Analysis & Planning Guide for Implementing the CORE Benefit Enrollment and Maintenance Operating Rules March 2024

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1. Introduction: Analysis & Planning for CORE Benefit Enrollment and Maintenance Operating Rule Implementation

This CORE Benefit Enrollment Analysis & Planning Guide is a resource for entities preparing to implement the CORE Benefit Enrollment and Maintenance Operating Rules. A solid understanding of the CORE Benefit Enrollment and Maintenance Operating Rules, combined with an effective planning effort, is the basis for a successful implementation project.

This document provides guidance for project managers, business analysts, system analysts, architects, and other project staff to complete the first step of a typical systems development life cycle: Systems Analysis & Planning. The purpose of this guide is to enable project managers and other staff to:

- Understand the applicability of the CORE Benefit Enrollment and Maintenance Operating Rules requirements to your organization's systems and business processes that support the X12/005010X220 Benefit and Enrollment Maintenance (834) and associated errata (hereafter referenced as X12 v5010 834).
- Identify and inventory all impacted internal systems, business processes (manual and automated), and functions/processes outsourced to an agent[1] (e.g., Business Associate) that process the transactions or perform other requirements of the CORE Benefit Enrollment and Maintenance Operating Rules.
- Perform a detailed rule requirements gap analysis to identify system(s) that may require remediation to conform to the CORE Benefit Enrollment and Maintenance Operating Rule requirements and to identify business processes which may be impacted by the CORE Benefit Enrollment and Maintenance Operating Rules (e.g., need for internal testing, project management, additional resources, etc.).

The appendices of this Analysis & Planning Guide include the following:

- **Stakeholder & Business Type Evaluation**: Use to determine your stakeholder type(s) and understand the role of your agents (Business Associates) that process the transactions and will be affected by connectivity requirements.
- **Systems Inventory & Impact Assessment Worksheet**: Use to perform a high-level inventory of all internal systems, business processes (manual and automated), and functions/processes outsourced to an agent that process the transactions and are impacted by the CORE Benefit Enrollment and Maintenance Operating Rules.
- **Gap Analysis Worksheet**: Use to determine the level of system(s) remediation necessary for implementing the business requirements of the CORE Benefit Enrollment and Maintenance Operating Rules.
- **Stakeholder Transaction Flow Diagrams**: An overview of the stakeholders involved in the Benefit Enrollment transaction.

NOTES:

- This document is for educational purposes only. In the case of a question between this document and CORE Operating Rule text or Federal regulations, the latter takes precedence.
- This Analysis & Planning Guide is scoped to general implementation planning of the CORE Benefit Enrollment and Maintenance Operating Rules and can assist with compliance with a potential Federal Regulation pursuant to ACA Section 1104 or CORE Certification; these are, however, separate projects requiring analysis and planning beyond that described in this document.[2]
- The CORE Benefit Enrollment and Maintenance Operating Rules reference three stakeholder categories: Provider or its agent; Health Plan or its agent; HIPAA-covered entity or its agent. This document references examples of these stakeholder categories to assist with applicability and implementation;

