CAQH CORE Phase IV Response Time Task Group (PIV TG)

Level Set Call

Call Doc #1

May 15, 2019

Agenda

Time	Agenda Item	Discussion Item or Action Required
3:00	**1. Antitrust Guidelines**	*Discussion*
3:02	**2. Roll Call and Administrative Items**	*Discussion*
3:05	**3. Background & CAQH CORE Role in Prior Authorization** • Review description of prior authorization and the challenges associated with the process. • Review current industry initiatives on prior authorization. • Review CAQH CORE's Vision for prior authorization and ongoing work efforts. • Describe the major parts of the prior authorization process.	*Discussion*
3:20	**4. Phase IV CAQH CORE 278 Infrastructure Rule: Proposed Updates**	*Discussion*
3:40	**5. Phase IV Task Group Roles & Responsibilities**	*Discussion*
3:50	**6. Next Steps** • Phase IV Response Time Task Group Participants: – Review Phase IV CAQH CORE 452 Health Care Services Review – Request for Review and Response (278) Infrastructure Rule v4.0.0 to become familiar with foundational prior authorization rule. – Complete the Impact Assessment Workbook **by Wednesday, 5/29/19** to help define proposed response time requirement updates to the Phase IV 278 Infrastructure Rule. – Participate in the next CAQH CORE PIV Task Group call: Wednesday, 06/12/19 from 2:30 - 4:00 PM ET. • CAQH CORE Staff & Co-Chairs: – Draft a Call Summary for today's call. – Analyze Impact Assessment Workbooks and adjust potential response time requirements for 06/12/19 call.	*Action Required* ▪ Agree to next steps.

Background & CAQH CORE Role in Prior Authorization

The Prior Authorization Challenge

Prior authorization (PA) began as a means to manage the utilization of healthcare resources: people, time and dollars. It requires providers to request approval from a health plan before a specific procedure, laboratory test, service, device, supply or medication is provided to the patient. Referrals require a provider to obtain approval from a health plan before a patient can be referred to another provider (e.g., specialist). Each step of the prior authorization process is labor-intensive and generates time-consuming and costly administrative burden in the industry.

Fast Facts

PA within the Context of Other Administrative Transactions	The PA process is separate from the patient eligibility and claims processes. Siloed processes can jeopardize provider reimbursement and/or result in unintended patient out of pocket costs.	Example 1. Even if a PA is approved, the patient's eligibility may not be confirmed, or may have changed.	Example 2. Even if a PA is approved, edits may be applied to the claim, and the service may still be denied.
Volume*	Approximately 182 million prior authorization transactions per year (in the medical, commercial market alone).		
Transaction Mode*	51% manual (phone, fax, email); 36% partially electronic (web portal; interactive voice response system), 12% electronic (5010X217 278 Request and Response).		
Wait Times**	Approx. 65% of physicians report waiting at least one business day for a PA response, and 26% report waiting at least 3 business days. 91% of Providers surveyed by the AMA reported that the PA process delays patient care.		
Potential Savings*	Full adoption of the standard prior authorization transaction (5010X217 278 Request and Response) by health plans and providers could result in a savings of $7.28 per transaction, for the portions of the prior authorization process included in the 5010X217 278 Request and Response.		

Sources: *CAQH Index (2018); commercial market figures only. | **AMA PA Physician Survey (2018).

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Continued Industry Engagement to Address PA

- In response to the Phase IV CAQH CORE Operating Rules, the National Committee on Vital and Health Statistics (NCVHS) recommended research and development of additional operating rules to address barriers to improving the prior authorization process. NCVHS also noted that accelerated turnaround times for transactions would result in better use of staff and resources.*
- Significant public and private sector interest in addressing challenges throughout the prior authorization continuum.
  - July 31, 2018 Senate Health, Education, Labor and Pensions (HELP) Committee hearing on "Reducing Health Care Costs: Decreasing Administrative Spending" was the third in a series of hearings the committee has held on reducing health care costs – prior authorization was a key topic in multiple testimonies.
  - Multiple industry statements and guiding principles from multi-stakeholder and provider coalitions.
    - CAQH CORE Board responded with an open letter to the authors of the Consensus Statement on Improving the Prior Authorization Process.
  - ONC's work on drafting a strategy to reduce clinician burden, to which CAQH CORE responded.
  - CMS' Documentation Requirement Lookup Service Initiative.
  - Other complementary work efforts include AMA research, WEDI PA Council and Subworkgroup efforts, HL7, HATA, DaVinci Project use cases, etc.

In total, more than 100 organizations have substantively contributed to the CAQH CORE prior authorization rule development process through interviews, site visits, subgroup and work group participation and surveys demonstrating the strong industry commitment to this topic.

*Letter to the Secretary - Findings from Administrative Simplification Hearing, Letter to the Secretary - Recommendations for the Proposed Phase IV Operating Rules, Review Committee Findings and Recommendations on Adopted Standards and Operating Rules.

