

**CORE Benefit Enrollment & Maintenance (834) Data
Content Rule
Version BEM.1.0
September 2023**

**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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DRAFT

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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 005010X318) Data Content Rule
- CORE Attributed Patient Roster (X12 005010X318) Infrastructure Rule

The National Committee for Vital and Health Statistics (NCVHS), the statutory public 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 payments was recommended for federal adoption by NCVHS. The Single Patient Attribution Rule is the foundation of which this rule builds upon.

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

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

9 In 2023, CORE convened a Value-based Payment Subgroup to evaluate these opportunities further and
10 assess the need for new or updated operating rules to de-burden and streamline the administration of
11 VBP.

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

13 **2.1. Problem Space**

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

21 Despite modest results, the penetration and perceived favorability of VBP continues to grow across the
22 industry. Part of this is attributable to methodology refinements applied to existing and new models that
23 may result in cost-savings or quality improvements. It is also driven by an increased realization among
24 stakeholders that the reach of VBP models coupled with their ability to pilot novel interventions on a large-
25 scale make them a valuable tool to address health inequities. The application of VBP to health equity is
26 demonstrated in CMMI sponsored models, such as ACO REACH.

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

32 **2.1.1. Process in Identifying the Problem Space and Barriers to Automating the 33 Exchange of Socio-demographic Information**

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

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

- 43 • Data alignment for the exchange of socio-demographic information.
- 44 • Infrastructure updates to improve the administration of VBP.
- 45 • Streamlining the claim submission process to support VBP methodologies.
- 46 • Simplification of contracting concepts and terminology to align industry language.

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

- 5 1. **Unaligned data sets:** Concepts, such as race and ethnicity, are exchanged using different
6 vocabulary standards. These are sometimes incompatible and limit translation and
7 generalizability between stakeholders.
8
- 9 2. **Industry interpretation:** Standards, both those that are widely implemented and those that are
10 emerging, can be subject to interpretative implementations based on the varying understandings
11 and needs of implementers.
12
- 13 3. **Evolving vocabulary:** Some concepts, such as gender identity or the documented sex of an
14 individual, are still being defined by industry groups as the need for standard data exchange is
15 balanced with inclusivity of new concepts.
16
- 17 4. **Security of Protected Health Information:** Socio-demographic information is sensitive and, if
18 misused or exchanged without appropriate acknowledgment of this fact, can result in harm
19 through discriminatory actions.

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

22 **2.2. Focus of the CORE Benefit Enrollment & Maintenance (834) Data Content Rule**

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

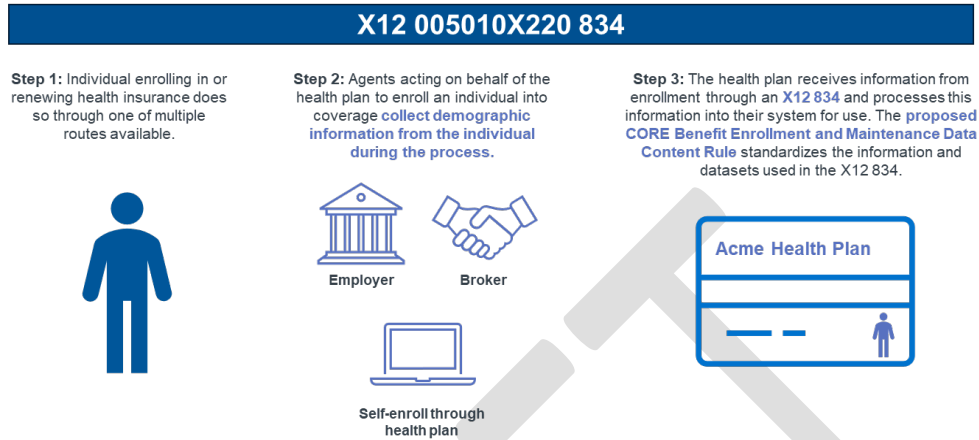
27 The following requirements included in the rule address data content of benefit enrollment related to key
28 socio-demographic data:

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

44 The flow of information from a member, to sponsor, to health plan is shown in the **Figure 1**. This rule
45 primarily contemplates the flow of information from sponsor to health plan.

