Review Work Group

Call #3

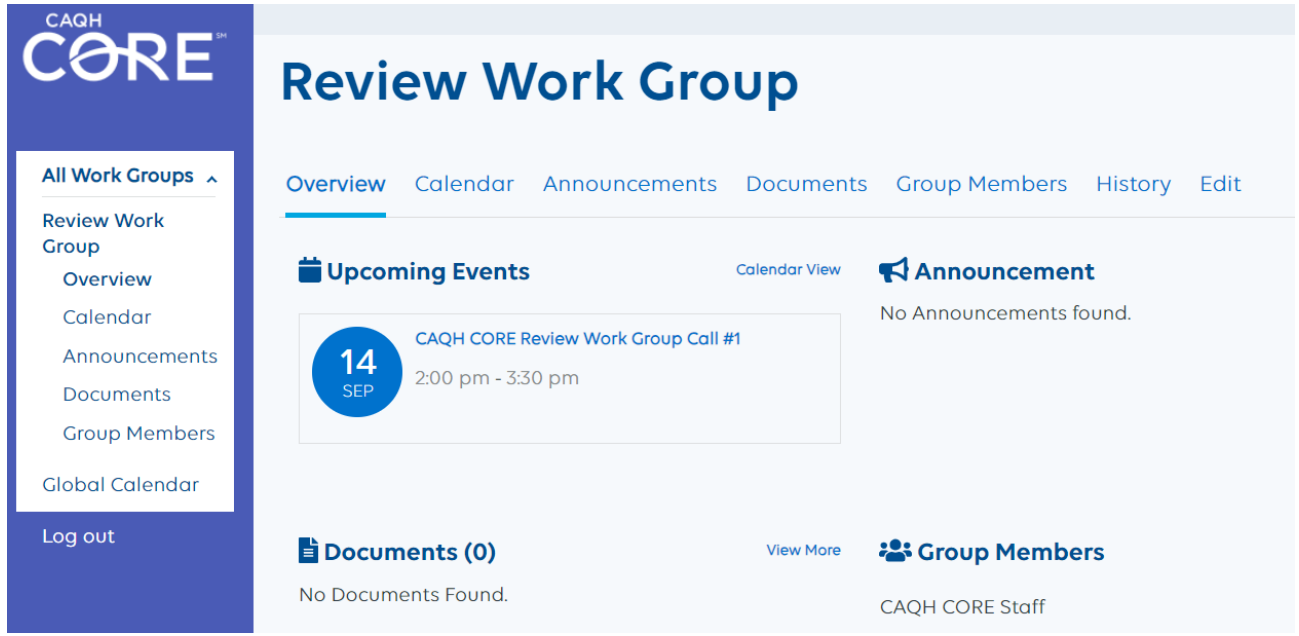
November 16, 2023

Agenda

1. Welcome, Antitrust Guidelines, and Roll Call
2. Summary of 10/19/23 Call
3. Level Set
   - Scope, Goals, and Timeline
4. Draft Health Care Claim Operating Rules
   - Straw Poll #2 Results
5. Draft EFT & ERA Enrollment Data Operating Rules
   - Updated EFT Enrollment Data Rule
   - Updated ERA Enrollment Data Rule
6. Next Steps
   - Straw Poll #3 open from November 27th – December 8th
   - Next Call on Thursday, December 14th 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.

Summary of RWG Call #2

October 19th, 2023
2p-3:30p ET

Agenda Item	Key Discussion Points	Decisions and Actions
1. Welcome, Antitrust Guidelines, and Participant Dashboard (Doc #1 Slides 1-4)	• Patricia Wiityk (Cognizant) opened the call and welcomed everyone to the group. Ms. Wiityk reviewed the antitrust guidelines, administrative items, and agenda items. • Kaitlin Powers (CAQH) conducted roll call. ○ [See call participant roster at the end of this meeting summary to view call attendees and affiliated organizations].	*Discussion*
2. Summary of 09/14/23 Work Group Call (Doc #2)	• Patricia Wiityk (Cognizant) provided a summary of RWG Call #1: ○ RWG Call #1 introduced the co-chairs and purpose of the RWG, along with the scope, timeline, and key focus areas. This first meeting introduced the relevant operating rules for discussion, which include draft and updated rules for Value-based Payments (VBP), Health Care Claims, and EFT & ERA Enrollment Data. • Ms. Wiityk (Cognizant) asked the group for a motion to approve the call summary.	**Action required:** • Approved 09/14/2023 call summary. • Motion to approve by Robert Tennant (WEDI) and seconded by Tara Rose (Optum).
3. Level Set (Doc #1 Slides 5-7)	• Donna Campbell (HCSC) reviewed the scope, goals, and timeline of the Review Work Group (RWG), including the updated and newly drafted operating rules for the group to review. Ms. Campbell also noted that the results of Straw Poll #1 will be reviewed in today's meeting.	*Discussion*