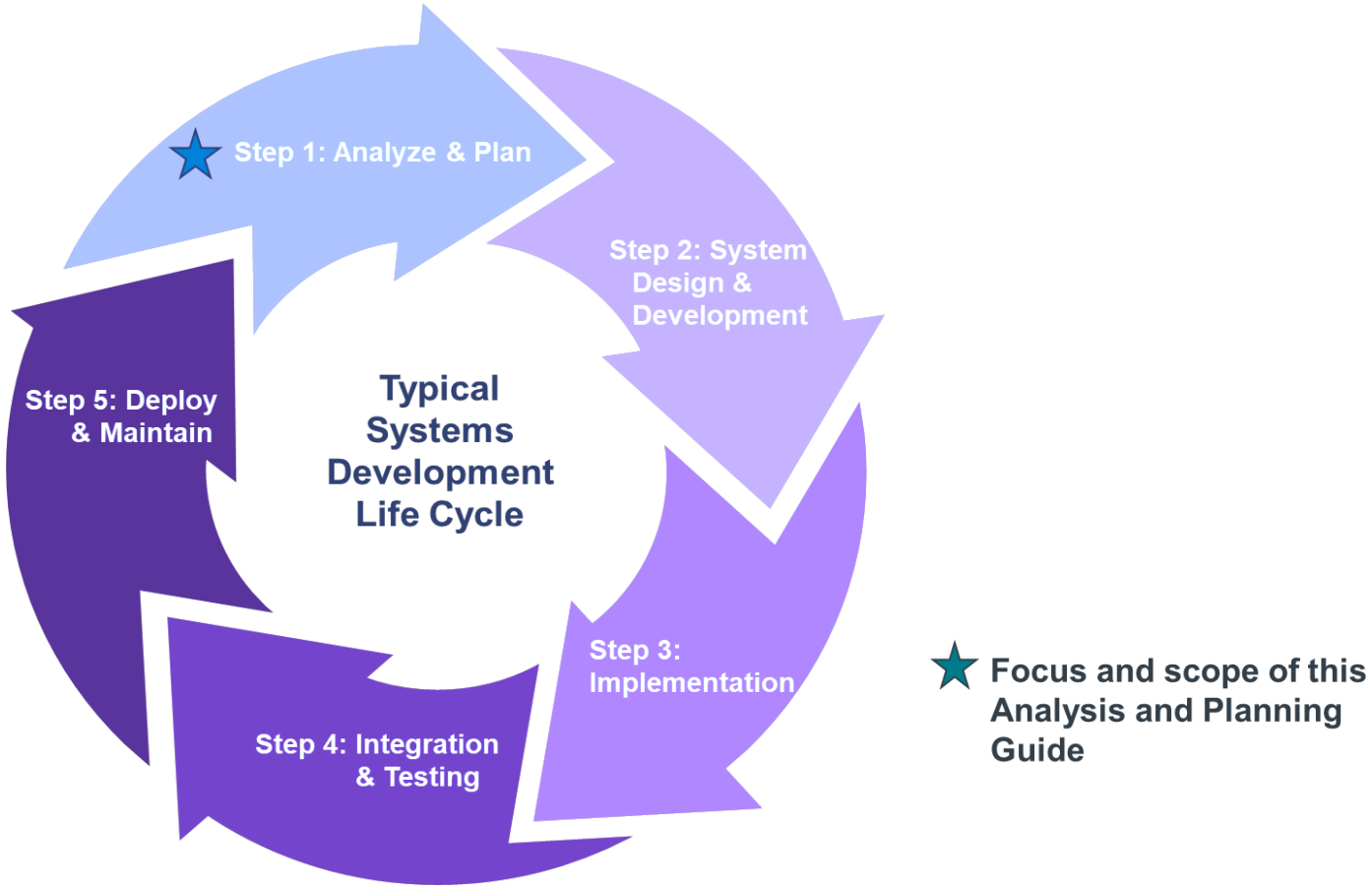
[1] One who agrees and is authorized to act on behalf of another, a principal, to legally bind an individual in particular business transactions with third parties pursuant to an agency relationship. Source: West's Encyclopedia of American Law, edition 2. Copyright 2008 The Gale Group, Inc. All rights reserved. The term "agent" as used in this document describes entities that provide outsourced functions/activities on behalf of HIPAA-covered health plans or providers, (e.g., Business Associate). The full definition of Business Associate can be found in the **Electronic Code of Federal Regulations** (Title 45, Subtitle A, Subchapter C, Part 160.103).
[2] The CORE Benefit Enrollment and Maintenance Operating Rules have not been mandated by HHS at the time of publishing of this guide.

these examples include clearinghouses and vendors. Please note that some stakeholder types are not necessarily HIPAA-covered entities (e.g., software or service vendors) and may not be directly required to implement the rule requirements but may need to because of being an agent of a HIPAA-covered entity.

2. Systems Development Life Cycle

The diagram below illustrates a typical systems development life cycle (SDLC) for developing or remediating information systems. SDLC includes five key steps, beginning with analysis and planning through deployment and ongoing maintenance. This Analysis & Planning Guide is scoped to assist your organization in the first step of an SDLC for the implementation of the CORE Benefit Enrollment and Maintenance Operating Rules given Step 1 sets the stage for all other steps. Note: The impacted system(s) may include an in-house developed system, commercial off the shelf (COTS)/cloud-based system, or a solution outsourced to a third party. The "system" in certain cases may also be a manual process or even include activities performed on your behalf by one or more agents.

Typical Systems Development Life Cycle



3. Analysis & Planning for the CORE Benefit Enrollment and Maintenance Operating Rules: Key Tasks

The following table outlines the key tasks necessary to complete Step 1: Analyze & Plan of a Systems Development Life Cycle. When the analysis and planning is completed, you will have created a high-level systems impact analysis and developed a detailed project plan for adopting the CORE Benefit Enrollment and Maintenance Operating Rules requirements.

Analysis and Planning: Key Tasks	
Task	**Activity**
Task A – Complete Staff Education and Training on the CORE Benefit Enrollment and Maintenance Operating Rules	• Thoroughly review and understand the CORE Benefit Enrollment and Maintenance Operating Rules. • Conduct general education and awareness of the CORE Benefit Enrollment and Maintenance Operating Rules for the impacted staff in your organization (see Section 4 of this document for additional resources available to educate staff on the CORE Operating Rules).
Task B – Determine Your Organization's Stakeholder & Business Type(s) (Stakeholder & Business Type Evaluation) *CORE Benefit Enrollment and Maintenance Operating Rule requirements are tied to applicable stakeholder type(s): HIPAA-covered provider, HIPAA-covered health plan, a HIPAA-covered entity, or their respective agents.* *Please note that some stakeholder types are not necessarily HIPAA-covered entities (e.g., software or service vendors) and may not be directly required to implement the rule requirements but may need to because of being an agent of a HIPAA-covered entity.*	• Determine your stakeholder and business type(s) to understand which CORE Benefit Enrollment and Maintenance Operating Rules apply to your organization. • Understand the role of agents that provide services or process the transactions on your behalf. • Consider the following based on your stakeholder type(s):
	• If your organization is a health plan that receives X12 v5010 834: – The majority of the CORE Benefit Enrollment and Maintenance Operating Rule requirements will apply to your systems. – Health plans that outsource a portion or all of the CORE Benefit Enrollment and Maintenance Operating Rules requirements to an agent to process may have some unique implementation considerations. Depending on the scenario between the health plan and its agent(s), the health plan may not need to implement some rule requirements directly and the agent will need to implement them on behalf of the health plan. For other transactions, agents may include other types of entities not involved in the implementation of the existing ACA-mandated CORE Operating Rules and the CORE Benefit Enrollment and Maintenance Operating Rules. The health plan, therefore, might have a different agent(s) to consider when implementing the Benefit Enrollment CORE Operating Rules. (See Appendix D for a diagram of potential stakeholders involved in the transactions addressed in the CORE Benefit Enrollment and Maintenance Operating Rules that may assist with identifying all entities involved.)
	• If your organization is an employer: – You likely are outsourcing some of the CORE Benefit Enrollment and Maintenance Operating Rule requirements to an agent. Employer organizations using a clearinghouse, a software vendor, or a third-party billing/collection service to process the transactions with health plans may have some unique implementation

