



**CORE Benefit Enrollment & Maintenance (834) Data
Content Rule
Version BEM.1.0
March 2024**

**CAQH Committee on Operating Rules for Information Exchange (CORE)
Benefit Enrollment & Maintenance (834) Data Content Rule vBEM.1.0**

Revision History for CORE Benefit Enrollment & Maintenance (834) Data Content Rule

Version	Revision	Description	Date
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1. Background Summary

1.1. CORE Overview

CAQH CORE is an industry-wide facilitator committed to the creation and adoption of healthcare operating rules that support standards, accelerate interoperability, and align administrative and clinical activities among providers, health plans and patients. Guided by over 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.¹

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

1.2. Industry Interest in Value-based Payment Focused 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 high-quality care, positive health 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 participating organizations 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. These are:

- 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.

In 2023, the National Committee for Vital and Health Statistics (NCVHS), the statutory federal advisory body 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.² This marks the first time an operating rule directly addressing value-based

¹ 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.

² 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.

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payments was recommended for federal adoption by NCVHS. The Single Patient Attribution Rule is the foundation of which this rule builds upon.

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 the 2018, and highlighted new challenges, including:

- Incorporation of methodologies to promote health equity.
- 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.

2. Issues to Be Addressed and Business Requirement Justification

2.1. Problem Space

Value-based payment models began principally as a tool to control healthcare expenditures, operating on the assumption that the incentivization of better outcomes leads to the judicious use of appropriate treatments, services, and care settings. Though these goals have been achieved for some models, the continued allure of and reliance on fee-for-service payments paired with operational difficulties in implementing and administering the programs has led to mixed results. Specifically, costs and quality have often remained stable despite the novel interventions and methodologies included in the payment models.

Despite modest results, the penetration and perceived favorability of VBP continues to grow across the industry. Part of this is attributable to methodology refinements applied to existing and new models that may result in cost-savings or quality improvements. It is also driven by an increased realization among stakeholders that the reach of VBP models coupled with their ability to pilot novel interventions on a large-scale make them a valuable tool to address health inequities. The application of VBP to health equity is demonstrated in models sponsored by the Center for Medicare and Medicaid Innovation (CMMI), such as Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH).

This emerging and laudable use of VBP models is limited by the non-uniform collection, exchange, and processing of socio-demographic data, which is necessary to identify population-level disparities and design generalizable interventions. CORE Operating Rules support the standard exchange of this information by identifying distinct data content requirements that trading partners must adhere to when exchanging this sensitive and valuable information.

2.1.1. Process in Identifying the Problem Space and Barriers to Automating the Exchange of Socio-demographic Information

CORE performed extensive environmental scanning to identify opportunities for operating rule development that would address automation and other operational difficulties in the administration of value-based payment models. This process involved a literature review of industry resources and in-depth one-on-one interviews with provider, health plan, vendor, and standard development organization stakeholders that highlighted directions CORE could take to standardize VBP data exchange and infrastructure requirements.

From here, CORE tested these findings and assumptions by convening a VBP Focus Group comprised of industry representatives. This group was essential in refining and finalizing the VBP-related topics to present to a CORE VBP Subgroup for rule development. These recommendations included:

- Data alignment for the exchange of socio-demographic information.
- Infrastructure updates to improve the administration of VBP.
- Streamlining the claim submission process to support VBP methodologies.

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- Simplification of contracting concepts and terminology to align industry language.

The opportunities presented to the Subgroup span multiple transactions. This operating rule focuses on standardizing the exchange of socio-demographic information to support the growth and continued implementation of VBP interventions that directly address health inequity. There are several key contributors to variation of socio-demographic information:

1. **Unaligned data sets:** Concepts, such as race and ethnicity, are exchanged using different vocabulary standards. These are often incompatible and limit translation and generalizability between stakeholders.
2. **Industry interpretation:** Standards, both those that are widely implemented and those that are emerging, can be subject to interpretative implementations based on the varying understandings and needs of implementers.
3. **Evolving vocabulary:** Some concepts, such as gender identity or the documented sex of an individual, are still being defined by industry groups as the need for standard data exchange is balanced with inclusivity of new concepts.
4. **Security of Protected Health Information:** Socio-demographic information is sensitive and, if misused or exchanged without appropriate acknowledgment of this fact, can result in harm through discriminatory actions.