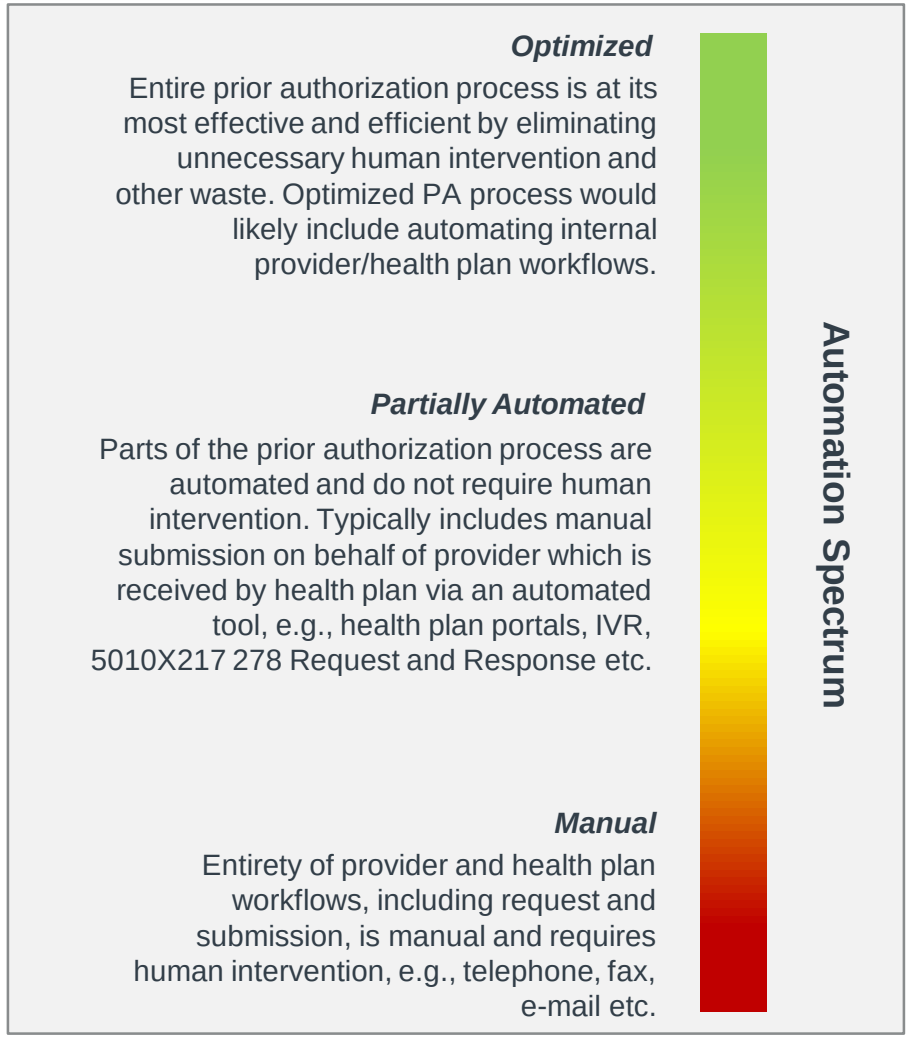
CAQH CORE Vision for PA

Introduce targeted change to propel the industry collectively forward to a prior authorization process optimized by automation, thereby reducing administrative burden on providers and health plans and enhancing timely delivery of patient care.

The Phase IV 278 Infrastructure Rule established **foundational infrastructure requirements such as connectivity, response time**, etc. and builds consistency with other mandated operating rules required for all HIPAA transactions.

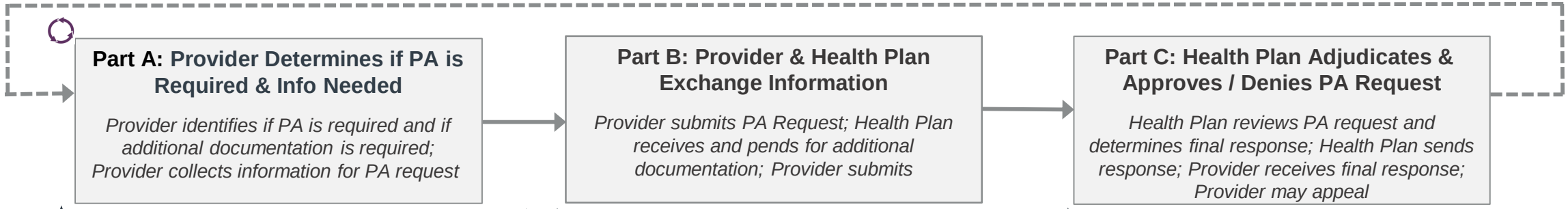
The Phase V Operating Rules address **needed data content** in the prior authorization standard electronic transaction and **enable greater consistency across other PA exchange mechanisms.**

Ongoing efforts in 2019 to **pilot test requirements** for a provider to **determine whether an authorization is needed** and update the Phase IV Rule with a **timeframe for final determination.**



CAQH CORE Operating Rules Address Pain Points in the PA Process

Key Components of the Prior Authorization Process*



- **Consistent patient identification** to reduce common errors and associated denials.
- **Application of standard X12 data field labels to web portals** to reduce variation in data elements to ease submission burden and encourage solutions that minimize the need for providers to submit information to multiple portals.
- **Standard Companion Guide format** to ensure trading partners are informed of the nuances required for successful transaction processing.

- **System availability** requirements for a health plan to receive a PA request.
- **Consistent review of diagnosis, procedure and revenue codes** to allow for full adjudication.
- **Consistent use of codes** to indicate errors/next steps for the provider, including need for additional documentation.
- **Detection and display of code descriptions** to reduce burden of interpretation.
- **Confirmation of receipt of PA submission** to reduce manual follow-up for providers.
- **Consistent connectivity and security methods** between trading partners to improve timely flow of transactions and data.
- **Time requirement for initial response.**

- **Consistent connectivity and security methods** between trading partners to improve timely flow of transactions and data.
- **Detection and display of code descriptions** to reduce burden of interpretation.

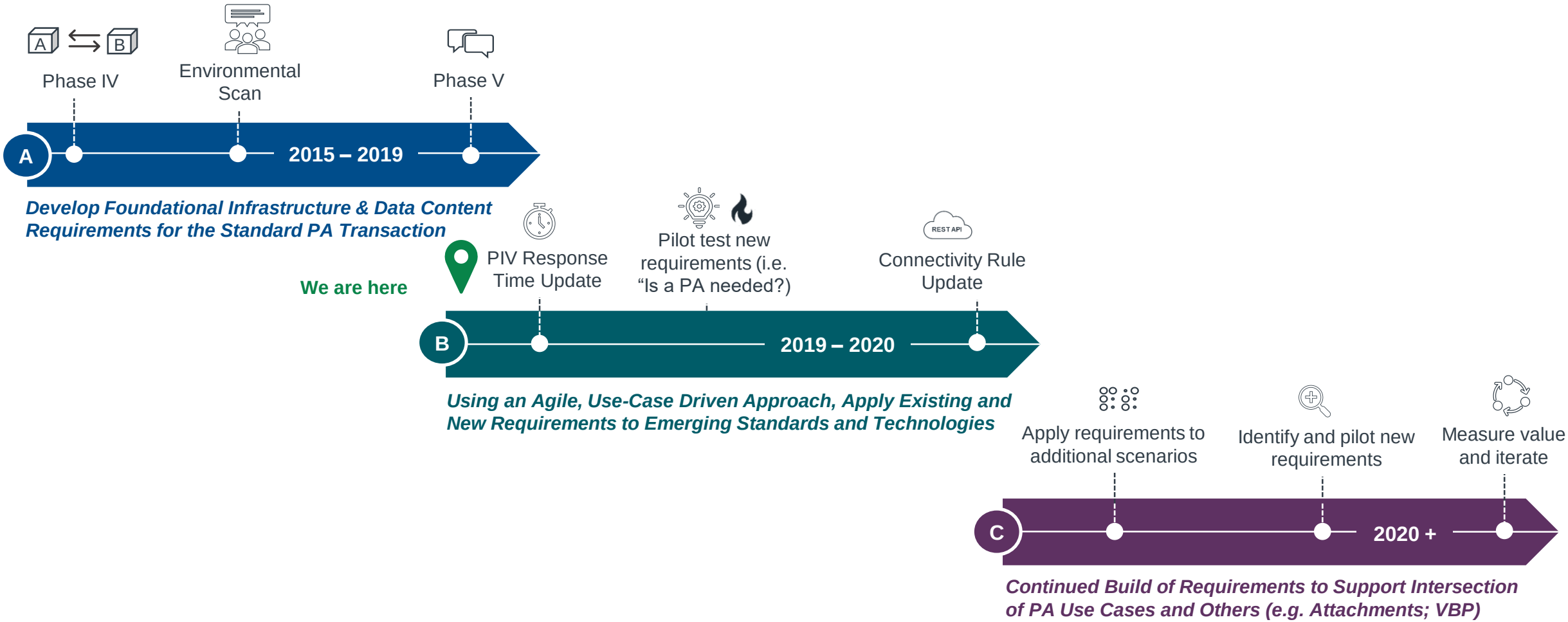
Requirement in CAQH CORE Phase IV 278 Infrastructure Rule

Requirement in CAQH CORE Phase V Operating Rule

Initial Focus of CAQH CORE PA Pilot

* Depicts the most common path for the PA process to follow.

