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TEFCA Payment and Healthcare Operations Stakeholder Input Webinar

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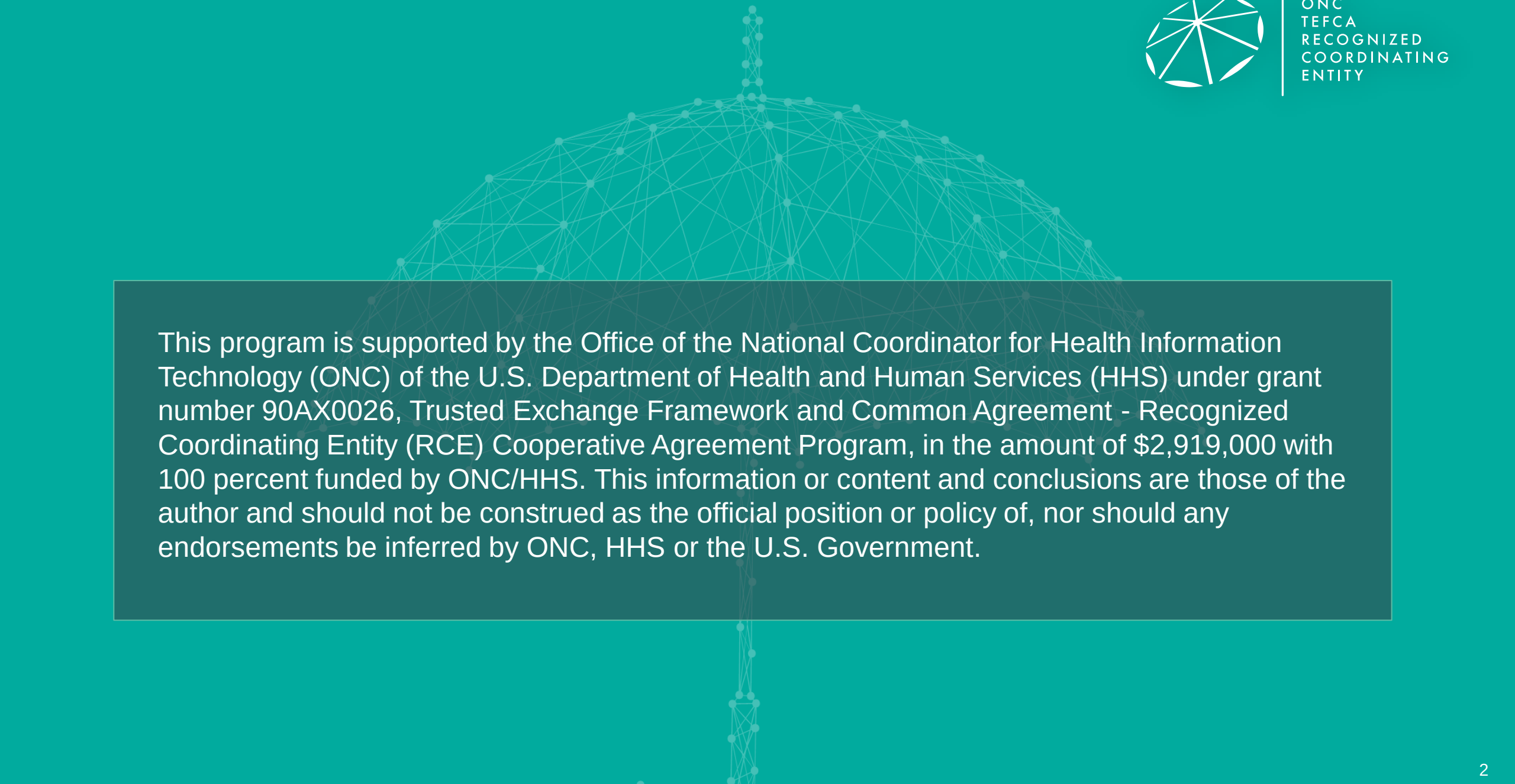

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Anti-Trust Law Compliance

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- Individual participants are affiliated with organizations that could be considered to be competitors
- It is important that this process operate in a way that acknowledges this and takes steps to assure that subgroup discussions do not cross into anti-competitive behavior
- Individual participants shall not discuss their pricing data or strategy, market share information, market strategy, acquisitions or divestitures or similar competitive information
- If an individual participant has questions about whether specific information is permissible to share, please contact the RCE (rce@sequoiaproject.org)

Agenda

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- Charge, approach, and timeline
- Level set and guiding principles
- Use case definition and scope
- SOP outline
- Questions and discussion

Charge and Approach

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Charge

- Collect stakeholder input to inform the first version of the Trusted Exchange Framework and Common Agreement Payment & Health Care Operations Exchange Purpose Implementation SOP.