CORE plays a central role in standardization of data exchange and each of these issues is addressed in the operating rule requirements.

2.2. Focus of the CORE Benefit Enrollment & Maintenance (834) Data Content Rule

The purpose of this operating rule is to identify and standardize the data used for collecting and exchanging key socio-demographic data at the point of member enrollment or renewal to a health plan using the HIPAA-mandated X12N 005010X220 Benefit and Enrollment Maintenance (834) transaction (hereafter referenced as X12 v5010X220 834).

The following requirements included in the rule address data content of benefit enrollment related to key socio-demographic data:

- Standardize how self-reported race and ethnicity data collected at enrollment and renewal is exchanged and processed using the unique identifiers contained in the CDC Detailed Race and Ethnicity Code Sets exchanged in the DMG segment of the X12 v5010X220 834.³
- Enhance the availability of member-facing information about the exchange, use, and benefit of collecting sensitive information, supporting a type of informed consent for sensitive data exchange.
- Streamline the collection, exchange, and processing of member language at the point of enrollment or renewal using ISO 639-3 language codes and use of language codes facilitated in the LUI segment of the X12 v5010X220 834.
- Align reporting of gender identity in the X12 v5010X220 834 with the United States Core Data for Interoperability (USCDI) version 3 or most recent highest numbered **regulated** version to expand and enrich the concepts currently included in the TR3.
- Elevate the importance of privacy by requiring an option be available to members at the point of enrollment or renewal to not disclose sensitive information for any of the indicated socio-demographic concepts included in this rule.

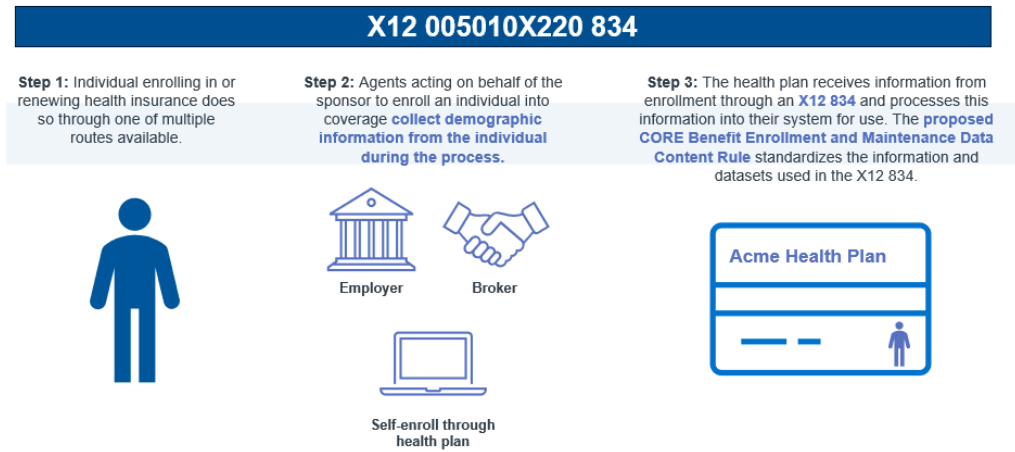
³ PHINVADS CDC Detailed Race Code Set:

<https://phinvasd.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.876> and PHINVADS Detailed Ethnicity Code Set: <https://phinvasd.cdc.gov/vads/ViewValueSet.action?id=34D34BBC-617F-DD11-B38D-00188B398520>. X12 Code Source 859.

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The flow of information from a member to a sponsor and then finally to a health plan is shown in **Figure 1**. This rule primarily contemplates the flow of information from sponsor to health plan.

FIGURE 1



2.3. Promotion of Self-Reported Data, Empowerment of Member Choice, and Maintenance of Privacy

Throughout the development of this and related operating rules, CORE Participants emphasized that collection and exchange of socio-demographic information necessitates requirements that ensure privacy and security, informed member consent, and “gold-standard” self-reporting of sensitive personal information. Where possible, and appropriate, this rule includes mandatory and discretionary requirements that fulfill these considerations.