4. Draft Value-based Payment Operating Rules Straw Poll #1 Results (Doc #1 Slides 8-21)	• Katie Gilfillan (HFMA) reviewed the overall results of Straw Poll #1.
	• Mike Phillips (CORE), Ms. Wiityk, Ms. Campbell, and Ms. Gilfillan reviewed the results and comments received in each section of Straw Poll #1.
	• **Summary of RWG Discussion**:
	  ○ Comments received regarding CORE Benefit Enrollment and Maintenance Data Content Rule:
	  – While Mr. Phillips reviewed the comments received in Straw Poll #1, Diana Fuller (State of Michigan Medicaid) asked about Section 4.3 of the Benefit Enrollment and Maintenance Data Content Rule.
	  – Ms. Fuller asked why "Middle Eastern" and "North African" were highlighted and if the TR3 5010 version of the 834 allows ethnicity fields to be repeated 10 times. Mr. Phillips responded that the two ethnicity categories were a type of "futureproofing", as CORE expects this collection standard to be emerging in the next few months. Mr. Phillips also confirmed that the technical report allows for up to 10 ethnicities to be entered.
	  – Ms. Fuller asked for clarification on the Gender Identity portion (Section 4.5) regarding "self-reporting" and why it is listed as "unknown" if the patient does not want to provide this
		Discussion

Level Set

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 (834**) Data Content Rule
- Updated: Draft CORE Attributed Patient Roster (834**) Infrastructure Content Rule
- New: Draft 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

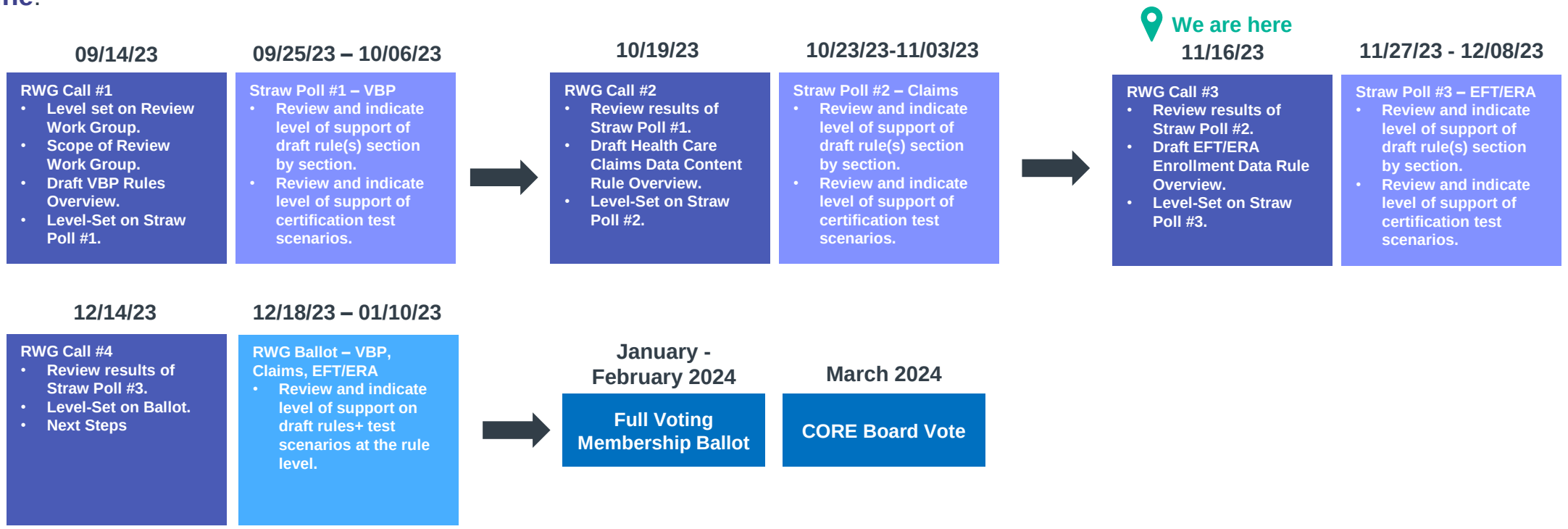
***X12 005010X220 834**
****X12 005010X318 834**

Review Work Group

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:



Draft Health Care Claims Operating Rules

Straw Poll #2 Results

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.

