TEFCA Frequently Asked Questions

July 2024

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Overview

The questions included in this FAQ were collected from the ASTHO Connects session, "TEFCA Overview and Perspectives from the Field" held on April 4, 2024 and follow-on questions from the session, as well as the ONC and CDC's TEFCA Community of Practice. The questions answered in this document are not exhaustive: this FAQ will be considered a living document with updates made as ASTHO and its partners are able to answer additional questions. TEFCA is a rapidly evolving area of work, and some questions will be better suited for a response as we learn more about its implementation.

Disclaimer: For definitive guidance related to TEFCA, please visit the Recognized Coordinating Entity's Resource Library for all formal guidance documents.

Technical

Use Cases

1. **Will TEFCA replace AIMS connections?**

   No, TEFCA will not replace data feeds such as electronic case reporting and electronic laboratory reporting on the AIMS platform. They will be integrated into TEFCA exchange and should be viewed as a public health resource. Further information can be found here and more details are expected in the near future.

2. **Does TEFCA change eCR flow routes or will current practices be maintained?**

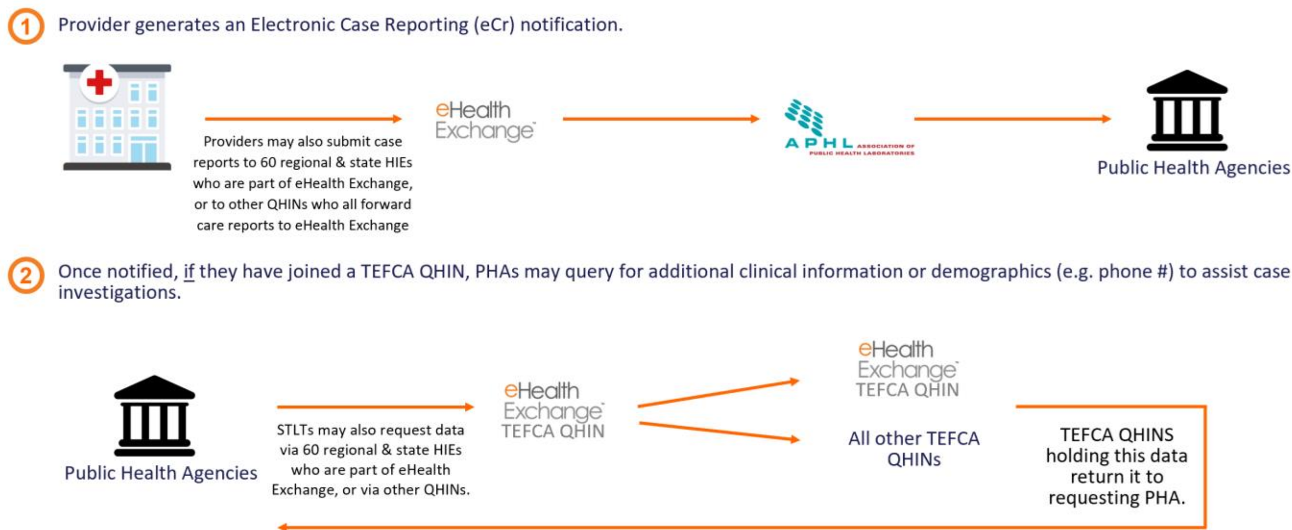
   Public Health Agencies (PHAs) continuing to receive electronic case reports outside of TEFCA will not experience any changes as they continue to receive these reports. When PHAs join

TEFCA, they will continue to receive case reports from the AIMS platform, but AIMS might change the technical endpoint. ASTHO will continue to work with its partners to provide further detail around eCR flow routes in future iterations of this FAQ.

3. **How do Query and Push work for eCR under TEFCA?**

   While ASTHO is currently working with its partners to clarify how Query and Push works for eCR under TEFCA, eHealth Exchange, one of the 7 QHINs, has provided a flow diagram that explains how this process works for eHealth Exchange. In general, the healthcare provider generates the eCR notification. Once the PHA has been notified of the case report, if they have joined a QHIN, they may query for additional clinical information or demographics to assist with case investigations. See Figure 1 for further detail.