CAQH CORE Prior Authorization Roadmap

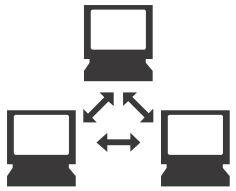


Phase IV CAQH CORE 278 Infrastructure Rule: Proposed Updates

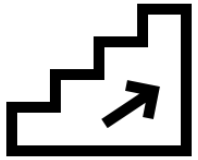
CAQH CORE Phase IV Operating Rules

Ongoing Industry Interest to Enhance PA

The Phase IV Operating Rules were approved by CAQH CORE Participants in September 2015 for four healthcare business transactions: healthcare claims, prior authorization, employee premium payment and enrollment and disenrollment in a health plan.



The Phase IV Operating Rules established foundational infrastructure requirements such as connectivity, response time, etc., and builds consistency with other mandated operating rules required for all HIPAA transactions.



CAQH CORE not only develops operating rules to automate the PA process, but also drives adoption to realize meaningful change.

Highlights of Phase IV Infrastructure Requirements
Connectivity Requirements Facilitate Electronic Information Exchange between Providers and Health Plans
Real-time and Batch Processing of PA Requests
Acknowledgement of Receipt of PA Request
Responses within Specified Timeframe

The Phase IV CAQH CORE 452 Health Care Services Review –Request for Review and Response (278) Infrastructure Rule v4.0.0 response time requirement represented a first step to setting national expectations for the completion of a PA request and response exchange. Since then, industry commitment towards improving PA response times has only strengthened.

CAQH CORE Phase IV Operating Rules

Updating the Phase IV Response Time Requirements

The need to evaluate opportunities to strengthen the Phase IV 278 Infrastructure Rule to include a response time requirement for a final PA determination came up throughout Phase V PA rule development. In response, CAQH CORE staff explored industry work groups, provider association research and state-level legislative activity to determine necessary updates.

1. A recent poll of CAQH CORE Participating Organizations engaged in PA rule development indicated 73% of participants support pursuing development of additional time requirements, building on the Phase IV 278 Infrastructure Rule.

2. CAQH CORE performed an extensive analysis of national and state-level PA response time requirements. The analysis revealed:
   - Over 30 states have a response time requirement included in their state legislation.
   - Response time requirements vary across states, ranging from **24 hours to 14 business days**.
   - Response time requirements are often different for **emergent/urgent services vs. non-emergent/non-urgent services**.
   - Response time requirements exist for **provider submission** of additional information/documentation when a request is pended as well as for **final determination** (approval/denial of PA) by the health plan once all information/documentation has been received.

3. CAQH CORE conducted interviews with a diverse mix of provider, health plan, and vendor industry experts representing CAQH CORE Participating Organizations, to gather more details on the feasibility and impact of the potential Phase IV response time scope and requirements.

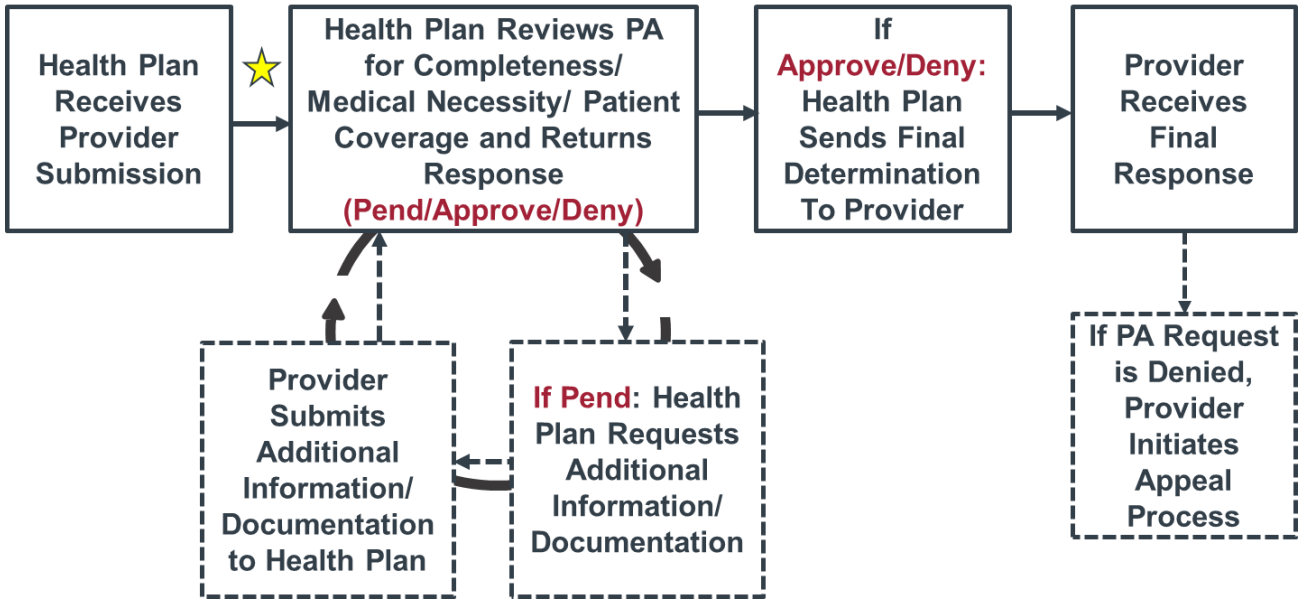
Reminder: Existing Phase IV Response Time Requirement

Batch Processing

The Phase IV Response Time Task Group will use the current Phase IV 278 Infrastructure Rule as a foundation for updated time requirements. Section 4.5 of the rule currently states:

"*Maximum* response time for availability of 5010X217 278 Response when processing 5010X217 278 Requests submitted in Batch Processing Mode by 9:00 pm Eastern Time of a business day by a provider or on a provider's behalf by a clearinghouse/switch must be no later than 7:00 am Eastern Time the third business day following submission.

While there could be a subsequent 5010X217 278 Response made available to the submitter for pick up at a later time this rule does not address that scenario."



Limitations of Current Requirement: 5010X217 278 Responses may contain a PA **APPROVAL**, **DENIAL** or **PEND**. As this requirement **does not specify the contents of the response**, timeframes to a final determination (**APPROVAL** or **DENIAL**) are still ambiguous. Furthermore, as it does not apply to subsequent 5010X217 278 Responses, there is no timeframe related to when a health plan must communicate the reason for the **PEND**.

