Review Work Group

Call #1

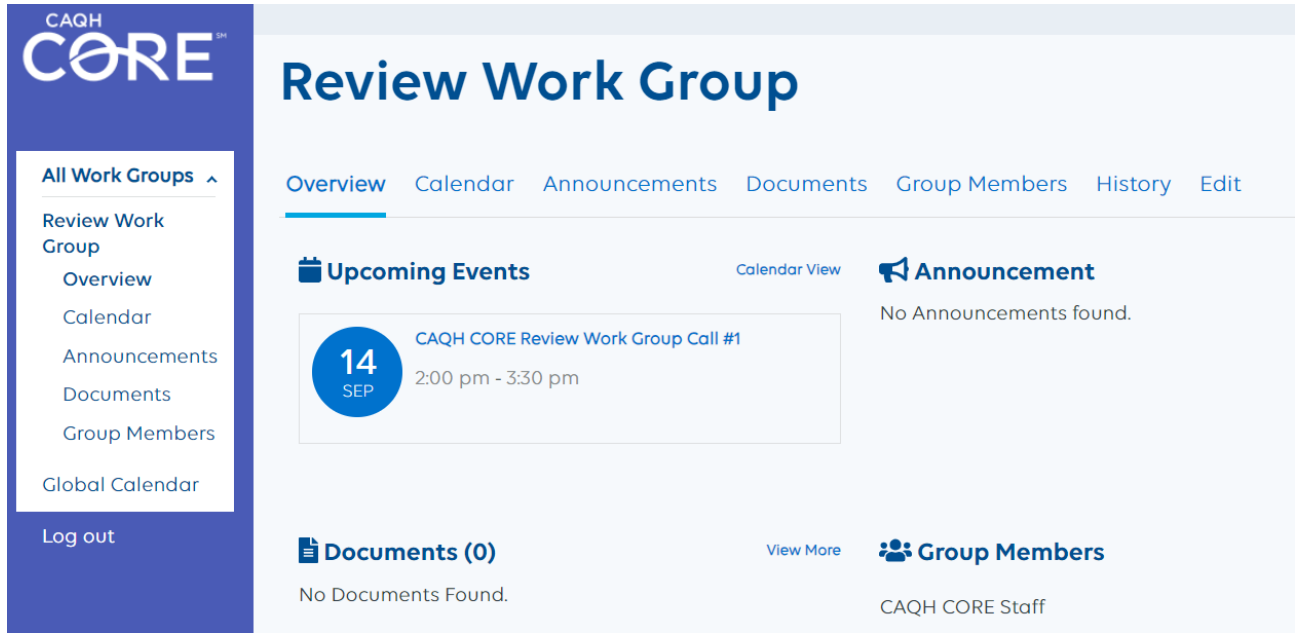
September 14, 2023

Agenda

1. Welcome, Antitrust Guidelines, and Roll Call
2. Level Set
   - CORE Overview
   - Scope, Goals, and Timeline
   - Participation Expectations
3. Scope for 2023 Review Work Group
   - Draft Value-based Payment Operating Rules
   - Draft Health Care Claims Data Content Operating Rules
   - Draft EFT & ERA Enrollment Data Operating Rules
4. Draft Value-based Payment Operating Rules
5. Next Steps
   - Straw Poll #1 open from September 25th – October 6th
   - Next Call on Thursday, October 19th from 2:00 - 3:30 pm

CORE Participant Dashboard

The **CORE Participant Dashboard** is a comprehensive resource for CORE Participants to access Task Group information and any CORE Participant resources and events.



- The dashboard is accessible only to CORE Participants.
- Participants can view the groups they are currently involved in and add themselves to new groups.
- Participants can view upcoming events, documents, announcements, and group member information.
- Email core@caqh.org if you need a login.

Level Set

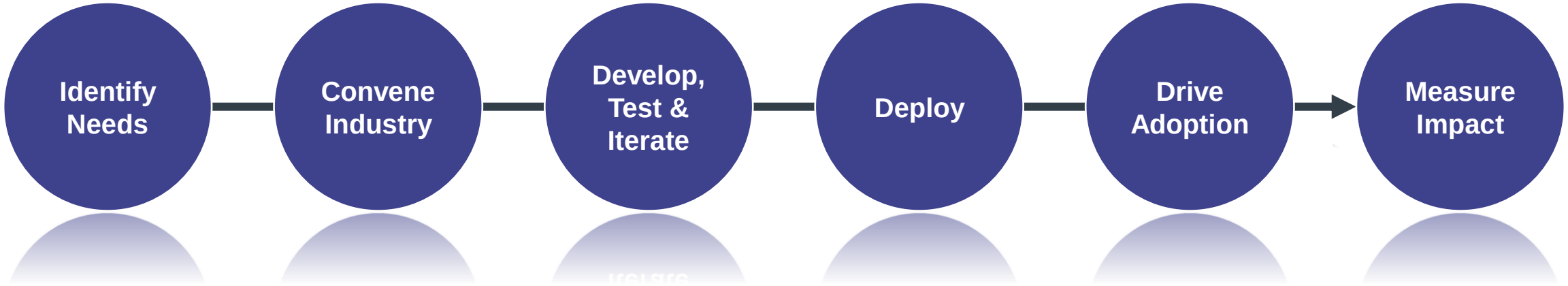
CORE Mission & Vision

Mission

Drive the creation and adoption of healthcare operating rules that **support standards, accelerate interoperability, and align administrative and clinical activities** among providers, payers, and consumers.

