
Cooperative Exchange
The National Clearinghouse Association
Clearinghouse Caucus
September 30, 2025
5:00pm EDT
Hyatt Regency Greenville
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, September 30, 2025
Regency DE
5:00 – 6:00pm
I. Welcome and Introduction of Cooperative Exchange - Pam Grosze, Board Chair, Cooperative Exchange and VP, Senior Product Manager, PNC Bank
II. MD Proposed Requirements to Send Unadjudicated Claims and Eligibility Data to HIEs, CE Concerns – Tara Rose, Manager, Standards, Compliance, and Regulatory Strategy, OptumInsight
III. 270/271 or HL7 Da Vinci Coverage Requirements Discovery (CRD) – Donna Campbell, Health Care Service Corporation and Nick Radov, Stedi
IV. Commercial Payers' Commitments RE Prior Authorization, Agreements to Participate in Networks – Gail Kocher, Blue Cross Blue Shield Association
V. Meeting Wrap-Up - Pam Grosze, Board Chair, Cooperative Exchange and VP, Senior Product Manager, PNC Bank
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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

Availity
CLAIM MD
enlyte
eTactics
experian health
FinThrive
HBMA
HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION
InstaMed
JOPARI SOLUTIONS, INC.
Office Ally
OPTUM
PHIcure
PNC
SMARTDATA SOLUTIONS
TODAY'S INNOVATIONS | TOMORROW'S SOLUTIONS
SSI
stedi
TRIZETTO Provider Solutions
A Cognizant Company
UHIN
veradigm
WAYSTAR
REVENUE CYCLE TECHNOLOGY

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2025 Board of Directors

Board Chair
Pamela Grosze
PNC Bank

Vice Chair
Jennifer Nereu
Jopari Solutions

Treasurer
Tina Greene
Enlyte

Secretary
Eric Grindstaff
Veradigm

Board Past Chair
Crystal Ewing
Waystar

Director
Rhonda Sapereira
Optum

Director
Cyndi Padilla
TriZetto Product Division at Cognizant Health Sciences

Executive Director
Lisa Beard
M3Solutions

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Board Elections

We are seeking volunteers for open board positions for The Cooperative Exchange that will begin January 2026.

Watch your email for additional information on how to apply or reach out to our office at lisa@cooperativeexchange.org for additional information. We appreciate your consideration.

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Maryland Health Care Commission COMAR 10.25.07

Tara Rose - Optum

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Background of COMAR 10.25.07

- **Purpose of COMAR 10.25.07**
  - This regulation aims to certify EHNs and clearinghouses to enhance data transparency and support public health.
- **Stakeholders Involved**
  - Key stakeholders include MHCC, Cooperative Exchange, healthcare providers, payors, and HIT vendors.
- **Regulatory Impact**
  - The regulation impacts data privacy, operational workflows, and legal compliance across healthcare entities.
- **CE submitted a comment letter on 9/8/25 on behalf of the membership**

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Section .02 Definitions

"Improvement of patient safety"

- The CE requested clarity on the definition and that MHCC consider "patient safety" include the activities covered in 42 CFR 3.20 of the HIPAA Privacy Rule

"State health improvement program"

- The CE appreciates the state's effort to support the Total Cost of Care model; however, there are concerns regarding the lack of specific use cases in the definition.
- The data requested is non-adjudicated claims data, including rejected or duplicate data which compromises the integrity of the data provided

The CE membership is still concerned that the proposed definitions are broad and potentially cover a range of use cases and the legality of releasing patient data restricted by HIPAA (i.e. ERISA and FEHBP data)

Section .09(B)

Proposed Text:

An MHCC-certified EHN shall submit electronic health care transactions information for services delivered in Maryland to the State-designated HIE that consist of the following transactions: (1) Health care claim or equivalent encounter information