In recognition of implementation guidance of federal privacy regulations, existing industry variability in how information is captured and shared, and understanding that operating rules do not prescribe health plan policy and procedures - this CORE Operating Rule provides a basis for implementing the collection and exchange of socio-demographic information in ways that are considerate of member privacy and consent, but does not prescribe the specific mechanisms that must be put in place to carry out these practices.

CORE Participants acknowledged that self-reported socio-demographic information is the “gold standard” as it avoids bias in reporting and is fully representative of the member experience. Despite the clear advantages of self-reported information, not all reporting and exchange is carried out using this method. For example, employers often send human resources records to fulfill race and ethnicity reporting, which may or may not include self-reported data. Accordingly, to support standardized data exchange, the requirements of this operating rule accommodate other methods of collection in-use by industry stakeholders. Exchange using best practice self-reporting is encouraged.

Though the CORE Operating Rules cannot be applied at the level of specificity necessary to guide the implementation of Federal Policy or to dictate health plan procedures, they can be used as a venue to transmit best practices that help guide implementation. As such, listed below are several best practices shared by CORE Participants during the development of this rule that guide implementation in a way that is sensitive to privacy, consent, and self-reporting.

- **Opt-in Consent:** Per the requirements of this operating rule, health plans and their agents must accommodate a consent process consistent with provisions in the HIPAA Privacy Law at 45 CFR 164.506 and as advised by their internal legal counsel. Implementers maintain the option to use opt-in or opt-out consent process.

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CORE Participants recognize “opt-in” consent as a best practice implementation method because it requires members to consciously agree to collection and exchange through a “box check” or some similar mechanism. Compared to “opt-out” methods, this strengthens privacy and increases engagement with any included disclosure language.

- **Self-reporting of Race and Ethnicity:** Where appropriate, this operating rule requires socio-demographic information to be self-reported by a member to a health plan or its agent. Self-reporting is required for member language and gender identity but is not specified for the collection and exchange of race and ethnicity. Per the preamble to this section, race and ethnicity are not always collected or exchanged based on what was self-reported by the member and can be fulfilled administratively.

The point of indicating how this information is collected is to empower evaluation of its quality and utility in the design and administration of value-based payment programs. With that point understood, CORE Participants acknowledge that collection of this information varies, but state that collection via self-reporting is a best practice and, as such, should be considered by health plans and their agents as they implement the requirements of this operating rule.

- **Recognition of the Fluidity of Collected Concepts:** A benefit of collecting sensitive socio-demographic information is more accurate and timely recognition of a member’s personal experience. This operating rule supports this by accommodating a maintenance process that allows reporting of new concepts over time. Though concepts such as race, ethnicity, and language may remain relatively stable, those encompassing self-reported gender identity can change more frequently.

Changes to socio-demographic concepts are supported through maintenance of member records and through member renewal. Current X12 v5010X220 834 requirements facilitate the exchange of information, including effective and maintenance dates, to indicate the currency of a reported concept. CORE Participants indicated potential need to catalogue changes over time to concepts, as opposed to overwriting previous concepts, which can be carried out at the discretion of the implementer using date and time fields in Member Reporting Categories.⁴

- **Display and Availability of Disclosure Language:** Operating rule requirements for this and related rules compel health plans and their agents to generate disclosure language detailing the collection, exchange, and potential uses of member socio-demographic information. This operating rule establishes a minimum requirement for this language to be included in the transaction-specific companion guide and to be displayed, unaltered, to members at the point of enrollment, renewal, or maintenance requests.

CORE Participants, in support of the requirement, encourage health plans and their agents to include the disclosure language in additional areas – such as member facing websites or collateral – to enhance the reach of the disclosure language. In turn, this increases the opportunity that members will engage with the language as they consider providing their consent for the collection, exchange and use of sensitive personal information.

Note that, though this section contains best practices that aid in the security of personal information, they are not presented as requirements in this operating rule. This section strives to provide best practice implementation guidance for the requirements outlined in §4 of this rule. Additional information, where appropriate, will be included in operating rule-specific frequently asked question (FAQ) documents.