Vision

An **industry-wide facilitator** of a trusted, simple, and sustainable healthcare data exchange that evolves and aligns with market needs.



CORE Operating Rule Sets
Support Electronic Transactions Across the Revenue Cycle

Rule Set	Infrastructure	Connectivity Rule	Data Content	Other	
Eligibility & Benefits	Eligibility (270/271) Infrastructure Rule	Connectivity Rule vC1.1.0 Connectivity Rule vC2.2.0	Eligibility (270/271) Data Content Rule	Single Patient Attribution Data Rule	
Claim Status	Claim Status (276/277) Infrastructure Rule	Connectivity Rule vC2.2.0			
Payment & Remittance	Claim Payment/Advice (835) Infrastructure Rule		EFT/ERA (835/CCD+) Reassociation Rule	EFT/ERA Enrollment Data Rules	Uniform Use of CARCs and RARCs (835) Rule
Prior Authorization & Referrals	Prior Authorization (278) Infrastructure Rule	Connectivity Rule vC4.0.0	Prior Authorization (278) Data Content Rule	Prior Authorization Web Portal Rule	Attachments Prior Authorization Rules
Health Care Claims	Health Care Claim (837) Infrastructure Rule		Health Care Claims Data Content Rule		Attachments Health Care Claims Rules
Attributed Patient Roster	Attributed Patient Roster (834) Infrastructure Rule		Attributed Patient Roster (834) Data Content Rule		
Benefit Enrollment	Benefit Enrollment (834) Infrastructure Rule		Benefit Enrollment Data Content Rule		
Premium Payment	Premium Payment (820) Infrastructure Rule				

Rules in [ ] are federally mandated.

Rules boxed in **BLUE** are currently under development or update.

Connectivity Rule vC4.0.0 can be used to support all rule sets for CORE Certification.

Operating Rule Development Process

1. Identify Opportunities

- Advisory Groups
- Focus Groups
- Environmental Scans/ Industry Interviews

Research opportunities for potential rules and provide industry guidance prior to commencing rule writing.

2. Draft Rules

- Subgroups
  e.g., Health Care Claims Subgroup
- Task Groups
  e.g., CORE EFT/ERA Enrollment Data Task Group

→ Review Work Group

- **Subgroups** draft new Operating Rules.
- **Task Groups** update/maintain existing Operating Rules.
- **Work Groups** review and ballot draft rules.

3. Ballot Participants

CORE Participants

Full Voting Membership ballot includes CORE Participants that create, transmit, or use transactions given these entities invest in implementation.

CORE Board

CORE Board votes on final approval once rule pass the Full Voting Membership.

Formal CORE Voting Process

CORE Body*	CORE Requirements for Operating Rules Approval
Level 1: Subgroups & Task Groups	Formal vote is not required, but consensus is assessed via straw poll and must be achieved prior to moving to the next level of voting.
Level 2: Work Groups	Work Groups require for a quorum that 60% of all organizational participants are voting. Simple majority vote (greater than 50%) by this quorum is needed to approve a rule.
Level 3: Full Voting Membership	Full CORE Voting Membership vote requires for a quorum that 60% of all Full CORE Voting Member organizations (i.e., CORE Participants that create, transmit, or use transactions) vote on the proposed rule at this stage. With a quorum, a 66.67% approval vote is needed to approve a rule.
Level 4: CORE Board	The CORE Board's normal voting procedures would apply. If the Board does not approve any proposed Operating Rule, the Board will issue a memorandum setting forth the reasons it did not approve the proposed Operating Rule and will ask the CORE Subgroups and Work Groups to revisit the proposed Operating Rule.