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FIGURE 1



1

2 **3. X12 v5010X220 834 Benefit Enrollment & Maintenance Data Content Rule: Requirements**
3 **Scope**

4 **3.1. What the Rule Applies To**

5 This CORE Operating Rule conforms with and builds upon the X12 v5010X220 834 implementation guide
6 and specifies the minimum socio-demographic data content that a health plan and its agent³ is required to
7 collect at the point of member enrollment or renewal. The operating rule further specifies minimum data
8 content requirements for how a health plan and its agents must process collected socio-demographic
9 information using the X12 834 transaction.

10 The collection and use of socio-demographic information necessitates the maintenance of privacy and retention
11 of enrollee choice of whether to share sensitive information. This operating rule requires health plans and their
12 agents to disclose exchange and use of socio-demographic information allowing enrollees to make an informed
13 choice of whether to share their personal information. Member socio-demographic information should be self-
14 reported and is marked as such throughout this operating rule. .

15 Consistent with this requirement, health plans and their agents are required to exercise optional provisions in
16 the HIPAA privacy law that allow covered entities to obtain consent from individuals in order to use or disclose
17 PHI for treatment, payment, and health care operations purposes.⁴ Per requirements, covered entities are
18 provided with complete flexibility as to the content and manner of obtaining the consent.⁵ This requirement is
19 further detailed in §4.2.

20 **3.2. When the Rule Applies**

21 This rule applies when:

- 22 • A health plan or its agent enrolls or renews an individual into a health plan.

23 **And**

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

26 **And**

³ 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."

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

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

4 **3.3. What this Rule Does Not Address**

- 5 • Requirements for the use of the X12 834 transaction by the Affordable Care Act or State Health
6 Information Exchanges.
7
8 • Infrastructure requirements applicable to the X12 005010X220 834.

9 **3.4. What the Rule Does Not Require**

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

13 **3.5. Applicable Loops, Data Elements & Code Sources**

14 This rule covers the following specified loops, segments, and data elements in the X12 v5010X220 834
15 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

16
17 **3.6. Data Classes, Code Sources, and Value Sets Addressed**

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

- 19 • Classification of Race or Ethnicity, which communicates the race and/or ethnicity of an enrolling
20 or renewing member using the CDC Race and Ethnicity Code Set. This code set is maintained by

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1 the CDC distributed through the Public Health Information Network Access and Distribution
2 System.⁶

- 3 • Race or Ethnicity Collection Code, which communicates how an enrolling members race and/or
4 ethnicity was recorded based on values in the CDC Race or Ethnicity Collection Code Set. This
5 code set is maintained by the CDC distributed through the Public Health Information Network
6 Access and Distribution System.⁷
- 7 • X12 External Code Source 102 ISO-639, which communicates a member language using the
8 ISO-639-3 standard where three characters represent macro and individual languages.⁸
- 9 • Codes from SNOMED International, Systematized Nomenclature of Medicine Clinical Terms
10 (SNOMED CT®) U.S. Edition, aligned with most current regulated USCDI version.⁹
- 11 • Codes from the HL7 Null Flavor data set to standardize reporting of unknown gender identity
12 values.¹⁰

13 **3.7. Maintenance of This Rule**

14 Any substantive updates to the rule (i.e., change to rule requirements) are determined based on
15 industry need as supported by the CORE Participants per the CORE Change and Maintenance
16 Process.

17 **3.8. Assumptions**

18 A goal of this rule is to adhere to the principles of electronic data interchange (EDI) in assuring
19 that transactions sent are accurately received and to facilitate the electronic exchange of data
20 content benefiting the use of socio-demographic data to combat health disparities.