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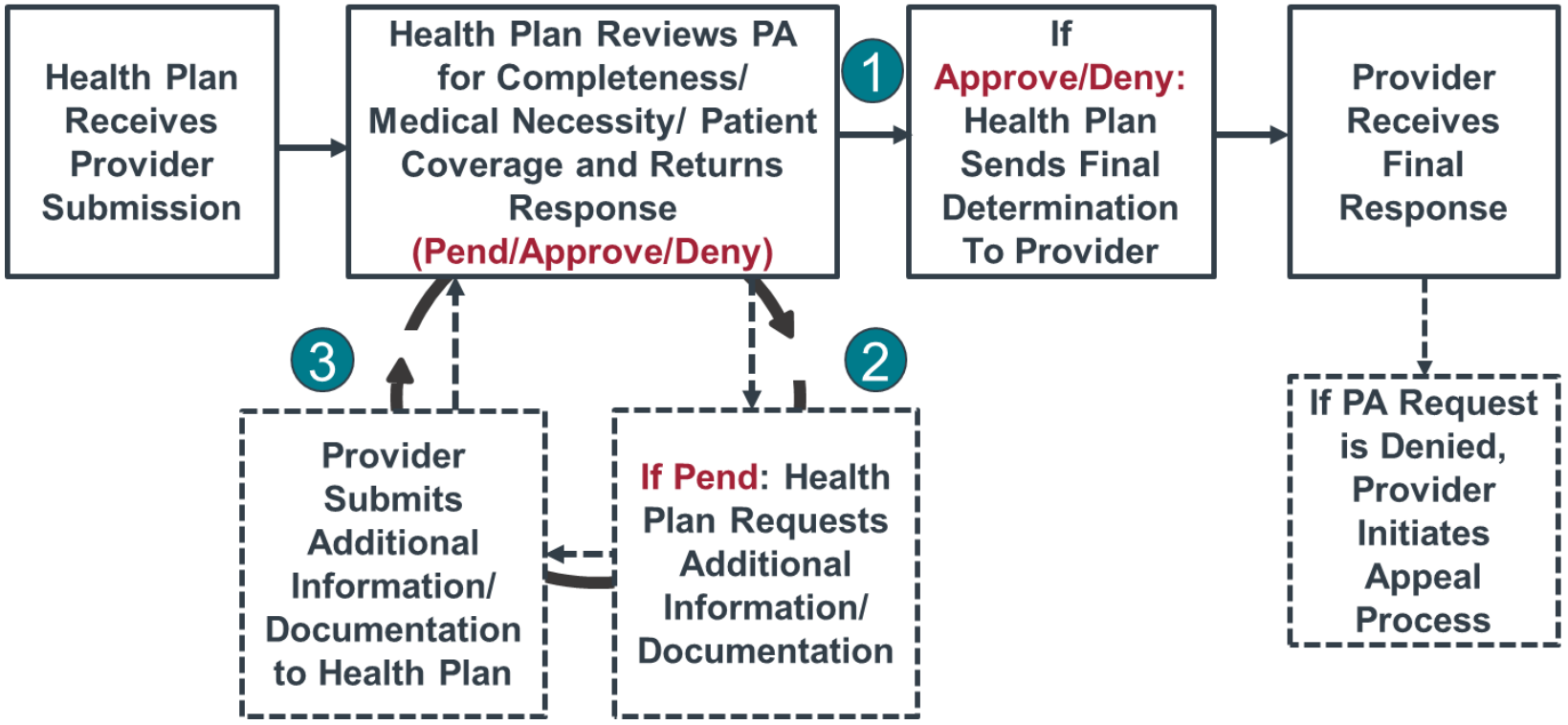
Potential Updated & New Phase IV PA Response Time Requirements

CAQH CORE research revealed three opportunities to adjust current or add new requirements to the Phase IV 278 Infrastructure Rule to reduce the timeframe to final determination. The two new options for requirements would address timeframes for requesting and sending additional documentation to determine patient coverage and medical necessity – a major component of the PA process and a significant source of administrative burden.

1. **ADJUST: Draft Phase IV Time Requirement #1: Health Plan Sends Final Determination to Provider (Approval/Denial)**
   - 1A Batch Processing
   - 1B Real Time Processing
2. **NEW: Draft Health Plan Response Time Requirement #2: Health Plan Request for Additional Information/ Documentation**
3. **NEW: Draft Provider Response Time Requirement #1: Provider Submits Additional Information/Documentation**



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Proposed Phase IV Response Time Requirement Update

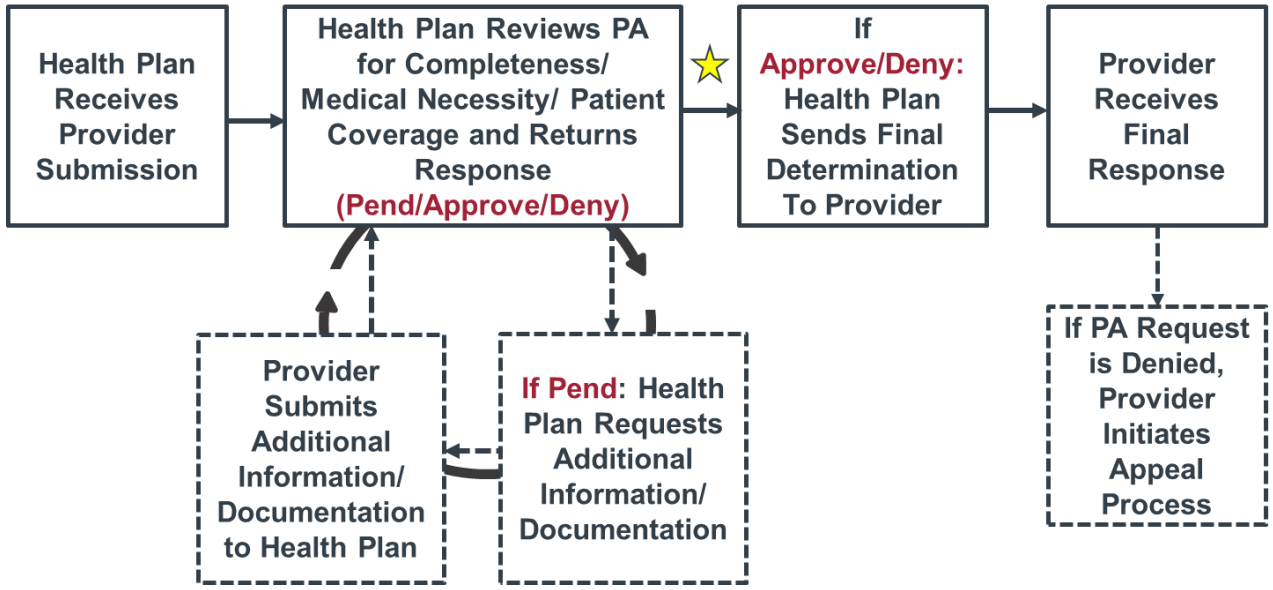
Batch Processing

1A **ADJUST:** To help eliminate ambiguity and reduce the average turnaround time to a final determination, the Task Group will evaluate the value of updating the Phase IV Response Time Requirement to apply only to final determinations (**APPROVALS** or **DENIALS**). An example of how this adjustment could be made is proposed in red below.

Once a health plan or its agent receives a complete prior authorization request with all information and documentation necessary to determine patient coverage and medical necessity, the health plan or agent must return a 5010X217 278 Response containing a prior authorization approval or denial.