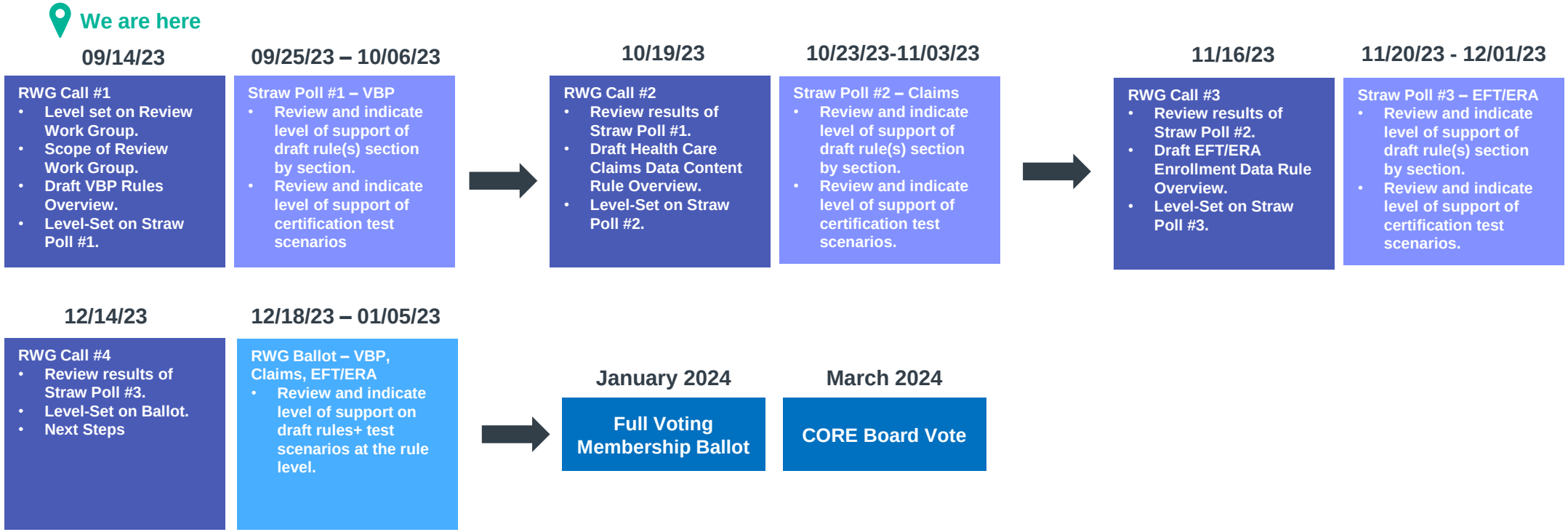
*__NOTES__: Neither the CAQH Board nor CAQH has veto or voting power over the CORE Operating Rules. Any entity that is a CORE Participant has a right to vote on the rules, understanding that at Level 3 only entities that will implement the rules vote on the rules.

Scope, Goals, and Timeline

Goal: Update, review, and refine existing and newly drafted Operating Rules currently under development per the formal CORE Voting Process.

Scope: Value-based Payments, Health Care Claims Data Content, and EFT/ERA Enrollment Data Operating Rules

Timeline:



**Timeline is subject to adjustments based on rule development needs.*

Review Work Group Group Co-Chairs

Representation across health plan, provider, and vendor/clearinghouse stakeholders

RWG Co-Chairs

Donna Campbell
Health Care Service Corporation (HCSC)

Patricia Wijtyck
Cognizant

Katie Gilfillan
Healthcare Financial Management Association (HFMA)

Thank You to our Subgroup and Task Group Co-Chairs!

Value-based Payments Subgroup

- Michael Alwell, St. Joseph's Health; Naveen Maram, Centene; Michael Patwell, Edifecs

Health Care Claims Subgroup

- Megan Soccorso, Gainwell Technologies; Randy Gabel, OhioHealth; Olga Khabinskay, HBMA; Mahesh Siddanati, Centene

EFT & ERA Enrollment Data Task Group

- Zach VanTrieste, J.P. Morgan; Erica Martin, AMA; Kiana Fitchett, Horizon BCBSNJ

Review Work Group Participants

Representation across health plan, provider, vendor/clearinghouse, association, and government stakeholders

61 participants from 43 organizations

Participant Expectations

- **Become familiar with CORE Operating Rules work and processes, including:**
  - CORE Benefit Enrollment Operating Rules and CORE Attributed Patient Roster Operating Rules
  - CORE Health Care Claims Operating Rules
  - CORE Payment & Remittance EFT & ERA Enrollment Data Rules

- **Attend and actively participate in calls.**
  - Read materials ahead of time whenever possible.
    - CORE staff assist Work Group Co-chairs with drafting call documents and ensure they are made available on the CORE Participant Dashboard.
    - Call summaries are created after each call and approved by the participants.

- **Participate in straw polls, ballots and cast votes, as appropriate.**
  - Participating organizations may have any number of participants in the Work Group, but each organization has only one vote on straw polls and ballots.
- **Work with your organization's subject matter experts (SMEs), as appropriate. SMEs should have:**

  - Knowledge of their organization's capabilities with respect to Value-Based Payments, Benefit Enrollment, Claims, and/or EFT & ERA processes.
  - Understanding of how the potential draft rules would impact their organization and the industry, both in terms of feasibility to implement and value.
- **Provide regular updates on Work Group's progress to Executive Sponsors.**
  - SMEs should regularly update their Executive Sponsors on the Work Group's progress to ensure larger organization buy-in of the drafted operating rule requirements and commitment to implementation.