21 The following assumptions apply to this rule:

- 22 • A successful communication connection has been established.
- 23 • This rule is a component of the larger set of CORE Benefit Enrollment & Maintenance
24 (834) Operating Rules.
- 25 • The CORE Guiding Principles apply to this rule and all other rules.
- 26 • This rule is not a comprehensive companion document addressing any content
27 requirements of the X12 v5010 834 Benefit Enrollment & Maintenance transaction.
- 28 • Compliance with all CORE Operating Rules is a minimum requirement; any entity is free
29 to offer more than what is required in the rule.
- 30 • Assumption receiver means health plan and their agents, brokers and their agents

31 **3.9. Value-based Payment Terminology**

32 To understand concepts, terms, and methodologies used to navigate and administer value-based
33 payment program CORE developed the CORE Framework for Semantic Interoperability in Value-based
34 Payments.¹¹

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

36 **4.1. Requirements for Receivers of a X12 v5010X220 834**

⁶ PHINVADS CDC Race and Ethnicity Code Set: <https://phinivads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.876>. X12 Code Source 859.

⁷ PHINVADS CDC Race and Ethnicity Collection Code: <https://phinivads.cdc.gov/vads/ViewValueSet.action?id=256BFE72-CB04-E011-9273-00188B39829B>. X12 Code Source: 860.

⁸ ISO 639-3 source: https://iso639-3.sil.org/code_tables/639/data

⁹ UMLS Licensees may download here: https://www.nlm.nih.gov/research/umls/rxnorm/sourcereleasedocs/snomedct_us.html

¹⁰ <https://terminology.hl7.org/3.1.0/CodeSystem-v3-NullFlavor.html>

¹¹ Once approved, a link to The Framework will be provided here.

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1 The receiver (e.g., health plan or broker) of an X12 v5010X220 834 is required to detect and extract all
2 data elements to which this rule applies. The receiver must display or otherwise make the data
3 appropriately available to the end user without altering the semantic meaning of the X12 v5010X220 834
4 data content.

5 **4.2. Disclosure of and Member Consent for the Collection, Exchange, and Use of Socio-**
6 **demographic Information**

7 When socio-demographic data is indicated for required or discretionary collection in this rule, a health
8 plan and its agent must develop language disclosing the purpose of data collection, detailing its exchange
9 and potential uses.¹² This disclosing language, required to be included in the transaction-specific
10 companion guide per the CORE Benefit Enrollment and Maintenance Infrastructure Rule, must also be
11 presented to members at the point of enrollment or renewal on the enrollment form or through another
12 electronic or published format determined by the health plan and its agent. Regardless of how it is
13 presented, the language presented to members at the point of enrollment or renewal must be identical to
14 what is published in the transaction-specific companion guide. To increase transparency and
15 accessibility, CORE also recommends making disclosure language publicly available outside the
16 enrollment or renewal process, potentially accomplished by a health plan and its agent posting the
17 language on its public-facing website.

18 At the point of enrollment or renewal, health plans and their agents must obtain consent from members to
19 use or exchange the PHI collected as part of the requirements outlined in this operating rule. As
20 referenced in §3. of this operating rule, this requirement leverages existing optional allowances in the
21 HIPAA privacy law and can be carried out in a form and manner of the health plan and its agents
22 choosing.¹³ Accommodating a consent process using existing regulatory flexibility facilitates individual
23 choice for how sensitive information is exchanged electronically.

24 **4.3. Collection, Exchange, and Processing of Race and Ethnicity Information**

25 When operationalizing rule requirements and recommendations, socio-demographic information should
26 be collected in the order it appears in this rule.¹⁴ The following subsections outline the requirements and
27 recommendations for collecting race and ethnicity information.

28 **4.3.1. Parameters for the Collection of Race and Ethnicity Information**

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

32 Health plans and their agents are not limited to the concepts contained in the [Office of Management and](#)
33 [Budget Statistical Directive 15](#). If health plans and their agents seek to expand the list, they must do so
34 using the concepts contained in the comprehensive CDC Race and Ethnicity Code Set from which the
35 unique identifier is used to standardize exchange of the collected concepts. The steps to process and
36 standardize exchange of race and ethnicity information are laid out in §4.3.2.