Figure 1: Public Health Agencies May Query for Additional Information for Case Investigations after Receiving Notifiable Condition Alerts via eCR



Source: eHealth Exchange

4. **How can jurisdictions or other public health partners share potential use cases for consideration with those involved in TEFCA implementation? Who assesses the use cases and how are they prioritized?**

   Any data exchange that falls under the PH Exchange Purpose/Authority is permitted (and encouraged) under TEFCA, not just those listed in the Public Health SOP (which is currently being finalized and will be published in the spring of 2024). The use cases listed in the SOP just provide additional specification that may be helpful for implementing a given use case in TEFCA. The national associations (including ASTHO) are collaborating with ONC and CDC to collect information on potential use cases from jurisdictions. We recommend

documenting the use cases that your jurisdiction would like to prioritize and we'll be reaching out soon with a pathway for input.

Identity Matching

5. **Have any QHINs clarified how identity matching will be implemented? Is there a plan to get to a best practice/standard approach?**

   In general, the QHIN that is facilitating a Query request on behalf of a Participant or Sub-Participant is responsible for sending all available patient demographics (including identifiers) to the receiving QHIN. Each QHIN will have their own algorithms to determine approaches to matching; some may use Master Patient Indexes and others may use Record Locator Services. There will likely be variation in approaches across QHINs, where some QHINs may do the matching themselves and others may have Participants and Sub-Participants do the matching. The TEFCA Recognized Coordinating Entity (RCE) plans to convene the QHINs, Participants, and Sub-Participants to identify best practices around patient matching; however, it is unlikely that all QHINs will use the same approach.

Volume

6. **Is there a concern that this type of network will overwhelm systems responding to queries? If every query can split into multiple queries and the original sender receives multiple responses, how do we make sure TEFCA participants can handle this sudden potential ramp up of electronic queries?**

   As we are in the early days of TEFCA transactions, we are still learning about whether transaction volume is a concern for QHINs, Participants, and Sub-Participants. QHINs are currently providing data to the RCE on network traffic, and the RCE is watching this issue closely. If the volume of transactions does become an issue, the RCE may work to develop policy solutions to address the issue through its TEFCA Governing Council.

Data Quality

7. **What are the opportunities for a PHA to troubleshoot data quality and ensure data standardization?**

   Processes to troubleshoot data quality and ensure standardization through TEFCA-based exchange are currently being developed. Each QHIN may approach data quality control and troubleshooting differently, as a service to Participants and Sub-Participants, and PHAs will need to compare the QHINs and their Participants (e.g., HIEs) to determine which offers data quality services that meet their needs. Varying approaches will be reflected in agreements (e.g., Common Agreement, between the RCE and the QHIN, and the Terms of Participation and Framework Agreements, between the QHIN and Participants/Sub-Participants). If data quality issues arise as a QHIN is transmitting data to a Participant or Sub-Participant, concerns can be escalated to the ONC under Provision 15.6 of the Common

Agreement Version 2 and may go through dispute resolution. Additionally, the RCE's TEFCA Governing Council may take up issues that are common to public health, such as data quality, if they do arise.

Security

8. **Which QHINs store data? If our selected QHIN does not store data, what happens when information is shared through our QHIN through another QHIN which does store data? What level of consent or oversight would we maintain on the use of our data which is stored in another QHIN?**

   As QHINs are intended to be pass-throughs for data, they generally won't store data (though some may choose to do so). PHAs will need to compare the QHINs and their Participants (e.g., HIEs) to understand their practices around data storage and select a QHIN that meets their needs and requirements. In general, when a Participant or Sub-Participant queries for data and consumes the data into their own system, they become the stewards of that data. Once data is consumed into a Participant or Sub-Participant's database, HIPAA and relevant Applicable Laws[1] apply to the use of that data. If there are any issues or concerns with the way the data is being accessed, stored, and used, the RCE's dispute resolution processes may assist in resolving these issues.