Scope for 2023 Review Work Group

Scope
Updated and Newly Drafted Operating Rules

Updated and Newly Drafted Operating Rules for RWG Review

1. New/Updated: Draft Value-based Payment Operating Rules and Industry Resource

- New: Draft CORE Benefit Enrollment (834) Data Content Rule
- Updated: Draft CORE Benefit Enrollment (834) Infrastructure Rule
- Updated: Draft CORE Attributed Patient Roster (X12 005010X318 834) Data Content Rule
- Updated: Draft CORE Attributed Patient Roster (X12 005010X318 834) Infrastructure Content Rule
- New: CORE Framework for Semantic Interoperability in Value-based Payment Models

2. New: Health Care Claims Data Content Rules

- New: Draft CORE Health Care Claims (837) Data Content Rule
- New: Draft CORE Health Care Claims Acknowledgment (277CA) Data Content Rule

3. Updated: EFT & ERA Enrollment Data Rules

- Updated: Draft CORE Payment & Remittance EFT Enrollment Data Rule
- Updated: Draft CORE Payment & Remittance ERA Enrollment Data Rule

2023 Operating Rule Development
Value-based Payments

Business Challenges

Inconsistent Data. Data-sharing is integral to success in VBP; however, exchanging key data such as SDOH information between industry stakeholders lacks standardization, thus hindering efficient data exchange and negatively impacting patient care.

Limited Results. A recent report from the Center for Medicare and Medicaid Innovation (CMMI) shows that VBP programs produce only modest cost-savings without significant improvements in care quality.

Program Complexity. Coordinating a population of patients across the spectrum of care poses difficulties that could be eased by defining terms and definitions across VBP programs.

2023 CORE Rule Development Group Vision

Leverage **HIPAA-mandated benefit enrollment and claim transaction** to facilitate uniform exchange of socio-demographic information and strengthen interoperability in VBP by aligning technical infrastructure requirements and industry terminology.

Environmental scanning and additional research conducted in 2022 and early 2023 identified preliminary opportunities to address business challenges.

The Subgroup launched on April 27, 2023 to begin evaluating opportunity areas for rule development.

Value-based Payment Rule Development Focus Areas

Strengthen Exchange of Socio-demographic Data

NEW DRAFT Benefit Enrollment and Maintenance (X220) Data Content Rule

UPDATED DRAFT Benefit Enrollment and Maintenance (X220) Infrastructure Rule

UPDATED DRAFT Attributed Patient Roster (X318) Data Content and Infrastructure Rules

- **Impactful** socio-demographic data inclusions, standardizing exchange.
- Enhanced **health plan-to-provider** exchange of socio-demographic information.
- Infrastructure rules **inclusive of value-based payment** requirements.

Significant because:

- Generates **usable** socio-demographic data for VBP designers and participants.
- Addresses with **CMMI** evaluations that data availability and quality slows health equity progress.

Empower Engagement with VBP Methodologies

NEW DRAFT Health Care Claim (X221 / X222) Submission Data Content Rule

- **Alignment** of industry requirements for additional claim submissions.
- **Structure** for the inclusion of information supporting value-based methodologies, such as risk adjustment.
- Component of a **suite** of operating rule requirements to reduce burden.

Significant because:

- Enhances **reporting of non-medical factors** increasingly used for quality and risk adjustment.
- Encourages **greater provider engagement** in the administration of VBP by easing reporting.

Maintain a Framework for Semantic Interoperability

NEW DRAFT CORE Framework for Semantic Interoperability in Value-based Payment Models

- **Clarity** around disparate concepts and terms prevalent in VBP.
- **Resource** for industry stakeholders to reference and for CORE to better define VBP in operating rules.
- Functions as a **compilation** of disconnected industry efforts.

Significant because:

- Centers language used in VBP that can otherwise **confuse contracting or policy efforts**.
- Creates a **basis for CORE Operating Rules** and aligns disparate industry initiatives.

5 NEW/UPDATED Operating Rules and 1 CORE and Industry Resource to drive automation and adoption of value-based payment models.

2023 Operating Rule Development
Health Care Claims

Business Challenges

Inconsistent Data
Information shared in claim transactions between providers and payers varies significantly, increasing administrative burden and requiring manual intervention for claims management.

Increasing Denial Rates
According to the Change Healthcare 2022 Revenue Cycle Denials Index, the average initial denial rate across 1,500 hospitals in the United States was almost 12% in the first half of 2022 compared to just 10% in 2020 and 9% in 2016.

2023 CORE Rule Development Group Vision

Establish **data content requirements** for transactions supporting claim submission, acknowledgment, and error reporting to help avoid rejections and costly downstream appeals.

Environmental scanning and additional research conducted in 2022 and early 2023 identified preliminary opportunities to address business challenges.

The Subgroup launched on April 13, 2023 to begin evaluating opportunity areas for rule development..

Health Care Claims Rule Development Focus Areas

Telehealth POS + Modifier Placement

DRAFT CORE Data Content Operating Rule for the Health Care Claim Transaction - Telehealth Claim Submission

- Modifier assignment for POS 10 and 02 is standardized to modifiers 93, 95, or GT.
- Definitions of POS + modifier combinations are established in an **accessible reference** resource.

