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

Version 2.0

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December 17, 2025

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Applicability: QHINs, Participants, Subparticipants

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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 DEFINITIONS

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The terms defined in this section are listed in the TEFCA Glossary and are repeated here for reference.

Moved down [1]: **Health Plan Parent**: the QHIN, Participant, or Subparticipant of which the Health Plan(s) is a part.¶

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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.

Deleted: **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

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

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

Deleted: **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.¶

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. Nothing in this SOP modifies the terms and conditions related to Health Care Operations, as enumerated in the Exchange Purposes (XPs) SOP.

Deleted: , including use cases of Care Coordination/Case Management, Quality Measure Reporting, and HEDIS Reporting.

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.

Participants and Subparticipant are permitted to use the HCO XP Codes in accordance with the Framework Agreements, SOPs, and QTF, as well as any agreements among themselves related to engaging as exchange partners (see the Exchange Purposes SOP).

Deleted: The initial requirements in this SOP specify that Responding Nodes SHOULD Respond to Queries for the HCO XP Codes. However, eighteen (18) months following the initial publication date of this SOP, February 16th, 2026, Responding Nodes MUST Respond to Queries for Care Coordination/Case Management, Quality Reporting, and HEDIS Reporting HCO XP Codes. 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 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 for HCO must use one of the following XP Codes (collectively, "HCO XP Codes") that best describes the purpose for the transaction. If there is a sub-XP Code that describes the reason for which an entity has initiated a QHIN Message Delivery or FHIR Push, then the entity MUST use the more specific sub-XP Code. To the extent that the entity believes that there is a sub-XP Code that describes the reason for which the entity has initiated a Query, then the entity MUST use the more specific sub-XP Code.

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HCO XP Name	HCO XP Code	Description
Health Care Operations	T-HCO	Data collection for any other HCO purpose that is not addressed through a different HCO XP Code.
Care Coordination/Case Management	T-HCO-CC	Data collection for a Health Plan to determine how to deliver care for an Individual 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.
HEDIS Reporting	T-HCO-HED	Data collection to support the Healthcare Effectiveness Data and Information Set (HEDIS) program's data reporting requirements, including audit, as required by the National Committee for Quality Assurance (NCQA).
Quality Assessment and Improvement	T-HCO-QAI	Data collection for 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.
Population-Based	T-HCO-POP	Data collection for 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
Patient Safety	T-HCO-PTSAFETY	Data collection for the following: (1) Efforts to improve patient safety and the quality of health care delivery; (2) The collection and analysis of patient safety work product;

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		(3) The development and dissemination of information with respect to improving patient safety, such as recommendations, protocols, or information regarding best practices; (4) The utilization of patient safety work product for the purposes of encouraging a culture of safety and of providing feedback and assistance to effectively minimize patient risk; (5) The maintenance of procedures to preserve confidentiality with respect to patient safety work product; (6) The provision of appropriate security measures with respect to patient safety work product; (7) The utilization of qualified staff; and (8) Activities related to the operation of a patient safety evaluation system and to the provision of feedback to participants in a patient safety evaluation system.
Performance Review	T-HCO-PERF	Data collection to support reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, or evaluating health plan performance

4.2 QHIN Technical Framework (QTF)

a. All TEFCA Exchange using an HCO XP Code MUST follow technical requirements as specified in the QTF.

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4.3 TEFCA Transactions

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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.¶

4.3.1 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.

4.3.2 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 HCO XP Codes, in accordance with Applicable Law.

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4.3.2.1 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.

4.3.3 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.

4.3.3.1 FHIR Push

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

4.3.3.2 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 HCO XP Codes, in accordance with Applicable Law.

Deleted: *<#>QHIN Query Response* ¶
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. ¶
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.¶
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. ¶

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[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.

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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"
}

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 RCE Directory Service

a. A Health Plan Parent listed in the RCE Directory Service SHOULD 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.

Deleted: *<#>FHIR Response* ¶
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. ¶
If a Responding Node with a FHIR Endpoint in the

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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.¶
Responses containing adjudicated claims data SHOULD abide by the requirements in the following implementation guides: ¶
CARIN for Blue Button Implementation Guide (IG) Version 2.0.0;[4]¶
HL7 Da Vinci Payer Data Exchange FHIR Implementation Guide Version 1.0.0;[5]¶
HL7 Da Vinci Payer Data Exchange FHIR U.S. Drug Formulary Implementation Guide Version 2.0.0;[6] and¶
HL7 Da Vinci Clinical Data Exchange FHIR Implementation Guide Version 2.0.0¶
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. ¶
RCE Directory Service

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Deleted: **<#>Health Care Operations (HCO) Care Coordination/Case Management**¶
Exchange Purpose Code (XP Code)¶
All TEFCA Exchange under HCO Care Coordination/Case Management MUST use the XP Code T-HCO-CC. ¶
QHIN Technical Framework (QTF) ¶
See requirement in Section 4.2 of this SOP¶
Definition¶
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- ... [1]

5 Version History

Version	Revision Date	Section #(s) of Update
Version 1.0	August 6, 2024	All Sections

[3] Implementation Guide available at https://hl7.org/fhir/us/udap-security/.

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Version 1.1	April 11, 2025	All Sections - Language aligned with Exchange Purposes (XPs) SOP Version 4.0
Version 2.0	December 17, 2025	All Sections – Language aligned with Exchange Purposes (XPs) SOP Version 5.0

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