Analysis and Planning: Key Tasks	
Task	**Activity**
	considerations, as the clearinghouse, software vendor, or billing/collection service is performing some functions on behalf of the employer as an agent.
	• If your organization is a clearinghouse: – If a health plan and/or employer outsource(s) certain functions to you to perform on their behalf, you are responsible for implementing all CAQH Benefit Enrollment Operating Rule requirements which have been outsourced to you. In this scenario, your organization will need to work with your business partners to determine applicable rule requirements.
	• If your organization is a software or services vendor: – Though you are not considered an agent of a HIPAA-covered entity, you may be responsible for incorporating many of the CORE Benefit Enrollment and Maintenance Operating Rule requirements into your services or software as a result of providing software or services solutions to a HIPAA-covered entity. For additional insight, please review the CORE Benefit Enrollment Certification Test Suite Section 2.2.4. – Note: If your services or software are employer-facing, you will have a unique set of requirements to implement that are different than health plan-facing services or software.
Task C – Conduct a Systems Inventory (Systems Inventory & Impact Assessment Sheet)	*Relative to your stakeholder type(s):* • Identify and inventory all impacted internal systems, business processes (manual and automated) and functions/processes outsourced to an agent that processes the transactions. • Determine which functions for each identified impacted system and business process are in-house developed and maintained, commercial-off-the-shelf (COTS)/cloud-based system, or outsourced to an agent. • Determine potential options for addressing the CORE Benefit Enrollment and Maintenance Operating Rule requirements applicable to your stakeholder type(s) (e.g., remediate an in-house developed system, replace, or upgrade any COTS/cloud-based system, or work with your vendor to ensure they meet CORE Benefit Enrollment and Maintenance Operating Rule requirements).
Task D – Conduct Detailed Rule Requirements Gap Analysis (Gap Analysis Worksheet)	• Identify the impacted systems (identified via the *Systems Inventory & Impact Assessment Worksheet*) responsible for satisfying each requirement of the CORE Benefit Enrollment and Maintenance Operating Rules. • Identify and document any gaps between the existing system's capability and each rule requirement. • Identify and document any business process which may also be impacted by each CORE Benefit Enrollment and Maintenance Operating Rule requirement and to what extent the process is impacted.

Analysis and Planning: Key Tasks	
Task	**Activity**
Task E – Develop a Detailed Project Plan	• A detailed project plan typically outlines steps for completion of the following key activities as Steps 2-5 of the System Development Life Cycle: – Determine required resources to complete the project (i.e., estimate resources, time, system release schedules, and money). – Develop a detailed Functional Requirements Document. – Create a detailed Systems Design Document describing the required functions and capabilities necessary to implement the CORE Benefit Enrollment and Maintenance Operating Rules. – Implement necessary system(s) enhancements. – Test impacted systems to ensure conformance to the requirements set forth in the Functional Requirements Document. – Deploy (i.e., implement system(s) into production environment). – Conduct trading partners implementation testing.
Other Considerations – CORE Certification	• Consider CORE Certification as part of your project plan[3] – CORE offers CORE Certification to the four stakeholder types that create, transmit or use the transactions: health plans, providers, software/services vendors, and clearinghouses. – Key benefits to completing CORE Certification: ▪ Certification testing provides an online mechanism for a stakeholder to test its system's ability to exchange eligibility and claim status data with its trading partners using the CORE Benefit Enrollment and Maintenance Operating Rules. ▪ Demonstrates, via a recognized industry "Seal", your organization's adoption of the CORE Benefit Enrollment and Maintenance Operating Rules to the industry. ▪ Encourages trading partners to work together on transaction data content, infrastructure, and connectivity needs. ▪ Promotes maximum ROI when all stakeholders in the information exchange are known to conform with the CORE Benefit Enrollment and Maintenance Operating Rules. • More information on the CORE Certification process is available on the CAQH website.

[3] **NOTE:** A CORE Certification Program is offered by CORE. Information on any regulatory action that CMS may issue regarding the health plan certification required by the ACA would be outlined by Federal regulation. Information on the CMS compliance program regarding standards and operating rules is under development and can be found HERE.