Legal/Policy

1. **Why does a PHA need to sign an agreement to access Protected Health Information (PHI) to which it has a legal right to access?**

   Agreements a PHA may sign with a QHIN or Participant, such as a Framework Agreement, address how information will be exchanged. They do not establish or alter existing legal authority for a PHA to receive information. This is similar to an agreement a PHA might execute with a third-party software vendor that was going to host a data server and handle the secured storage and exchange of data. The agreement will outline the terms of how the PHA will work with the QHIN or Participant to exchange data.

2. **Does sharing data through QHIN constitute 'public health disclosure' under the Health Insurance Portability and Accountability Act (HIPAA)?**

   Sharing data via a QHIN may constitute a public health disclosure depending on the type of data being shared, whether the PHA is a covered entity (or hybrid entity and sharing data from a covered entity), with whom the data is being shared, and for what purpose. Given this complexity, each PHA will need to discuss allowable disclosures under HIPAA with their attorney(s).

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[1] The Common Agreement for Nationwide Health Information Interoperability Version 2.0 defines Applicable Law as, "All federal, State, local, or tribal laws and regulations then in effect and applicable to the subject matter herein. For the avoidance of doubt, federal agencies are only subject to federal law."

3. **If a public health organization is also a provider of health care (e.g., Tuberculosis care), are they subject to the Information Blocking Rule if they're queried as a QHIN participant?**

   Yes, if a public health agency is acting as a healthcare provider and holds patient electronic health information, they may be subject to the Information Blocking Rule. Consult with legal counsel about the specific requirements or whether an identified exception in 45 CFR Part 171 may apply.

4. **How might agreements and responsibilities differ for hybrid agencies (those that have a PHA and HIPAA-covered entity) versus those that serve solely as PHAs?**

   Public health agencies who are hybrid authorities under HIPAA should discuss what will specifically need to be included into any agreement they plan to sign with a QHIN or Participant and whether a Business Associates Agreement (BAA) will need to be included.

5. **Have any states taken legislative action in an effort to enact TEFCA, and if so, are there examples of actions taken?**

   To our knowledge, no states have specifically enacted TEFCA into legislation, but most states won't need to in order to participate. Florida introduced SB 668 this session which would have required hospitals to make patient records available through a "nationally recognized trusted exchanged framework," however, this bill was not passed into legislation. While this would have applied only to hospitals, it is the first instance we've seen of state legislation seemingly specifically refer to TEFCA.

6. **Do the QHINs operate in a way in which our data is protected from sharing inappropriately with others (e.g., can we legally exchange data via TEFCA)?**

   This depends: the agreements that state agencies sign with their respective QHINs will define all the security measures and applicable state laws that will apply to any data shared. States should have both their data security teams and legal counsel carefully review, discuss, and negotiate these agreements to ensure compliance. Also, public health authorities are not currently obligated to respond to data queries from QHINs so a state agency could participate in TEFCA without sharing any public health or patient data, and instead use the connections only as a means of collecting data.

7. **Have there been any discussions around proposed rulemaking to address the challenges the Information Blocking Rule may pose for PHAs under TEFCA? This might be needed to allow public health to fully utilize the data sharing possible via QHINs; otherwise, hybrid PHAs may not participate out of fear of non-compliance.**

   Regardless of a public health agency's status under HIPAA (as either a fully covered entity or a hybrid-entity), the Information Blocking Rule applies whenever the agency is serving as a provider and holding electronic health information. Agencies should work with their legal counsel to make sure they are in compliance with the rule through current sharing methods or future sharing plans under TEFCA, or to identify any relevant Information Blocking Exceptions found in 45 C.F.R. § part 171. The HTI-1 Final Rule was published in 2023, introducing the TEFCA Manner Exception, found in subpart D) and ASTHO is not currently aware of future rulemaking to further clarify this.