Significant because:

- A rule provides needed clarity on place of service and modifier alignment.

277CA Data Alignment

DRAFT CORE Data Content Operating Rule for the 277CA Transaction

- Claim Status Category Codes (CSCC) and Claim Status Code (CSC) errors and rejection reasons are standardized into business scenarios and code combinations.
- Standardized data used to associate the 277CA transaction with an 837 transaction.
- Standardized data used to associate a 277CA error code with an 837 service line item.

Significant because:

- Standardized use of the 277CA could increase transaction adoption.
- With improved data quality and greater transaction adoption comes simplified claim resubmission.

COB Claim Submission

DRAFT CORE Data Content Operating Rule for the Health Care Claim Submission Transaction

- Standardized **minimum required data elements** for successful processing of COB.
- Standardized **format** for listing health plan COB data requirements.
- Alignment on **electronic access** of health plan COB data requirements.

Significant because:

- Lack of uniform 837 COB requirements creates additional administrative burden.
- Uniform data content requirements can remediate questions on payment or care attribution, among other items.

2023 Operating Rule Development
EFT/ERA Enrollment Data Rules Update

Business Needs

Industry stakeholders requested that CORE make substantive adjustments to the enrollment data sets to **improve the ability to detect fraud and support streamlined workflows**.

Ongoing need to drive payment and remittance automation through **greater adoption of EFT/ERA standards.**

2023 CORE Rule Development Group Vision

Explore updating operating rules intended to **simplify provider enrollment for EFT and ERA through consistent data requirements** and electronic enrollment methods to address security and other business needs.

In Q2 of 2023, **CORE conducted industry interviews to evaluate current and emerging business needs** to improve EFT/ERA enrollment which identified five opportunity areas for Task Group consideration.

The Task Group launched on August 15, 2023 to begin evaluating opportunity areas for rule updates.

EFT/ERA Enrollment Data Rules Update
Five Opportunity Areas Under Consideration

Enhancement to Data Sets

Revise and improve data element groups and elements.

Flexible Data Sets

Enable flexible arrangement and externalization of data sets.

Fraud Detection

Strengthen fraud detection capabilities through the addition of new data elements.

Bulk Enrollment

Facilitate efficient enrollment across multiple entities.

Notification of Enrollment, Disenrollment, or Updates

Establish clear requirements for notifying providers of enrollment, disenrollment, or updates.

Draft Value-based Payment Operating Rules

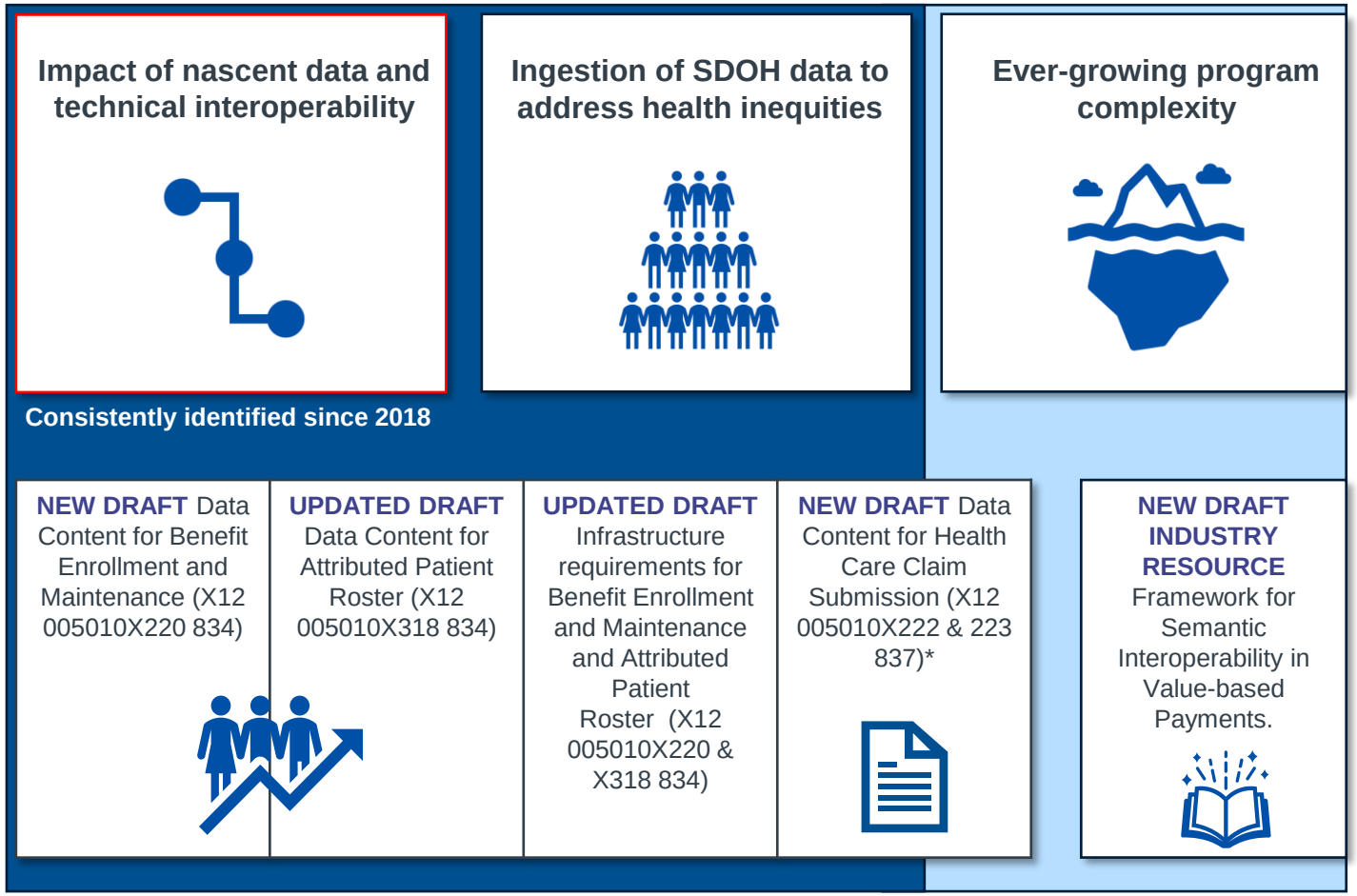
NEW and UPDATED Draft Value-based Payment Operating Rules