37
38 In addition to these concepts, a health plan and its agent:

- 39 • Must provide members with the option **to not disclose their race and/or ethnicity** and collect
40 and exchange this information when it is indicated.
- 41
42 • Must require the collection and exchange how race and ethnicity information was collected.
- 43

¹² Uses of this data should be representative of currently identified applications and may require periodic updates as utility evolves.

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

¹⁴ Note that the concept of “order” used to specify flow and format of operating rule requirements does not extend to any ordinal requirements in the X12 Standard, which would be inconsistent with guidance in the X12 TR3.

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

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- 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.¹⁶

4.3.2. Parameters to Process Race and Ethnicity Information Using the X12 005010X220 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 834.¹⁷ 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 or Ethnicity**

Loop 2100A – Member Name
DMG – Member Demographics
DMG05-01 = '7' (Not Provided)

- **When a Member Chooses to Disclose Race or Ethnicity**

Loop 2100A – Member Name
DMG – Member Demographics
DMG05-02 = 'RET'
DMG05-03 = <Unique Identifier from CDC Race and Ethnicity Code Set>¹⁸

- **Processing of How Race and Ethnicity was Collected**

Loop 2100A – Member Name
DMG – Member Demographics
DMG10 = 'REC'
DMG11 = <Unique Identifier from CDC Race and Ethnicity Collection Code>^{19,20}

4.3.3. Discretionary Race and Ethnicity Data Processing Requirements Using the X12 005010X220 834

When operating rule requirements are designated as discretionary for the X12 v5010X220 834, it is at the discretion of the health plan or its agent whether to process the data in accordance with the indicated requirements. When a health plan exercises this discretion to process the data, any included loop, segment, or data elements designated as required must be collected.

- **Processing Using the CDC Race and Ethnicity Hierarchical Code**

The DMG05 segments can be repeated up to 10 times. When a health plan and its agent meet the requirements in §4.3.2 to process race and ethnicity using the CDC Race and Ethnicity Code Set unique

¹⁶ 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.

¹⁷ 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 v5010X220 834 requirements.

¹⁸ The CDC Race and Ethnicity Code Set is maintained by the PHIN Vocabulary Access and Distribution System (PHINVADS) and contains unique identifiers and hierarchical categorization for a comprehensive – but not exhaustive – list of racial and ethnic concepts. Extensions to these code sets are in the external code set reference '859 – Classification of Race or Ethnicity' in the X12 v5010 TR3. <https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.876>.

¹⁹ The CDC Race and Ethnicity Code Set is maintained by the PHIN Vocabulary Access and Distribution System (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. <https://phinvads.cdc.gov/vads/ViewValueSet.action?id=256BFE72-CB04-E011-9273-00188B39829B>.

²⁰ CORE recommends 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.

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1 identifier in fewer than 10 repeats of the DMG05 segments, using the remaining repeats, a health plan
2 and its agent may additionally process the CDC Race and Ethnicity Hierarchical Code²¹ for informational
3 purposes using the following:

4 Loop 2100A – Member Name
5 DMG – Member Demographics
6 **DMG05-02 = ‘RET’**
7 **DMG05-03 = <CDC Race and Ethnicity Hierarchical**
8 **Code>**

9 **4.4. Collection, Exchange, and Processing of Self-Reported Member Language**

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

13 **4.4.1. Requirement to Collect Self-Reported Member Language at Enrollment or Renewal**

14 As part of the operating rule, a health plan and its agent are required to collect member language – when
15 it is not English²² – at the point of enrollment or renewal. When the member’s language is English,
16 member language should not be collected by a health plan and its agent.

17 **4.4.2. Processing of Self-Reported Member Language**

18 For the language(s) collected in §4.4.1, a health plan and its agent must process that information
19 consistent with the ISO 639-3 standard using the following loops, segments, and data elements. The ISO
20 639-3 standard provides a granular view of member language, identifying parent language concepts, as
21 well as dialects.