Response Rate by Stakeholder Type

33 out of 42 (79%) organizations responded to Straw Poll #2

Participant Type	Response Percentage
Provider/Provider Association	**24%**
Health Plan/Health Plan Association	**31%**
Vendor or Clearinghouse	**18%**
Government/Other	**27%**

CORE Health Care Claims Data Content Rule

Overall support for the NEW DRAFT CORE Health Care Claims Data Content Rule

#	Section / Subsection	Support
1	Section 1: Background Summary *N=29*	**100%**
2	Section 2: Business Requirement Justification *N=28*	**100%**
3	Section 3: Scope *N=29*	**83%**
4	Section 4: Rule Requirements	**87%**
5	*4.1: Requirements for Providers* *N=24*	**88%**
6	*4.2: Requirements for Health Plans* *N=26*	**81%**
7	*4.3: Detection of Display of X12 v5010 Claim Transaction Data Elements* *N=27*	**93%**
8	Section 5: Conformance *N=26*	**100%**

Average support across all sections ~92%

Substantive Comments Received for CORE Health Care Claims Data Content Rule

#	Substantive Comments	Co-Chair and Staff Response
	General Comments	
1	**Section 4.1:** Three commenters encouraged consistency between publishing requirements for COB, which is currently listed as an electronic method TBD in the draft rule requirements, and other rule requirements – like additional claim submission – that indicate electronic publishing on the plan website and companion guide.	**Adjust.** CORE Staff will edit rule language to ensure that electronic publication is applied consistently across rule requirements and is in-line with expectations established with CORE Participants.
	Remote Care Delivery	
2	**Section 4.1:** One commenter noted that the reference to Service Type Codes covered for Telemedicine is inappropriate as the service type code element is not used in the v5010 837P.	**Adjust.** CORE will adjust language to "categories of service" to align with other CORE Operating Rules for the grouping of services or procedures.

Points of Clarification Received for CORE Health Care Claims Data Content Rule

#	Points of Clarification	Co-Chair and Staff Response
	General Comments	
1	**Section 3.5:** A commenter recommended improving the display of referenced information of Tables in Section 3 by including the full subtext of applicable data.	CORE Staff will review how data is represented across tables in Section 3 and align for consistency. Additionally, CORE Staff will provide industry guidance to support implementation.
	Remote Care Delivery	
2	**Section 3:** One commenter recommended adding specificity for the use of Place of Service Codes 02 and 10, potentially by using the transaction-specific companion guide to indicate when a health plan requires this level of specificity for claim payment and processing. The commenter also asked whether providers are asking patient location during visits.	CORE Participants agreed that knowing a patient's location is a requirement to choose the appropriate POS Code for those health plan products that support healthcare delivery through telemedicine. Implementation guidance will be outlined in rule-specific FAQs. Notably, POS Codes 02 and 10 are indicated in the CORE Eligibility and Benefits Data Content Rules, and it is understood that these codes are built into provider workflows.
3	**Section 3.2.1:** Three commenters do not support limiting POS Codes for telehealth and state that CORE cannot require situational segments/elements/composite elements.	The requirements do not preclude the use of other POS codes to report telehealth care delivery; rather, they align industry usage of common POS codes and related modifiers for consistency and uniformity – in this case POS 02 and 10. These requirements received overall high support from CORE Participants and align with rule requirements currently recommended by the National Committee for Vital Health and Statistics (NCVHS). CORE rule requirements align and build upon the existing standard.
4	**Section 3.2.1:** One commenter requested additional clarity to specify when the rule applies to remote care delivery claims.	This section is dependent upon the POS that is assigned and included on the claim. The modifiers are not listed in this section but rather the detailed requirements section (section 4.1.1).
5	**Section 4.2.1:** One commenter asked what the impact would be should the included modifiers be discontinued.	Any substantive updates to the rule (i.e., change to rule requirements) will be determined based on industry need as supported by the CORE Participants per the CORE Change and Maintenance Process.