Opportunities in Value-based Payment

CORE and its Participating Organizations identified several opportunities to strengthen interoperability and standardization in value-based payment programs. Opportunities are detailed in: Unifying Value: Industry Opportunities to Streamline Value-based Payment Data Exchange.

Solutions from CORE and Participating Organizations

CORE convened the Value-based Payment Subgroup in 2023, to facilitate the consensus-based development of new and updated operating rules and industry guidance addressing the presented opportunities.



***Collaborative effort with CORE Health Care Claims Subgroup**

NEW Benefit Enrollment and Maintenance Data Content Rule
X12 005010X220 834

Target
Addresses variance in data collection and exchange at the point of member enrollment and renewal by identifying uniform data sets and expanding socio-demographic data collection.

Rationale
Upstream data collection is highly variable, particularly for socio-demographic information which is increasingly being ingested and used in value-based payment programs. Defining standard collection and exchange strengthens value-based payment design and the ability to target ‘at-need’ populations.

Impact
Increases the quality and exchangeability of the information available to health plans, leading to the thoughtful, patient-centered design of value-based payment programs and the ability to share high-quality, usable information with providers.

Draft Rule Requirements

REQUIRED collection and exchange of race and ethnicity information

- Standard exchange using unique identifiers from the CDC Race and Ethnicity Code Set.
- Identification of how race and ethnicity information was collected (e.g., self reported).
- Alignment to existing requirements and imminent updates to the OMB 15 collection standard.

REQUIRED collection and exchange of member language* and use

- Standard exchange of member language using the ISO 639-3 standard.
- Indication of how a member language is used – reading, writing, speaking or native language.

DISCRETIONARY collection and exchange of member gender identity

- Standard exchange of member gender identity using SNOMED CT and HL7 v3 vocabulary.
- Alignment to minimum reporting concepts supported by the HL7 Gender Harmony Project.

***If member language is not English.**

UPDATED Attributed Patient Roster Data Content Rule
X12 005010X318 834

Target
Updates rule requirements to facilitate the exchange of socio-demographic information collected at member enrollment or renewal directly with providers participating in a value-based contract.

Rationale
Aligning the CORE Attributed Patient Roster Data Content Rule with corresponding initiatives that encourage and standardize the collection socio-demographic information allows providers to ingest and use this valuable information in practice.

Impact
Providers administering value-based contracts that increasingly put emphasis on and incentivize interventions against health inequity can use this information to identify at-risk individuals and coordinate care across medical and community resources.

Draft Rule Requirements

REQUIRED addition of the following data elements to the Attributed Patient Roster

- Member race and ethnicity
- Member language*
- Member use of language
- Member gender identity (if self-reported)

***If member language is not English**

UPDATED Benefit Enrollment and Maintenance and Attributed Patient Roster Infrastructure Rules (X12 005010X220 & 318 834)

Target
Updates rule requirements that accommodate the secure exchange of socio-demographic information, language disclosing the use of sensitive information, and requirements to align infrastructure requirements with EDI best practices.

Rationale
Socio-demographic information is sensitive; therefore, health plans and other collectors of this information must – to the best of their ability – inform members of the collection, exchange, and potential use of this sensitive information.

Additionally, alignment between the suite of infrastructure rules is necessary to maintain EDI best practice.

Impact
Members are more likely to share personal, sensitive information if its use is disclosed and its security understood, enhancing the frequency and quality of socio-demographic information. Further, the addition of real-time exchange requirements – for those who support it – sets the stage for on-demand attributed roster sharing using the X12 Standard.

