



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

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BEM.1.0	Major	DRAFT requirements approved for inclusion by the CORE Value-based Payments Subgroup	December 2023

DRAFT

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1 **1. Background Summary**

2 **1.1. CORE Overview**

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

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

14 **1.2. Industry Interest in Value-based Payment Focused Operating Rules**

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

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

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

- 29 • A lack of data uniformity.
- 30 • Challenges with patient attribution.
- 31 • Nascent technical interoperability.

32 This pioneering work led to the consensus-based development of a set of CORE Operating Rules  
33 addressing patient attribution. These are:

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

37 In 2023, the National Committee for Vital and Health Statistics (NCVHS), the statutory federal advisory  
38 body to the Department of Health and Human Services (HHS), sent a letter to the Secretary of HHS  
39 recommending several CORE Operating Rules for federal adoption, including the CORE Single Patient  
40 Attribution Operating Rule.<sup>2</sup> This marks the first time an operating rule directly addressing value-based

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

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

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

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

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

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

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

### 55 **2.1. Problem Space**

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

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

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

#### 75 **2.1.1. Process in Identifying the Problem Space and Barriers to Automating the 76 Exchange of Socio-demographic Information**

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

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

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

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

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

- 94 1. **Unaligned data sets:** Concepts, such as race and ethnicity, are exchanged using different  
95 vocabulary standards. These are often incompatible and limit translation and generalizability  
96 between stakeholders.  
97
- 98 2. **Industry interpretation:** Standards, both those that are widely implemented and those that are  
99 emerging, can be subject to interpretative implementations based on the varying understandings  
100 and needs of implementers.  
101
- 102 3. **Evolving vocabulary:** Some concepts, such as gender identity or the documented sex of an  
103 individual, are still being defined by industry groups as the need for standard data exchange is  
104 balanced with inclusivity of new concepts.  
105
- 106 4. **Security of Protected Health Information:** Socio-demographic information is sensitive and, if  
107 misused or exchanged without appropriate acknowledgment of this fact, can result in harm  
108 through discriminatory actions.

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

111 **2.2. Focus of the CORE Benefit Enrollment & Maintenance (834) Data Content Rule**

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

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

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

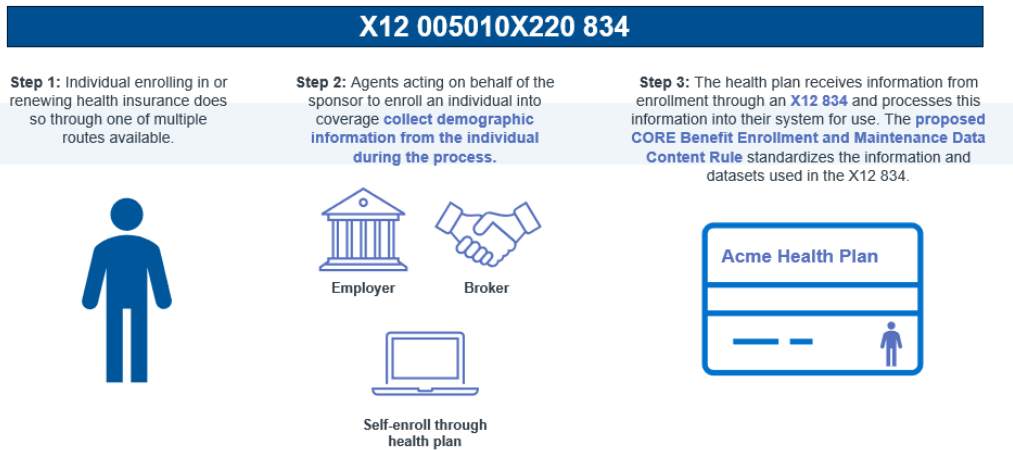
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<sup>3</sup> PHINVADS CDC Detailed Race Code Set: <https://phinvasd.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.876> and PHINVADS Detailed Ethnicity Code Set: <https://phinvasd.cdc.gov/vads/ViewValueSet.action?id=34D34BBC-617F-DD11-B38D-00188B398520>. X12 Code Source 859.

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

**FIGURE 1**



135

136 **2.3. Promotion of Self-Reported Data, Empowerment of Member Choice, and Maintenance of**  
137 **Privacy**

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

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

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

156  
157 Though the CORE Operating Rules cannot be applied at the level of specificity necessary to guide the  
158 implementation of Federal Policy or to dictate health plan procedures, they can be used as a venue to  
159 transmit best practices that help guide implementation. As such, listed below are several **best practices**  
160 shared by CORE Participants during the development of this rule that guide implementation in a way that  
161 is sensitive to privacy, consent, and self-reporting.

