ONC TEFCA RECOGNIZED COORDINATING ENTITY

Standard Operating Procedure (SOP): Exchange Purpose (XP) Implementation: Health Care Operations

Version 1.0

August 6, 2024

Applicability: QHINs, Participants, Subparticipants

1 COMMON AGREEMENT REFERENCES

The requirements set forth in this Standard Operating Procedure (SOP) are for implementation, in addition to the terms and conditions found in the Framework Agreements, the Qualified Health Information Network™ (QHIN™) Technical Framework (QTF), and applicable SOPs. 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 here and can be found in the TEFCA Glossary. Capitalized terms used in this SOP have the respective meanings assigned to such term in the TEFCA Glossary.

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

Health Care Operations (HCO) Care Coordination/Case Management (HCO-CC): means TEFCA Exchange for the purposes of determining how to deliver care for a particular patient by performing one or more actions in order to organize the provision and case management of an Individual's health care, including monitoring an Individual's goals, needs, and preferences; acting as the communication link between two or more parties (e.g., providers and/or case management companies) concerned with an Individual's health and wellness; organizing and facilitating care activities and promoting self-management by advocating for, empowering, informing, and educating a patient; and ensuring safe, appropriate, nonduplicative, and effective integrated care.

HCO HEDIS Reporting (HCO-HED): means TEFCA Exchange for the purposes of data collection to support the Healthcare Effectiveness Data and Information Set (HEDIS) as required by the National Committee for Quality Assurance (NCQA).

HCO Quality Measure Reporting (HCO-QM): means TEFCA Exchange for the purposes of data collection to support quality measure reporting.

The following defined terms from the Common Agreement are repeated here for reference.

Delegate: A First Tier Delegate or Downstream Delegate.

Downstream Delegate: a QHIN, Participant, or Subparticipant that (i) is not acting as a Principal when initiating or Responding to a transaction via TEFCA Exchange and (ii) has a direct written agreement with a First Tier Delegate or another Downstream Delegate authorizing the respective Downstream Delegate to initiate or Respond to transactions via TEFCA Exchange for or on behalf of a Principal.

First Tier Delegate: a QHIN, Participant, or Subparticipant that (i) is not acting as a Principal when initiating or Responding to a transaction via TEFCA Exchange and (ii) has a direct written agreement with a Principal authorizing the First Tier Delegate to initiate or Respond to transactions via TEFCA Exchange for or on behalf of the Principal. For purposes of this definition, a "written agreement" shall be deemed to include a documented grant of authority from a government agency.

Health Care Operations (HCO): 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: meets the definition of such term in either 45 CFR § 171.102 or in the HIPAA Rules at 45 CFR § 160.103.

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

Principal: a QHIN, Participant, or Subparticipant that is acting as a Covered Entity, Government Health Care Entity, Non-HIPAA Entity (NHE) Health Care Provider, a Public Health Authority, a government agency that makes a Government Benefits Determination, or an Individual Access Services (IAS) Provider (as authorized by an Individual) when engaging in TEFCA Exchange.

XP Code: the code used to identify the XP in any given transaction, as set forth in the applicable SOP(s).

3 PURPOSE

In addition to the Framework Agreements, QTF, and applicable SOPs, this SOP identifies implementation specifications QHINs, Participants, and Subparticipants must follow when asserting the Health Care Operations (HCO) Exchange Purpose, including Level 2 use cases of Care Coordination/Case Management, Quality Reporting, and HEDIS Reporting. 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 health care 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.

The initial requirements in this SOP specify that Responding Nodes SHOULD Respond to Queries for each of the HCO Level 1 and Level 2 XP Codes. However, eighteen (18) months following the initial publication date of this SOP, Responding Nodes MUST Respond to Queries for all HCO Level 2 XP Codes specified in this SOP. This transition period supports TEFCA's goal of bolstering exchange for all Exchange Purposes in an iterative and predictable way that encourages broad participation, trust, and reciprocity.

4 Level 1: Health Care Operations (HCO)

Permitted users for purposes of this SOP include QHINs, Participants, and Subparticipants that are authorized by Applicable Law and the Framework Agreements to assert the HCO Exchange Purposes, as further specified below.

4.1 Exchange Purpose Code (XP Code)

a) All TEFCA Exchange under HCO MUST use the XP Code T-HCO.

