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14 # 1. NEW: CORE Benefit Enrollment (834) Data Content Rule Test Scenario

1.1 Key Rule Requirements

Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.

Requirements for Receivers (§4.1)

- Detect and extract all data elements to which the rule applies.
- Display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the data content.

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

- Health plans and their agents must develop language disclosing the purpose, exchange, and potential uses of socio-demographic data collected under this rule, for inclusion in a companion guide.
- Health plans and their agents 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)

- Health plans 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 Race and Ethnicity Code Set.
- Health plans and their agents must provide members the option to not disclose their race and/or ethnicity information and exchange this information when non-disclosure is indicated.
- Health plans may discretionally provide members with the option to choose the Middle Eastern or North African racial concept when indicated.
- To process race and ethnicity information collected, health plans and their 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.
- 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)

- Health plans and their agents are required to provide the option for a member to disclose or not disclose their language at the point of enrollment, renewal, and maintenance.
- To process member languages collected, health plans and their agents must use Loop 2100A and LUI segments, with LUI01 specifying 'LE' (ISO 639 Language Codes) and LUI02 indicating the applicable ISO 639-3 code.
- For each language collected at enrollment, renewal and maintenance, health plans and their agents must collect at least one and a maximum of four member language uses, which can be reading, writing, speaking, or native language

1.1 Key Rule Requirements

- To process language use data collected, health plans and their agents must use Loop 2100A and LUI segments, with LUI04 being assigned an applicable X12 use code corresponding to reading (5), writing (6), speaking (7), or native language (8).

Discretionary Collection, Exchange, and Processing of Self-reported Member Gender Identity (§4.5)

- A health plan and their agents have the discretion to collect a member's self-reported gender identity during enrollment or renewal, but members must have the option to not disclose. If gender identify is collected, it should align with the concepts defined by the HL7 Gender Harmony Project, which includes categories such as Male, Female, Non-binary, and Unknown.
- To process self-reported member gender identify, health plans and their agents must use a unique sequential, non-negative integer to differentiate gender identity data from other member reporting categories within Loop 2700 using LS01 as '2700' for Additional Reporting Categories, and assigning unique sequential non-negative integers to LX01.
- To indicate reporting category for self-reported member gender identify reporting, a health plan and their agents must use the Loop 2750 to specify the type of information being exchanged, with specific values N101 = '75' (Participant) and N102 = 'Gender' for self-reported member gender identity data.
- 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. To process this, health plans and their agents must use Loop 2750 – Reporting Category with REF01 'ZZ' and REF02 accommodating the appropriate SNOMED CT code for the collected concept or 'UNK'.

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1.2 Conformance Testing Requirements

These scenarios test the following conformance requirements of the X12 v5010 834 Requirements. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario.

- Provide a copy or electronic access to member enrollment form and companion guide. Such submission may be in the form of a hard copy paper document, an electronic document, or a URL
- The ability to process an X12 v5010 834 transaction generated using the CORE Master Test Bed Data providing the following information socio-demographic information about an individual:
    - Race and Ethnicity
    - Self-Reported Member Language
    - Self-Reported Gender Identity
- System receiving the X12 v5010 834 must demonstrate its capability to detect and extract the data elements addressed in this rule and display such data and appropriate text to the end user.

1.3 Test Scripts Assumptions
• The test scripts do not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.

1.4 Detailed Step-By-Step Test Scripts

CORE Certification Testing is not exhaustive. The CORE Certification Test Suite does not include comprehensive testing requirements that test for all possible permutations of each rule. An individual test script may be testing for more than one item, and, as noted in the "Stakeholder" column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

The Detailed Step-by-Step Test Scripts below specify the stakeholder type to which each test script applies. A stakeholder may indicate that a specific test script does not apply to it. In this case the stakeholder is required to provide a rationale for why a specific test script is not applicable and be prepared for a review of the rationale with CORE staff.

When establishing a Certification Test Profile with a CORE-authorized Testing Vendor a Vendor will be given the option to indicate if the product it is certifying is a Provider-facing product or a Health Plan-facing product. Therefore, the Detailed Step-by-Step Test Scripts applicable to a Provider apply to a Provider-facing product. Similarly, Detailed Step-by-Step Test Scripts applicable to a Health Plan apply to a Health Plan-facing product.