Maximum response time for availability of 5010X217 278 Response, communicating an approval or denial when processing 5010X217 278 Requests submitted in Batch Processing Mode by 9:00 pm Eastern Time of a business day by a provider or on a provider's behalf by a clearinghouse/switch must be no later than 7:00 am Eastern Time the third business day following submission.

~~While there could be a subsequent 5010X217 278 Response made available to the submitter for pick up at a later time this rule does not address that scenario."*~~



NOTE: CAQH CORE is **NOT** recommending any changes to the definitions, (e.g. business day), audit requirements, or conformance requirements to the Phase IV Rule. Current conformance requirements require Each HIPAA-covered entity or its agent must support this maximum response time requirement to ensure that at least 90 percent of all required responses are returned within the specified maximum response time as measured within a calendar month.

Proposed Phase IV Response Time Requirement Update

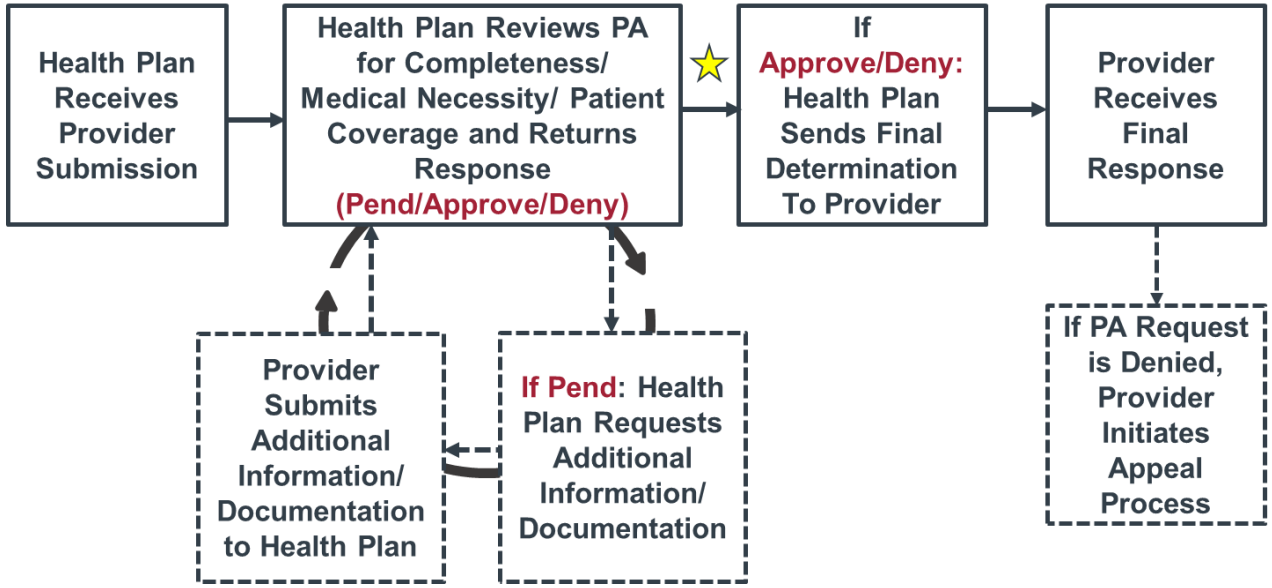
Real Time Processing

1B **ADJUST:** Similar changes could be applied to real time processing pending Task Group feedback and support. A parallel example of how this adjustment could be applied to Section 4.4 of the Phase IV CAQH CORE 278 Infrastructure Rule is highlighted in red below.

Once a health plan or its agent receives a complete prior authorization request with all information and documentation necessary to determine patient coverage and medical necessity, the health plan or agent must return a 5010X217 278 Response containing a prior authorization approval or denial.

Maximum response time for the receipt of an ASC X12N v5010 278 Response from the time of submission of an ASC X12N v5010 278 Request must be 20 seconds when processing in Real Time Processing Mode. ASC X12C v5010 999 response errors must be returned within the same response timeframe.

~~While there could be a subsequent ASC X12N v5010 278 Response made available to the submitter for pick up at a later time this rule does not address that scenario.~~

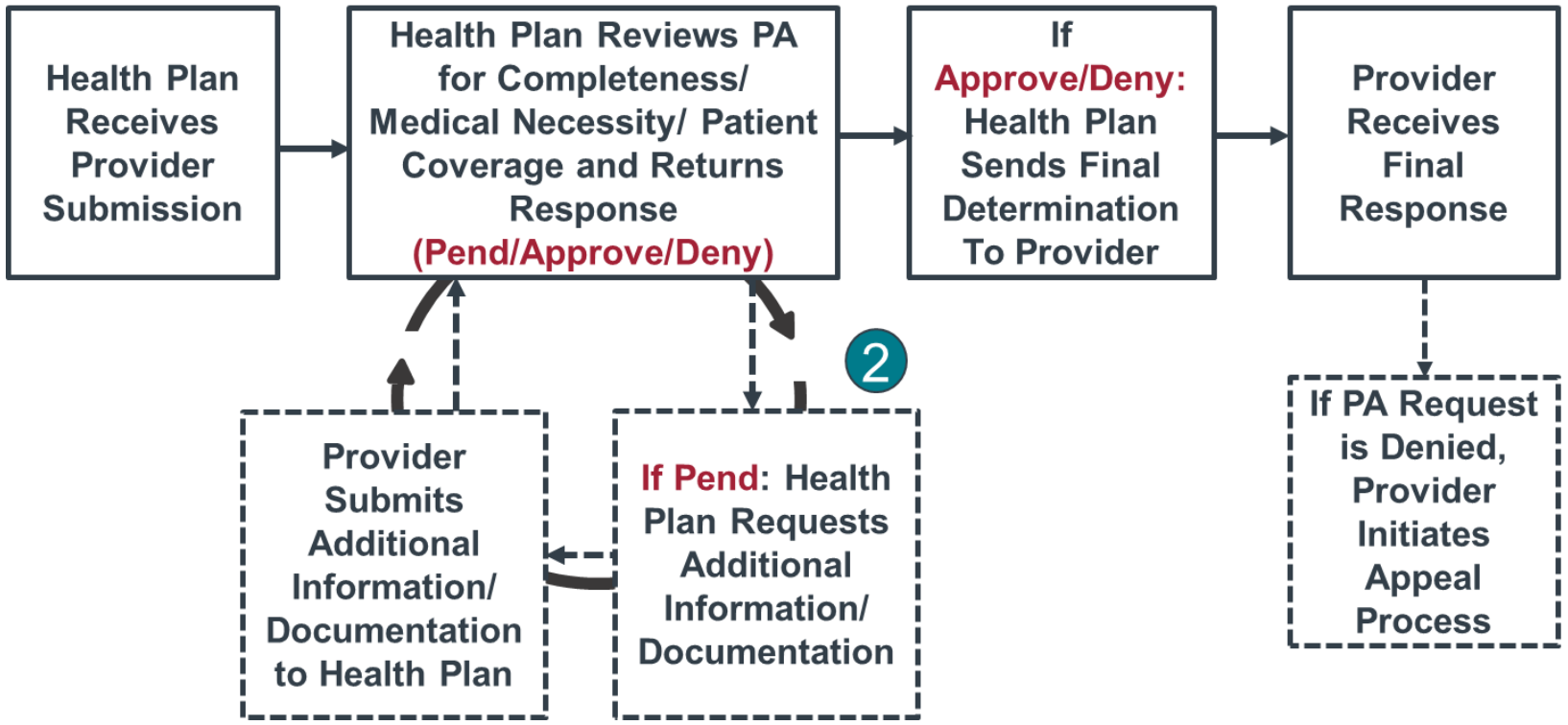


CAQH CORE also recommends **adding two additional requirements** specifically addressing 5010X217 278 Responses containing **PENDs** for both batch and real time processing, which are addressed on the following slides.

