ONC TEFCA RECOGNIZED COORDINATING ENTITY

Exchange Purpose (XP) Implementation SOP: Health Care Operations SubXP-1

Version 1.0

DRAFT for Stakeholder Feedback

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Applicability: QHINs, Participants, and Subparticipants

1. Common Agreement References

The requirements set forth in this Standard Operating Procedure (SOP) are required for implementation in addition to the terms and conditions found in the applicable Framework Agreement, the Qualified Health Information Network™ (QHIN™) Technical Framework (QTF), and applicable SOPs, including the Exchange Purposes (XPs) SOP. The Trusted Exchange Framework and Common Agreement℠ (TEFCA℠) Cross Reference Resource identifies which SOPs provide additional detail on specific references from the Common Agreement.

All documents cited in this SOP can be found on the Recognized Coordinating Entity® (RCE™) website.

2. SOP Definitions

Terms defined in this section are introduced herein and can be found in the TEFCA Glossary. Capitalized terms used in this SOP without definition shall have the respective meanings assigned to such term in the TEFCA Glossary.

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

Health Plan Parent: the QHIN, Participant, or Subparticipant of which the Health Plan(s) is a part.

Health Care Operations (HCO) SubXP-1: means transactions for any of the following activities, under TEFCA Exchange, to the extent permitted by Applicable Law and the Common Agreement:

> Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities (as defined in 42 CFR 3.20); population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment.[1]

[1] This language mirrors that in 45 CFR 164.501 Health Care Operations definition section (1).

3. PURPOSE

This SOP defines the Health Care Operations (HCO) SubXP-1, which is a subset of Health Care Operations, as defined in the Exchange Purposes (XPs) SOP. In addition to the Common Agreement, QTF, and applicable SOPs, this SOP identifies specific requirements that QHINs, Participants, and Subparticipants must follow when asserting HCO SubXP-1 for TEFCA Exchange. Nothing in this SOP modifies the terms and conditions related to Health Care Operations, as enumerated in the Exchange Purposes (XPs) SOP.

Use and Disclosure of health information for Health Care Operations is an important tool for health care providers, health plans, and other healthcare stakeholders to support the core functions of their business and efficiently and effectively care for the individuals they serve. Use cases under this Exchange Purpose (XP) Implementation SOP, including quality assessment and improvement and care management, allow stakeholders to enhance quality of treatment, reduce healthcare spending, and improve health outcomes, while still protecting the privacy of individuals.

4. PROCEDURE

Permitted users for purposes of this SOP include QHINs, Participants, and Subparticipants that are authorized by Applicable Law and the Common Agreement to assert the HCO SubXP-1, as further specified below.

4.1 Exchange Purpose Code (XP Code)

a) All TEFCA Exchange under HCO SubXP-1 MUST use the XP Code T-HCO1. For HCO purposes that are not covered by this or a subsequent XP Implementation SOP, TEFCA Exchange MUST use the more general T-HCO code, as defined in the Exchange Purposes (XPs) SOP.

4.2 QHIN Technical Framework (QTF)

a) All TEFCA Exchange under HCO SubXP-1 MUST follow technical requirements as specified in the QTF.

4.3 QHIN Message Delivery

This SOP supports TEFCA Exchange in the form of a Message Delivery from any Initiating Node to any Responding Node that is listed in the RCE Directory Service as capable of receiving Message

Deliveries, in accordance with Applicable Law. Further requirements for initiating a Message Delivery are in the QTF.

4.4 QHIN Query

This SOP supports TEFCA Exchange in the form of a QHIN Query. Only Initiating Nodes of Health Plans and Health Care Providers that are Covered Entities or their Delegates may Request Required Information under HCO SubXP-1, in accordance with Applicable Law.

4.4.1 QHIN Query Request

a) 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:
      a. the Health Care Provider's individual or organizational National Provider Identifier (NPI) and/or Tax Identification Number (TIN), as applicable; and
         1. The NPI Attribute MUST be encoded in the SAML attributes with a FriendlyName of NPI and MUST be NameFormat urn:oasis:names:tc:xspa:2.0:subject:npi.
         2. The TIN attribute MUST be encoded in the SAML attributes with a FriendlyName of TIN and MUST be NameFormat urn:nhin:names:saml:tin.
   (ii) If the Request is originating from a Health Plan, it MUST include:
      a. the Health Plan's National Association of Insurance Commissioners (NAIC) Code, if available;
         1. the NAIC code MUST be encoded in the SAML attributes with a FriendlyName of NAIC and MUST be NameFormat .urn:nhin:names:saml:naic.
      b. the RCE Directory Organization.ID of the Health Plan or of the Health Plan Parent.
         1. This <Attribute> element shall have the Name attribute set to urn:oasis:names:tc:xspa:1.0:subject:organization-id with FriendlyName set to FHIRInitiating. The value shall be the Resource ID of the Organization entry in the RCE Directory for the entity that is initiating the Request.

c) Patient Identifying Information
   (i) Requestors MUST include the Individual's Member ID and/or Subscriber ID,[2] if known, as additional patient identifiers in the Request.