⁴ This rule is silent on requirements to employ Loop 2750 DTP fields to report change in socio-demographic concepts. Understanding that this rule establishes baseline requirements for the collection and exchange of socio-demographic concepts, CORE Participants intend to monitor implementation and, if these fields are routinely used in reporting, consider amendments to rule requirements that employ Member Reporting Category DTP fields.

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3. Scope

3.1. What the Rule Applies To

This CORE Operating Rule conforms with and builds upon the X12 v5010X220 834 implementation guide and specifies the minimum socio-demographic data content that a health plan and its agent⁵ is required to collect at the point of member enrollment or renewal and maintenance of member records. The operating rule further specifies minimum data content requirements for how a health plan and its agents must process collected socio-demographic information using the X12 v5010X220 834 transaction.

The collection and use of socio-demographic information necessitates the maintenance of privacy and member consent. This operating rule requires health plans and their agents to disclose exchange and use of socio-demographic information, allowing enrollees to make an informed choice of whether to share their personal information.

Consistent with this requirement, health plans and their agents are required to exercise optional provisions in the HIPAA privacy law that allows covered entities to obtain consent from individuals in order to use or disclose PHI for treatment, payment, and health care operations purposes.⁶ Per requirements, covered entities are provided with complete flexibility as to the content and manner of obtaining the consent.⁷ This requirement is further detailed in §4.2. Implementation guidance, containing best practices identified by CORE Participants, is detailed in §2.3.

3.2. When the Rule Applies

This rule applies when:

- A health plan or its agent enrolls or renews an individual into a health plan.
- A health plan or its agent updates enrolled member records in a maintenance request.

AND

- A health plan or its agent successfully collects required and recommended socio-demographic information.

AND

- A health plan or its agent receives socio-demographic information collected at the point of member enrollment or renewal and processes the information into enrollment and membership databases using the X12 v5010X220 834 transaction.

3.3. What this Rule Does Not Address

- Requirements for the use of the X12 834 transaction by the Affordable Care Act or State Health Information Exchanges.
- Infrastructure requirements applicable to the X12 v5010X220 834.

⁵ Merriam-Webster defines 'Agent' as "one who is authorized to act for or in the place of another: such as a representative, emissary, or official of a government." In the context of this rule, 'agent' may include but is not limited to: a plan sponsor, employer, broker, or other such entity.

⁶ 45 CFR 164.506: <https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164/subpart-E/section-164.506>

⁷ US Department of Health and Human Services (2008). HHS – HIPAA Home – For Professionals – FAQ - 555: [Can a covered entity use existing aspects of the HIPAA Privacy Rule to give individuals the right to Opt-In or Opt-Out of electronic health information exchange?](#)

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3.4. What the Rule Does Not Require

- This rule does not require any HIPAA-covered entity to modify its use and content of other loops and data elements that may be submitted in the X12 v5010X220 834 that are not addressed in this rule.

3.5. Applicable Loops, Data Elements & Code Sources

This rule covers the following specified loops, segments, and data elements in the X12 v5010X220 834 Benefit Enrollment & Maintenance transactions:

Applicable Loops & Segments in X12 v5010X220 834 Benefit Enrollment and Maintenance		
Loop ID	Segment	Element
Exchange of Race and Ethnicity		
Loop ID 2100A Member Name	DMG Member Demographics	DMG05-01 Race or Ethnicity Code
		DMG05-02 Code List Qualifier Code
		DMG05-03 Industry Code
		DMG10 Code List Qualifier Code
		DMG11 Industry Code
Exchange of Member Language		
Loop ID 2100A Member Name	LUI Member Language	LUI01 Identification Code Qualifier
		LUI02 Identification Code
		LUI04 Use of Language Indicator
Exchange of Gender Identity		
Loop ID 2000 Member Level Detail	LS Additional Reporting Categories	LS01 Loop Identifier Code
	LE Additional Reporting Categories Loop Termination	LE01 Loop Identifier Code
Loop ID 2700 Member Reporting Categories	LX Member Reporting Categories	LX01 Assigned Number
Loop ID 2750 Reporting Category	N1 Reporting Category	N101 Entity Identifier Code
		N102 Name
	REF Reporting Category Reference	REF01 Reference Identification Qualifier
		REF02 Reference Identification

3.6. Data Classes, Code Sources, and Value Sets Addressed

This rule addresses the following data classes, code sources, and value sets:

- Classification of Race or Ethnicity, which communicates the race and/or ethnicity of member using the Detailed Race (PHVS_Race_CDC) and Detailed Ethnicity (PHVS_Ethnicity_CDC) Code Sets. The code sets are maintained by the CDC and are distributed through the Public Health Information Network Vocabulary Access and Distribution System (PHINVADS).⁸ Note that the code sets align with the aggregated version 1.2 of the CDC Race and Ethnicity Code Set, indicated for use in USCDI version 3.
- Method of Race and Ethnicity Data Collection, which communicates how an enrolling members' race and/or ethnicity was recorded based on values in the CDC Race or Ethnicity Collection Code

⁸ PHINVADS CDC Detailed Race Code Set: <https://phinvasd.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.876> and PHINVADS Detailed Ethnicity Code Set: <https://phinvasd.cdc.gov/vads/ViewValueSet.action?id=34D34BBC-617F-DD11-B38D-00188B398520>. X12 Code Source 859.

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Set. This code set is maintained by the CDC distributed through the Public Health Information Network Access and Distribution System.⁹

- International Organization for Standardization (ISO) *Codes for the representation of names of languages – Part 3: Alpha-3 code for comprehensive coverage of languages* (ISO-639), which communicates all known member languages through three-letter identifiers.¹⁰
- Codes from SNOMED International, Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®) U.S. Edition, aligned with most current regulated USCDI version.¹¹
- Codes from the HL7 Null Flavor data set to standardize reporting of unknown gender identity values.¹²

3.7. 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](#).

3.8. 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 data content benefiting the use of socio-demographic data to combat health disparities.

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 Benefit Enrollment & Maintenance (834) Operating Rules.
- The CORE Guiding Principles apply to this rule and all other rules.
- This rule is not a comprehensive companion document addressing any content requirements of the X12 v5010 834 Benefit Enrollment & Maintenance transaction.
- Compliance with all CORE Operating Rules is a minimum requirement; any entity is free to offer more than what is required in the rule.

3.9. Value-based Payment Terminology

To understand concepts, terms, and methodologies used to navigate and administer value-based payment program CORE developed the CORE Framework for Semantic Interoperability in Value-based Payments.¹³ The Framework is intended to promote the standardized use of VBP terminology and is used as a reference within VBP-related CORE Operating Rules. The CORE Benefit Enrollment and Maintenance Data Content Rule vBEM.1.0 does not require implementation or alignment with the concepts listed in The Framework.

⁹ PHINVADS CDC Race and Ethnicity Collection Code:
<https://phinivads.cdc.gov/vads/ViewValueSet.action?id=256BFE72-CB04-E011-9273-00188B39829B>. X12 Code Source: 860.

¹⁰ ISO 639-3 source: https://iso639-3.sil.org/code_tables/639/data. X12 Code Source 102.

¹¹ UMLS Licensees may download here:
https://www.nlm.nih.gov/research/umls/rxnorm/sourcereleasedocs/snomedct_us.html.

¹² <https://terminology.hl7.org/3.1.0/CodeSystem-v3-NullFlavor.html>

¹³ [CORE Framework for Semantic Interoperability in Value-based Payments](#)

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4. X12 v5010X220 834 Benefit Enrollment & Maintenance: Technical Requirements

4.1. Requirements for Receivers of a X12 v5010X220 834

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. 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.

End users of this information vary and can include, but are not limited to health plans, members accessing their information through a member portal, or providers receiving the information as part of a contractual agreement as either an extract or electronically through a portal. Regardless of end user type, receivers should follow HIPAA Minimum Necessary standards to guide disclosure.¹⁴

4.2. Disclosure of and Member Consent for the Collection, Exchange, and Use of Socio-demographic Information

When socio-demographic data is indicated as required for collection or discretion to collection non-mandatory information is exercised, a health plan and its agent must develop language disclosing the purpose of data collection, detailing its exchange and potential uses.¹⁵ This disclosing language, required to be included in the transaction-specific companion guide per the CORE Benefit Enrollment and Maintenance Infrastructure Rule, must also be presented to members at the point of enrollment, renewal, and maintenance on the enrollment form or through another electronic or published format determined by the health plan and its agent.

