 Description	Data Facilitated for Collection by Related CORE Data Content Rules
19.	Date Time Period	Loop 2100A – DMG02_1251	<i>Required Use</i>	Expression of a date, a time, or range of dates, times or dates and times.	
20.	Gender Code	Loop 2100A – DMG03_1068	<i>Required Use</i>	Code indicating the sex of the individual.	
21.	Race or Ethnicity Code	Loop 2100A – DMG05-01_1109	<i>Situational Use</i>	Code indicating the racial or ethnic background of a person; it is normally self-reported, under certain circumstances this information is collected for US Government Statistical Purposes.	Either: a) Unpopulated b) Populated as '7' if member chooses to not disclose race or ethnicity.
22.	Industry Code (Code Source 859: Classification of Race or Ethnicity)	Loop 2100A – DMG05-03_1271	<i>Situational Use</i>	Code indicating a code from a specific industry code list.	Populated with unique identifier from Classification of Race and Ethnicity Code Sets specified in Code Source 859 of the X12 Standard.
23.	Identification Code	Loop 2100A – LUI02_67	<i>Situational Use</i>	Code identifying a party of other code.	Populated with the appropriate ISO-639-3 language code representing self-reported member language. If blank, either not reported or assumed language is English.
24.	Use of Language Indicator Code	Loop 2100A – LUI04_1303	<i>Situational Use</i>	Code indicating the use of a language.	Populated using corresponding values in the transaction specific X12 TR3.
25.	Name	Loop 2750 – N102_93	<i>Required Use</i>	Free-form name	Populated as 'Gender' (if provided)
26.	Reference Identification (Member Reporting Category Reference ID)	Loop 2750 – REF02_127	<i>Required Use</i>	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.	Populated with corresponding SNOMED-CT code or HL7 v3 nullvalue code of self-reported member gender identity.

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<b>Table 2: Applicable Loops and Segments – Value-Based Health Plan Coverage</b>					
<b>#</b>	<b>X12 Data Element Name</b>	<b>Applicable Loop and Segment in the X12 v5010X318 834</b>	<b>Use of Applicable Loop and Segment in the X12 v5010X318 834</b>	<b>X12 Description</b>	<b>Data Facilitated for Collection by Related CORE Data Content Rules</b>
1.	Maintenance Type Code	Loop 2300 – HD01_875	<i>Required Use</i>	Code identifying the specific type of item maintenance.	
2.	Date/Time Qualifier	Loop 2300 – DTP01_374	<i>Required Use</i>	Code specifying type of date or time, or both date and time. <sup>8</sup>	
3.	Date/Time Format	Loop 2300 – DTP02_1250	<i>Required Use</i>	Code indicating the date or time period format that will appear in DTP03.	
4.	Date/Time Period	Loop 2300 – DTP03_1251	<i>Required Use</i>	Expression of a date, a time, or range of dates, times or dates and times.	
5.	Reference Identification Qualifier	Loop 2300 – REF01_128	<i>Required Use</i>	Code identifying the reference identification.	
6.	Member Group or Policy Number	Loop 2300 – REF02_127	<i>Required Use</i>	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.	

<b>Table 3: Applicable Loops and Segments – Attributed Provider Identifying Information</b>					
<b>#</b>	<b>X12 Data Element Name</b>	<b>Applicable Loop and Segment in the X12 v5010X318 834</b>	<b>Use of Applicable Loop and Segment in the X12 v5010X318 834</b>	<b>X12 Description</b>	<b>Data Facilitated for Collection by Related CORE Data Content Rules</b>
1.	Assigned Number	Loop 2310 – LX01_554	<i>Required Use</i>	Number assigned for differentiation within a transaction set.	

<sup>8</sup> Reference X12 v5010X318 Plan Member 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.

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#	X12 Data Element Name	Applicable Loop and Segment in the X12 v5010X318 834	Use of Applicable Loop and Segment in the X12 v5010X318 834	X12 Description	Data Facilitated for Collection by Related CORE Data Content Rules
2.	Entity ID Code	Loop 2310 – NM101_98 <i>Required Use</i>	<i>Required Use</i>	Code identifying an organizational entity, a physical location, property, or an individual.	
3.	Entity Type Qualifier	Loop 2310 – NM102_1065 <i>Required Use</i>	<i>Required Use</i>	Code identifying the type of entity.	
4.	Last Name or Organization Name	Loop 2310 – NM103_1035 <i>Situational Use</i>	<i>Situational Use</i>	Individual last name or organizational name.	
5.	First Name	Loop 2310 – NM104_1036 <i>Situational Use</i>	<i>Situational Use</i>	Individual first name.	
6.	Middle Name	Loop 2310 – NM105_1037 <i>Situational Use</i>	<i>Situational Use</i>	Individual middle name or initial.	
8.	Name Suffix	Loop 2310 – NM107_1039 <i>Situational Use</i>	<i>Situational Use</i>	Suffix to individual name.	
9.	Identifier Qualifier	Loop 2310 – NM108_66 <i>Situational Use</i>	<i>Situational Use</i>	Code specifying the system/method of code structure used for Identification Code (67).	
10.	Identification Code	Loop 2310 – NM109_67 <i>Situational Use</i>	<i>Situational Use</i>	Code identifying a party or other code.	
12.	Address Line 1	Loop 2310 – N301_166	<i>Required Use</i>	Address information.	
13.	Address Line 2	Loop 2310 – N302_166	<i>Situational Use</i>	Address information.	
14.	City	Loop 2310 – N401_19	<i>Required Use</i>	Free-form text for city name.	
15.	State/Province	Loop 2310 – N402_156	<i>Situational Use</i>	Code specifying the Standard State/Province as defined by appropriate government agency.	
16.	ZIP Code/Postal Code	Loop 2310 – N403_116	<i>Situational Use</i>	Code specifying international postal zone code excluding punctuation and blanks (zip code for U.S.)	
17.	Country Code	Loop 2310 – N404_26	<i>Situational Use</i>	Code identifying the country.	

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

**3.8. Value-based Payment Terminology**

To understand concepts, terms, and methodologies used to navigate and administer value-based payment programs, CORE developed the CORE Framework for Semantic Interoperability in Value-based Payments.<sup>9</sup> Definitions included in the Framework apply to the terminology used in this operating rule and others containing references to value-based payment models. The CORE Attributed Patient Roster Data Content Rule vAPR.2.0. does not require the adoption of any term or concept included in The Framework.

**4. CORE Attributed Patient Roster (X12 v5010X318 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.<sup>10</sup>

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<sup>9</sup> [CORE Framework for Semantic Interoperability in Value-based Payments](#)

<sup>10</sup> Reference Footnote 8 for detail.

**CAQH Committee on Operating Rules for Information Exchange (CORE)  
Attributed Patient Roster (X12 v5010X318 834) Data Content Rule vAPR.2.0**

**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.