Governance

1. **Which organizations can be classified as having "Public Health Authority?"**

   The RCE defines the term "Public Health Authority" in reference to 45 CFR § 164.501: "Public health authority means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate."

2. **What level of control/oversight does a PHA have over another entity with whom they have shared their data and then may subsequently share their data with others?**

   As control and oversight of data access and use depends on Applicable Law, PHAs must ensure that their legal counsel has reviewed all legal agreements related to TEFCA participation. If data access issues arise as a QHIN is transmitting data to a Participant or Sub-Participant, concerns can be escalated to the ONC under Provision 15.6 of the Common Agreement Version 2 and may go through dispute resolution. Additionally, PHAs may leverage ONC's "EHR Contracts Untangled" resource to identify approaches and considerations for reviewing TEFCA-related agreements.

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3. **As insurance companies are able to access data for adverse event claims, underwriting, rate adjustments, and other activities, would this access impact only EHR/identifiable patient data only, or would it have broader implications for public health data?**

   The RCE is continuing to build out the Exchange Purposes of Healthcare Operations and Payment, creating SOPs that detail specific use cases such as Public Health. The Exchange Purpose SOP provides initial insight into the types of entities that can be Participants and Sub-Participants, and more information is forthcoming.

4. **What is the enforcement mechanism or authority for TEFCA principles for conduct?**

   First, participation in TEFCA is voluntary, but the "enforcement" for abiding by the Common Agreement and flow down provisions is via the RCE, as the RCE oversees and manages the QHINs. Second, trust is built in the agreements between the RCE and QHINs (the Common Agreement) and between QHINs and Participants and Participants and Sub-Participants (the Terms of Participation and Framework Agreement), and these agreements serve as enforcement mechanisms. If a QHIN is violating terms in agreements (e.g., related to privacy and security), there are provisions in the Common Agreement that allow the RCE to suspend or terminate a QHIN. Finally, the RCE's dispute resolution process described in the Common Agreement and ONC's appeals process can address issues related to enforcement of TEFCA principles for conduct. The TEFCA Governing Council may also address more pervasive issues across the network.

5. **How will public health be involved in TEFCA governance?**

   The Common Agreement creates a TEFCA Governing Council to support the RCE as a permanent governing body for activities conducted under the Terms of Participation and Framework Agreements as well as other functions. The SOP for the Governing Council can be found here on the RCE's website. While the current Governing Council is set up to include QHIN and Participant/Sub-participant Caucuses, and Public Health is not yet structured into the Governance as an exchange purpose, the RCE is exploring opportunities for the Governing Council to include various voices representing the exchange purposes, such as Public Health.

6. **The phrase "health equity by design" seems ambiguous and conceptual. How will this be operationalized in TEFCA?**

   In April 2024, ONC released its "Advancing Health Equity by Design and Health Information Technology: Proposed Approach, Invitation for Public Input, and Call to Action" to seek stakeholder feedback on their proposed Health Equity by Design (HEBD) approach. The proposed approach states that "HEBD focuses on the need to include health equity at the outset and as a key feature during the design, build, and implementation of health IT

policies, programs, projects, and workflows." In essence, HEBD uses, "health IT to move data into action by identify and reducing health disparities, and promoting health equity."

While the proposed approach does not specifically address how HEBD will be operationalized in TEFCA, it does speak to the need for more equitable data standards (e.g., social determinants of health (SDOH), race/ethnicity, sexual orientation and gender identity (SOGI), and disability data elements). ONC has made progress on data standards in these areas through its work on the U.S. Core Data for Interoperability (USCDI) over the past four years, from initially including race and ethnicity data elements in 2020 to adding SDOH and SOGI data elements in subsequent years, and most recently adding 20 new data elements focused on equity, diversity, and access across all healthcare settings in 2023.