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

26 **4.4.3. Requirement to Collect Self-Reported Use of Member Language for Each Recorded**
27 **Language**

28 For each language collected in §4.4.1, a health plan or its agent must collect at least one and a maximum
29 of four member language uses for each recorded language at the point of enrollment or renewal.²³ The
30 four valid indicators of use, defined in the X12 v5010X220 834 are:

- 31 • Reading
32 • Writing
33 • Speaking
34 • Native Language

35
36
37 **4.4.4. Processing of Self-reported Use of Member Language**

²¹ Note that exchange using the hierarchical code cannot be standardized as it may change over time as additional race and ethnicity concepts are introduced into the CDC Race and Ethnicity Code Set. The hierarchical code should only be included for informational purposes.

²² 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.

²³ The X12 v5010X220 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.

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1 For each use of language collected in §4.4.3., a health plan and its agent must process the information
2 consistent with the loops, segments, and data elements indicated below:²⁴

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

10 **4.5. Discretionary Collection, Exchange, and Processing of Self-Reported Member Gender**
11 **Identity**

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

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

20 **4.5.1. Collection of Self-Reported Member Self-reported Gender Identity**

21 A health and its agent at their discretion can require collection of a member’s self-reported gender identity
22 at the point of enrollment or renewal, providing members with the opportunity to not disclose their gender
23 identity. **At a minimum**, if exercising discretion to collect this information, it should be done so consistent
24 with the set of concepts maintained by the HL7 Gender Harmony Project.²⁵ The current value-set is
25 shown below.

26

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 ²⁶	A proper value is applicable but not known.

27

²⁴ 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.

²⁵ <https://confluence.hl7.org/pages/viewpage.action?pagelD=94656132#GenderIdentity-Expansion>

²⁶ Includes, but is not limited to, when collector is unable to ask or a member declines to share the information.

1 **4.5.2. Processing of Member Self-reported Gender Identity**

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

5 • **Member Reporting Categories for Gender Identity Processing**

6 A health plan and its agent must use a sequential non-negative integer consistent with requirements in
7 the X12 v5010X220 834 to differentiate from other Member Reporting Categories shared in the X12
8 005010X220 834. This number must not conflict with values already in use for other member reporting
9 categories unrelated to this rule requirement.

10 LS – Additional Reporting Categories

11 **LS01 = '2700'**

12 Loop 2700 – Member Reporting Categories

13 LX – Member Reporting Categories

14 **LX01 = <unique sequential, non-negative integer>**

15 • **Reporting Category for Gender Identity Reporting**

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

18 Loop 2750 – Reporting Category

19 N1 – Reporting Category

20 **N101 = '75' (Participant)**

21 **N102 = 'Gender'**

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

23 Once Member Reporting Categories are specified for self-reported member gender identity, a health plan
24 and its agent must process the member's gender identity collected as part of §4.5.1. consistent with
25 USCDI version 3 or the highest regulated version.²⁷ USCDI v3 requires the exchange of gender identity
26 concepts using SNOMED-CT.²⁸

27
28 If collection and exchange was consistent with the minimum requirements listed in §4.5.1. and 'Unknown'
29 is reported, REF02 should be populated with the HL7 Null Flavor²⁹ value of 'UNK'. Unknown may have
30 multiple meanings but should be used when a member chooses not to disclose their gender identity.

31
32 Loop 2750 – Reporting Category

33 REF – Reporting Category Reference

34 **REF01 = 'ZZ' (Mutually Defined)**

35 **REF02 = <Appropriate SNOMED CT code for**
36 **collected concept or HL7 Null Flavor code for**
37 **Unknown>**

38 LE – Additional Reporting Categories Loop Termination

39 **LE01 = '2700'**

²⁷ <https://www.healthit.gov/isa/taxonomy/term/741/uscdi-v2>

²⁸ UMLS Licensees may download here: https://www.nlm.nih.gov/research/umls/rxnorm/sourcereleasedocs/snomedct_us.html

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1 SNOMED CT codes for the **minimum** requirements indicated in §4.5.1. are shown below.
2

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

3
4 **5. Conformance Requirements**

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

DRAFT