- *(837P and 837I); (2) Health plan eligibility inquiry and response (270); or (3) Benefit enrollment and maintenance (834).*
- *(1) Health care claim or equivalent encounter information (837P and 837I);*
- *(2) Health plan eligibility inquiry and response (270); or*
- *(3) Benefit enrollment and maintenance (834).*

CE Comments:

- Concerns about transactions for payors that operate outside of Maryland for members that seek care in Maryland.
- Secondary, tertiary claims are not taken into consideration
- CE members would be required to update BAAs which has significant logistical and financial implications, even if a partner agrees to update the BAA
- Called out concerns, again, about sharing patient data restricted by HIPAA
- Transaction list isn't complete: missing the 271 and 837D. The 834 isn't generally transmitted by CE members
- Called out concerns, again, about duplicate and inaccurate claim data
- The regulation doesn't take the "jumps" between clearinghouses into consideration

Section .09(F) Submission Schedule

Proposed Text:

- *(1) No later than the last business day of each month, an MHCC-certified EHN shall submit electronic health care transactions information from the preceding month to the State-designated HIE.*
- *(2) An MHCC-certified EHN shall submit electronic health transaction information at least once per month, but may submit data more often*

CE Comments:

- Monthly reporting is not sustainable, and we recommended quarterly reporting
- CE requested that the regulation provide a timeframe for when the State needs to receive the data.
- We reminded the State that the work required to filter the transactions appropriately is significant and costly, especially since EHNs aren't allowed to recoup any costs associated with providing the data.
- The method of transmission of the data is a concern. The size of the data requested is large and may not be possible to transmit, even in a flat file.
- CE requested that a safe, secure, and efficient process be established.

Section .09(H) Exemptions

Proposed Text:

(1) An MHCC-certified EHN may request a 1-year exemption from certain reporting requirements in this regulation.
(2) An exemption request shall:
(a) Be in writing;
(b) Identify each specific requirement of this regulation from which the EHN is requesting an exemption;
(c) Identify the time period of the exemption, if any;
(d) State the reason for each exemption request; and
(e) Include information that justifies the exemption request.
(3) Within 45 days after receipt of complete information from an EHN requesting an exemption, the Commission shall take one of the following actions:
(a) Grant the exemption by providing written notification; or
(b) Deny the exemption request by providing written notification that enumerates the reasons for the denial to the EHN.
(4) The Commission may not exempt an MHCC-certified EHN from any requirement within this regulation that is otherwise required by federal or other State law.
(5) The Commission may grant an exemption on the following grounds:
(a) The absence of functionality in the infrastructure of the EHN that prevents the EHN from complying with the requirement;
(b) The requirement would hinder the ability of the EHN to comply with other requirements of this chapter or federal or other State laws; or
(c) The requirement would cause an undue burden or hardship on the EHN, such that the EHN would no longer be able to provide EHN services in the State.
(6) For good cause shown, the Commission may renew a 1-year exemption for an additional 1-year period

CE Comments:

- CE recommended that MHCC incorporate outright exclusions into the regulation, rather than relying on an exemption process.
- At a minimum, compliance with federal and other state laws should be recognized as grounds for automatic exclusions (ERISA, FEHBP).
- Requested clarification on if an EHN is unable to obtain timely updated BAAs would qualify as a valid exemption.

Section .09(E) Electronic Health Care Transactions Technical Submission Guidance

The good news!

MHCC did update the regulation with details on how MHCC-certified EHNs will consult with the State designated HIE on the submission of data to the State. We were very pleased to see that MHCC heard and responded to the CE recommendation about expanding the submission guidance by adding a detailed process.

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270/271 or HL7 Da Vinci Coverage Requirements Discovery (CRD)

They're not competing!

Donna Campbell, Health Care Service Corporation
Nick Radov, Stedi

270/271 – When is it used and why?

Varying and repeated stages in a member's care journey, including (but not limited to):

- When the member calls to make an appointment with each provider
- When member checks in for said appointment and payment liability is required to be paid
- When needing, at post-service, when the provider may file a claim and needs to verify patient information
- When needing to determine if a prior authorization for a service is required.
- When determining benefit limitations and exclusions
- When determining UMO designation identification
- When reaffirming and/or validating the patient liability and coverage specifics for benefits/services in a retrospective way.