Draft Rule Requirements

UPDATED Benefit Enrollment and Maintenance and Attributed Patient Roster Infrastructure Rules

- Requirement to add language disclosing collection, exchange, and use of socio-demographic information in the transaction-specific companion guide.

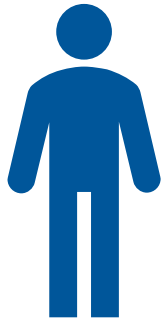
UPDATED Attributed Patient Roster Infrastructure Rule

- Addition of Real-time Reporting requirements for entities that support them.

Benefits of CORE Socio-demographic Data Content Requirements X12 005010X220 & 318 834

X12 005010X220 834

Step 1: Individual enrolling in or renewing health insurance does so through one of multiple routes available.



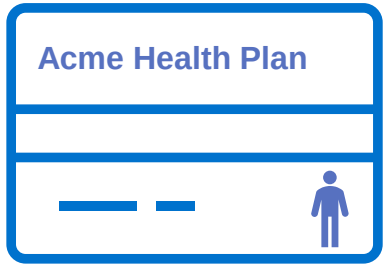
Step 2: Agents acting on behalf of the health plan to enroll an individual into coverage **collect demographic information from the individual during the process.**

Employer

Broker

Self-enroll through health plan

Step 3: The health plan receives information from enrollment through an **outbound X12 834** and processes this information into their system for use. The **proposed CORE Benefit Enrollment and Maintenance Data Content Rule** standardizes the information and datasets used in the X12 834.



X12 005010X318 834

Step 4: The health plan then can send the socio-demographic and other information to providers participating in a sponsored value-based contract, facilitated by the **voluntary CORE Attributed Patient Roster Operating Rule (X12 005010X318 834).**

Strengthened data content requirements streamlines and increases the quality of upstream data collection, enhancing the ability for meaningful socio-demographic information to be used in the design and administration of value-based payment programs.

NEW CORE Framework for Semantic Interoperability in Value-based Payments

Target
Compiles and aligns definitions from across industry resources to simplify the language used and applied to value-based payment programs and methodologies.*

Rationale
VBP is subject to interpretative definitions that lead to a proliferation of drastic and subtle differences in how common terms and concepts are applied in the administration of VBP programs.

Impact
Creation of an industry resource – and one supporting CORE Operating Rules – that can be updated over time unifies disparate definitions, effectively aligning the language used in the administration of VBP.

This simplifies activities related to contracting, day-to-day operations, and participant engagement with methodologies.

***The Framework does not require the use of specific methodologies.**

The Framework has 47 unique concepts split across the following categories
General Terminology
Episodic Care
Population-based Models
Patient Attribution
Risk Adjustment
Quality Measurement
Payment Concepts

Summary of VBP Operating Rules and Industry Resources

Benefit Enrollment and Maintenance
(X12 v5010X220 834)

Required and discretionary collection, exchange, and processing of socio-demographic data elements.

1. **Race and Ethnicity**
2. **Member Language**
3. **Self-reported Gender Identity**

Also includes the development of socio-demographic disclosure language to drive informed consent.

Substantive, non-substantive, and typographical updates to support additions to the X12 v5010X220 834.

1. **Inclusion of socio-demographic disclosure language in the transaction-specific companion guide.**

Attributed Patient Roster
(X12 v5010X318 834)

Alignment with X220 Data Content Rule to include collected and processed socio-demographic data elements in the attributed patient roster provided by health plans to providers.

1. **Race and Ethnicity**
2. **Member Language**
3. **Self-reported Gender Identity**

Substantive, non-substantive, and typographical updates to support additions to the X12 v5010X318 834.

1. **Inclusion of socio-demographic disclosure language in transaction specific companion guide.**
2. **Addition of real-time processing mode requirements for entities who support that exchange.**

Health Care Claim Submission
(X12 v5010222 & 223 837)

Data content requirements to support the submission of additional claims at a single encounter. Information between initial and additional claims must match.

1. **Member ID**
2. **Rendering Provider NPI**
3. **Billing Provider NPI**
4. **Dates of Service**

Note that this represents a collaborative effort with the CORE Healthcare Claims Subgroup and will be reviewed in detail on the next Review Work Group call.

"The Framework"

Next Steps

Next Steps

Compete Straw Poll #1
September 25th – October 6th
	Objective: Collect each Participating Organization's feedback and level of support for each new/updated section of the Draft Value-based Payment Operating Rules, VBP Framework, and Test Scenarios
	
	Format:
	• Support for New Value-based Payment Operating Rules – *Section by Section*
	  • CORE Benefit Enrollment (834) Data Content Rule
	• Support for Updated Value-based Payment Operating Rules – *Updated Sections Only*
	  • Draft CORE Benefit Enrollment (834) Infrastructure Rule
	  • Draft CORE Attributed Patient Roster (X12 005010X318 834) Data Content Rule
	  • Draft CORE Attributed Patient Roster (X12 005010X318 834) Infrastructure Content Rule
	• Support for DRAFT CORE Framework for Semantic Interoperability in Value-based Payment Models
	• Support for New/Updated Value-based Payment Test Scenarios – *Updated Sections Only*
	  • CORE Benefit Enrollment (834) Test Scenarios
	  • CORE Attributed Patient Roster (X12 005010X318 834) Test Scenarios
	
	• Note: The form is to be completed by RWG Participants only; **please coordinate to submit <u>one</u> response for your organization**.