4. Additional Resources

Beyond the information provided in this CORE Analysis & Planning Guide, there are additional resources for entities preparing to implement the CORE Benefit Enrollment and Maintenance Operating Rules:

- **CORE Benefit Enrollment and Maintenance Operating Rules**
- **Operating Rules Implementation Resources** from CORE and its partners to help you implement the CORE Operating Rules (note: these resources were developed for CORE Certification, however, include the same concepts, e.g., role of trading partners, apply for general adoption of the CORE Operating Rules).
- **CORE FAQs** address typical questions regarding the CORE Operating Rules.
    - If your question is not answered by the FAQs, email your question to **CORE@caqh.org** to have it submitted to the formal CORE Request Process.
- Upcoming CORE **Education Sessions** (as well as presentations and recordings from previous sessions) for further clarification on rule requirements.
- **CMS FAQs** (FAQs on a wide range of topics)
- **X12 Requests for Interpretation** provide information related to the meaning, use, and interpretation of X12 Standards, Guidelines, and Technical Reports, including implementation guidelines for the transactions can be obtained from X12.

Entities seeking to implement the CORE Benefit Enrollment and Maintenance Operating Rules are encouraged to note the following:

- The CORE Benefit Enrollment and Maintenance Operating Rules assume that any HIPAA-covered entity implementing the operating rules is compliant with HIPAA; HIPAA compliance is not defined by CORE.
- The CORE Benefit Enrollment and Maintenance Operating Rule requirements are specific to either a HIPAA-covered entity or its respective agent(s). The applicability of a specific CORE Benefit Enrollment and Maintenance Operating Rule requirement may vary according to trading partner relationship, contracted services, and other arrangements. If you have specific questions concerning applicability, please **contact CORE Staff**.
- CORE staff is available to assist with questions about understanding the requirements of the CORE Benefit Enrollment and Maintenance Operating Rules in regard to your stakeholder type(s); implementing entities are responsible for gap analysis and systems remediation.

5. Appendix

Appendix A: CORE Stakeholder & Business Type Evaluation

Purpose: After becoming educated on the CORE Benefit Enrollment and Maintenance Operating Rules, you need to determine your stakeholder type(s). The *CORE Benefit Enrollment Stakeholder & Business Type Evaluation* below assists in determining which CORE Benefit Enrollment and Maintenance Operating Rules apply to your organization and which trading partners you need to work with on planning and implementation. Knowing your stakeholder type(s) helps you complete the *Systems Inventory & Assessment Worksheet.*

NOTE: Applicability of a specific rule requirement may vary according to trading partner relationship, contracted services, and other arrangements.[4] Some example business models include:

- Employer direct-to-Health plan connection:
  - Health plan implements all requirements of the CORE Benefit Enrollment Rule Set.
  - Employer receives and processes acknowledgements as required by the CORE Benefit Enrollment Rules.
- Health plan-to-agent connection:
  - Health plan outsources the return or elements of X12 v5010 834 to an agent (e.g., business associate or third-party administrator).
  - Health plan agent acts as a proxy for health plan's CORE Benefit Enrollment conformance for the contracted services.
- Single/dual clearinghouse-to-health plan connection:
  - Health plan outsources infrastructure and connectivity functions to a clearinghouse.
  - Health plan-facing clearinghouse acts as a proxy for health plan's CORE Benefit Enrollment conformance for the contracted services.

Key Takeaway: Understand what aspects of your business and/or outsourced functions are impacted by the CORE Benefit Enrollment and Maintenance Operating Rules (e.g., products, business lines, etc.).

[4] The CORE Benefit Enrollment and Maintenance Operating Rule Set requirements are tied to applicable stakeholder type(s): HIPAA-covered provider, HIPAA-covered health plan, a HIPAA-covered entity, or their respective agents. This document references examples of these stakeholder categories to assist with applicability and implementation. Please note that some stakeholder types that are part of the entities involved in exchanging the Benefit Enrollment transaction are not necessarily a HIPAA-covered entity. Some stakeholders (software or service vendors) may not be directly required to implement the rule requirements but may need to as a result of being an agent of a HIPAA-covered entity.

Stakeholder & Business Type Evaluation		
Question	**Points for Consideration**	**Your Response**
1. What is your stakeholder type(s): health plan, provider, employer, vendor, clearinghouse? (See question 3 for more information on other trading partners)	The Benefit Enrollment CORE Certification Test Suite defines four stakeholder types that implement the operating rules: health plan, clearinghouse, provider, and vendor; the applicability of specific CORE Benefit Enrollment and Maintenance Operating Rule requirements vary according to stakeholder type. Please reference Section 2 of the Benefit Enrollment CORE Certification Test Suite for further information.	
2. What role and responsibilities does my organization have for implementing the CORE Benefit Enrollment and Maintenance Operating Rules, given our stakeholder type(s)?	The CORE Benefit Enrollment and Maintenance Operating Rules outline the specific roles and responsibilities for each stakeholder type; review CORE Benefit Enrollment and Maintenance Operating Rule text for more detail.	
3. Does my organization rely on other organizations (e.g., software vendors, clearinghouses, business associates) to assist with X12 v5010 834 processing?	The applicability of a specific CORE Benefit Enrollment and Maintenance Operating Rule requirements may vary according to trading partner relationship, contracted services, and other arrangements. If your organization relies on a software vendor or a clearinghouse or other business associate to meet any of the CORE Benefit Enrollment and Maintenance Operating Rule requirements, you will need to coordinate with that entity as part of your pre-implementation planning and outline the applicability of each requirement to the vendor, clearinghouse, or business associate. See Section 4 of this document (above) for additional resources. Ensure appropriate business associate agreements are in place with necessary stakeholders.	