Potential Draft Phase IV PA Response Time Requirement

Potential Draft Phase IV Response Time Requirement for Health Plans

2 **NEW: Draft Health Plan Response Time Requirement #2: Health Plan Request for Additional Information/ Documentation:** When a health plan or its agent receives a prior authorization request and **PENDS** the request due to a need for additional information/documentation from the provider, it has **X business days** to communicate what additional information/documentation is needed from the provider or its agent in order to reach a final determination.



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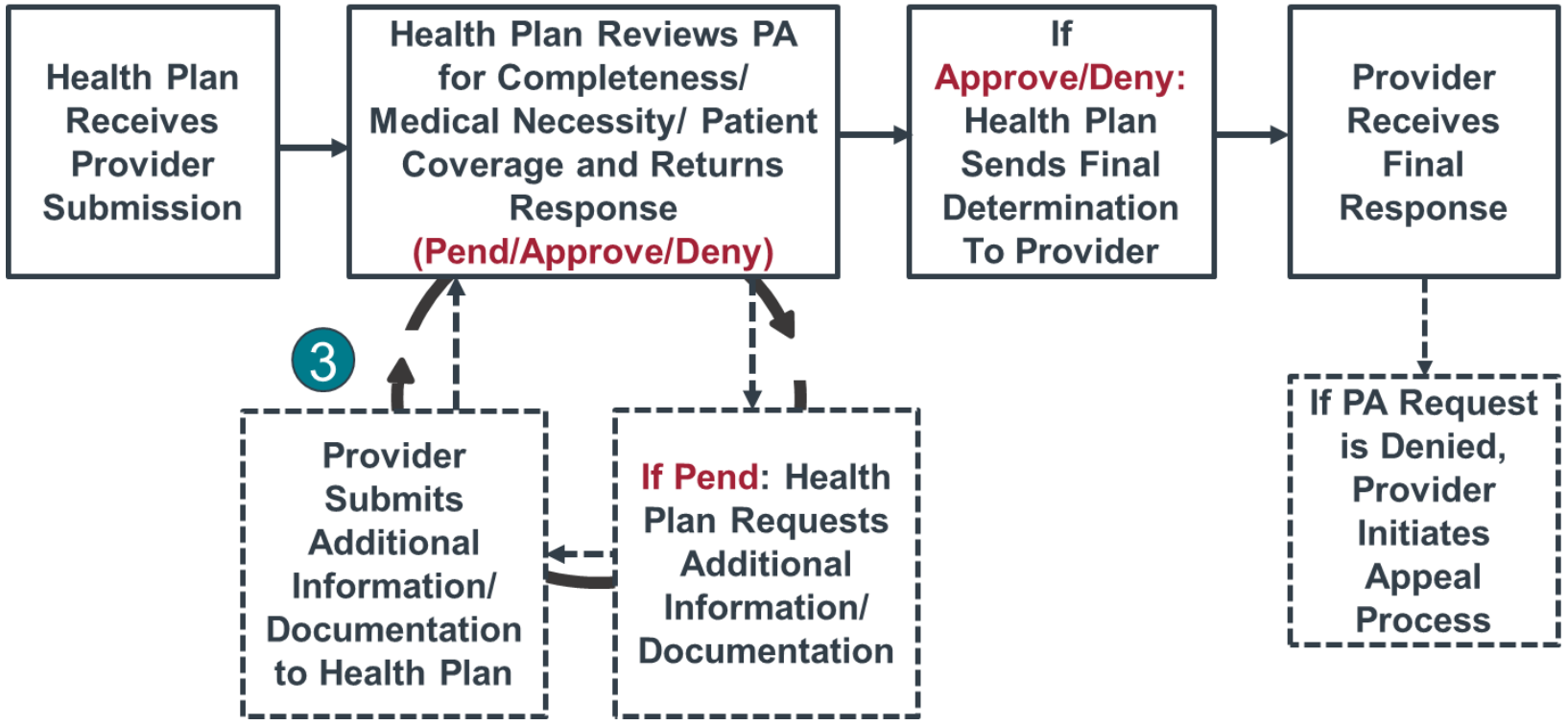
Potential Draft Phase IV Prior PA Response Time Requirement

Potential Draft Phase IV Response Time Requirement for Health Plans

3 **NEW: Draft Provider Response Time Requirement #1: Provider Submits Additional Information/Documentation:** Once a provider or its agent has received information on what additional information/documentation is needed to complete a **PENDED** prior authorization request, the provider or its agent has **X business days** to return the information to the health plan or its agent.



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Potential Draft Phase IV PA Response Time Requirements

Proposed Scope

Scoping the applicability of the proposed adjustments and new requirements is a critical part of the Task Group's responsibility. CAQH CORE research indicated the proposed scope below would best align with current state and industry approaches.

Proposed Scope for Potential Draft Phase IV Prior Authorization Response Time Requirements

Applies to:	Does Not Address:
▪ The 5010X217 278 Request / Response transactions for prior authorizations for medical services. ▪ Prospective and concurrent reviews of prior authorization requests. ▪ Non-emergent and non-urgent prior authorization requests for medical services.	× Prior authorizations covered by retail pharmacy benefit. × Prior authorization specific to emergency, urgent or expedited requests. × Retrospective reviews of prior authorization requests. × Prior authorizations undergoing the appeals process (internal or external)

Black text represents existing scope of Phase IV Prior Authorization Rule. Green text represents recommended adjustments.