Points of Clarification Received for CORE Health Care Claims Data Content Rule

#	Points of Clarification	Co-Chair and Staff Response
	Coordination of Benefits	
1	**Section 3.2.2:** One commenter requested clarification regarding the data flow and use of the 835 in COB Scenarios #1 and #2.	It is an assumption in this rule that providers will use the information contained in the X12 835 sent by the primary health plan to populate and generate the secondary claim submitted to the secondary health plan. If remittance advice is shared in another format other than the X12 835, secondary claims can still be generated consistent with the required CORE Data Content and submitted to the secondary health plan.
2	**Section 3.5:** Three commenters requested the addition of data elements that specify tooth numbers, subscriber names, additional CAS codes, and other information to Table 3 of the Health Care Claim Data Content Rule.	As applicable, CORE Staff will add the requested information to ensure consistency and completeness of the data content specified in this operating rule.
3	**Section 4.2.2:** Three commenters requested clarification regarding the data flow and the use of the 837 in COB Scenarios #1 and #2. Specifically, commenters were concerned because providers do not receive an 837.	Providers do not receive 837s, but they do receive data that originated from 837s in both COB Scenarios #1 and #2. -Scenario #1 - Providers receive data from health plan 835s, and then include that data in subsequent 837s to health plans. Most data elements exist in both the 837 and 835. -Scenario #2 - Providers receive 835s from health plans, where the data elements are communicated between health plans using the 837. Health plans then include that data in their 835s sent back to providers. CORE Staff will add clarifying content in the next draft of the rule.
4	**Section 4.2.2:** One commenter requested clarity on the applicability of COB requirements across hypothetical COB scenarios.	COB requirements are not limited to a specific use case and are meant to standardize data flow between health plans and providers so trading partners can manage COB more effectively. CORE Staff will revise for clarity.

Points of Clarification Received for CORE Health Care Claims Data Content Rule

#	Points of Clarification	Co-Chair and Staff Response
	Matching Information Between Initial and Supplementary	
1	**Section 2.1.3:** One commenter shared that not all Z-codes are SDOH-related and suggested clarifying this point.	Non-substantive edits will be made to the draft operating rule delineating Z55-Z65 as SDOH-related Z-codes.
2	**Section 3.5:** A commenter observed that dental was not included in the table for additional claim submission.	Table 5 does not have an 837D column because the draft rule for matching information between an initial and supplementary claim to submit additional diagnoses for a single encounter does not apply to dental claims. This is due to reasons including the relative lack of penetration of value-based payment models in the dental industry.
3	**Section 4.1.3:** Several commenters requested clarity around the additional claim submission requirements, asking how they differed from current X12 requirements, how they support the intended workflow, when the rule applies in relation to X12 standard requirements, and how they account for atypical scenarios – such as when a provider does not have an NPI.	CORE recognizes that the draft requirements align with current X12 Standard requirements and clarifies that the rule indicates what information must match in currently required fields in the X12 837P and 837I. These data elements and use cases received high support from the VBP and Claims Subgroups. Exceptions to these requirements are footnoted and CORE Staff will review for clarity. Though the rule does not contemplate all scenarios, those that are common are addressed in the rule requirements. Additional implementation guidance will be shared in rule-specific FAQs.
4	**Section 4.3:** One commenter requested clarity on whether all data elements submitted by a provider must be made available by the health plan.	Any additional data elements submitted by the provider that are not outlined in the draft rule are not required to be made available by the health plan. With that said, the draft rule is intended to set a baseline for information exchange and health plans may extract and display additional data at their discretion.

CORE Claim Acknowledgement Data Content Rule

Overall support for the NEW DRAFT CORE Claim Acknowledgment Data Content Rule

#	Section / Subsection	Support
1	Section 1: Background Summary *N=28*	**96%**
2	Section 2: Business Requirement Justification *N=25*	**96%**
3	Section 3: Scope *N=27*	**93%**
4	Section 4: Rule Requirements	**94%**
5	***4.1: Requirements for Health Plans*** *N=24*	**92%**
6	***4.2: General Requirements*** *N=27*	**96%**
7	Section 5: Conformance *N=26*	**96%**

Average support across all sections ~95%

Comments Received for CORE Claim Acknowledgment Data Content Rule

#	Substantive Comments	Co-Chair and Staff Response
	Requirements for Health Plans	
1	**Section 4.1:** One commenter shared that returning line level and claim level data elements can situationally be redundant.	**Adjust.** CORE Staff will revise the draft rule language for clarity as returning redundant rejection messages is not intended; however, all distinct and unique errors should be returned.