Attend RWG Call #2 October 19th from 2:00-3:30 pm ET	• RWG participants will review the results of Straw Poll #1 and level-set on Draft Health Care Claims Data Content Operating Rules.

Appendix

Today’s Call Documents

Document Name
Doc 1 RWG Call 1 Deck 09.14.2023

CORE Staff	Email Address
Erin Weber, Vice President	eweber@caqh.org
Bob Bowman, Principal, Interoperability and Standards	rbowman@cahq.org
Taha Anjarwalla, Associate Director	tanjarwalla@caqh.org
Pete Benziger, Sr. Manager	pbenziger@caqh.org
Mike Phillips, Sr. Manager	mphillips@caqh.org

CORE Review Work Group
Roster

Name	Organization
Kellene Parthemore	Aetna
Heather Morgan	Aetna
Mark Rabuffo	Aetna
Rose Hodges	Aetna
Mark Warren	Aetna
Marianne Davidson	Aetna
Andrea Preisler	AHA
Terrence Cunningham	AHA
Errallyn Rodriguez	AHCCCS
Heather McComas	AMA
Nancy Spector	AMA
Erica Martin	AMA
Noah Mastel	Ameritas Life Insurance Corp.
Margaret Schuler	Aspen Dental
Emidio Depina	athenahealth
Tonya Moffitt	Availity
Cindy Monarch	BCBS Michigan
Heather Sammons	BCBS NC
Susan Langford	BlueCross BlueShield of Tennessee
Meredith Ray	Cigna
Nihal Titan	Claim.MD
Daniel Kalwa	CMS
Dawn Duchek	Cognizant/ Trizetto
Patricia Wijtyck	Cognizant/ Trizetto
Daniel Saunders	Cognosante
Cristina Boincean	Edifecs
Meg Kutz	Elevance Health
Christol Health	Elevance Health
James Habermann	Epic
Megan Soccorso	Gainwell Technologies
Donna Campbell	Health Care Service Corporation

Name	Organization
Brian Pickens	Health Care Service Corporation
Andrea Huffstetler	Health Care Service Corporation
Christopher Gracon	HealtheNET
Katie Gilfillan	HFMA
Shawn Stack	HFMA
Athalage Bandula	Horizon BCBS
Zach VanTrieste	JP Morgan/Instamed
Gheisha-Ly Rosario Diaz	Labcorp
Kevin Mulcahy	MGMA
Chuck Veverka	Michigan Medicaid
Diana Fuller	Michigan Medicaid
Brad Smith	NACHA
Charles Hawley	NAHDO
Margaret Weiker	NCPDP
Nancy Team	NextGen Healthcare
Mary Alexander	Ohio Health
Lynn Chapple	Optum
Tara Rose	Optum
Kristin Thonsgaard	Optum
Nathaniel Boer	Optum
Everet Ford	Optum
Rene Utley	OSF Healthcare
Marie Becan	PeaceHealth
Monal Patel	Point32
Nina Boldosser	SS&C Health
Mary Susman	Tata Consulting Services (TCS)
Holly Gilligan	UnitedHealthcare
Stephanie Farley	US Department of Veteran Affairs
Robert Tenant	WEDI
Michelle Barry	X12

CORE Review Work Group
Schedule

Dates	Activity
Thursday, September 14th	**RWG Call #1**: • Group level set on Review Work Group • Draft VBP Rule(s) Overview • Level-Set on Straw Poll #1
Monday, September 25th – Friday, October 6th	**Straw Poll #1: VBP Rule(s), Industry Resource & Test Scenarios**
Thursday, October 19th	**RWG Call #2**: • Review results of Straw Poll #1 • Draft Health Care Claims Rule(s) Overview • Level-Set on Straw Poll #2
Monday, October 23rd – Friday, November 3rd	**Straw Poll #2: Health Care Claims Data Content Rule(s) & Test Scenarios**
Thursday, November 16th	**RWG Call #3**: • Review results of Straw Poll #2 • Draft EFT/ERA Enrollment Rule(s) Update Overview • Level-Set on Straw Poll #3
November 20th – December 1st	**Straw Poll #3: EFT/ERA Enrollment Data Rule(s) & Test Scenarios**
Thursday, December 14th	**RWG Call #4**: • Review results of Straw Poll #3 • Level-Set on Ballot • Next Steps
Monday, December 18th – Friday, January 5th	**Ballot: VBP, Health Care Claims Data Content, EFT/ERA Enrollment Data Rules & Test Scenarios**

**Timeline is subject to adjustments based on work group needs.*