4.4.2 QHIN Query Response

a) All Responding Nodes SHOULD respond to QHIN Query Requests for HCO SubXP-1 that contain the information specified in this SOP, in accordance with the Common Agreement and Applicable Law.

b) If a Responding Node responds to a Request for HCO SubXP-1, then it MUST respond with all Required Information that it maintains, that are within the parameters of the Request, in accordance with Applicable Law, including, but not limited to:
   (i) The data classes and data elements, as identified in USCDI v1[3]
   (ii) Adjudicated claims

c) For any Social Determinants of Health (SDOH) data elements, Responding Node MUST include the SDOH Z ICD-10-CM SDOH encounter reason codes ("Z-Codes"), if available, in addition to any other codes, as appropriate.

4.5 Facilitated FHIR

This SOP supports TEFCA Exchange in the form of Facilitated FHIR between Nodes with FHIR Endpoints published in the RCE Directory Service. FHIR refers to the Health Level Seven (HL7®) Fast Healthcare Interoperability Resources® (FHIR) standard.

FHIR Push. Any Initiating Node may push to any other Responding Node, in accordance with Applicable Law.

FHIR Query. Only Initiating Nodes of Health Plans and Health Care Providers that are Covered Entities and their Delegates may Request Required Information for HCO SubXP-1, in accordance with Applicable Law.

[2] See the Health Insurance Information data class in USCDI v3 available at https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi#uscdi-v3.
[3] Data classes and data elements available at https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi#uscdi-v1.

4.5.1 Facilitated FHIR Query

a) If the Request is originating from a Health Care Provider, it MUST include, as part of the United Data Access Profiles (UDAP) authorization and authentication flow in the FHIR Security IG[4] OAuth hl7-b2b extension:
   (i) the Health Care Provider's individual or organizational NPI and/or TIN, as applicable, appended to the Human readable name within organization_name; and
   (ii) the ResourceID of the Organization entry in the RCE Directory of the Health Care Provider as organization_id.

b) If the Request is originating from a Health Plan, it MUST include:
   (i) the Health Plan's NAIC Code, if available, appended to the Human readable name within organization_name.
      a. If no NAIC is available, 000000 MUST be appended.
   (ii) the ResourceID of the Organization entry in the RCE Directory of the Health Plan or of the Health Plan Parent, as organization_id.

c) The Individual's Member ID and/or Subscriber ID, if known, as additional patient identifiers in the Request Patient resource. The member ID/subscriber ID Patient.identifier code MUST be of system http://hl7.org/fhir/us/davinci-hrex/CodeSystem/hrex-temp and code umb.

4.5.2 Facilitated FHIR Response

a) All Responding Nodes with a FHIR Endpoint in the RCE Directory Service MUST use that FHIR Endpoint to Respond to Facilitated FHIR Queries for HCO SubXP-1 that contain the information in Section 4.5.1 of this SOP.

b) All Responding Nodes with a FHIR Endpoint in the RCE Directory Service MUST Respond with all Required Information it maintains that are within the parameters of the Request, in accordance with Applicable Law, including but not limited to:
   (i) The data classes and data elements, as identified in USCDI v1[5]
   (ii) Adjudicated claims

c) Responses containing adjudicated claims data SHOULD abide by the requirements in the following implementation guides:
   (i) CARIN for Blue Button IG Version 2.0.0[6]

[4] Implementation Guide available at https://hl7.org/fhir/us/udap-security/.
[5] Data classes and data elements available at https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi#uscdi-v1.
[6] Implementation Guide available at https://hl7.org/fhir/us/carin-bb/.

(ii) HL7 Da Vinci Payer Data Exchange FHIR Implementation Guide Version 1.0.0[7]
(iii) HL7 Da Vinci Payer Data Exchange FHIR U.S. Drug Formulary Implementation Guide Version 2.0.0[8]

4.6 RCE Directory Service

a) A Health Plan Parent listed in the RCE Directory Service MUST publish all of its participating Health Plans to the RCE Directory in order to identify the source of a Request as required in Section 4.4.1 and Section 4.5.1 of this SOP.

[7] Implementation Guide available at https://hl7.org/fhir/us/davinci-pdex/index.html.
[8] Implementation Guide available at https://hl7.org/fhir/us/davinci-drug-formulary/.