Deliverable

- Draft Payment & Health Care Operations Exchange Purpose Implementation SOP, version 1

Approach

- Targeted stakeholder input meetings
- Begin by defining an initial sub use-case

Priorities for Use Case Selection

- High benefit to participants
- Strong likelihood of voluntary adoption
- Increase patient access and interoperability
- Reduce provider/payer burden

Timeline

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Activity	Date
Targeted stakeholder input meetings	July-November 2022
Public input webinars	October and November 2022
Draft deliverable to ONC	November 2022
Publish for stakeholder feedback	December 2022
Publish v1 for production	Early 2023

Questions

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- What challenges do you experience with exchange for payment and healthcare operations use cases?
- Have we struck the right balance in our scope of the definition of risk management? For health plans? For providers?
- What is the appropriate scope for data sharing for risk management? For health plans? For providers?
  - Sharing the clinical record?
  - Sharing claims?
- Who determines what is minimally necessary? Does transfer via TEFCA impact this?
- How do you ensure transparency around who is requesting the data?
- What type of guidance is needed from regulators?
- What else should TEFCA consider when designing this SOP?

Level Set On Where the Market and TEFCA Are Today

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- Current market for payment & health care operations
  - » Commercial market for P&HCO data exchange services
  - » Challenges with identifying and collecting the “right” data
    - – Minimum necessary concerns
    - – Challenges with data tagging and segmentation (e.g., for self-pay or sensitive data)
    - – Primary source verification requirements
  - » Trust is hard to build - Divergent perspectives among payers and providers
  - » Value proposition on both sides not always clear
  - » Unintended consequences (e.g., pre-mature denials)
- Current TEFCA environment
  - » TEFCA will initially operate in an IHE environment– eventually move to FHIR
  - » Exchange modalities include Query Solicitation and Message Delivery
  - » TEFCA prohibits fees between QHINs but is silent on other fees
  - » TEFCA participation limited to one QHIN

Guiding Principles — What does good look like?

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- Improve **transparency** of why the data is being requested
- Enable **reciprocity** between participant types- shared value
- Provide the **right information** and nothing more
- Provide **consistent** information
- Be **transport agnostic**
- Support **integration into existing workflows**
- Account for both **EHR and non-EHR technologies**
- Get to **win-win-wins** (patient, provider, payer)
  - » Patient at the center
  - » Reducing payer and provider burden
  - » Value proposition- define beyond cost/efficiency.
- **Contain costs**

Use Case Definition: Risk Management

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- *Disclose risk-based information to support health plans with the cost associated with their members*
- *Disclose health information to appropriate parties to use to identify risk*

Risk Management may include activities related to both payment and healthcare operations, as defined by the Common Agreement. Such activities include, but are not limited to:

- Adequately compensating health plans for the costs associated with members with higher-than-average needs
- Making equitable quality and cost comparisons among health plans and providers
- Set and update spending benchmarks in value-based payment arrangements
- Identifying and targeting future high-cost or high-utilizing individuals
- Directing high-risk individuals towards appropriate treatment options, allocating resources for that treatment, and evaluating outcomes

Balance point

- Need for exchange of the whole medical record for the full scope of payment and healthcare operations in order to best support whole-patient care
- Need to limit the exchange to specific sub-use cases and specific data elements due to patient privacy, compliance, and liability concerns

SOP Outline

- Use Case Definition
- Query Request
  - Guidelines around specifying sub purpose of use?
  - What are the parameters for the date range/timeframe of the request?
  - What identifying information about the requestor and patient should be included?
- Query Response
  - What formats do payers/providers need in a response?
  - What types of information (content) do providers/payers need?
  - Whose responsibility is it to determine what data should be sent?
  - Optionality

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- Who determines what is minimally necessary? Does transfer via TEFCA impact this?
- How do you ensure transparency around who is requesting the data?
- What type of guidance is needed from regulators?
- What else should TEFCA consider when designing this SOP?
- What resources should we reference?