Disclosure of and Member Consent										
Test #	Criteria	Expected Result	Actual Result	Pass	Fail	N/A	Stakeholder *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	Health Plan	Clearinghouse	Vendor
1	Health plans and their agents must obtain member consent at enrollment, renewal, and maintenance.	Submission of member enrollment form or other form showing conformance to member consent requirements.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
2	Health plans and their agents must develop language disclosing the purpose, exchange, and potential uses of socio-demographic data for inclusion in a companion guide.	Submission of companion guide showing conformance to socio-demographic data disclosure requirements.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒

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Race and Ethnicity Information										
Test #	Criteria	Expected Result	Actual Result	Pass	Fail	N/A	Stakeholder *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	Health Plan	Clearinghouse	Vendor
3	Health plans must collect and exchange race and ethnicity data as per OMB Statistical Directive 15.	Submission of member enrollment form or other form showing conformance to ability to collect race and ethnicity date per OMB Statistical Directive 15.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
4	Health plans and their agents must provide members the option to not disclose their race and/or ethnicity information	Submission of member enrollment form or other form showing conformance to ability for members to opt-out from sharing race and ethnicity information.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
5	Health plans must optionally include the Middle Eastern or North African racial concept when indicated.	Submission of member enrollment form or other form showing conformance to ability to collect Middle Eastern or North American racial concepts.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
6	Extract from a X12 v5010 834 transaction as defined in the CORE rule the data indicating when a member chooses not to disclose their race or ethnicity.	Provide a screen print of the output from Test #6 showing that the required information can be processed and displayed.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
7	Extract from a X12 v5010 834 transaction as defined in the CORE rule the data indicating when a member chooses to disclose their race or ethnicity.	Provide a screen print of the output from Test #7 showing that the required information can be processed and displayed.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒

Race and Ethnicity Information										
Test #	Criteria	Expected Result	Actual Result	Pass	Fail	N/A	Stakeholder *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	Health Plan	Clearinghouse	Vendor
8	Extract from a X12 v5010 834 transaction as defined in the CORE rule the data indicating processing of how race and ethnicity was collected.	Provide a screen print of the output from Test #8 showing that the required information can be processed and displayed.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒

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Self-Reported Member Language										
Test #	Criteria	Expected Result	Actual Result	Pass	Fail	N/A	Stakeholder *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	Health Plan	Clearinghouse	Vendor
9	A health plan and its agent are required provide the option for a member to disclose or not disclose their language at the point of enrollment, renewal, and maintenance.	Submission of member enrollment showing conformance to ability to collect member languages, when not English.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
10	Extract from a X12 v5010 834 transaction as defined in the CORE rule the data indicating processing of member language.	Provide a screen print of the output from Test #11 showing that the required information can be processed and displayed.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒

Self-Reported Member Language										
Test #	Criteria	Expected Result	Actual Result	Pass	Fail	N/A	Stakeholder *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	Health Plan	Clearinghouse	Vendor
11	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.	Submission of member enrollment showing conformance to ability to collect member language uses.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
12	Extract from a X12 v5010 834 transaction as defined in the CORE rule the data indicating processing use of member language.	Provide a screen print of the output from Test #13 showing that the required information can be processed and displayed.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒

Self-Reported Gender Identify										
Test #	Criteria	Expected Result	Actual Result	Pass	Fail	N/A	Stakeholder *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	Health Plan	Clearinghouse	Vendor
13	A health plan and its agent, at their discretion, can require the collection of a member's self-reported gender identity at the point of enrollment, renewal, and maintenance.	Submission of member enrollment showing conformance to ability to collect self-reported gender identity using value sets maintained by HL7 Gender Harmony Project.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
14	Health plans and their agents must offer members the choice to not disclose their gender identity.	Submission of member enrollment form or other form showing conformance to ability for members to opt-out from sharing gender identify information.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
15	Extract from a X12 v5010 834 transaction as defined in the CORE rule the data indicating member reporting categories for gender identity processing.	Provide a screen print of the output from Test #16 showing that the required information can be processed and displayed.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
16	Extract from a X12 v5010 834 transaction as defined in the CORE rule the data indicating reporting category for gender identity reporting.	Provide a screen print of the output from Test #17 showing that the required information can be processed and displayed.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
17	Extract from a X12 v5010 834 transaction as defined in the CORE rule the data indicating gender identify reporting values.	Provide a screen print of the output from Test #18 showing that the required information can be processed and displayed.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒

2. UPDATED: CORE Benefit Enrollment (834) Infrastructure Rule Test Scenario

2.1 Key Rule Requirements

Note: This section identifies at a high level the key requirements of this rule. Refer to the rule document for the specific language of the rule which governs. Section numbers in parentheses following each key requirement refer to the specific rule section which applies.

Processing Mode Requirements (§4.1)

- A HIPAA covered health plan or its agent must implement server requirements for Batch Processing Mode.
- A HIPAA covered health plan or its agent may optionally implement server requirements for Real Time Processing Mode.