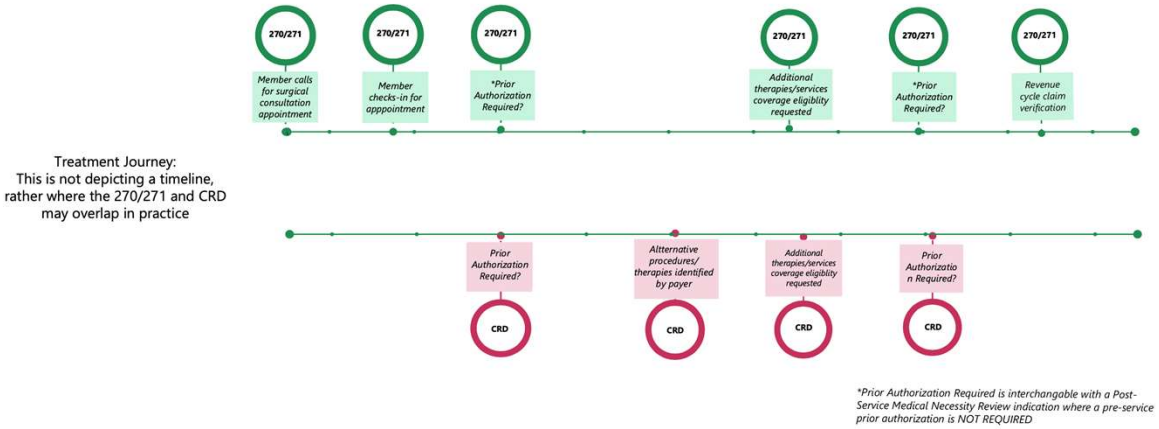
HL7 Da Vinci Coverage Requirement Discovery – When is it used and why?

Varying clinical settings in a member's care journey, including (but not limited to):

- During provider and member discussions regarding a provider's recommended treatment plan
- Prior to submitting prior authorizations to determine if a service
- Assessing possible optional additional treatment/therapies which may be required to assess to 'qualify' for a particular service or set of services before that service will be considered necessary
- Coverage Requirement Discovery (CRD) is particularly useful for ensuring that when a prior authorization is required
  - Provider knows exactly what they need to include in the request so that the health plan will approve it correctly the first time rather than rejecting it or pending it with a request for additional documentation.
  - If used correctly by both parties, it has the potential to cut administrative waste and prevent delays in patient care.
- The whole point is to reduce burden, and have a more effective, efficient workflow

Use Case: Surgical Consult for a Total Knee Replacement

Member has extreme pain in her knee, finds an in-network orthopedic surgeon to consult on treatment options



Example of CRD and 270/271 uses

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What are the commonalities between the two?

Both can do benefit determination, naturally by default that means membership validation/eligibility for coverage determination. Coverage Requirement Discovery implicitly does membership eligibility for coverage determination

Both can support prior authorization indication for a service or treatment

Both can support a mechanism for sharing what is required when submitting a prior authorization (MSG segment applies on 271 response)

Both can be integrated with practice management systems EHR vended software

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What are the differences between the two?

Returned on the CRD API response:

- Alternative therapies or procedures
- Step therapy requirements needed prior to the Total Knee Replacement surgery approval
- SNOMED is supportable on Coverage Requirements Discovery, while SNOMED is not supportable on 270/271
- CRD lacks a batch mechanism so provider organizations can't use it to periodically refresh health plan coverage data for their whole active patient population. The intent is meant to be real-time, and interactive – where batch support doesn't really make sense

The 270/271 and Coverage Requirements Discovery are complementary to one another, not in competition!

What are the differences between the two?