#	Points of Clarification	Co-Chair and Staff Response
	General Comments	
1	Two commenters suggested that industry would benefit from rules for v8030 of the 277CA and CORE should consider aligning requirements with this version.	This draft rule is written to align with the mandated version of the 837 (v5010). As industry use-cases change and new business needs align, the rule can be updated consistent with the CORE Change and Maintenance Process.
2	Two commenters responded suggesting that they do not use the 277CA. Two other commenters stated the opposite, in that they do support the transaction, but were concerned with the burden of implementation to meet the draft requirements.	This draft rule does not mandate use of the 277CA and, as such, applies only to those who support the transaction. For those who do use the transaction, the draft rule supports greater standardization and utility across the industry. Implementation burdens are a consideration and CORE Participants will have the opportunity to provide insight of the value of implementation relative to the resources required during the RWG Ballot. **NOTE**: The CAQH CORE Health Care Claim (837) Infrastructure Rule Version HC.2.0 requires the use of the 277CA for those entities that receive 837 transactions.
3	Two commenters stated that the 277CA requires standardization, but a mandate is the only reliable way to drive adoption and improvement. This applies to establishing a baseline and the accommodation of future updates.	The draft rule requirements provide a foundation for uniform implementation, greater utility and increased adoption. The baseline requirements do not contemplate all uses or scenarios applicable to the 277CA, but new and emerging business needs can be addressed through the CORE Change and Maintenance Process. Note that operating rules have demonstrated an ability to drive adoption of non-mandated transactions, such as the X12 999. CORE Certification will require the use of the 277CA and associated rules.

CORE-required Error Code Combinations for CORE-defined Claim Rejection Business Scenarios Document

Support for Error Code Combinations Document

Support	Do Not Support
80%	20%

N=25

Comments on CORE-required Error Code Combinations for CORE-defined Claim Rejection Business Scenarios

#	Points of Clarification	Co-Chair and Staff Response
1	Two commenters indicated that current business scenarios do not capture all potential code combinations and that there may be a need for additional business scenarios.	The draft CORE-Required Error Code Combinations establish a foundation for the expansion of error reporting using the 277CA. At present, if an implementer encounters a business scenario as outlined by in this document, they must draw from the maximum set of code combinations. Additional business scenarios and their associated code combinations will be maintained through an ongoing process as defined in the rule.
2	One commenter shared that for some of the code combination scenarios, their process is to ingest the claim and return a denial rather than an up front, 277CA rejection.	Different trading partners have different roles within the claim adjudication process and manage errors differently. The CORE-Required Error Code Combinations are intended to relate how an entity has processed the claim at their respective system. Additionally, these business scenarios are specifically related to claim rejection, so if a health plan does not reject the claim, then the 277CA Rejection would not be generated.
3	One commenter suggested aligning the review of the CORE-Required Error Code Combinations for the 277CA with the Code Combinations Task Group, which reviews CARCs and RARCs.	While these X12 code sets are distinct from the CARCs and RARCs, the "Business Scenario" methodology is intentionally similar. CORE plans to manage updates to the CORE-Required Error Code Combinations similarly to the Code Combinations Task Group.

CORE Certification Test Scenarios

Support for Certification Test Scenarios

Support	Do Not Support
88%	12%

N=25

No substantive or point of clarification comments received for CORE Certification Test Scenarios

Summary and Next Steps

#	DRAFT Rule	Avg. Support	Next Steps
1.	CORE Health Care Claims Data Content Rule	**92%**	• Move forward with presented revisions that ensure consistency. • Modify language to clarify rule requirements, where appropriate. • Support construction of Industry FAQ to assist implementation.
2.	CORE Claim Acknowledgment Data Content Rule	**95%**	• Move forward with presented revisions.
3.	CORE-required Error Code Combinations for CORE-defined Claim Rejection Business Scenarios Document	**80%**	• Clarify intent of version 1 of the CORE-required Error Code Combinations relative to future versions of the document.
4.	CORE Certification Test Scenarios	**88%**	• Ensure consistency of test scenarios with any updates presented above.