Connectivity Requirements (§4.2)

- HIPAA-covered entity and its agent must be able to support the most recent published and CORE adopted version of the CORE Connectivity Rule.

System Availability Requirements (§4.3)

- A HIPAA-covered health plan or its agent's system availability must be no less than 90 percent per calendar week.
- A HIPAA-covered health plan and its agent may choose to use an additional 24 hours of scheduled system downtime per calendar quarter.
- A HIPAA covered health plan or its agent must publish their regularly scheduled system downtime in an appropriate manner.
- A HIPAA covered health plan or its agent must publish the schedule of non-routine downtime at least one week in advance.
- A HIPAA covered health plan or its agent must provide information within one hour of realizing downtime will be needed in the event of unscheduled/emergency downtime.
- No response is required during scheduled or unscheduled/emergency downtime(s).
- A HIPAA covered health plan or its agent must establish and publish its own holiday schedule.

Response Time Requirements (§4.4, §4.6)

- When an ASC X12N v5010 834 has been submitted in Real Time Processing Mode by any entity, an ASC X12C v5010 999 must be returned with 20 seconds. In the case of a rejection of the ASC X12N v5010 834 Functional Group the ASC X12C v5010 999 must be returned within the same response time.
- When an ASC X12N v5010 834 has been submitted in Batch Processing Mode by any entity by 9:00 pm Eastern Time of a business day, an ASC X12C v5010 999 must be available for pick up by 7:00 am Eastern Time on the third business day following submission.
- Each HIPAA covered entity must support this maximum response time to ensure that at least 90 percent of all required responses are returned within the specified maximum response time as measured within a calendar month.
- Each HIPAA covered entity must capture, log, audit, match and report the date (YYYYMMDD), time (HHMMSS), and control numbers from its own internal systems and the corresponding data received from its trading partners.

2.1 Key Rule Requirements

Use of Acknowledgements Requirements (§4.5, §4.7)

- When an ASC X12N v5010 834 has been submitted in Real Time Processing Mode by any entity, an ASC X12C v5010 999 must be returned to indicate the acceptance, acceptance with errors, or rejection of the Functional Group of an ASC X12N v5010 834.
- When an ASC X12N v5010 834 has been submitted in Batch Processing Mode by any entity, an ASC X12C v5010 999 must be returned to indicate the acceptance, acceptance with errors, or rejection of the Functional Group of an ASC X12N v5010 834.
- The ASC X12C v5010 999 must report each error detected to the most specific level of detail supported by the ASC X12C v5010 999.

Elapsed Time for Enrollment System Processing of Received Enrollment Data (§4.8)

- A HIPAA covered health plan must process the enrollment data in its internal enrollment application system within five business days following successful receipt and verification of the data.

Companion Guide Requirements (§4.9)

- A Companion Guide covering the ASC X12N v5010 834 published by a HIPAA covered health plan or its agent must follow the format/flow as defined in the CORE Master Companion Guide Template.
- When 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, renewal, and maintenance is collected, exchanged, processed, and used. The disclosure must be hyperlinked in the table of contents for easy access.

2.2 Conformance Testing Requirements

These scenarios test the following conformance requirements of the ASC X12N v5010 834 Requirements. Other requirements of this rule that may not be listed below are not included in this test scenario. Notwithstanding, CORE-certified entities are required to comply with all specifications of the rule not included in this test scenario. Note: Clearinghouses and/or vendors undergoing CORE Certification Testing should refer to Detailed Step-by-Step Test Scripts for applicable test scripts.

System Availability

Demonstrate its ability to publish to its trading partner community the following schedules:

- Its regularly scheduled downtime schedule, including holidays, and
- Its notice of non-routine downtime showing schedule of times down, and
- A notice of unscheduled/emergency downtime notice.

Acknowledgements

- An ASC X12C v5010 999 is returned to indicate either acceptance, acceptance with errors, or rejection a Functional Group of an ASC X12N v5010 834.

2.2 Conformance Testing Requirements

Response Time

- Demonstrate the ability to capture, log, audit, match, and report the date (YYYYMMDD), time (HHMMSS) and control numbers from its own internal systems and its trading partners.

Companion Guide

Submission to a CORE-authorized Testing Vendor the following:

- A copy of the table of contents of its official ASC X12N v5010 834 companion guide, and
- A copy of a page of its official ASC X12N v5010 834 companion guide depicting its conformance with the format for specifying the ASC X12N v5010 834 data content requirements.
- A copy of a page of its official ASC X12N v5010 834 companion guide depicting its conformance with the content requirements to include language disclosing collection, exchange, processing, and use of socio-demographic information collected at enrollment, renewal, and maintenance.
- Such submission may be in the form of a hard copy paper document, an electronic document, or a URL where the table of contents and an example of the companion guide is located.