Appendix B: CORE Systems Inventory & Impact Assessment Worksheet

Purpose: After you complete the *Stakeholder & Business Type Evaluation,* your next step is to complete the *CORE Systems Inventory & Impact Assessment Worksheet* which enables you to identify and inventory all impacted systems that process the X12 v5010 834 transaction.

This assessment worksheet helps you identify your systems impacted by the implementation of the CORE Benefit Enrollment and Maintenance Operating Rules, including in-house developed and maintained systems, COTS/cloud-based systems, and those functions outsourced to a third party. While completing this analysis you should also consider potential options for addressing applicable CORE Benefit Enrollment and Maintenance Operating Rule requirements (e.g., remediate an in-house developed system, replace or upgrade any COTS/cloud-based system, or work with third-party vendor).

Instructions:

1. In the second column of the worksheet, note if one of your system(s) is impacted by each rule and list the name of the impacted system(s).
    - **NOTE**: The impacted system(s) may include an in-house developed system, COTS/cloud-based system, or a capability outsourced to a third party. The "system" in certain cases may also be a manual process.
2. In the third column, identify potential options for addressing the rule requirements for each impacted system(s).
3. Use the worksheet findings to inform completion of the *Gap Analysis Worksheet* for any identified system impacted by the rule requirements (Task D of the Key Analysis & Planning Tasks in Section 3 of this document).

Key Takeaway: Understand how many of your systems/products are impacted by each CORE Benefit Enrollment and Maintenance Operating Rule and understand with which vendors you will need to coordinate.

CORE Systems Inventory & Impact Assessment Worksheet			
CORE Operating Rule Requirements	**Are One or More Systems/Processes Impacted?** *(Yes/No; Name of Impacted System/Process)*	**Is the System/Process In-House, COTS/Cloud-based, or Outsourced to a Third Party?**	**Potential Options to Address Rule Requirements** *(e.g., remediate an in-house developed system, replace, or upgrade any COTS/cloud-based system, work with third party vendor to ensure they meet CORE Operating Rule requirements, or update manual processes)*
CORE Benefit Enrollment and Maintenance (834) Infrastructure Rule			
CORE Benefit Enrollment (834) Infrastructure Rule vBE.3.0			
CORE Benefit Enrollment and Maintenance (834) Data Content Rule			
CORE Benefit Enrollment (834) Data Content Rule vBE.1.0			
CORE Connectivity Rule			
CORE Connectivity Rule vC4.0.0 (HTTPS Safe Harbor; continued support for SOAP and added support for REST; authorization: OAuth 2.0.; security: TLS 1.2)			

Appendix C: CORE Gap Analysis Worksheet

Purpose: After the *Systems Inventory & Impact Assessment*, the next task is for entities to determine the level of system(s) remediation necessary for adopting the business and technical requirements of the CORE Benefit Enrollment and Maintenance Operating Rules using the *CORE Gap Analysis Worksheet*. Each rule requirement in the *Gap Analysis Worksheet* includes a section reference to the corresponding operating rule for more detail.

NOTES:

- For more detail on rule requirements refer to the actual CORE Benefit Enrollment and Maintenance Operating Rule text which takes precedence over this worksheet.
- If your entity has identified more than one impacted system, you may need to complete a *Gap Analysis Worksheet* for each system.

Instructions:

1. The *Gap Analysis Worksheet* contains each CORE Operating Rule Requirement in the first column by CORE Benefit Enrollment and Maintenance Operating Rule. In the second column, enter the system(s) impacted by the CORE Benefit Enrollment and Maintenance Operating Rule Requirement. If there is no system impacted by the requirement, enter N/A.
    - **NOTE**: The impacted system(s) may include an in-house developed system, a COTS/cloud-based system, or a capability outsourced to a third party or business associate.
2. In the third column, note if the system currently meets the CORE Benefit Enrollment and Maintenance Operating Rule Requirement or not.
3. In the fourth column, briefly describe any gap between the CORE Benefit Enrollment and Maintenance Operating Rule Requirement and the system under evaluation, if applicable. The high-level findings from the *Systems Inventory & Impact Assessment* informs the input in this column.
4. In the fifth column, estimate the effort required to remediate the impacted system(s). This can include the type of skilled resource required, the number of such resources, and the potential hours required to fill the identified gap.
5. In the sixth column, identify and describe any impacted business process. These often include potential training and education of staff, clients, and other users of the system's new capabilities.
6. In the seventh column, estimate and describe the effort required to revise the impacted business process. This can include the type of skilled resources required, the number of such resources, and the potential hours required to fill the gap identified.
7. The results of the completed *Gap Analysis Worksheet* will allow for the development of a detailed project plan.