Draft EFT & ERA Enrollment Data Operating Rules

EFT Enrollment Data Rule

ERA Enrollment Data Rule

EFT & ERA Enrollment Data Rules
Background

The CORE EFT & ERA Enrollment Data Rules remove barriers to provider enrollment in EFT and ERA by addressing variance in required processes and data elements. The rules establishes a maximum set of standard data elements (CORE-required Maximum EFT & ERA Enrollment Data Sets), a clear flow and format for electronic data collection, and a safe harbor.

Development

- Maximum Enrollment Data Sets were developed based on extensive research of online/paper forms and extensive dialogue from a range of health plans, clearinghouses, etc. to support individual provider and group enrollment.

Flexibility

- Rules do not preclude health plans or their agents from:
  - Optimizing capabilities for electronic enrollment methods.
  - Collecting additional data elements beyond the enrollment form.

Maintenance

- Updated draft rules recognize that increased EFT/ERA enrollment may identify future updates and/or modifications to:
  - Meet emerging, new, or changing industry needs.
  - Support business rationale for the addition/removal of data elements, etc.

EFT & ERA Enrollment Data Rules
Maximum Enrollment Data Sets

CORE-required Maximum EFT Enrollment Data Element Groups

- DEG1: Provider Information
- DEG2: Provider Identifiers Information
- DEG3: Provider Contact Information
- DEG4: Provider Agent Information
- DEG5: Federal Agency Information
- DEG6: Retail Pharmacy Information
- DEG7: Financial Institution Information
- DEG8: Submission Information

CORE-required Maximum ERA Enrollment Data Element Groups

- DEG1: Provider Information
- DEG2: Provider Identifiers Information
- DEG3: Provider Contact Information
- DEG4: Provider Agent Information
- DEG5: Federal Agency Information
- DEG6: Retail Pharmacy Information
- DEG7: Electronic Remittance Advice Information
- DEG8: Electronic Remittance Advice Clearinghouse Information
- DEG9: Electronic Remittance Advice Vendor Information
- DEG10: Submission Information

Example Data Set

Individual Data Element Name (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/ Optional for plan to collect)	Data Element Group Number (DEG#)
PROVIDER INFORMATION (Data Element Group 1 is a Required DEG)					
Provider Name		Complete legal name of institution, corporate entity, practice or individual provider	Alphanumeric	Required	DEG1
Provider Address				Optional	DEG1
	Street	The number and street name where a person or organization can be found	Alphanumeric	Required	DEG1
	City	City associated with provider address field	Alphanumeric	Required	DEG1
	State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country	Alpha	Required	DEG1
	ZIP Code/ Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities	Alphanumeric, 15 characters	Required	DEG1
	Country Code	ISO-3166-1 Country Code	Alphanumeric, 2 characters	Optional	DEG1

Opportunities Addressed to Improve EFT & ERA Enrollment

Opportunities for Enhancement

CORE Participants identified opportunities for substantive updates to the EFT & ERA enrollment data rules **to align with current and emerging business needs**.

Solutions from Task Group Discussion

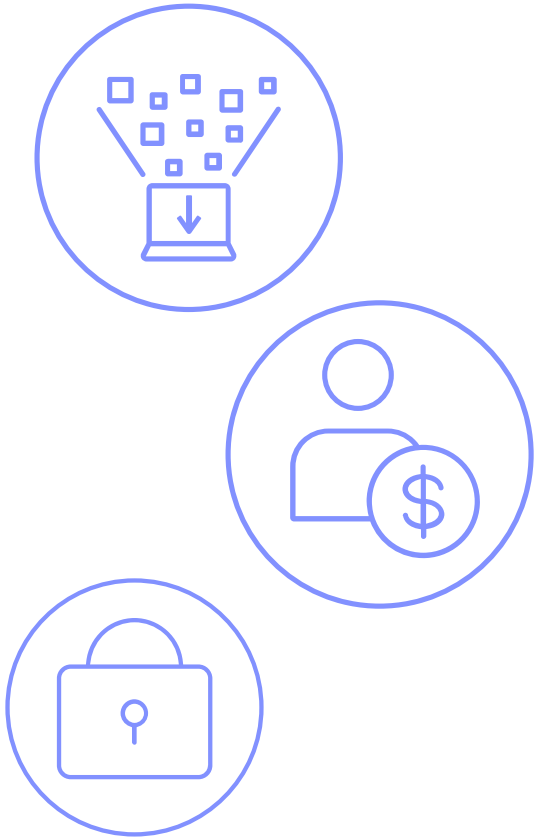
The EFT & ERA Enrollment Data Task Group, launched in August 2023, drafted consensus-based rule updates to **simplify provider enrollment** in EFT & ERA through consistent data requirements. The task group also addressed **security and other business needs** relevant to electronic enrollment.

