eHealth Exchange
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Payers at the Table: Collaboration Beyond 0057-F

Panelists featuring

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Facilitated by

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Panel



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Michael McEachern
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Rakesh Mathew
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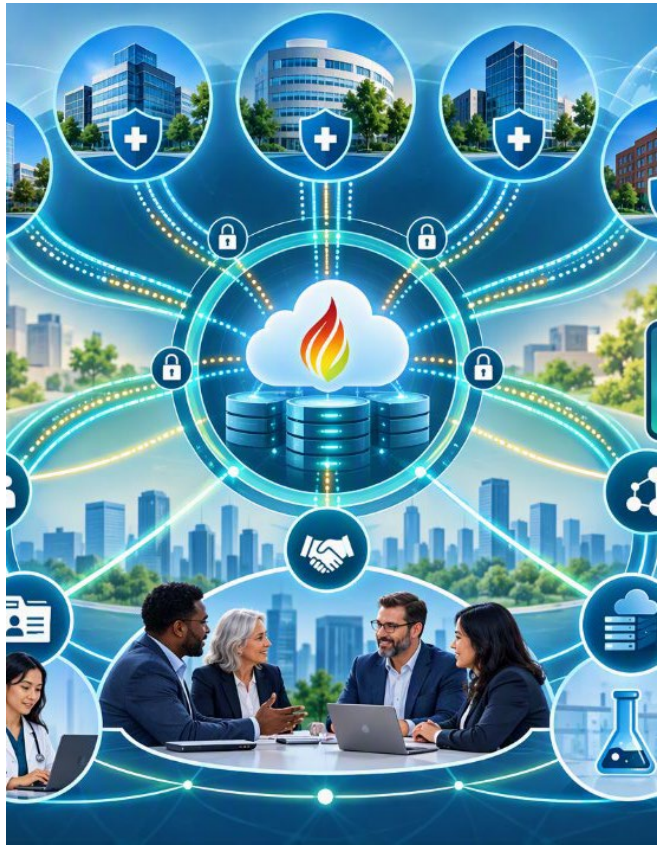
From compliance to connected care

Payers as trusted care operators, not just API operators

1. What does clinical data exchange “at scale” require?

2. What are non-negotiables beyond compliance?

3. Where are the biggest policy-to-practice gaps today?



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Diagnosing scalability issues



			Payer Solution Advancement*
Exchange Mechanisms	• Member matching • Endpoint discovery • Large attachments / Bulk transactions	• Supported FHIR operations • Consent • Attribution, attestation	
Connectivity Choices	• National networks • HIEs and other intermediaries	• Point-to-point • EHR solutions • Use-case alignment	
Trust and Permission	• Purpose of use • Contracts • Governance	• Sensitive health data • Payer / provider authentication • Dynamic registration	

* For illustrative purposes only

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Member matching: the 2027 problem

What one health plan MPI tells us about Payer-to-Payer and Provider Access matching before the January 2027 go-live

What we found in our own house

1.49M → 888K
Enrollment, a behavioral health vendor and HIE C-CDAs loaded for one plan. Every 1.7 records were the same person.

54% to 79%
Phone completeness by source. DOB dropped to 92% on the HIE feed. These are the fields that break ties.

~105K
Records sitting as a possible match, waiting on a human. About 7% of the load, and that is with a shared member ID.

69%
Practitioner records with a name on file. NPI was always there, the name often was not. Providers need matching too.

Payer-to-Payer: what breaks

The member has no shared ID with the old plan
$member-match leans on the prior coverage and demographics the member types into a portal. With phone and address this incomplete, the fallback is thin.

One match or an error
7% of our own records were ambiguous with a member ID in hand. Two plans with no common key will see more. Nothing in the spec says what to do with those people.

Your duplicates travel with you
Send by source record and the receiving plan gets the same member 1.7 times with conflicting demographics. Vendor and delegated data has to be linked before it leaves.

Five years of history means five years of member IDs
Re-enrollments, plan changes and name changes inside your own book have to resolve to one person first.