Phase IV Task Group Roles & Responsibilities

Phase IV Response Time Task Group

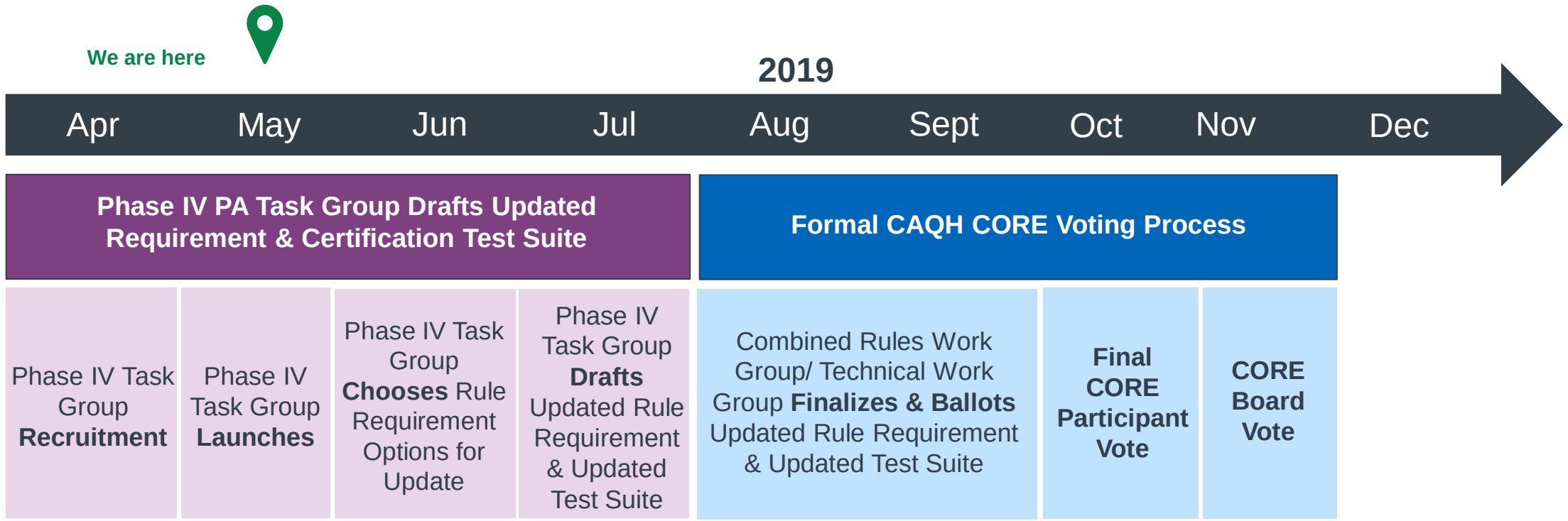
Expectations & Responsibilities

- **Become familiar with CAQH CORE's work and processes, including:**
  - CAQH CORE Phase I, II, III, IV, and V Operating Rules.
  - CAQH CORE Guiding Principles, Board Evaluation Criteria, and Voting Process.
- **Attend and actively participate in meetings.**
  - Read materials whenever possible.
    - CAQH CORE staff assist Co-chairs with drafting meeting materials and ensure they are made available on the CAQH CORE Calendar.
    - Meeting summaries are created after each call/meeting and approved by the participants.

- **Reach out within your respective organization to bring in other subject matter experts (SMEs) as appropriate. SME's should have:**
  - Knowledge of how their organization operates today (with respect to PA final determination and response times).
  - Understanding of how a standard response time requirement would impact their organization, both in terms of feasibility to implement as well as value across business functions.

- **Provide regular updates on task group's progress to Executive Sponsors.**
  - SMEs should regularly update their Executive Sponsors on the task group's progress to ensure larger organization buy-in of the updated requirement and commitment to implementation.
- **Participate in workbooks/straw polls and cast votes as appropriate.**
  - Participating organizations may have any number of participants in a group, but each organization has only one vote.

Timeline for Phase IV Requirement Enhancements



*Timeline may be subject to adjustments based on Task Group needs.

PIV Task Group Next Steps: Impact Assessment Workbook

Impact Assessment Workbook

Potential Response Time Requirement Considerations

Response time requirements across states and health plans are disjointed and inconsistent. Applying a national approach for greater uniformity and consistency is critical to **enabling shorter time to final adjudication and more timely delivery of patient care.**

Massachusetts requires health plans to return a final determination for a non-urgent prior authorization **2 business days** after receiving all necessary information from the provider.

Ohio requires health plans to return a final determination for a non-urgent prior authorization **10 calendar days** after receiving all necessary information from the provider.

- ❑ The specific response time requirements included in the Impact Assessment Workbook represent some of the **most restrictive timeframes** we saw in our research.
- ❑ Task Group members will complete the Impact Assessment based on these timeframes so we can better understand the **feasibility and impact implementing the most restrictive requirements** would have on your organization.
- ❑ The response time requirement considerations listed in the Impact Assessment Workbook will be **adjusted based on the feedback** provided in the Impact Assessment Workbook.

Impact Assessment Workbook

Instructions, Guidelines & DUE DATE

Your Submissions will Provide Further Insight into the Impact and Feasibility of the Most Restrictive Potential Response Time Requirements Under Consideration

- **Phase IV Task Group SMEs from each stakeholder type will complete the excel Impact Assessment Workbook.** Responses should be representative of your organization's stakeholder type. *NOTE: Vendor organizations may select to complete the tabs corresponding to either the health plan or the provider requirements.*
- **Tabs 4-6 (Health Plan Assessment Tabs):**
  - Tabs 4-6 should be reviewed and filled out by **SMEs from health plan organizations**.
  - It will take an estimated 3 – 6 hours for SMEs to complete the health plan assessment tabs.
- **Tabs 7-8 (Provider Assessment Tabs):**
  - Tabs 7 and 8 should be reviewed and filled out by **SMEs from provider organizations**.
  - It will take an estimated 2 – 3 hours for SMEs to complete the provider assessment tabs.

- The tables included in the Impact Assessment tabs for health plans and providers ask specific questions on the systems and business processes impacted by the potential response time requirement, whether your organization's system currently meets the requirement, gaps your organization faces to meeting the requirements, and potential options to address rule requirements.
- **Please coordinate to submit only <u>one</u> excel Impact Assessment Workbook for your organization.**
- Excel Impact Assessment Workbooks must be submitted to Emily TenEyck, Senior Associate, at eteneyck@caqh.org by **Wednesday, 05/29/19 end of day**.

NOTE: In accordance with CAQH CORE policy, all responses will be kept strictly confidential.

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Appendix

CAQH CORE Phase IV Task Group

*Activity Schedule**

Date	Task Group Activity	Topic
Wednesday, 05/15/19 3:00 – 4:00 PM ET	**PIV Task Group Call #1**	▪ Review Phase IV CAQH CORE 278 Infrastructure Rule and research completed by CAQH CORE staff on national and state-level response time requirements. ▪ Discuss PIV Task Group goals and potential updated requirements. ▪ Review PIV Task Group timeline and next steps including Task Group Impact Assessment Workbook.
Wednesday, 05/15/19 – Friday, 05/24/19	**PIV Impact Assessment Workbook**	▪ Provide feedback on the potential impact of updated PIV rule requirement(s) on your organization as well as process/technology changes that may be necessary for successful implementation.
Wednesday, 06/12/19 2:30 – 4:00 PM ET	**PIV Task Group Call #2**	▪ Review results of Task Group Impact Assessment Workbook. ▪ Discuss potential updated PIV rule requirement(s). ▪ Review next steps including PIV Task Group Straw Poll #1
Monday, 06/17/19 – Friday, 06/28/19	**PIV Task Group Straw Poll #1**	▪ Provide feedback on organization's support/lack of support for updated rule requirement(s).
Wednesday, 07/10/19 2:30 – 4:00 PM ET	**PIV Task Group Call #3**	▪ Review quantitative results and comments from Straw Poll #1. ▪ Agree on requirements and scope changes to updated rule requirement(s). ▪ Provide guidance on upcoming straw poll.
Monday, 07/15/19 – Friday, 07/24/19	**PIV Task Group Straw Poll #2**	▪ Provide organization's support/lack of support for sending updated rule requirement(s) to Rules/Technical Work Group (RWG/TWG) for further refinement.
Wednesday, 08/07/19 2:30 – 4:00 PM ET	**PIV Task Group Call #4**	▪ Review quantitative results and comments from Straw Poll #2. ▪ Agree on substantive changes to rule requirement(s). ▪ Finalize rule requirements prior to forwarding to combined RWG/TWG.