EFT & ERA Enrollment Data Rule Opportunities

Enhancement to Data Sets 	**Fraud Detection** 
Bulk Enrollment 	**Notification Requirements** 
Fee Disclosures 	**Alternative Payments** 

UPDATED DRAFT EFT & ERA Enrollment Data Rules

The EFT & ERA Enrollment Data Task Group is currently evaluating a set of draft rule updates to improve the accuracy, efficiency, and security of the enrollment process. The proposed rule updates include:



- ✓ Updated **data element groups and data elements** to meet current and emerging business needs.
- ✓ Externalizing the enrollment data sets from the Operating Rules to help **facilitate updates.**
- ✓ New process-oriented measures to **enhance fraud detection.**
- ✓ Language aligned with Nacha's Operating Rules to **minimize the opportunity for fraud** in the ACH Network.
- ✓ Specific requirements to allow for data elements to be repeated to **support bulk enrollment.**
- ✓ **Notification delivery and response time requirements** for health plans to acknowledge that an enrollment, disenrollment, or update was received and successfully processed.
- ✓ Required **disclosure of applicable EFT fees.**

Also under consideration:
Added requirements to opt in/out of alternative electronic payments.

Next Steps

Summary of Operating Rules

Reviewed in RWG Call #1		Reviewed in RWG Call #2		To be Reviewed in RWG Call #3
Benefit Enrollment and Maintenance	**Attributed Patient Roster**	**Health Care Claim**	**Claim Acknowledgement**	**Payment & Remittance**
New Rule: X12 834 (220) Data Content	**Updated:** X12 834 (318) Data Content	**New Rule:** X12 837 (222, 223, 224) Data Content	**New Rule:** X12 277CA (214) Data Content	**Updated:** EFT Enrollment Data
Updated: X12 834 (220) Infrastructure	**Updated:** X12 834 (318) Infrastructure			**Updated:** ERA Enrollment Data
Ready for Ballot	*Ready for Ballot*	*Ready for Ballot*	*Ready for Ballot*	*RWG to review in Straw Poll #3*





Next Steps

Compete Straw Poll #3
November 27th – December 8th
	Objective:
	• Collect each Participating Organization's feedback and level of support for each updated section of the EFT & ERA Enrollment Data Rules and Certification Test Scenarios.
	
	Format:
	• Support for Updated EFT & ERA Enrollment Data Rules – *Section by Section*
	  • Draft CORE Payment & Remittance EFT Enrollment Data Rule
	  ○ CORE-required Maximum EFT Enrollment Data Set Companion Document
	  • Draft CORE Payment & Remittance ERA Enrollment Data Rule
	  ○ CORE-required Maximum EFT Enrollment Data Set Companion Document
	• Support for Updated Payment & Remittance Test Scenarios
	  • UPDATED EFT Enrollment Test Scenarios
	  • UPDATED ERA Enrollment 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 #3 December 14th from 2:00-3:30 pm ET	• RWG participants will review the results of Straw Poll #3 and level-set on Ballot.

Appendix

Today's Call Documents

Document Name
Doc #1 RWG Call 3 Deck 11.16.23
Doc #2 RWG Call 2 Summary 10.19.23

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, Associate Director	mphillips@caqh.org
Kaitlin Powers, Sr. Associate	kpowers@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
Gheisha-Ly Rosario Diaz	Labcorp
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
Wednesday, October 25th – Friday, November 10th	**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 27th – December 8th	**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 – Wednesday, January 10th	**Ballot: VBP, Health Care Claims Data Content, EFT/ERA Enrollment Data Rules & Test Scenarios**

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