4.2 QHIN Technical Framework (QTF)

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

4.3 Definition

a. TEFCA Exchange under the XP Code T-HCO 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.

4.4 TEFCA TRANSACTIONS

4.4.1 QHIN Message Delivery

a. 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.

4.4.2 QHIN Query

a. 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 initiate Queries under the XP Code T-HCO, in accordance with Applicable Law.

4.4.2.1 QHIN Query Request

a. Queriers MUST specify the date range for the requested data.

b. Querier Identifying Information

(i) If the Query is originating from a Health Care Provider or its Delegate, 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 and MUST be Name urn:oasis:names:tc:xspa:2.0:subject:npi.

2. The TIN attribute MUST be encoded in the SAML attributes and MUST be Name urn:nhin:names:saml:tin.

(ii) If the Query is originating from a Health Plan or its Delegate, it MUST include:

a. The Health Plan's National Association of Insurance Commissioners (NAIC) Code, if available; and

1. The NAIC code MUST be encoded in the SAML attributes and MUST be Name urn:nhin:names:saml:naic.

c. Patient Identifying Information

(i) Requestors MUST include the Individual's Member Identification (ID) and/or Subscriber ID,[1] if known, as additional patient identifiers in the Query.

[1] 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.

4.4.2.2 QHIN Query Response

a. All Responding Nodes SHOULD Respond to QHIN Queries for the T-HCO XP Code that contain the information specified in this SOP, in accordance with the Common Agreement and Applicable Law.

b. A Responding Node Responding to the XP Code T-HCO SHOULD return, at a minimum, the USCDI v1 data classes[2] and adjudicated claims data that are maintained and requested, in accordance with Applicable Law. Additional implementation specifications are in the QTF.

c. For any Social Determinants of Health (SDOH) data elements, Responding Nodes SHOULD include the SDOH related ICD-10-CM encounter reason codes (i.e., Z-codes), if available, in addition to any other codes, as appropriate.

4.4.3 FHIR

This SOP supports TEFCA Exchange in the form of 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.

4.4.3.1 FHIR Push

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

4.4.3.2 FHIR Query

a. Only Initiating Nodes of Health Plans and Health Care Providers that are Covered Entities and their Delegates may initiate FHIR Queries for T-HCO, in accordance with Applicable Law.

b. Queriers MUST specify the date range for the requested data.

c. If the Query is originating from a Health Care Provider, it MUST include, as part of the Authorization and Authentication flows in the FHIR Security IG[3] OAuth hl7-b2b extension:

(i) The Health Care Provider's individual or organizational NPI and/or TIN, as applicable, must be appended to the hl7-b2b extension as an additional element named "provider_identifier" as a value array.

For example:

{
"tin":"o2i9uy540917345",
"npi":"9949202959"

[2] United States Core Data for Interoperability (USCDI) | Interoperability Standards Platform (ISP) (healthit.gov)
[3] Implementation Guide available at https://hl7.org/fhir/us/udap-security/.

}

d. If the Query is originating from a Health Plan, it MUST include:

(i) The Health Plan's NAIC Code, if available, must be appended to the hl7-b2b extension as an additional element named "naic_identifier".

a. If no NAIC is available, 00000 MUST be included.

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

4.4.3.3 FHIR Response

a. All Responding Nodes SHOULD respond to FHIR Queries for the T-HCO XP Code that contain the information specified in Section 4.4.3.2 of this SOP, in accordance with the Common Agreement and Applicable Law.

b. If a Responding Node with a FHIR Endpoint in the RCE Directory Service Responds to a FHIR Query for T-HCO it MUST use that FHIR Endpoint to Respond.

c. A Responding Node Responding to the XP Code T-HCO SHOULD return, at a minimum, the USCDI v1 data classes and adjudicated claims data that are maintained and requested, in accordance with Applicable Law. Additional implementation specifications are in the Facilitated FHIR Implementation SOP.

(i) Responses containing adjudicated claims data SHOULD abide by the requirements in the following implementation guides:

a. CARIN for Blue Button Implementation Guide (IG) Version 2.0.0;[4]

b. HL7 Da Vinci Payer Data Exchange FHIR Implementation Guide Version 1.0.0;[5]

c. HL7 Da Vinci Payer Data Exchange FHIR U.S. Drug Formulary Implementation Guide Version 2.0.0;[6] and

d. HL7 Da Vinci Clinical Data Exchange FHIR Implementation Guide Version 2.0.0

e. For any Social Determinants of Health (SDOH) data elements, Responding Nodes SHOULD include the SDOH related ICD-10-CM encounter reason codes (i.e., Z-Codes), if available, in addition to any other codes, as appropriate.