In addition to enabling PHAs to access health equity data (e.g., SDOH, SOGI, disability) they were previously unable to access due to network complexity and lack of connections to various data providers, TEFCA can advance the exchange of *standardized health equity data* (e.g., as defined by USCDI data classes and elements) that may assist PHAs in achieving HEBD goals. USCDI provides conformance requirements for data exchanged in TEFCA: when TEFCA exchange occurs for data in the USCDI version specified in the QTF, then the data needs to conform to the requirements specified in USCDI. This can be accomplished by the Participants or Sub-Participants or by the responding QHIN depending on the internal configuration and policies of the QHIN. Please refer to the QTF for greater detail.

Funding/Costs

1. What are the costs of participating in TEFCA?

The costs of a PHA participating in TEFCA depend on a variety of factors and the fees of each QHIN:

- Onboarding fees and annual fees to join a QHIN as a Participant or Sub-Participant. If a PHA chooses to join multiple QHINs (permitted per the Common Agreement Version 2, Section 6.2.1, "Prohibition Against Exclusivity), the PHA would need to cover fees for each QHIN.
- Internal develop costs, such as state IT resources, informatics and programmatic experts for use cases and requirements development.
- Ongoing operational costs, such as IT and informatics resources, as well as experts to support new use cases.
- Legal/policy costs for review and signing of Terms of Participation and Framework Agreements.

2. **What are the potential grant and funding sources that public health organizations can leverage to participate in TEFCA?**

   Jurisdictions may leverage funds from the Public Health Infrastructure Grant and the Epidemiology and Laboratory Capacity grant to support participation in TEFCA. Additionally, the CDC has funded 3 national partners (ASTHO, the Public Health Accreditation Board, and the National Network for Public Health Institutes) to stand up the Public Health Data Modernization Implementation Center Program to further support jurisdictions in exchanging data via TEFCA. The Implementation Centers will provide funds to PHAs to assist with the costs of participation. The Program, anticipated to start in the summer of 2024 and run through the fall of 2027, will also work with PHAs to explore innovative approaches for funding participation in TEFCA, such as the leveraging of Medicaid funds and blending and braiding different funding sources.

3. **What is the fee structure for each QHIN?**

   Each QHIN will likely have different fee structures, which will be made public when they are available. As of May 2024, eHealth Exchange has published its fee structure. The Public Health Data Modernization Implementation Center Program will be working to compare QHINs for PHAs, with a breakdown of fee structure options.

Getting Started

1. **How would you recommend a state health department get started in exploring participation in TEFCA?**

   There are several steps a PHA can take at this time to prepare to participate in TEFCA; these have been outlined in ASTHO's blog post and are summarized below:

   - **Compatibility of Requirements**: PHAs (including legal staff) may review the Common Agreement, the QHIN Technical Framework, the Terms of Participation, and other guidance documents provided by the RCE. Once reviewed, the PHA should assess whether current state and local legal requirements are compatible with the new requirements under TEFCA.
   - **Current Data Exchange Environment**: PHAs can assess whether and how health information is currently being exchanged in their jurisdiction. This assessment can help jurisdictions identify use cases for TEFCA, as well as gaps in current infrastructure so they can plan for upgrades that will support TEFCA participation.
   - **Funding:** PHAs may consider the costs of participation, which can include onboarding and annual fees to join as Participants or Sub-Participants, internal development costs, ongoing operational costs, and legal/policy costs. PHAs may consider blending and braiding existing funding sources to participate, such as the Public Health Infrastructure Grant, the Implementation Center Program, the Epidemiology and Laboratory Capacity Grant, as well as more non-traditional sources such as Medicaid Enterprise Federal Financial Participation.

- **Partnerships with QHINs**: PHAs may explore partnerships with potential QHINs, evaluating each one to ensure they support the unique types of exchange needed by the PHA. PHAs may want to consider existing partnerships with HIEs to participate as well.
- **Interoperability Standards**: PHAs may need to consider how the standards and technology they are currently using or plan to adopt for interoperability may impact their ability to participate in the network.