Key Takeaway: Understand the level of system(s) remediation necessary for adopting each CORE Benefit Enrollment and Maintenance Operating Rule requirement.

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
CORE Benefit Enrollment (834) Infrastructure Rule vBE.3.0							
	Processing Mode Requirements (§4.1)						
1	Health plan must support server requirements for Batch processing mode.						
2	Health plan may optionally also support server requirements for Real Time processing mode.						
	Connectivity Requirements (§4.2)						
3	A HIPAA-covered entity must be able to support the most recent published and CORE adopted version of the CORE Connectivity Rule.						
	System Availability Requirements (§4.3.1)						
4	System availability must be no less than 90 percent per calendar week for both real-time and batch processing modes. This will allow for health plan (or other information source) clearinghouse/switch, or other intermediary system updates to take place within a maximum of 17 hours per calendar week for regularly scheduled downtime.						
5	Publication of regularly scheduled downtime, including holidays and method(s) for such publication.						
6	Publication of non-routine downtime notice and method(s) for such publication.						
7	Publication of unscheduled/emergency downtime notice and method(s) for such publication.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	Real Time Processing Mode Response Time Requirements (§4.4)						
8	Support maximum response time requirement (receipt of a X12 v5010 999 transaction within 20 seconds of submitting a 5010X220 834 when processing in Real Time Processing Mode) to ensure that least 90 percent of required responses are returned within specified maximum response time as measured within a calendar month.						
	Real Time Acknowledgement Requirements (§4.5)						
9	A X12 v5010 999 is returned on an X12 Functional Group of X12 v5010 834 that has been accepted, accepted with errors, or rejected.						
	Batch Processing Mode Response Time Requirements (§4.6)						
10	Support maximum response time requirement (receipt of a X12 v5010 999 transaction by 7 am ET if a X12 v5010 834 was submitted by 9 pm ET three business days prior when processing in Batch Processing Mode) to ensure that least 90 percent of required responses are returned within specified maximum response time as measured within a calendar month.						
	Batch Acknowledgement Requirements (§4.7)						
11	A X12 v5010 999 is returned on a Functional Group of X12 v5010 834 that has been accepted, accepted with errors, or rejected.						
	Elapsed Time for Enrollment System Processing of Received Benefit Enrollment Data (§4.8)						
12	A health plan or its agent must process the benefit enrollment and maintenance data by its enrollment						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	application system within five business days following the successful receipt and validation of the data as defined in the rule.						
	Companion Guide Requirements (§4.9)						
13	If a HIPAA covered health plan or its agent publishes a companion guide covering the X12 v5010 834 transaction, the companion guide must follow the format/flow of the CORE Master Companion Guide Template.						
14	If a HIPAA-covered health plan or its agent publishes a companion guide for the X12 v5010X220 834 transaction, it must include a language disclosure in the appendix that explains how socio-demographic information collected at enrollment or renewal is collected, exchanged, processed, and used. The disclosure must be hyperlinked in the table of contents for easy access.						
CORE Benefit Enrollment (834) Data Content Rule vBE.1.0							
	Requirements for Receivers (§4.1)						
1	The receiver (e.g., health plan or broker) of an X12 v5010X220 834 is required to detect and extract all data elements to which this rule applies.						
2	The receiver must display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the X12 v5010X220 834 data content.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	Disclosure of and Member Consent for the Collection, Exchange, and Use of Socio-demographic Information (§4.2)						
3	A health plan and its agent must develop language disclosing the purpose, exchange, and potential uses of socio-demographic data collected under this rule, for inclusion in a companion guide.						
4	A health plan and its agent must obtain member consent to use or exchange PHI collected under the rule at enrollment, renewal, and maintenance.						
	Collection, Exchange, and Processing of Race and Ethnicity Information (§4.3)						
5	Health plan must facilitate collection and exchange race and ethnicity data consistent with the most current OMB Statistical Directive 15 and may expand the list using the concepts included CDC PHINVADS Race and Ethnicity Code Sets.						
6	A health plan and its agent must provide members the option to not disclose their race and/or ethnicity information and exchange this information when non-disclosure is indicated.						
7	Health plan may discretionally provide members with the option to choose the Middle Eastern or North African racial concept when indicated.						
8	To process race and ethnicity information collected, a health plan and its agents must use the following elements in Loop 2100A when indicated: • DMG05-01 = '7' when a member chooses not to disclose their race or ethnicity. • DMG05-02 = 'RET' and DMG05-03 = CDC Race and Ethnicity Code Set ID when a member chooses to disclose their race or ethnicity.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	• DMG05-10 = 'REC' and DMG05-11 = CDC Race and Ethnicity Collection Code ID to process how race and ethnicity was collected.						
	Collection, Exchange, and Processing of Self-Reported Member Language (§4.4)						
9	A health plan and its agent are required to provide the option for a member to disclose or not disclose their language at the point of enrollment, renewal, and maintenance.						
10	To process member languages collected, a health plan and its agent must use:[5] • Loop 2100A – Member Name • LUI – Member Language • LUI01 = 'LE' (ISO 639 Language Codes) • LUI02 = <applicable ISO 639-3 code>						
11	For each language collected at enrollment, renewal and maintenance, a health plan and its agent must collect at least one and a maximum of four member language uses, which can be reading, writing, speaking, or native language.						