[4] Implementation Guide available at https://hl7.org/fhir/us/carin-bb/.
[5] Implementation Guide available at https://hl7.org/fhir/us/davinci-pdex/index.html.
[6] Implementation Guide available at https://hl7.org/fhir/us/davinci-drug-formulary/.

4.5 RCE Directory Service

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

5 Level 2: Health Care Operations (HCO) Care Coordination/Case Management

5.1 Exchange Purpose Code (XP Code)

a. All TEFCA Exchange under HCO Care Coordination/Case Management MUST use the XP Code T-HCO-CC.

5.2 QHIN Technical Framework (QTF)

a. See requirement in Section 4.2 of this SOP

5.3 Definition

a. HCO Care Coordination/Case Management (HCO-CC) means TEFCA Exchange for the purposes of determining how to deliver care for a particular patient by performing one or more actions in order to organize the provision and case management of an Individual's healthcare, including: monitoring an Individual's goals, needs, and preferences; acting as the communication link between two or more parties (e.g. providers and/or case management companies) concerned with an Individual's health and wellness; organizing and facilitating care activities and promoting self-management by advocating for, empowering, informing, and educating a patient; and ensuring safe, appropriate, nonduplicative, and effective integrated care.

5.4 TEFCA Transactions

5.4.1 QHIN Message Delivery

a. See requirements under Section 4.4.1 of this SOP.

5.4.2 QHIN Query

a. Only Health Plans are permitted to initiate QHIN Queries using the XP Code T-HCO-CC.

5.4.2.1 QHIN Query Request

a. See requirements in Sections 4.4.2.1(a), 4.4.2.1(b)(ii), and 4.4.2.1(c).

5.4.2.2 QHIN Query Response

a. Beginning eighteen (18) months following the initial publication date of this SOP, all Responding Nodes MUST Respond to QHIN Queries for the T-HCO-CC XP Code that contain the information specified in this SOP, in accordance with the Common Agreement and Applicable Law. Prior to that date, Responding Nodes SHOULD Respond.

b. See requirements Sections 4.4.2.2(b) and 4.4.2.2(c) of this SOP.

5.4.3 FHIR

5.4.3.1 FHIR Push

a. See requirements 4.4.3.1 as applied to the XP Code T-HCO-CC.

5.4.3.2 FHIR Query

a. Only Health Plans are permitted to initiate FHIR Queries using the XP Code T-HCO-CC.

b. See requirements in Section 4.4.3.2(b), Section 4.4.3.2(d), and Section 4.4.3.2(e) of this SOP.

5.4.3.3 FHIR Response

a. Beginning eighteen (18) months following the initial publication date of this SOP, all Responding Nodes MUST Respond to FHIR Queries for the T-HCO-CC XP Code that contain the information specified in this SOP, in accordance with the Common Agreement and Applicable Law. Prior to that date, Responding Nodes SHOULD Respond.

b. See requirements in Sections 4.4.3.3(b), 4.4.3.3(c), and 4.4.3.3(d) of this SOP.

5.5 RCE Directory Service

a. See requirements in Section 4.5 of this SOP.

6 Level 2: Health Care Operations (HCO) HEDIS Reporting

6.1 Exchange Purpose Code (XP Code)

a. All TEFCA Exchange under HCO HEDIS Reporting MUST use the XP Code T-HCO-HED.

6.2 QHIN Technical Framework (QTF)

a. See requirement in Section 4.2 of this SOP.

6.3 Definition

a. HCO HEDIS Reporting (HCO-HED) means TEFCA Exchange for the purposes of data collection to support the Healthcare Effectiveness Data and Information Set (HEDIS) as required by the National Committee for Quality Assurance (NCQA).

6.4 TEFCA Transactions

6.4.1 QHIN Message Delivery

a. See requirements in 4.4.1 of this SOP.

6.4.2 QHIN Query

a. See requirements in Section 4.4.2 of this SOP as applied to the XP Code T-HCO-HED.

6.4.2.1 QHIN Query Request

a. See requirements in Section 4.4.2.1 of this SOP as applied to the XP Code T-HCO-HED.