2.3 Test Scripts Assumptions

- The entity has implemented in its production environments the necessary policies, procedures and method(s) required to conform to the requirements of the System Availability requirements.
- The test scripts will not include comprehensive testing requirements to test for all possible permutations of the CORE requirements of the rule.
- All communications sessions and logons are valid; no error conditions are created or encountered.
- The health plan's EDI management system generates a syntactically correct ASC X12 interchange containing the ASC X12N v5010 834 and ASC X12C v5010 999 transactions.
- Test scripts will test ONLY for valid and invalid ASC X12 Interchange, Functional Group, Transaction Set control segments and will not test for ASC X12N v5010 834 and ASC X12C v5010 999 data content.
- The detailed content of the companion guide will not be submitted to the CORE-authorized Testing Vendor.
- The detailed content of the companion guide will not be examined nor evaluated.

2.4 Detailed Step-By-Step Test Scripts

CORE Certification Testing is not exhaustive. The CORE Certification Test Suite does not include comprehensive testing requirements that test for all possible permutations of each rule. An individual test script may be testing for more than one item, and, as noted in the "Stakeholder" column, each test script tests for the role of the Stakeholder(s) to which the test script applies.

The Detailed Step-by-Step Test Scripts below specify the stakeholder type to which each test script applies. A stakeholder may indicate that a specific test script does not apply to it. In this case the stakeholder is required to provide a rationale for why a specific test script is not applicable and be prepared for a review of the rationale with CORE staff.

When establishing a Certification Test Profile with a CORE-authorized Testing Vendor a Vendor will be given the option to indicate if the product it is certifying is a Provider-facing product or a Health Plan-facing product. Therefore, the Detailed Step-by-Step Test Scripts applicable to a Provider apply to a Provider-facing product. Similarly, Detailed Step-by-Step Test Scripts applicable to a Health Plan apply to a Health Plan-facing product.

System Availability										
Test #	Criteria	Expected Result	Actual Result	Pass	Fail	N/A	Stakeholder *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	Health Plan	Clearinghouse	Vendor
1	Publication of regularly scheduled downtime, including holidays and method(s) for such publication.	Submission of actual published copies of regularly scheduled downtime including holidays and method(s) of publishing.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
2	Publication of non-routine downtime notice and method(s) for such publication.	Submission of a sample notice of non-routine downtime including scheduled of down time and method(s) of publishing.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
3	Publication of unscheduled/emergency downtime notice and method(s) for such publication.	Submission of a sample notice of unscheduled/emergency downtime including method(s) of publishing.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒

Acknowledgements										
Test #	**Criteria**	**Expected Result**	**Actual Result**	**Pass**	**Fail**	**N/A**	**Stakeholder** *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	**Health Plan**	**Clearinghouse**	**Vendor**
4	An ASC X12C v5010 999 is returned on a rejected ASC X12 Functional Group of ASC X12N v5010 834 in either real time or batch.	An ASC X12C v5010 999 is returned.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
5	An ASC X12C v5010 999 is returned on any accepted ASC X12 Functional Group of an ASC X12N v5010 834 in either real time or batch.	An ASC X12C v5010 999 is returned.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒

Response Time										
Test #	Criteria	Expected Result	Actual Result	Pass	Fail	N/A	Stakeholder *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	Health Plan	Clearinghouse	Vendor
6	Verify that outer most communications module(s) transmits all required data elements in the message. If the entity uses an alternate communication method to HTTP/S the entity must store enough information from the ASC X12 Interchange, Functional Group and Transaction Set to uniquely identify the transmission in addition to the times that the request was received and response was sent.	Submission of the output of a system-generated audit log report showing all required data elements.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒

Companion Guide										
Test #	Criteria	Expected Result	Actual Result	Pass	Fail	N/A	Stakeholder *A checkmark in the box indicates the stakeholder type to which the test applies*			
							Provider	Health Plan	Clearinghouse	Vendor
7	Companion Guide conforms to the flow and format of the CORE Master Companion Guide Template.	Submission of the Table of Contents of the 834 companion guide, including an example of the 834 content requirements.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
8	Companion Guide conforms to the format for presenting each segment, data element and code flow and format of the CORE Master Companion Guide Template.	Submission of a page of the 834 companion guide depicting the presentation of segments, data elements and codes showing conformance to the required presentation format.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒
9	Companion Guide conforms to the data content requirements for including language disclosing collection, exchange, processing, and use of socio-demographic information collected at enrollment, renewal, and maintenance.	Submission of a page of the 834 companion guide depicting the presentation of disclosure language.		☐ Pass	☐ Fail	☐	☐	☒	☒	☒