12	To process language use data collected, a health plan and its agent must use the loops, segments and data elements listed below:
	• Loop 2100A – Member Name
	• LUI – Member Language
	• LUI04 = <applicable X12 use code>
	  ○ Reading = 5
	  ○ Writing = 6						

[5] Note: if member language is 'English' it must not be exchanged consistent with X12 TR3 requirements.

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
	○ Speaking = 7 ○ Native Language = 8						
	Discretionary Collection, Exchange, and Processing of Self-reported Member Gender Identity (§4.5)						
13	A health plan and its agent has the discretion to collect a member's self-reported gender identity during enrollment, renewal or maintenance, but members must have the option to not disclose. If gender identify is collected, it should align with the minimum set of concepts endorsed by the HL7 Gender Harmony Project, which includes categories for Male, Female, Non-binary, and Unknown.						
14	A health plan and its agent must use a sequential non-negative integer consistent with requirements in the X12 v5010X220 834 to differentiate from other Member Reporting Categories shared in the X12 v5010X220 834. • LS – Additional Reporting Categories • LS01 = '2700' • Loop 2700 – Member Reporting Categories • LX – Member Reporting Categories LX01 = <unique sequential, non-negative integer>						
15	A health plan and its agent must specify the name of the reporting category consistent with X12 447 v5010X220 834 reporting requirements to indicate the type of information being exchanged. • Loop 2750 – Reporting Category • N1 – Reporting Category • N101 = '75' (Participant) • N102 = 'Gender'						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
16	Health plans and their agents must process self-reported member gender identity collected as part of this rule consistent with USCDI v3 or the highest regulated version. If the collection and exchange meet the minimum requirements in this rule and 'Unknown' is reported, REF02 should be filled with the HL7 Null Flavor value 'UNK,' indicating undisclosed gender identity. Unknown may have multiple meanings but should be used when a member chooses not to disclose their gender identity. To process this, health plans and their agents must use: • Loop 2750 – Reporting Category • REF – Reporting Category Reference • REF01 = 'ZZ' (Mutually Defined) • REF02 = <Appropriate SNOMED CT code for collected concept or HL7 Null Flavor code for Unknown> • LE – Additional Reporting Categories Loop Termination • LE01 = '2700'						
CORE SOAP Connectivity Rule vC4.0.0							
	Message Envelope Requirement (§4.1)						
1	Requires the use of SOAP+WSDL.						
	Submitter Authentication Requirement (§4.1.1)						
2	Requires the use of X.509 Client Authentication (mutual authentication) over TLS 1.2 or higher.						
	Submitter Authorization Requirements (§4.1.2)						

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3	Requires support for OAuth 2.0 Client Authorization over TLS 1.2 or higher						
	Real Time and Batch Payload Attachment Handling (§4.1.4)						
4	Payload must be sent as an MTOM encapsulated object.						
	Required Transport Method (§4.2.1)						
5	HIPAA-covered entities or their agents must implement HTTP/S Version 1.1 over the public internet.						
6	Receivers must perform the role of an HTTP/S server; Senders must perform the role of an HTTP/S client.						
7	All information exchanged between the client and server is encrypted by a session-level private key negotiated at connection time.						
	Real Time Requests (§4.2.3)						
8	Real Time requests must include a single inquiry or submission as specified in the transaction's corresponding CORE Infrastructure Rule.						
	Batch Submission (§4.2.4)						
9	Batch requests are sent in the same way as Real Time requests.						
10	Response must be only the standard HTTP message indicating whether the request was accepted or rejected.						
11	Message receivers must not respond to a batch submission with an X12 response such as a 5010 X12 999 in the HTTP response to the batch request, even if their systems' capabilities allow such a response.						

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12	All X12 responses must be available for pick up by the message sender (client) in accordance with the respective CORE Infrastructure Rule for the transaction.						
	Batch Response Pickup (§4.2.5)						
13	Batch responses must be picked up after the message receiver has had a chance to process a Batch submission in the timeframes specified in the transaction's corresponding CORE Infrastructure Rule.						
	Error Handling (§4.2.6)						
14	The appropriate HTTP error or status codes and SOAP Faults as applicable to the error/status situation must be used.						
	Tracking of Date and Time and Payload ID (§4.2.8)						
15	Servers are required to track the times of any received inbound messages, and respond with the outbound message for that Payload ID.						
16	Clients must include the date and time the message was sent in the CORE metadata element Time Stamp.						
	Capacity Plan (§4.2.9.1, §4.2.9.2)						
17	A HIPAA-covered entity or its agent's messaging system must have a capacity plan such that it can receive and process a large number of single concurrent Real Time transactions via an equivalent number of concurrent connections which must be received, processed, and the appropriate response provided within response time requirements specified in the transaction's corresponding CORE Operating Rule.						

