



Cooperative Exchange Clearinghouse Caucus

September 29, 2026
5:00pm EST

Hyatt Regency Jacksonville

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.

Clearinghouse Caucus Agenda

Tuesday, September 29, 2026

Clearwater Room

5:00 – 6:00pm



- I. ***Welcome and Introduction of Cooperative Exchange*** - Pam Grosze
- II. ***Trebuchet Project Update*** – Nick Radov
- III. ***MHCC Testing Requirements and CE Concerns*** – Tara Rose and Jamie Mosteller
- IV. ***CMS Physician 2027 Fee Schedule (CMS-1848) Section H. Current Procedural Terminology (CPT) RFI*** – Tara Rose and Jamie Mosteller
- IV. ***SFC Health Coverage RFI 07302026*** – Tara Rose and Jamie Mosteller

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



Our Members



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The National Clearinghouse Association

NOMINATIONS ARE OPEN

The Board of Directors for the Cooperative Exchange would like to announce that nominations are open for Director Board positions for the **2027-2028** term starting **January 1, 2027**.



WE HAVE
THREE
OPEN DIRECTOR
POSITIONS.

Only Voting Members may be elected to the Board of Directors, limited to one Voting Member per Company serving concurrently.



If you are interested, please submit your completed Candidate Application to Lisa Beard at lisa@cooperativeexchange.org no later than **October 31st**. This can be downloaded from the home page of our website www.cooperativeexchange.org.

Cooperative Exchange / HL7 Da Vinci Project Trebuchet Pilot Update

Nick Radov



CE/HL7-Trebuchet FHIR Pilot: Overview

Goals, expected outcomes and current workstream status

Summarized goals

What the pilot is intended to prove

- Demonstrate clearinghouse-to-clearinghouse prior authorization interoperability
- Validate real-world hybrid workflows using FHIR and X12
- Define routing, identity resolution, endpoint discovery, and scalable security approach

Expected outcomes

What the pilot should produce

- Functional prototype for CH-to-CH exchange using Da Vinci CRD+PAS, FAST IGs, and X12
- Implementation playbook with technical specifications and operational guidance
- Documented barriers and recommendations for standards enhancements

Current work underway

What is being analyzed now

- Agreements with X12 regarding IP use for mapping and outcomes
- Identify missing or required values discovered during implementation and connectivity testing
- Focus current scope on 278 X217/X215 to FHIR, FHIR to X12, and FHIR-to-FHIR exchange

The pilot is moving from concept to practical implementation guidance by validating the data, routing, security, and standards gaps needed for scalable CH-to-CH prior authorization.

CE/HL7-Trebuchet FHIR Pilot: Business Update

- **The pilot work proceeding slower than we anticipated**
 - Live testing may require new legal agreements and reviews
 - CMS 0053 and 0062 implementation competing for same resources
- **Gaps found by standing up and implementing new processes**
 - Identifying and engaging correct SME and decision makers
 - Building solid process due to lack of repetition
 - Mismatches in supported Da Vinci IG versions (i.e. 2.1 server with 2.2 clients)
 - Need for **standardized** legal agreement
- **Technical knowledge of data exchange is still siloed between clinical and administrative**
 - Takes extra time to learn to speak each other's language
 - The worktime is mostly spent discussing and trying to come to agreement on those items not defined in the IGs such as payer_id, submission_id and other components clearinghouses need to identify and route to a specific endpoint
- **Veradigm and TriZetto have completed limited client/server testing a few auth and CRD test cases**

CE/HL7-Trebuchet FHIR Pilot: Technical Workstream Update

- **Da Vinci IGs prioritized**
 1. Coverage Requirements Discovery (CRD)
 2. Prior Authorization Support (PAS)
 3. Documentation Templates and Rules (DTR)
- **Defined supported CDS Hooks**
- **Profiled key FHIR resources**
 - ServiceRequest
 - Patient
 - Practitioner / PractitionerRole
 - Organization
 - Location
 - Coverage
 - Extension for EDI payer ID
- **Matrix of trading partners and roles**
 - Simulated provider
 - Simulated payer
 - Intermediary

CE/HL7-Trebuchet FHIR Pilot: Resources

- **Confluence pages**
 - <https://confluence.hl7.org/spaces/DVP/pages/453906458/Da+Vinci+Trebuchet+Cooperative+Exchange+Pilot>
 - <https://confluence.hl7.org/spaces/DVP/pages/453927891/Workstream>
- **Zulip chat channel**
 - <https://chat.fhir.org/#narrow/channel/607369-Da-Vinci-Trebuchet>
- **Meeting schedule**
 - CE Trebuchet Pilot: Bi-weekly Wednesdays 2:00 PM ET
 - HL7 Da Vinci Trebuchet: Bi-weekly Thursdays 2:00 PM ET

MHCC Testing Requirements and CE Concerns

Testing timeline

Tara Rose and Jamie Mosteller



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.