162

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

167



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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, the 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 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. The 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.<sup>4</sup>

- **Display and Availability of Disclosure Language:** 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. The 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 rule requirements. 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 rule specific frequently asked question (FAQ) documents.

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<sup>4</sup> 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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215 **3. Scope**

216 **3.1. What the Rule Applies To**

217 This CORE Operating Rule conforms with and builds upon the X12 v5010X220 834 implementation guide  
218 and specifies the minimum socio-demographic data content that a health plan and its agent<sup>5</sup> is required to  
219 collect at the point of member enrollment or renewal and maintenance of member records. The operating  
220 rule further specifies minimum data content requirements for how a health plan and its agents must process  
221 collected socio-demographic information using the X12 v5010X220 834 transaction.

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

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

232 **3.2. When the Rule Applies**

233 This rule applies when:

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

236 AND

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

239 AND

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

243 **3.3. What this Rule Does Not Address**

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

247

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<sup>5</sup> 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.

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

<sup>7</sup> 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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248 **3.4. What the Rule Does Not Require**

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

252 **3.5. Applicable Loops, Data Elements & Code Sources**

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

Applicable Loops & Segments in X12 v5010X220 834 Benefit Enrollment and Maintenance		
Loop ID	Segment	Element
<b>Exchange of Race and Ethnicity</b>		
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
<b>Exchange of Member Language</b>		
Loop ID 2100A Member Name	LUI Member Language	LUI01 Identification Code Qualifier
		LUI02 Identification Code
		LUI04 Use of Language Indicator
<b>Exchange of Gender Identity</b>		
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

255 **3.6. Data Classes, Code Sources, and Value Sets Addressed**

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

- 257 • Classification of Race or Ethnicity, which communicates the race and/or ethnicity of member  
258 using the Detailed Race (PHVS\_Race\_CDC) and Detailed Ethnicity (PHVS\_Ethnicity\_CDC)  
259 Code Sets. The code sets are maintained by the CDC and are distributed through the Public  
260 Health Information Network Vocabulary Access and Distribution System (PHINVADS).<sup>8</sup> Note that  
261 the code sets align with the aggregated version 1.2 of the CDC Race and Ethnicity Code Set,  
262 indicated for use in USCDI version 3.
- 263 • Method of Race and Ethnicity Data Collection, which communicates how an enrolling members'  
264 race and/or ethnicity was recorded based on values in the CDC Race or Ethnicity Collection Code

<sup>8</sup> 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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- 265 Set. This code set is maintained by the CDC distributed through the Public Health Information  
266 Network Access and Distribution System.<sup>9</sup>
- 267 • International Organization for Standardization (ISO) *Codes for the representation of names of*  
268 *languages – Part 3: Alpha-3 code for comprehensive coverage of languages* (ISO-639), which  
269 communicates all known member languages through three-letter identifiers.<sup>10</sup>
  - 270 • Codes from SNOMED International, Systematized Nomenclature of Medicine Clinical Terms  
271 (SNOMED CT®) U.S. Edition, aligned with most current regulated USCDI version.<sup>11</sup>
  - 272 • Codes from the HL7 Null Flavor data set to standardize reporting of unknown gender identity  
273 values.<sup>12</sup>

274 **3.7. Maintenance of This Rule**

275 Any substantive updates to the rule (i.e., change to rule requirements) are determined based on  
276 industry need as supported by the CORE Participants per the [CORE Change and Maintenance](#)  
277 [Process](#).

278 **3.8. Assumptions**

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

282 The following assumptions apply to this rule:

- 283 • A successful communication connection has been established.
- 284 • This rule is a component of the larger set of CORE Benefit Enrollment & Maintenance  
285 (834) Operating Rules.
- 286 • The CORE Guiding Principles apply to this rule and all other rules.
- 287 • This rule is not a comprehensive companion document addressing any content  
288 requirements of the X12 v5010 834 Benefit Enrollment & Maintenance transaction.
- 289 • Compliance with all CORE Operating Rules is a minimum requirement; any entity is free  
290 to offer more than what is required in the rule.

291 **3.9. Value-based Payment Terminology**

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

298

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

<sup>10</sup> ISO 639-3 source: [https://iso639-3.sil.org/code\\_tables/639/data](https://iso639-3.sil.org/code_tables/639/data). X12 Code Source 102.