Rule Req. #	CORE Operating Rule Requirement	System/Process Impacted *(Based on results from System Inventory and Impact Analysis Worksheet; if no impact enter N/A)*	System/ Process Currently Meets the Requirement *(Yes/No)*	Gap *(Briefly describe gap)*	Estimated System/ Process Remediation Effort *(Required number of resources, type of skilled resource, person hours required)*	Business Processes Impacted *(Briefly describe)*	Business Processes/ Documentation Revisions Required & Effort Estimates
18	A HIPAA-covered entity or its agent's messaging system must have the capability to receive and process large Batch transaction files which must be received, processed, and the appropriate response provided within the time specified in the applicable CORE Operating Rule.						
	Response Time, Time Out Parameters, and Re-transmission (§4.2.10)						
19	If the HTTP Post Reply Message is not received within the 60 second response period, the client system should send a duplicate transaction no sooner than 90 seconds after the original attempt was sent.						
20	Client system should submit no more than 5 duplicate transactions within the next 15 minutes if no response is received after the second attempt.						
21	If the additional attempts result in the same timeout termination, the client system should notify the submitter to contact the receiver directly to determine if system availability problems exist or if there are known internet traffic constraints causing the delay.						
	Publication of Entity-Specific Connectivity Companion Document (§4.3)						
22	Servers must publish detailed specifications in a Connectivity Companion Document on the entity's public web site.						
	Envelope Metadata (§4.4.2)						
23	The Envelope Metadata specified in Table 4.4.2 pertains to the Message Envelope SOAP+WSDL. With the exception of *ErrorCode* and *ErrorMessage* fields, which						

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	are only sent in the response, the CORE required envelope metadata for the request and response are required to be identical.						
	Processing Mode (§4.4.3.1)						
24	A HIPAA-covered entity or its agent must support the transaction processing mode requirements specified in the *COREProcessingModePayloadTypeTables.docx* companion document when exchanging transactions in conformance with this CORE Connectivity Rule vC4.0.0.						
25	The Processing Mode requirements specified also apply when a HIPAA-covered entity or its agent are exchanging the transactions addressed by this rule using any other connectivity method as permitted by the CORE Safe Harbor.						
	Enumeration of Payload Type Fields (§4.4.3.2)						
26	A HIPAA-covered entity or its agent must support the requirements for identifying the Payload (*PayloadType)* carried within the content of the Message Envelope as specified in the *COREProcessingModePayloadType Tables.docx* companion document to this CORE Connectivity Rule v4.0.0.						
CORE REST Connectivity Rule vC4.0.0							
	API Interface Format Requirement (§5.1.1)						
1	HIPAA-covered entities and their agent must use JavaScript Object Notation (JSON) for REST Interfaces.						
	Authentication Requirement (§5.1.2)						

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2	Requires the use of X.509 Client Authentication (mutual authentication) over TLS 1.2 or higher.						
	Submitter Authorization Requirements (§4.1.2)						
3	Requires support for OAuth 2.0 Client Authorization over TLS 1.2 or higher						
	Transport Method (§5.2.1)						
4	HIPAA-covered entities and their agents must be able to implement HTTP/S Version 1.1 over the public internet.						
	Request and Response Handling (§5.2.2)						
5	Request and response handling for both Synchronous Real-time and Asynchronous Batch Process.						
	Error Handling (§5.2.6)						
6	Message receiver must notify the message sender if the request was successfully handled during the processing of HTTP headers and processing of the Payload.						
	Tracking of Date and Time and Payload (§5.2.8)						
7	Servers are required to track the times of any received inbound messages and respond with the outbound message for that Payload.						
8	Clients must include the date and time the message was last modified.						
	Capacity Plan (§5.2.9., §5.2.11)						

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9	A HIPAA-covered entity or its agent's messaging system must have a capacity plan such that it can receive and process a large number of single concurrent Synchronous Real Time transactions via an equivalent number of concurrent connections which must be received, processed, and the appropriate response provided within response time requirements specified in the transaction's corresponding CORE Operating Rule.						
10	A HIPAA-covered entity or its agent's messaging system must have the capability to receive and process large Batch transaction files which must be received, processed, and the appropriate response provided within the time specified in the applicable CORE Operating Rule.						
	Specifications for REST API Uniform Resource Identifiers (URI) Paths (§5.3.1, §5.3.2)						
11	Servers are required to communicate the version of the CORE Connectivity Rule implemented and version of the REST API through the URI Path, per Table 5.3.1.						
12	Requires entities to use standard naming conventions for REST API endpoints to streamline and support uniform REST implementations.						
	REST HTTP Request Method Requirements (§5.4)						
13	Requires entities to use HTTP Methods listed in Table 5.4 to indicate the desired action to be performed for a given resource.						

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	REST HTTP Metadata, Descriptions, Intended Use, and Values (§5.5)						
14	Entities are required to use the metadata specified in Table 5.5 for HTTP Requests and HTTP Responses for REST Exchanges.						
	Publication of Entity-Specific Connectivity Companion Document (§5.7)						
15	Servers must publish detailed specifications in a Connectivity Companion Document on the entity's website.						

Appendix D: Stakeholder Overview Transaction Flow Diagrams[6]

*Defined in 45 CFR Section 162.1501 as " . . . transmission of subscriber enrollment information from the sponsor of the insurance coverage, benefits, or policy, to a health plan to establish or terminate insurance coverage."

[6]For connectivity requirements and related information regarding the actual exchange of the transactions, please reference §8.3 Sequence Diagrams of the CORE Connectivity Rule vC4.0.0.