CE Letter to MHCC and CRISP

The CE raised significant concerns regarding the administrative burden of implementing this reporting requirement. The Industry Affairs and Emerging Trends committees convened joint sessions to identify topics for a letter to MHCC. Following extensive discussion, the group elected to focus solely on the timeline in order to reduce the risk of legislative action by MHCC to compel EHN compliance on an accelerated schedule. The final letter was therefore narrowed to address only the testing and implementation timeline.

Prior to approval of the CE letter, CRISP published version 2 of the Regulatory Guidance, which addressed the implementation timeline, including the testing schedule. CRISP indicates that the 18-month period established in the regulation is intended to provide a workable timeframe. While MHCC does not intend to impose penalties on EHNs for noncompliance during that 18-month period, it expects EHNs to advance testing substantially sooner and to begin submitting production data as early as 10/1/26.

The CE membership continues to have concerns regarding the timeline for beginning testing and achieving full implementation, and agreed to revise the letter to address the timeline and associated burden while acknowledging version 2 of the Regulatory Guidance. Key concerns include:

- How is the 18-month period measured — from the draft technical guidance date (12/19/25) or the final guidance date (3/25/26)?
- Are interim testing activities intended as preparation toward compliance rather than as compliance milestones in themselves?
- Variation in requirements across individual EHNs
- The need for clear testing expectations and implementation guidance

CE Comments: CMS-1848-P

CMS Physician 2027 Fee Schedule: Section H. Current Procedural Terminology (CPT) RFI

Tara Rose



Overview of Section H. Current Procedural Terminology (CPT) RFI

In the CY 2027 Physician Fee Schedule proposed rule, CMS outlines the history and governance of the CPT coding system and signals concern that the current physician coding and valuation process may not fully align with evolving healthcare priorities.

Key Points:

- CPT® has been the foundation of physician procedure coding since 1966 and serves as the basis for HCPCS Level I, which is widely used for Medicare payment and HIPAA-standard healthcare transactions.
- The AMA controls CPT® code development, while the AMA's Relative Value Scale Update Committee (RUC) has significant influence over the valuation of physician services used in Medicare payment rates.
- CMS highlights longstanding criticism of the RUC process, citing concerns from MedPAC that payment recommendations rely heavily on physician specialty societies with financial interests in reimbursement outcomes.
- Questions are raised about governance and transparency, including whether reliance on a private organization is the most appropriate mechanism for establishing Medicare payment values.
- CMS suggests the current framework may favor treatment-focused care over prevention and primary care, potentially contributing to a healthcare system that emphasizes "sick care" rather than population health and wellness.
- Recent recommendations from the National Academies of Sciences, Engineering, and Medicine (NASEM) are cited as support for exploring alternative approaches to primary care valuation and physician practice data collection.

Implications:

While CMS does not propose immediate changes to CPT® or the RUC process, the discussion represents a notable policy signal that the agency is evaluating whether the decades-old physician coding and valuation framework should evolve to better support prevention, primary care, and broader healthcare transformation goals. For stakeholders across healthcare, this could foreshadow future debates regarding code set governance, physician payment methodology, and alternative valuation models.

Overview of CE Comments

The CE, via the IAC, drafted and submitted comments to CMS on 9/14/2026

Section H (3) A combination of CPT-4 and HCPCS codes were formally adopted by HHS as the legal standard for national coding for physician and other services as part of implementing HIPAA ([45 CFR 162.1002\(a\)\(5\)](#)). If CMS were to revisit this standard in future rulemaking, which if any alternatives exist to CPT-4 for CMS to consider as part of the national coding standard for physician services? Would CMS need to specify a separate legal standard, or could CMS allow for private competition to supplement the existing CPT-4 coding standard?

- Preserve national consistency. CPT-4 remains the only broadly adopted national standard that reliably supports physician and professional service billing across providers, payers, clearinghouses, vendors, and government programs.
- No comprehensive replacement exists today. Alternatives such as SNOMED CT and ICD-10-PCS serve important purposes, but they do not currently replace CPT-4's role in fee schedules, medical policy, adjudication, coordination of benefits, appeals, and historical claims.
- Avoid unnecessary operational disruption. Replacing CPT-4 would require a costly, high-risk national migration across policy, standards, systems, vendors, and payment workflows at a time when the industry is already implementing major administrative simplification and interoperability requirements.
- Reject fragmented code-set competition without strong governance. Allowing multiple competing code sets could create inconsistent mappings, payment outcomes, denials, crossover failures, reconciliation issues, and confusion over patient responsibility.
- Address licensing burden without destabilizing the system. If CPT-4 licensing cost is the concern, CMS should consider federal support or subsidization rather than introducing competing standards before a viable, nationally governed alternative exists.

