



Cooperative Exchange Clearinghouse Caucus

June 9, 2026
5:00pm EST

Sonesta Philadelphia
Rittenhouse Square

The Cooperative Exchange is committed to promote and advance electronic data exchange for the healthcare industry by improving efficiency, advocacy, and education to industry stakeholders and government entities.

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Clearinghouse Caucus Agenda Tuesday, June 9, 2026

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5:00 – 6:00pm



- I. *Welcome and Introduction of Cooperative Exchange* - Pam Grosze
- II. *Trebuchet Project Update* – Pam Grosze
- III. *Attachments Rule and Impact to Clearinghouses* – Stanley Nachimson
- IV. *CMS 0062 Overview and CE Areas of Concern* - Tara Rose
- V. *MD Electronic Transactions Technical Submission Guidance – Changes in Final and Impact* – Tara Rose

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Overview of Cooperative Exchange (CE)

- 20 Clearinghouse Member Companies
- Represent over 85% of the clearinghouse industry
- Over 750,000 submitting provider organizations
- Maintain over 8,000 Payer connections
- 1000 plus HIT vendor connections
- Process over 4 plus billion claims annually
- Value of transactions –over \$1.1 Trillion
- Infrastructure framework supports BOTH administrative and clinical transactions



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Our Members



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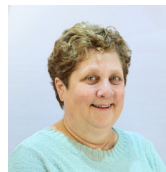
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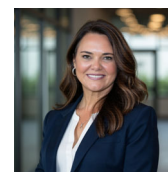
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Cooperative Exchange/HL7 DaVinci Trebuchet Project Update

Pam Grosze



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CMS-0057-F Prior Authorization Overview and Requirements

What is CMS-0057-F?

- CMS Interoperability & Prior Authorization Final Rule
- Requires impacted payers to support **FHIR-based electronic prior authorization (ePA)**
- Improves transparency, turnaround time, and interoperability
- Compliance deadline: **January 1, 2027**

Note: CDex (Clinical Data Exchange Implementation Guide) is not explicitly mandated in CMS-0057-F, but it plays an important supporting role in a complete Da Vinci prior authorization ecosystem. It enables payers and providers to exchange clinical attachments and additional documentation using FHIR.

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Required Da Vinci Implementation Guides (IGs)

CRD – Coverage Requirements Discovery

- Enables providers to identify PA requirements at point of care
- Returns documentation rules, coverage details, and forms
- Integrates with EHR workflows

DTR – Documentation Templates & Rules

- Automates questionnaire completion
- Pulls structured data directly from EHR
- Reduces manual entry and incomplete submissions

PAS – Prior Authorization Support

- FHIR-based PA submission & response workflow
- Converts to X12 278 where required
- Supports status checks and determinations

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HL7 Da Vinci Trebuchet Pilot: Clearinghouse-to-Clearinghouse Prior Authorization

- The purpose of this initiative is to reduce the administrative burden of prior authorization by enabling scalable, standards-based interoperability between clearinghouses. By forming a new HL7 Da Vinci Trebuchet pilot cohort focused on clearinghouse-to-clearinghouse (CH-to-CH) prior authorization workflows, this effort will explore how FHIR-based and X12 transactions can be operationalized across clearinghouse networks.
- The initiative aims to extend existing Da Vinci prior authorization standards beyond point-to-point implementations, ensuring clearinghouses can effectively support automated prior authorization at scale.
- Through industry collaboration, policy and security alignment, and technical piloting, this project will accelerate adoption of interoperable workflows that improve efficiency for payers, providers, and the broader healthcare ecosystem.

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Goals and Objectives

- Demonstrate interoperability between multiple clearinghouses using FHIR-based prior authorization workflows.
- Validate hybrid workflows that incorporate both FHIR and X12 standards to support real-world implementation.
- Develop a reference architecture for CH-to-CH routing, identity resolution, and endpoint discovery.
- Validate standard clearinghouse approach to scalable security for FHIR- based prior authorization stakeholder registration, authentication and authorization.
- Reduce provider burden by enabling clearinghouses to automate prior authorization across networks.

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Expected Outcomes

- A functional prototype demonstrating CH-to-CH prior authorization exchange using Da Vinci , FAST IGs and X12.
- A documented implementation playbook for clearinghouses including development technical specifications and operational guidance.
- Identification of policy and technical barriers to CH-to-CH interoperability.
- Recommendations for future enhancements to Da Vinci IGs, FAST IGs X12, and related HL7 standards based on pilot findings.