*Please note that the call schedule has been updated from the emailed schedule. Updated calendar invites will be sent following this Task Group call.

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Today's Call Documents

Document Name
Doc #1: Phase IV TG Call #1 Deck 05.15.19
Doc #2: Phase IV TG Impact Assessment Workbook 05.15.19

CAQH CORE Staff Contact Information

CORE Staff	Email Address
Erin Weber *Director, CORE*	eweber@caqh.org
Lina Gebremariam *Manager, CORE*	hgebremariam@caqh.org
Emily TenEyck *Senior Associate, CORE*	eteneyck@caqh.org

CAQH CORE Prior Authorization

Suitability Evaluation Criteria

The CAQH CORE Board Evaluation Criteria (which include the CAQH CORE Guiding Principles) apply to all CORE rule development. For Prior Authorization rule development, PA-specific criteria are also used. The PA-specific criteria were developed by the CAQH CORE PA Advisory Group.

#	PA Evaluation Criteria	Description
1.	Effective Approach	Opportunity must be an effective approach to increasing electronic PA adoption, minimizing manual processes, and/or incentivizing automated final adjudication of PA requests.
2.	Broad Set of Clinical Services	Affects a broad set of clinical services that require PA.
3.	Benefits Across Stakeholder Types	Opportunity should offer business benefits or ROI across stakeholder groups.
4.	Does Not Pose Barrier to Existing Federal or State Regulations	Opportunity area does not pose a barrier to existing federal or state regulations.
5.	Supports Attachments (Additional Documentation)	Supports adoption of electronic additional documentation through multiple formats and delivery mechanisms.
6.	Advances Interoperability	Supports interoperability between clinical and administrative systems.
7.	Patient Centric	Supports the patient experience and the delivery of timely care.

#	CAQH CORE Board Evaluation Criteria
1.	Strategic and organizational fit (CORE Guiding Principles).
2.	Goal and expected impact/accomplishment.
3.	ROI: Benefit to provider, health plan and system (immediate or long-term).
4.	Ability to drive participation/adoption/ease of implementation.
5.	Timing considerations.

#	CAQH CORE Guiding Principles
1.	CAQH CORE will not create or promote proprietary approaches to electronic interactions/transactions.
2.	Whenever possible, CAQH CORE has used existing market research and proven rules. CAQH CORE Rules reflect lessons learned from other organizations that have addressed similar issues.
3.	CAQH CORE will suggest migration steps to promote successful and timely adoption of CAQH CORE Rules.
4.	All CAQH CORE recommendations and rules will be vendor neutral.
5.	Rules will not be based on the least common denominator but rather will encourage feasible progress, promote cost savings, and efficiency.
6.	To promote interoperability, rules will be built upon HIPAA, and align with other key industry initiatives.
7.	Where appropriate, CAQH CORE will address the emerging interest in evolving standards.
8.	CAQH CORE will not build a switch, database, or central repository of information.
9.	CAQH CORE participants do not support “phishing.”
10.	CAQH CORE Rules address both Batch and Real Time, with a movement towards Real Time (where/when appropriate).
11.	All of the CAQH CORE Rules are expected to evolve in future phases.

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CAQH CORE Phase IV Task Group

Roster (as of 05/14/19)

CAQH CORE Participating Organization	Last Name	First Name
Accenture	Anderson	Lisa
Accenture	Marker	Todd
Aetna	Bellefeuille	Bruce
Aetna	Egebergh	Heidi
Aetna	Bakos	Janice
American Medical Association	Scheid	Tyler
American Medical Association	McComas	Heather
American Medical Association	Otten	Robert
Ameritas	Ninneman	Kyle
Anthem	Cioff	Chris
Anthem	Gwinn	Kena
Anthem	Ryan	Reddick
athenahealth	Prichard	Emily
athenahealth	Holtschlag	Joe
athenahealth	Pooler	Nikki
Blue Cross Blue Shield Association	Kocher	Gail
Blue Cross Blue Shield Association	Cullen	Rich
Blue Cross Blue Shield of Michigan	Turney	Amy
Blue Cross Blue Shield of Michigan	McNeilly	Ann
Blue Cross Blue Shield of Michigan	Larson	Carol
Blue Cross Blue Shield of Michigan	Monarch	Cindy
Blue Cross Blue Shield of Michigan	Long	Susan
Blue Cross Blue Shield of North Carolina	Hillman	Barry
Blue Cross Blue Shield of North Carolina	Maness	Christine
Blue Cross Blue Shield of North Carolina	Wheatly	James
Blue Cross Blue Shield of North Carolina	Zarate	Sal
Blue Cross Blue Shield of North Carolina	Howard	Wanda
Blue Cross Blue Shield of Tennessee	Poteet	Brian
Blue Cross Blue Shield of Tennessee	Tuggle	Brian
CMS	Meisheid	Anna
CMS	Green	Denesecia
CMS	Calvert	Emily

CAQH CORE Participating Organization	Last Name	First Name
CMS	Keyes	Katrina
CMS	Combs-Dyer	Melanie
Change Healthcare	McCachern	Deb
Change Healthcare	Denison	Mike
CIGNA	Maisano	Marci
CIGNA	Soccorso	Megan
DST Health Solutions	Lynam	Mary
Harvard Pilgrim Health Care	Starkey	Rhonda
HealthCare Service Corp	Harley	Melanie
Health Care Service Corp	Washburn	Racheal
Healthcare Financial Management Association	Koopman	Chris
Humana	Zutterman	Michelle
ioHealth	Marlow	Kristian
Marshfield Clinic	Weik	Kari
Marshfield Clinic	Foemmel	Sara
MGMA	Tennant	Robert
Medical Mutual of Ohio	Headland	Carla
Medical Mutual of Ohio	Conklin	Deborah
Michigan Department of Community Health	Veverka	Chuck
Michigan Department of Community Health	Fuller	Diana
Michigan Department of Community Health	Hinkle	Lori
Montefiore Medical Center	Wasp	Eric
Montefiore Medical Center	Kaufhold	Cynthia
Montefiore Medical Center	Kelly-Manza	Sandra
Montefiore Medical Center	Siena	Giuseppe
NextGen Healthcare information Systems	Hurgeton	George
OhioHealth	Gabel	Randy
OhioHealth	Stratton	LeAnne
Premera Blue Cross Blue Shield	McJannet	Kate
Unitedhealthcare	Reigel	Jordan
URAC	Merrick	Donna
URAC	Adams	Robin

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