ONC TEFCA RECOGNIZED COORDINATING ENTITY

DRAFT Standard Operating Procedure (SOP): Payment: Risk Adjustment Exchange Purpose Implementation

Applicability: QHINs, Participants, and Subparticipants

1. Definitions

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 Plan: has the meaning assigned to such term at 45 CFR § 160.103

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

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

Payor[1]: Public or private party which offers and/or administers health insurance plan(s) or coverage and/or pays claims directly or indirectly. Examples include Insurance company, Health Maintenance Organization, Medicare, Third-Party Administrator, and Repricer.

Capitalized terms used below without definitions shall have the respective meanings assigned to such terms in the Common Agreement and the QHIN Technical Framework.

2. Purpose

This SOP defines the Exchange Purpose of Payment: Risk Adjustment (Risk Adjustment) and identifies specific requirements that QHINs, Participants, and Subparticipants must follow when exchanging information for Risk Adjustment. It also specifies the conditions under which the Exchange Purpose would require a Response.

Risk Adjustment is generally understood to be the statistical processes that take into account the underlying health status and health spending of the individuals in an insurance plan when looking at their health care outcomes or health care costs. Risk adjustment levels the playing field so that health plans are appropriately compensated for taking on high risk patients, which increases access to healthcare for all individuals. This SOP provides specifications for exchanging TEFCA Information (TI) to support the risk adjustment process.

[1] Definition of Payor from HL7: https://confluence.hl7.org/pages/viewpage.action?pageId=80119875

3. FHIR Roadmap

This SOP is limited to the QHIN exchange modalities defined in the QHIN Technical Framework (QTF) [2] . The Recognized Coordinating Entity (RCE) recognizes that HL7 Fast Healthcare Interoperability Resources (FHIR) can allow for more dynamic exchange that makes it easier for entities to share data. The RCE intends to update the Common Agreement and QTF and publish the Facilitated FHIR Implementation Guide to enable FHIR-based exchange in alignment with the published FHIR Roadmap[3] for TEFCA exchange. The RCE will update this SOP in accordance with those specifications and align the updates with the API requirements in the Centers for Medicare and Medicaid Services (CMS) Advancing Interoperability and Improving Prior Authorization Processes Final Rule, which, as of March 2023, is a proposed rule.[4] Additionally, the RCE intends to require a Response to this Exchange Purpose in coordination with the updates to incorporate FHIR.

4. Risk Adjustment Definition

Risk Adjustment means the following:

- Risk adjusting amounts due based on individual and/or enrollee health status and demographic characteristics.[5]

5. Permitted Actors

Only Health Plans and Health Care Providers may request TEFCA Information for the purpose of Risk Adjustment.

QHINs, Participants, and Subparticipants MUST use the code RISKADJ[6] when initiating a QHIN Query or QHIN Message Delivery for Risk Adjustment.

[2] https://rce.sequoiaproject.org/tefca-and-rce-resources/
[3] https://rce.sequoiaproject.org/tefca-and-rce-resources/
[4] https://www.federalregister.gov/documents/2022/12/13/2022-26479/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability
[5] As modified from 45 CFR 164.501 Payment definition section (2)(ii).
Citation: 45 CFR 164.501 (*Payment),* (2)(ii).
[6] This code is an addition to the six Purpose of Use values listed in the QHIN Technical Framework.

6. PROCEDURE

6.1 QHIN Query Request

a) Date Range. Requestors MUST specify the date range for the requested data.

b) Requestor Identifying Information

i. If the Request is originating from a Health Care Provider, it MUST include:

1. the Health Care Provider's individual or organizational NPI and/or TIN, as applicable; and
2. the Health Care Provider organization's RCE Directory HomeCommunity.ID.

ii. If the Request is originating from a Health Plan, it MUST include:

1. the Health Plan's NAIC Code, if available;
2. the RCE Directory Home Community ID of the Payor that the Health Plan is a part of; and
3. the Directory Resource ID of the Health Plan, if different from (2).

c) Patient Identifying Information

i. QHINs, Participants and Subparticipants MUST include the patient demographics, as specified in the QHIN Technical Framework (QTF), when initiating a Request.

ii. If the request originates from a Health Plan, it MUST include the individual's Member ID and/or Subscriber ID, or equivalent,[7] if available, as additional patient identifiers in the Request.

6.2 QHIN Query Response

a) All QHINs, Participants, and Subparticipants SHOULD Respond to Requests for Risk Adjustment that contain the information specified in 6.1 of this document, in accordance with the Common Agreement and Applicable Law.

b) If a Health Care Provider Responds to a Request for Risk Adjustment, then it MUST Respond with all Required Information that is maintained by the Health Care Provider, including but not limited to:

[7] See the Health Insurance Information data class in USCDI v3 https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi#uscdi-v3

i. The following data classes identified in the USCDI v2[8]

1. Allergies and Intolerances
2. Assessment and Plan of Treatment
3. Clinical Notes
4. Clinical Tests
5. Diagnostic Imaging Results
6. Encounter Information
7. Health Concerns
8. Laboratory
9. Medications
10. Patient Demographics/Information
11. Problems
12. Procedures
13. Provenance
14. Smoking Status
15. Vital Signs

ii. The Health Care Provider's Legal Authenticator

iii. The Health Status/Assessments data class, as identified in USCDI v3. Notwithstanding the foregoing, Disability Status MAY be shared.[9]

c) If a Heath Plan Responds to a Request for Risk Adjustment, then it MUST Respond with all Required Information that is maintained by the Health Plan, including but not limited to:

i. The data classes from Sections 6. 2(b)(i) and 6.2(b)(iii) in this document

ii. Adjudicated claims (not including provider remittances and enrollee cost sharing)

d) For any Social Determinants of Health (SDOH) data elements, Query Responder MUST include the SDOH Z CD-10-CM SDOH encounter reason codes ("Z-Codes"), if available.

6.3 RCE Directory Service

a) A Payor that is a QHIN, Participant, or Subparticipant listed in the RCE Directory Service MUST publish all of its participating Health Plans to the RCE Directory Service in order to identify the source of a Request as required in Section 6.1(b)(ii) of this document.

[8] https://www.healthit.gov/isa/sites/isa/files/2021-07/USCDI-Version-2-July-2021-Final.pdf
[9] https://www.healthit.gov/isa/sites/isa/files/2022-07/USCDI-Version-3-July-2022-Final.pdf