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Scope Summary

In Scope

- ✓ X12 278 5010 X217 and/or X215 to FHIR translation between clearinghouses
- ✓ FHIR to X12 278 5010 X217 and/or X215 translations between clearinghouses
- ✓ FHIR to FHIR between clearinghouses
- ✓ Gaps identified between X12 278 5010 X217 and/or X12 5010 X215 and FHIR
- ✓ Future phase is attachments and X12 and FHIR

Out-of-Scope

- ***DTR – Future Phase for Testing***
- X12 X216 Notice of Admissions
- X12 X217 use of Referrals
- X12 to X12 between Clearinghouses

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Participants and Meeting Schedule

- Kickoff held on April 23, 2026
- Bi-weekly HL7 Da Vinci Trebuchet pilot calls
- Pilot-specific working sessions as needed

Pilot Participants

Availity, L.L.C.
 Claim.MD
 Experian Health, Inc.
 Jopari Solutions
 Office Ally
 Optum
 Stedi, Inc.
 TriZetto Provider Solutions, LLC (a Cognizant company)
 UHIN, Inc.
 Veradigm
 Waystar

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Impact of Attachments Rule on Clearinghouses

Stanley Nachimson



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Administrative Simplification; Adoption of Standards for Health Care Claims Attachments Transactions and Electronic Signatures Final Rule

- Establishes the first national HIPAA standards for electronic health care claims attachments and electronic signatures
- Effective May 26, 2026, with full compliance required by May 26, 2028.
- Standards adopted were:
 - X12N 275: Additional Information to Support a Health Care Claim or Encounter
 - X12N 277: Health Care Claim Request for Additional Information
 - HL7 Consolidated Clinical Document Architecture (C-CDA) IG Volumes One and Two
 - HL7 Attachments Implementation Guide (March 2022 version)
 - Electronic Signatures: HL7 IG for CDA Release 2: Digital Signatures and Delegation of Rights, Release 1 (Digital Signatures Guide)

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New Requirements for Clearinghouses to Support

X12 transactions

- Should be relatively simple, as X12 familiarity is resident
- May need to do mapping from non-standard information to the new standard

HL7 segment

- New capability to accept HL7 data or convert data to HL7 and insert into transactions
- Will need to determine provider capabilities

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New Requirements for Clearinghouses to Support

• Electronic Signatures

- These will probably need to be included in attachment information sent by the provider.
- Question – can the clearinghouse add an electronic signature to guarantee the authenticity of the attachment?
- This may be a new capability for the clearinghouse

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Operational Considerations

- Maintaining the connection between the claim and the attachment
- Differences in timing among health plans – how much time between the claim and the attachment
- Will all health plans accept non-solicited attachments in all cases
- Maintaining LOINC code updates
- Testing and implementation schedules
 - Internal testing
 - Individual partner testing (with providers, with plans, with other clearinghouses)
 - Round trip testing for solicited and unsolicited attachments
 - Maintaining readiness schedules for providers and health plans

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CE Comments: CMS-0062-P

2026 CMS Interoperability Standards and Prior Authorization for Drugs Proposed Rule

Tara Rose



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Overview of Proposed CE Comments

1. **Section II.H.9 Statutory Authority:** “We do not meaningfully address clearinghouses in this proposed rule because we do not believe they play a significant role in prior authorization transactions, that we understand are typically made directly between health care providers and health plans, and as contrasted with clearinghouses’ significant roles with many other HIPAA transactions. Nothing, however, would preclude the use of health care clearinghouses with respect to the proposed standards”
 - The CE is commenting that clearinghouses do process PA transactions and serve provider and plan customers in those transactions. We explain that the CE launched a clearinghouse PA pilot initiative with the Da Vinci Trebuchet Project and to provide our results from pilot testing.
2. **Section II.H.2.A Referral Certification and Authorization Transactions:** There is an implication that CMS could mandate the use of FHIR for referrals.
 - The CE is recommending that CMS only adopt FHIR transactions for PA and not referrals. Clearinghouses currently process millions of 278 referral transactions successfully and that the FHIR transactions have not been pilot tested for referrals in the exception, only for PA. There isn’t a need to replace the 278 for referrals.
3. **Section II.H.2.B Eligibility for Health Plan Transaction:** This proposes the use of CRD for eligibility when asking a health plan if a PA is needed.
 - The CE is commenting that this is confusing. It appears to adopt a second standard based on the “intent” of the query to check on a PA requirement for a service. We are suggesting that CMS define a new transaction – a request from a provider to a health plan regarding the need for a PA.
4. **Section II.H.11 Requests for Comment: Eliminating the DDE exception –** CMS is seeking comments on whether they should revisit the DDE exception, amend it, remove it, and benefits of it.
 - The CE strongly recommends keeping the DDE as an option. DDE serves as a critical redundancy option for providers to use during the enrollment period with payers and avoiding disruptions when EDI channels have an issue.