<sup>11</sup> UMLS Licensees may download here:  
[https://www.nlm.nih.gov/research/umls/rxnorm/sourcereleasedocs/snomedct\\_us.html](https://www.nlm.nih.gov/research/umls/rxnorm/sourcereleasedocs/snomedct_us.html).

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

<sup>13</sup> Version pending approval [here](#).

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

300 **4.1. Requirements for Receivers of a X12 v5010X220 834**

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

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

309 **4.2. Disclosure of and Member Consent for the Collection, Exchange, and Use of Socio-**  
310 **demographic Information**

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

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

323 At the point of enrollment, renewal, and maintenance, health plans and their agents must obtain consent  
324 from members to use or exchange the PHI collected as part of the requirements outlined in this operating  
325 rule. As referenced in §3. of this operating rule, this requirement leverages existing optional allowances in  
326 the HIPAA privacy law and can be carried out in a form and manner of the health plan's and its agent's  
327 choosing.<sup>16</sup> Health plans and their agents are required to implement a consent process in line with advice  
328 from their internal legal counsel.

329 **4.3. Collection, Exchange, and Processing of Race and Ethnicity Information**

330 When operationalizing rule requirements and recommendations, socio-demographic information should  
331 be collected in the order it appears in this rule.<sup>17</sup> The following subsections outline the requirements and  
332 recommendations for collecting race and ethnicity information.

333 **4.3.1. Parameters for the Collection of Race and Ethnicity Information**

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

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<sup>14</sup> 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)).

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

<sup>16</sup> 45 CFR 164.506: <https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164/subpart-E/section-164.506>

<sup>17</sup> 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.

<sup>18</sup> Current OMB Statistical Direct 15 Collection Requirements  
[https://obamawhitehouse.archives.gov/omb/fedreg\\_1997standards](https://obamawhitehouse.archives.gov/omb/fedreg_1997standards)

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337 Health plans and their agents are not limited to the concepts contained in the [Office of Management and](#)  
338 [Budget Statistical Directive 15](#). If health plans and their agents seek to expand the concepts collected,  
339 they must do so using the concepts contained in the Detailed Race and/or Ethnicity Code Sets referenced  
340 at X12 code source 859, which, as previously stated are aligned with the values in the comprehensive  
341 CDC Race and Ethnicity Code Set version 1.2. This requirement ensures that the collected race and  
342 ethnicity concepts can be standardly exchanged using a unique identifier.

343 The steps to process and standardize the exchange of race and ethnicity information are laid out in  
344 §4.3.2. In addition to these concepts, a health plan and its agent:

- 345 • Must provide members with the option to not disclose their race and/or ethnicity and collect and  
346 exchange this information when non-disclosure is indicated.
- 347
- 348 • Must report how the method by which race and/or ethnicity information was determined (e.g.,  
349 member self-reporting).
- 350
- 351 • At their discretion, provide members with the option to choose the **Middle Eastern or North**  
352 **African** racial concept and collect and exchange this information when it is indicated.<sup>19</sup>

353 **4.3.2. Parameters to Process Race and Ethnicity Information Using the X12 v5010X220**  
354 **834**

355 Once the information indicated in §4.3.1 is collected and shared with a health plan or its agent, the  
356 following loops, segments, and data elements must be used to process the information in the X12  
357 v5010X220 834.<sup>20</sup> Please note, it is incumbent on the health plan to require its agents executing  
358 enrollment or renewal to comply with these requirements.

- 359 • **When a Member Chooses NOT to Disclose Their Race and/or Ethnicity**

360 Loop 2100A – Member Name  
361 DMG – Member Demographics  
362 **DMG05-01 = '7'**<sup>21</sup>

- 363 • **When a Member Chooses to Disclose Race and/or Ethnicity**

364 Loop 2100A – Member Name  
365 DMG – Member Demographics  
366 **DMG05-02 = 'RET'**  
367 **DMG05-03 = <Unique Identifier(s) CDC Detailed Race and/or Detailed Ethnicity**  
368 **Code Sets>**<sup>22</sup>

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

370 Loop 2100A – Member Name  
371 DMG – Member Demographics  
372 **DMG10 = 'REC'**

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<sup>19</sup> 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.

<sup>20</sup> 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.

<sup>21</sup> 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.