6.4.2.2 QHIN Query Response

a. Beginning eighteen (18) months following the initial publication date of this SOP, all Responding Nodes MUST Respond to QHIN Queries for the T-HCO-HED XP Code that contain the information specified in this SOP, in accordance with the Common Agreement and Applicable Law. Prior to that date, Responding Nodes SHOULD Respond.

b. If a Responding Node responds to a Query for T-HCO-HED, then it SHOULD Respond with the data specified by National Committee for Quality Assurance (NCQA).[6]

6.4.3 FHIR

6.4.3.1 FHIR Push

a. See requirements in 4.4.3.1 of this SOP.

6.4.3.2 FHIR Query

a. See requirements in Section 4.4.3.2 of this SOP.

6.4.3.3 FHIR Response

a. Beginning eighteen (18) months following the initial publication date of this SOP, all Responding Nodes MUST Respond to QHIN Queries for the T-HCO-HED XP Code that contain the information specified in this SOP, in accordance with the Common Agreement and Applicable Law. Prior to that date, Responding Nodes SHOULD Respond.

b. If a Responding Node Responds to a Query for T-HCO-HED, then it SHOULD respond using the appropriate, corresponding content standards indicated in the Data Exchange for Quality Measures Implementation Guide 4.0.0 - STU4.[7]

c. See Requirements in Section 4.4.3.3(b).

6.5 RCE Directory Service

a. See requirements in Section 4.5 of this SOP as applied to the XP Code T-HCO-HED.

7 Level 2: Health Care Operations (HCO) Quality Measure Reporting

7.1 Exchange Purpose Code (XP Code)

a. All TEFCA Exchange under HCO Quality Reporting other than HEDIS MUST use the XP Code T-HCO-QM.

7.2 QHIN Technical Framework (QTF)

a. See requirement in Section 4.2 of this SOP

7.3 Definition

a. HCO Quality Measure Reporting (HCO-QM) means TEFCA Exchange for the purpose of data collection to support Quality Measure reporting.

7.4 TEFCA Transactions

7.4.1 QHIN Message Delivery

a. See requirements in 4.4.1 of this SOP as applied to the XP Code T-HCO-QM.

7.4.2 QHIN Query

a. See requirements in Section 4.4.2. of this SOP as applied to the XP Code T-HCO-QM.

7.4.2.1 QHIN Query Request

a. See requirements in Section 4.4.2.1 of this SOP as applied to the XP Code T-HCO-QM.

7.4.2.2 QHIN Query Response

a. Beginning eighteen (18) months following the initial publication date of this SOP, all Responding Nodes MUST Respond to QHIN Queries for the T-HCO-QM XP Code that

[7] Implementation Guide available at https://www.hl7.org/fhir/us/davinci-deqm/datax.html

contain the information specified in this SOP, in accordance with the Common Agreement and Applicable Law. Prior to that date, Responding Nodes SHOULD Respond.

b. If a Responding Node responds to a Request for T-HCO-QM, then it SHOULD Respond with a Quality Reporting Document Architecture STU 5.3 with errata.[8]

7.4.3 FHIR

7.4.3.1 FHIR Push

a. See requirements in 4.4.3.1 of this SOP as applied to the XP Code T-HCO-QM.

7.4.3.2 FHIR Query

a. See requirements in 4.4.3.2 of this SOP as applied to the XP Code T-HCO-QM.

7.4.3.3 FHIR Response

a. Beginning eighteen (18) months following the initial publication date of this SOP, all Responding Nodes MUST Respond to QHIN Queries for the T-HCO-QM XP Code that contain the information specified in this SOP, in accordance with the Common Agreement and Applicable Law. Prior to that date, Responding Nodes SHOULD Respond.

b. If a Responding Node responds to a Request for T-HCO-QM, then it SHOULD respond using the appropriate, corresponding content standards indicated in the QI-Core Implementation Guide 4.1.1 – STU4.[9]

c. See requirements in 4.4.3.3(b).

7.5 RCE Directory Service

a. See requirements in Section 4.5 of this SOP as applied to the XP Code T-HCO-QM.

[8] See https://www.hl7.org/implement/standards/product_brief.cfm?product_id=35 for details.
[9] See https://hl7.org/fhir/us/qicore/STU4.1.1 for details.