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Overview of Proposed CE Comments

1. **Section II.E Reporting Payer API Endpoints and Associated Information for CMS to Publish**
 - The CE recommends that CMS develop a process for reporting issues with endpoints. Clearinghouses can identify broken or missing links due to the volume of transactions more quickly than individual entities. A process for reporting endpoint issues will alert impacted parties and initiate the resolution processes.

General Concerns

- Timing and reporting requirements indicate a need for consistent timestamping of transactions. The CE recommends that the IGs and instructions include a timestamping process.
- Enforcement: The CE requests clarification on how compliance would be assessed when both a health plan and a clearinghouse are involved in delivering an untimely PA result. Would CMS consider the health plan, the clearinghouse, or both out of compliance with the timing requirements?
- CE requests that CMS publish information and tools for testing and conformance of these new FHIR requirements in future publications

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Electronic Health Care Transactions Technical Submission Guidance

MHCC-CRISP Final Technical Submission Guidance and Flat File Maps

Tara Rose



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Background

The Chesapeake Regional Information System for our Patients (CRISP) is Maryland's state-designated Health Information Exchange (HIE). CRISP is responsible for collecting and using health care data to support public health, interoperability, and care coordination across the state.

COMAR 10.25.07 – Certification of Electronic Health Networks and Medical Care Electronic Claims Clearinghouses
This is the Maryland regulation governing how the MHCC certifies EHNs and medical care electronic claims clearinghouses operating in Maryland. Under this regulation, any entity that facilitates electronic health care transactions (such as claims, eligibility inquiries, and related administrative health transactions) in Maryland must be MHCC-certified to operate. Maryland health insurance payers are legally required to accept electronic transactions only from MHCC-certified networks. Certification ensures that these networks meet standards for privacy, security, technical performance, and regulatory compliance.

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Technical Submission Guidance Final Summary

Final published: 03/25/2026

1. **Section 2.1 Submission Process Overview** – The CE recommended a separate workflow for the flat file submission
 - CRISP did not create a separate flow, however, they did add comments about
2. **Section 2.2.1 Submission Schedule Alternations Due to System Failures**
 - The CE requested that CRISP provide a defined submission timeframe for when the CRISP system becomes available, aligned with the submission expectations applied during an EHN outage. CRISP did not update their guidance to include this same level of detail.
3. **Section 2.3.5 Telehealth & Virtual Care, criteria 3: Patient address**
 - The CE recommended that CRISP expand the criteria to include the subscriber address. CRISP added the subscriber address to the criteria as the second level check.
4. **Section 2.6.2.2 Security Requirement Updates**
 - The CE recommended extending the 60-day to 90-day notice when security requirements change. CRISP acknowledged and changed it to 90-days
5. **Section 2.6.2.3 Security Incidents**
 - CRISP originally stated that they would advise EHNs of a CRISP security issue within 2 business days and this was not acceptable to the CE members. The CE stated that we need immediate notice of a security issue. CRISP changed this to state that the notification timeline will be documented in the CRISP-EHN Data Connectivity Agreement with the EHN.
6. **Section 3.2.3 Handling “In-Flight” Data (Pre-Adjudication)**
 - The CE recommended the exclusion of payer-adjudicated data. CRISP did not remove this section; however, they clarified in the response to comments document that the EHN could elect to not provide payer data.

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2026 Membership Meeting Calls



January 16, 2026

February 20, 2026

March 20, 2026

April 17, 2026

May 15, 2026

June 19, 2026

July 17, 2026

August 21, 2026

September 18, 2026

October 16, 2026

November 20, 2026

December – no meeting

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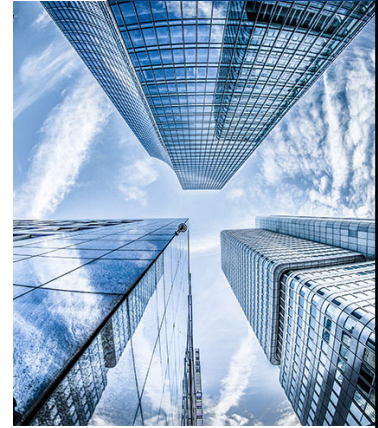
Thank You for Attending!

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