There are some differences from a legal and regulatory perspective

- CMS mandates that essentially all health plans support X12 270/271, but the CRD mandate will primarily only apply to Medicare Advantage and related government-sponsored plans
- Some large commercial payers are ***voluntarily*** implementing CRD across all lines of business but that will be spotty.
- CMS-0057 allows for an exception to the usual adopted standards when using the HL7 Da Vinci Prior Authorization API support, but keep in mind that is NOT Coverage Requirements Discovery
- 271 transactions typically don't help to ***prevent*** prior authorization denials (regardless of whether the prior auth is requested via EDI, portal, or paper form).
  - The 271 doesn't include the necessary data elements for a coded representation of prior authorization requirements **beyond** the Service Type Code or procedure code level
  - In theory the necessary prior authorization artifacts could be sent as unstructured text in MSG segments in practice health plans don't do this.
  - 271 can't be used effectively within a clinician's EHR ordering or referral workflow to surface lower-cost alternative treatment options that would be more in line with health plan coverage policies and reduce patient out-of-pocket expense.

What can 270/271 NOT do?

- Cannot support SNOMED based inquiry/responses
- Cannot support identifying services or procedures as alternative options to inquired procedures
- Cannot directly advise of a payer's Medical Policy (exception: MSG segment but this is unstructured and not commonly supported as a means for information exchange today)

What can Coverage Requirements Discovery NOT do?

- Cannot provide patient financial liability, including accumulator/utilization of services already provided
  - Generally, CRD doesn't tell the provider anything about patient financial responsibility, in terms of what the provider needs to collect from the patient at the encounter. CRD also doesn't necessarily give the full set of member identity and demographic details that providers will need to include on a subsequent 837 claim transaction. CRD doesn't include any coordination of benefits data about known secondary payers
- Does not necessarily determine if services or procedure have been completed
- Limited payer's medical policy information supported on a CRD response, but….
  - To the extent CRD can inform a provider about a health plan's policies on how they determine medical necessity, much of those details are handled through Documentation, Templates and Rules (DTR), which is typically used **after** CRD in the workflow

In summary, where do we go next?

- The 270/271 is a powerhouse when it's used to its fullest capability and functionality
- The 270/271 will not necessarily lose its place in the care journey/provider workflow as it's has significant value to the industry in the administrative setting
- The 270/271 is still presently required, and still mandated under HIPAA Transactions and Code Sets Rule
- Newer requirements in recently published 8060 version of the TR3 incorporate significant improvements to the prior authorization indication on the 271

- CRD is a valuable, and robust vehicle to integrate in provider and payer systems to ensure efficiency and timeliness of care when in a treatment setting
- CRD will reduce the burden of 'overhead' that today plagues providers with delays in prior authorization determination, including, but not limited to, covered services and treatment alternatives. This is most important when the provider and patient are discussion care and treatment options
- CRD can be used standalone and in a hook fashion in the clinician workflow

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Commercial Payers' Commitments RE Prior Authorization, Agreements to Participate in Networks

Gail Kocher, Blue Cross Blue Shield Association

Health Plan Commitment to PA Optimization

June 2025, approximately 50 major commercial health plans voluntarily committed to streamlining prior authorization

- Includes many Blue Cross plans, Elevance, United Healthcare, Cigna, Humana

Commitment includes

- Developing standardized data and submission requirements (FHIR APIs) by 1/1/27
- Reducing claims requiring prior authorization by 1/1/26
- Ensuring continuity of care when patients change plans by 1/1/26
- Enhancing communication and transparency on determinations by 1/1/26
- Expanding real-time responses by 2027
- Ensuring medical review of non-approved requests

2025 Membership Meeting Calls

January 17, 2025
February 21, 2025
March 21, 2025
April 18, 2025
May 16, 2025
June 20, 2025
July 18, 2025
August 15, 2025
September 19, 2025
October 17, 2025
November 21, 2025
December – no meeting

Thank You for Attending!

Cooperative Exchange Contact Information

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