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Appendix

Common Agreement Definitions

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- **Health Care Operations:** has the meaning assigned to such term at 45 CFR § 164.501, except that this term shall apply to the applicable activities of a Health Care Provider regardless of whether the Health Care Provider is a Covered Entity.

- **Health Care Provider:** has the meaning assigned to such term in the information blocking regulations at 45 CFR § 171.102 or in the HIPAA Rules at 45 CFR § 160.103.
  - The term ‘‘health care provider’’ includes a hospital, skilled nursing facility, nursing facility, home health entity or other long term care facility, health care clinic, community mental health center (as defined in section 300x–2(b)(1) of this title), renal dialysis facility, blood center, ambulatory surgical center described in section 1395l(i) of this title, emergency medical services provider, Federally qualified health center, group practice, a pharmacist, a pharmacy, a laboratory, a physician (as defined in section 1395x(r) of this title), a practitioner (as described in section 1395u(b)(18)(C) of this title), a provider operated by, or under contract with, the Indian Health Service or by an Indian tribe (as defined in the Indian Self-Determination and Education Assistance Act [25 U.S.C. 5301 et seq.]), tribal organization, or urban Indian organization (as defined in section 1603 of title 25), a rural health clinic, a covered entity under section 256b of this title, an ambulatory surgical center described in section 1395l(i) of this title,1 a therapist (as defined in section 1395w–4(k)(3)(B)(iii) of this title), and any other category of health care facility, entity, practitioner, or clinician determined appropriate by the Secretary.

- **Health Plan:** Health plan means an individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)).

- **Payment:** has the meaning assigned to such term at 45 CFR § 164.501.

HIPAA Definitions

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“Payment”

Payment encompasses the various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain premiums, to fulfill their coverage responsibilities and provide benefits under the plan, and to obtain or provide reimbursement for the provision of health care. The Privacy Rule includes some examples, but is not limited:

- Determining eligibility or coverage under a plan and adjudicating claims
- Risk adjustments based on enrollee health status and demographic characteristics
- Billing and collection activities and related health care data processing
- Reviewing health care services for medical necessity
- Utilization review activities
- Disclosures to consumer reporting agencies of limited information

“Health Care Operations”

Health Care Operations (“HCO”) are certain administrative, financial, legal, and quality improvement activities of a covered entity that are necessary to run its business and to support the core functions of treatment and payment. They are limited to an enumerated list:

- Conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, and case management and care coordination
- Reviewing competence or qualifications of professionals
- Underwriting and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to health care claims
- Medical review, legal, and auditing services
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies
- Business management and general administrative activities

HIPAA Uses and Disclosures

A covered entity may, without the individual's authorization:

- Use or disclose PHI for its own treatment, payment, and health care operations activities.
- A covered entity may disclose PHI for the treatment activities of any health care provider.
- A covered entity may disclose PHI to another covered entity or a health care provider for the payment activities of the entity that receives the information.
- A covered entity may disclose PHI to another covered entity for certain health care operations activities of the entity that receives the information IF:
  - Each entity either has or had a relationship with the individual; AND
  - The information pertains to their relationship; AND
  - The disclosure is for conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, case management, care coordination, reviewing competence or qualifications of professionals or fraud and abuse detection or compliance

Minimum Necessary Standard

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- A covered entity must develop policies and procedures that reasonably limit its disclosures of, and request for, PHI for payment and HCO to the minimum necessary.
- The rule requires covered entities to make their own assessment of what protected health information is reasonably necessary for a particular purpose. To reiterate, this is a *reasonableness* standard, and the absolute minimum is not a requirement.
- For non-routine requests and disclosures, the Privacy Rule requires that criteria be developed for purposes of applying the minimum necessary standard on an individual basis to each request or disclosure. For requests for PHI by another covered entity, the disclosing covered entity may rely, if reasonable under the circumstances, on the requested disclosure as the minimum necessary.
- For routine requests, the application of the minimum necessary standard can be automated through the use of standard protocols, business rules, and standardization of data.
- If a covered entity does not agree that the amount of information requested by another covered entity is reasonably necessary for the purpose, it is up to both covered entities to negotiate a resolution of the dispute as to the amount of information needed.
- Nothing in the Privacy Rule prevents a covered entity from discussing its concerns with another covered entity making a request and negotiating an information exchange that meets the needs of both parties.