<sup>22</sup> 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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373 DMG11 = <Unique Identifier from CDC Race and Ethnicity Collection Code><sup>23,24</sup>

374 **4.4. Collection, Exchange, and Processing of Self-Reported Member Language**

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

378 **4.4.1. Requirement to Provide Members the Opportunity to Self-report Member Language**  
379 **at Enrollment, Renewal, or Maintenance**

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

- 382 • When a member discloses that their language that is not English<sup>25</sup> sections §4.4.2. – 4.4.4. apply.
- 383 • When a member chooses not to disclose their language, regardless of whether it is English,  
384 sections §4.4.2. – 4.4.4. do not apply.
- 385 • When a member chooses to disclose their language, but it is English, sections 4.4.2. – 4.4.4. do  
386 not apply.

387 **4.4.2. Processing of Self-Reported Member Language**

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

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

397 **4.4.3. Requirement to Collect Self-Reported Use of Member Language for Each Recorded**  
398 **Language**

399 For each language collected in §4.4.1, a health plan or its agent must collect at **least one** and a  
400 **maximum of four** member language uses for each recorded language at the point of enrollment,  
401 renewal, and maintenance.<sup>26</sup> The four valid indicators of use, defined in the X12 v5010X220 834 are:

- 402 • Reading.
- 403 • Writing.
- 404 • Speaking.
- 405 • Native Language.

---

<sup>23</sup> 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.](#)

<sup>24</sup> 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.

<sup>25</sup> 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.

<sup>26</sup> 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.

406 **4.4.4. Processing of Self-reported Use of Member Language**

407 For each use of language collected in §4.4.3., a health plan and its agent must process the information  
408 consistent with the loops, segments, and data elements indicated below:<sup>27</sup>

- 409 Loop 2100A – Member Name  
410 LUI – Member Language  
411 **LUI04 = <applicable X12 use code>**  
412 - **Reading = 5**  
413 - **Writing = 6**  
414 - **Speaking = 7**  
415 - **Native Language = 8**

416 **4.5. Discretionary Collection, Exchange, and Processing of Self-Reported Member Gender**  
417 **Identity at Enrollment, Renewal or Maintenance**

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

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

426 **4.5.1. Collection of Self-Reported Member Self-reported Gender Identity**

427 A health and its agent, at their discretion, can require collection of a member’s self-reported gender  
428 identity at the point of enrollment, renewal, or maintenance. As part of this collection, a health plan and its  
429 agent must provide members with the opportunity to not disclose their gender identity. Collection should  
430 be carried out consistent with the minimum set of concepts supported by the HL7 Gender Harmony  
431 Project.<sup>28</sup>

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 <sup>29</sup>	A proper value is applicable but not known.

432

<sup>27</sup> 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.

<sup>28</sup> <https://confluence.hl7.org/pages/viewpage.action?pageId=94656132#GenderIdentity-Expansion>

<sup>29</sup> Includes, but is not limited to, when health plan or its agent is unable to ask or a member declines to share the information.



433 **4.5.2. Processing of Member Self-reported Gender Identity**

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

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

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

442 LS – Additional Reporting Categories

443 **LS01 = '2700'**

444 Loop 2700 – Member Reporting Categories

445 LX – Member Reporting Categories

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

447 • **Reporting Category for Gender Identity Reporting**

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

450 Loop 2750 – Reporting Category

451 N1 – Reporting Category

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

453 **N102 = 'Gender'**

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

455 Once Member Reporting Categories are specified for self-reported member gender identity, a health plan  
456 and its agent must process the member's gender identity collected as part of §4.5.1. consistent with  
457 USCDI version 3 or the highest regulated version.<sup>30</sup> USCDI v3 requires the exchange of gender identity  
458 concepts using SNOMED-CT.<sup>31</sup>

459 If collection and exchange was consistent with the minimum requirements listed in §4.5.1. and 'Unknown'  
460 is reported, REF02 should be populated with the HL7 Null Flavor<sup>32</sup> value of 'UNK'. Unknown may have  
461 multiple meanings but should be used when a member chooses not to disclose their gender identity.

462 Loop 2750 – Reporting Category

463 REF – Reporting Category Reference

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

465 **REF02 = <Appropriate SNOMED CT code for collected concept or HL7 Null Flavor**  
466 **code for Unknown>**

467 LE – Additional Reporting Categories Loop Termination

468 **LE01 = '2700'**

469

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<sup>30</sup> <https://www.healthit.gov/isa/taxonomy/term/2736/uscdi-v3>

<sup>31</sup> UMLS Licensees may be download here:

[https://www.nlm.nih.gov/research/umls/rxnorm/sourcereleasedocs/snomedct\\_us.html](https://www.nlm.nih.gov/research/umls/rxnorm/sourcereleasedocs/snomedct_us.html)

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470 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

471

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

475 **5. Conformance Requirements**

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