Regardless of how it is presented¹⁶, the language presented to members at the point of enrollment, renewal, and maintenance must be identical to what is published in the transaction-specific companion guide. To increase transparency and accessibility, CORE also recommends making disclosure language publicly available outside the enrollment or renewal process, potentially accomplished by a health plan and its agent posting the language on its public-facing website. See §2.3. for additional commentary.

At the point of enrollment, renewal, and maintenance, health plans and their agents must obtain consent from members to use or exchange the PHI collected as part of the requirements outlined in this operating rule. As referenced in §3. of this operating rule, this requirement leverages existing optional allowances in the HIPAA privacy law and can be carried out in a form and manner of the health plan's and its agent's choosing.¹⁷ Health plans and their agents are required to implement a consent process in line with advice from their internal legal counsel.

4.3. Collection, Exchange, and Processing of Race and Ethnicity Information

The following subsections outline the requirements and recommendations for collecting race and ethnicity information.

4.3.1. Parameters for the Collection of Race and Ethnicity Information

At a **minimum**, a health plan and its agent are required to collect race and ethnicity concepts consistent with those contained in the most current version of the [Office of Management and Budget Statistical Directive 15](#) required under regulation for the collection of race and ethnicity for federal programs.¹⁸

Health plans and their agents are not limited to the concepts contained in the [Office of Management and Budget Statistical Directive 15](#). If health plans and their agents seek to expand the concepts collected,

¹⁴ 45 CFR 164.502(b). [https://www.ecfr.gov/current/title-45/part-164#p-164.502\(b\)](https://www.ecfr.gov/current/title-45/part-164#p-164.502(b)).

¹⁵ Uses of this data should be representative of currently identified applications and may require periodic updates as utility evolves.

¹⁶ Operating rule requirements do not dictate how this language must be displayed. CORE acknowledges that electronic distribution aids in consistency and clarity.

¹⁷ 45 CFR 164.506: <https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164/subpart-E/section-164.506>

¹⁸ Current OMB Statistical Direct 15 Collection Requirements
https://obamawhitehouse.archives.gov/omb/fedreg_1997standards

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they must do so using the concepts contained in the Detailed Race and/or Ethnicity Code Sets referenced at X12 code source 859, which, as previously stated are aligned with the values in the comprehensive CDC Race and Ethnicity Code Set version 1.2. This requirement ensures that the collected race and ethnicity concepts can be standardly exchanged using a unique identifier.

The steps to process and standardize the exchange of race and ethnicity information are laid out in §4.3.2. In addition to these concepts, a health plan and its agent:

- Must provide members with the option to not disclose their race and/or ethnicity and collect and exchange this information when non-disclosure is indicated.
- Must report how the method by which race and/or ethnicity information was determined (e.g., member self-reporting).
- At their discretion, provide members with the option to choose the **Middle Eastern or North African** racial concept and collect and exchange this information when it is indicated.¹⁹

4.3.2. Parameters to Process Race and Ethnicity Information Using the X12 v5010X220 834

Once the information indicated in §4.3.1 is collected and shared with a health plan or its agent, the following loops, segments, and data elements must be used to process the information in the X12 v5010X220 834.²⁰ Please note, it is incumbent on the health plan to require its agents executing enrollment or renewal to comply with these requirements.

- **When a Member Chooses NOT to Disclose Their Race and/or Ethnicity**
Loop 2100A – Member Name
DMG – Member Demographics
DMG05-01 = '7'²¹
- **When a Member Chooses to Disclose Race and/or Ethnicity**
Loop 2100A – Member Name
DMG – Member Demographics
DMG05-02 = 'RET'
DMG05-03 = <Unique Detailed Race and/or Ethnicity Identifier(s)>²²
- **Processing of How Race and Ethnicity was Collected**
Loop 2100A – Member Name
DMG – Member Demographics
DMG10 = 'REC'

¹⁹ Note that Middle Eastern and North African may become mandated in future versions of the OMB 15, in which case, requirements align with the most current version and the collection and exchange of Middle Eastern and North African would no longer be discretionary.

²⁰ Note that if more than one concept is shared, they must be processed in separate repeats of the data segment up to 10 times, in line with the X12 005010X220 834 requirements.