Overview of CE Comments

Section H (4) What objective alternatives exist, or could be developed, to maintain a more objective process to the current AMA CPT and RUC committee processes? How would these alternatives support or inhibit innovation?

- Preserve national consistency. CPT-4 is imperfect, but it remains the only broadly adopted national vocabulary for reporting billable physician and professional services.
- Improve governance without destabilizing operations. Any alternative process should strengthen transparency, objectivity, accountability, and stakeholder balance while preserving a single national code set.
- Avoid payer-controlled governance. A neutral public or quasi-public entity may be appropriate, but assigning code maintenance directly to CMS could create perceived or actual conflicts because CMS is also a payer.
- Do not treat existing code sets as ready replacements. SNOMED CT and ICD-10-PCS serve important purposes, but they do not currently support the full professional claims lifecycle, including billing, adjudication, COB, appeals, and historical claims.
- Support innovation through coordinated governance. A well-governed national process could create a clearer pathway for new services and technologies, while fragmented or incomplete alternatives would increase uncertainty, cost, and administrative burden.

Overview of CE Comments

Section H (5) What are the benefits and drawbacks of paying for physician procedural services on the basis of the underlying International Classification of Diseases, 10th Revision (ICD-10) procedure code, as an alternative to CPT-4 code? How could the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) services be grouped or bundled into payment categories, similar to Medicare Severity Diagnosis Related Groups (MS-DRGs), or Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classifications (APCs)? What other alternatives exist for bundling or grouping procedural services?

- ICD-based code sets are not fit-for-purpose replacements for CPT-4. ICD-10-PCS was designed for inpatient facility reporting, not physician-service billing, adjudication, or professional fee schedule payment.
- Replacing CPT-4 would require a new national payment infrastructure. Moving to ICD-10-PCS, ICD-10-CM, ICD-11, or grouped ICD-based payment would require rebuilding grouping, pricing, billing, adjudication, historical claims, provider workflows, payer systems, and vendor processes.
- Payment accuracy and transparency could be weakened. ICD-based payment could shift focus away from the specific service performed toward diagnosis or broad procedural groupings, making payment outcomes, patient responsibility, and reimbursement differences harder to explain.
- The transition would increase cost, burden, and operational risk. Such a change would create significant disruption across payers, providers, clearinghouses, vendors, and government programs without clearly improving care, efficiency, or administrative simplification.
- Address licensing concerns without destabilizing national standards. If CPT-4 licensing costs are the concern, CMS should consider federal support or subsidization rather than replacing a functioning national code set before a comprehensive alternative exists.

CE Comments: SFC Health Coverage RFI

Tara Rose



Overview of SFC Health Coverage RFI – Single Independent Clearinghouse

The proposal calls for creating a single independent clearinghouse to standardize healthcare coding and billing processes. Supporters argue that a single, neutral entity could reduce administrative complexity, eliminate financial incentives tied to billing inefficiencies, and provide providers and hospitals with one consistent system instead of navigating multiple payer-specific requirements. The request seeks stakeholder feedback on whether this approach would improve efficiency and, if so, what type of organization should own and operate such a clearinghouse.

Clarifying the Role of Clearinghouses

- Facilitate connectivity, standardization, validation, transformation and routing
- Do not adjudicate claims, determine coverage, or set payments
- Coding and billing decisions occur within provider and payer systems
- Support administrative simplification and interoperability

Resiliency & Cybersecurity Considerations

- Single independent clearinghouse could create a significant point of failure
- Centralized infrastructure may attract domestic and international threat actors
- Concentration of PHI raises governance, security and oversight questions
- Decentralized models provide redundancy and alternate routing options

Overview of SFC Health Coverage RFI – Single Independent Clearinghouse, continued

Cost, Competition, & Market

- Clearinghouse services are highly competitive and commoditized
- Competition drives efficiency, innovation and value-added services
- Centralization may shift intermediary functions rather than eliminate them
- National infrastructure would require substantial investment and oversight

Infrastructure Analogies & Key Takeaways

- Medicare infrastructure has historically been regionalized
- TEFCA/QHIN adopted a network-of-networks approach
- Resiliency should be evaluated alongside efficiency and standardization
- Policy decisions should reflect the distinct role of clearinghouses

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

Thank You for Attending!

Cooperative Exchange Contact Information

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