2. Should Local Health Departments be getting involved at this point and if so how?

Local Health Departments would benefit from discussing potential TEFCA participation at this stage, exploring the steps for initial participation listed above. Participation will depend on your state's public health governance structure, and we would recommend communicating with the state PHA to better understand their plans and vision for participation.

3. What is the advantage from state perspective to be an "early adopter?"

As many jurisdictions are experiencing challenges around the network complexity of exchanging data with various data providers and partners, TEFCA aims to reduce this complexity to enable public health to access more timely and complete data. The sooner a PHA begins to adopt TEFCA-based exchange, the sooner this network complexity will be reduced. Additionally, TEFCA will enable bidirectional data exchange between PHAs and healthcare providers, which will enable healthcare providers to benefit from public health data as well.

While TEFCA is a new opportunity for all data providers and receivers alike (health care, public health, government agencies, payers, etc.), being an early adopter offers a PHA the opportunity to be an innovator in this space. For example, PHAs that are early adopters will be able to be the first to engage with QHINs to explore and sign Framework Agreements; these early experiences will inform how Framework Agreements may be developed and agreed upon in the future by other PHAs. Early adopters will be the first to identify both the on-ramps and challenges for participation, which will be documented by programs such as the Public Health Data Modernization Implementation Center Program and will inform future TEFCA implementation in other jurisdictions.

Additionally, the CDC has committed to providing both financial and technical support for early adopters through programs such as the Public Health Data Modernization Implementation Center Program, as discussed above.

4. What are your recommendations for choosing QHIN?

Initial considerations include: (1) what the QHIN has to offer your PHA; (2) costs; and (3) legal/policy considerations.. The Public Health Data Modernization Implementation Center Program will be developing further guidance to assist PHAs in selecting a QHIN to join as a

Participant or Sub-Participant. In the meantime, PHAs will need to evaluate what kinds of services they need as an agency, and then explore whether specific QHINs offer those services and the costs of those services. Per the Common Agreement Version 2, a PHA can join multiple QHINs in order to meet specific needs.

5. **The majority of healthcare providers in my state are using an EHR developed by a specific QHIN. Is there an advantage to choosing that QHIN to sign on as a Participant or Sub-Participant?**

   Jurisdictions will need to explore what the specific QHIN has to offer your PHA versus what the other QHINs have to offer. If another QHIN is better poised to meet your health agency's needs, we'd recommend that QHIN over the QHIN that supports EHRs in your state.

Health Information Exchanges

1. **If public health is already exchanging data with an HIE, and if that HIE becomes a Participant, does PHA have to be a Sub-Participant in order to continue sharing data with the HIE?**

   In most cases, the PHA does not need to be a Sub-Participant to a Participant HIE to continue exchanging data using existing processes. However, this determination depends on the relationship and agreements between the PHA and the HIE, and the HIE may need to request input from the RCE to determine whether this practice is appropriate.

2. **Are the QHINs technically also HIEs themselves that just happen to be certified under TEFCA?**

   The 7 current QHINs are all health information networks that have gone through the RCE's rigorous and lengthy process of application and designation. Becoming a QHIN is not limited to health information networks: any entity may apply to become a QHIN, as long as they meet the eligibility requirements as defined in the RCE's SOP for QHIN Onboarding and Designation (and the definition of a Health Information Network or a Health Information Exchange described in the Information Blocking regulations (this is a threshold requirement)). As such, HIEs may apply to become a QHIN or may be involved in TEFCA-based exchange as Participants or Sub-Participants.

Other

1. **Given the 6 Exchange Purposes, how can research benefit from TEFCA?**

The 6 exchange purposes are planned in the near-term, but Research is currently planned as a potential 7th Exchange Purpose with its own SOP. The research community may benefit from improved data quality, reduced costs of data access, and expanded participation in clinical research.