²¹ CORE Participants recognize the value '7' can be interpreted in several ways. For the purposes of implementing rule requirements, however, '7' should be interpreted as the member chose to not disclose their race and ethnicity.

²² PHINVADS CDC Detailed Race Code Set:

<https://phinivads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.876> and PHINVADS Detailed Ethnicity Code Set: <https://phinivads.cdc.gov/vads/ViewValueSet.action?id=34D34BBC-617F-DD11-B38D-00188B398520>. X12 Code Source 859.

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DMG11 = <Unique Identifier from CDC Race and Ethnicity Collection Code>^{23,24}

4.4. Collection, Exchange, and Processing of Self-Reported Member Language

Standardized collection of member language assists in promoting equitable access to healthcare and, when care is sought, increases the likelihood it is delivered in a way that is culturally appropriate and meaningful to a patient.

4.4.1. Requirement to Provide Members the Opportunity to Self-report Member Language at Enrollment, Renewal, or Maintenance

As part of this operating rule, a health plan and its agent are required to provide the option for a member to disclose or not to disclose their language at the point of enrollment, renewal, or maintenance.²⁵

- When a member discloses that their language that is not English²⁶ sections §4.4.2. – 4.4.4. apply.
- When a member chooses not to disclose their language, regardless of whether it is English, sections §4.4.2. – 4.4.4. do not apply.
- When a member chooses to disclose their language, but it is English, sections 4.4.2. – 4.4.4. do not apply.

4.4.2. Processing of Self-Reported Member Language

For the language(s) collected in §4.4.1., regardless of the format that member language is collected in (e.g., plain text, another ISO 639 format, etc.), upon receipt a health plan and its agent must process that information consistent with the ISO 639-3 standard using the following loops, segments, and data elements. The ISO 639-3 standard provides the most granular view of member language, identifying parent language concepts, as well as dialects.

Loop 2100A – Member Name
LUI – Member Language
LUI01 = ‘LE’ (ISO 639 Language Codes)
LUI02 = <applicable ISO 639-3 code>

4.4.3. Requirement to Collect Self-Reported Use of Member Language for Each Recorded Language

For each language collected in §4.4.1, a health plan or its agent must collect at **least one** and a **maximum of four** member language uses for each recorded language at the point of enrollment, renewal, and maintenance.²⁷ The four valid indicators of use, defined in the X12 v5010X220 834 are:

- Reading.
- Writing.
- Speaking.
- Native Language.

²³ The CDC Race and Ethnicity Code Set is maintained by PHINVADS and contains unique codes for how a race and ethnicity was collected. Extensions to these code sets are in the external code set reference ‘860 – Race or Ethnicity Collection Code’ in the X12 v5010 TR3. [Link here.](#)

²⁴ CORE Participants recommend that health plans and their agents do not rely on observer-identified reporting of race and ethnicity given the opportunity to introduce bias or inaccuracy into datasets, potentially harming its generalizability and applicability to health equity initiatives in VBP. CORE and its Participating Organizations support any race and ethnicity collection that relies on member self-reporting, either recorded directly during enrollment or renewal or sourced from employer human resources data bases.

²⁵ Consistent with the X12 TR3, a health plan and its agent must also indicate that collection of member language is required under the insurance contract between the sponsor and payer.

²⁶ The X12 005010X220 834 TR3 states that member language should not be sent when it is known the member’s language is English and when not prohibited by state or federal regulations.

²⁷ The X12 005010X220 834 TR3 defines four values for use of member language. CORE requires the collection, exchange, and processing of this information, the four values are an X12 TR3 requirement.

4.4.4. Processing of Self-reported Use of Member Language

For each use of language collected in §4.4.3., a health plan and its agent must process the information consistent with the loops, segments, and data elements indicated below:²⁸

- Loop 2100A – Member Name
- LUI – Member Language
- LUI04 = <applicable X12 use code>**
 - **Reading = 5**
 - **Writing = 6**
 - **Speaking = 7**
 - **Native Language = 8**

4.5. Discretionary Collection, Exchange, and Processing of Self-Reported Member Gender Identity at Enrollment, Renewal or Maintenance

To align X12 reporting with new and emerging standards, requirements can be met by using alphanumeric reference fields in the X12 v5010X220 834 transactions.

Industry conformance with the requirements in §4.5.1.-4.5.2. and related subsections is **discretionary**. When requirements are designated as discretionary for the X12 v5010X220 834, it is at the discretion of the health plan or its agent whether to collect, exchange, and process the data in accordance with the indicated requirements. When a health plan or its agent exercises this discretion to collect, exchange, and process the data, any included loop, segment, or data elements designated as required must be collected.

4.5.1. Collection of Self-Reported Member Self-reported Gender Identity

A health plan and its agent, at their discretion, can require collection of a member's self-reported gender identity at the point of enrollment, renewal, or maintenance. As part of this collection, a health plan and its agent must provide members with the opportunity to not disclose their gender identity. Collection should be carried out consistent with the minimum set of concepts supported by the HL7 Gender Harmony Project.²⁹

Description	Definition
Male	A person's self-identification as a man, as male, or as a boy.
Female	A person's self-identification as a woman, as female, or as a girl.
Non-binary	Having a specific identity which is nonbinary (not within a binary construct of male or female) or having an identity which falls under the nonbinary umbrella (i.e., any or all gender identities which are not female or male).
Unknown ³⁰	A proper value is applicable but not known.

²⁸ Each repeat of the LUI segment can only contain one language and one use of language. For a language where multiple uses are reported, each repeat must contain the same language in LUI02 with the unique indicated use in LUI04.

²⁹ <https://confluence.hl7.org/pages/viewpage.action?pageId=94656132#GenderIdentity-Expansion>

³⁰ Includes, but is not limited to, when health plan or its agent is unable to ask or a member declines to share the information.

4.5.2. Processing of Member Self-reported Gender Identity

When the information specified in §4.5.1. is collected and shared a health plan and its agent must process the information using the X12 v5010X220 834 consistent with the indicated loops, segments, and data elements listed below.

- **Member Reporting Categories for Gender Identity Processing**

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. This number must not conflict with values already in use for other member reporting categories unrelated to this rule requirement.

LS – Additional Reporting Categories

LS01 = '2700'

Loop 2700 – Member Reporting Categories

LX – Member Reporting Categories

LX01 = <unique sequential, non-negative integer>

- **Reporting Category for Gender Identity Reporting**

A health plan and its agent must specify the name of the reporting category consistent with X12 v5010X220 834 reporting requirements to indicate the type of information being exchanged.

Loop 2750 – Reporting Category

N1 – Reporting Category

N101 = '75' (Participant)

N102 = 'Gender'

- **Self-Reported Gender Identity Reporting Values**

Once Member Reporting Categories are specified for self-reported member gender identity, a health plan and its agent must process the member's gender identity collected as part of §4.5.1. consistent with USCDI version 3 or the highest regulated version.³¹ USCDI v3 requires the exchange of gender identity concepts using SNOMED-CT.³²

If collection and exchange was consistent with the minimum requirements listed in §4.5.1. and 'Unknown' is reported, REF02 should be populated with the HL7 Null Flavor³³ value of 'UNK'. Unknown may have multiple meanings but should be used when a member chooses not to disclose their gender identity.

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'

³¹ <https://www.healthit.gov/isa/taxonomy/term/2736/uscdi-v3>

³² UMLS Licensees may be download here:

https://www.nlm.nih.gov/research/umls/rxnorm/sourcereleasedocs/snomedct_us.html

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SNOMED CT and HL7 codes for the **minimum** requirements indicated in §4.5.1. are shown below.

Description	Data Set	Value
Male	SNOMED	446151000124109
Female	SNOMED	446141000124107
Non-binary	SNOMED	33791000087105
Unknown	HL7 Null Flavor	UNK

Requirements in vBEM.1.0 indicate that changes to gender concepts reported by a member overwrite past reported concepts and rely on the effective and maintenance dates included in the structure of the X12 v5010X220 834. Please reference discussion in §2.3. for attendant implementation considerations.

5. Conformance Requirements

Conformance with this rule is considered achieved when all the required detailed step-by-step test scripts specified in the Benefit Enrollment and Maintenance CORE Certification Test Suite are successfully passed.