Provider Access: what breaks

Attribution lists arrive with provider demographics
An MRN, a name and a DOB. The HIE feed is the preview: 92% DOB, 54% phone. Expect lower match rates than anything you see internally.

You have to match the provider too
Rosters, delegated groups and practitioner moves. We saw NPI at 100% and names at 69%. Organization matching is messier again.

A wrong match is a wrong disclosure
Opt-out is per member. The matching bar is higher here than for internal analytics, and the volume is bulk, not one lookup at a time.

Nobody has agreed what a possible match means
Reject, hold, or ask? Each plan picks its own answer today, and providers will feel every difference.

The 2026 job: get the house MPI clean, decide what happens to a possible match, and agree a minimum demographic set with the plans and providers you will exchange with. In 2027 every mismatch is a disclosure, not a report.

Source: Hike Health MPI dashboards (Smile CDR MDM) for a Medicaid/MA plan with three source systems including an HIE, plus a second regional Medicaid plan loaded from a single system. Latest weekly reports, 2026. Shown to illustrate the pattern, not as plan-reported metrics.

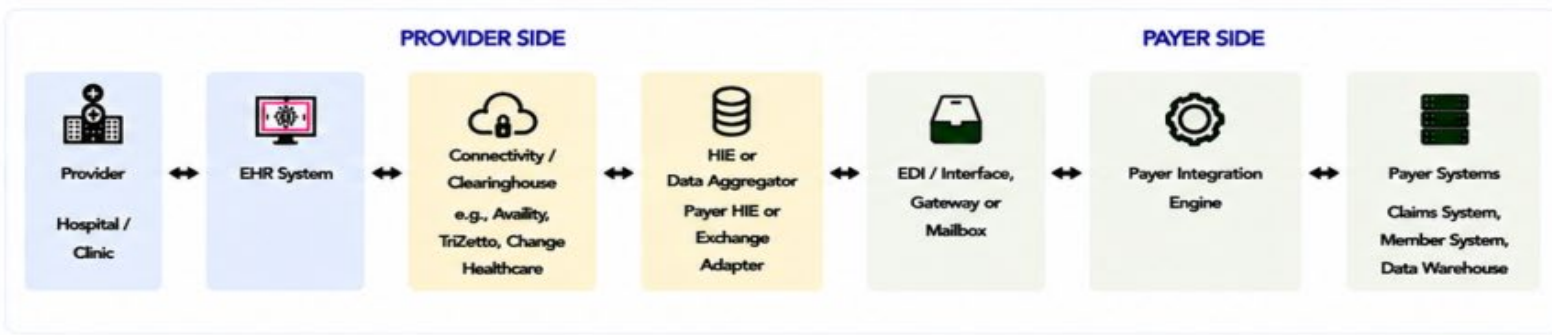
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How Data Flows: Systems Between Provider and Payer Across Exchange Models

Different exchange approaches use different systems, infrastructure, and workflows to move data from provider to payers.

1 ADT / CCD / FHIR FEEDS (Point-to-Point Push)

Event-based data sent from providers to payers via direct or established point-to-point connections.



Typical Use Cases

- Care coordination (transitions)
- Quality reporting (e.g., HEDIS)
- Case management triggers
- Provider directory updates
- Referrals, care plans, authorizations
- ADT (A01, A03, A08) admit / discharge / transfer notifications
- CCD / C-CDA documents

2 TEFCA QUERY-BASED EXCHANGE (QHINs)

On-demand query and retrieve across TEFCA-connected networks using QHINs.



TEFCA Use Cases (by Explicit Exchange Purpose)

Treatment	Clinical data for individual care
Payment	Claims processing, reimbursement
Healthcare Operations	Care coordination, quality measurement, provider mgmt.
Public Health	Disease surveillance, reporting
Individual Access Services	Patient-facing app access
Government Benefits Determination	Eligibility determinations
Research	IRB-approved research
Law Enforcement	Authorized investigations
Organ, Eye, & Tissue Donation	Matching, donor management
Other Permitted Purposes	As defined in TEFCA Common Agreement

All queries must be for a permitted Exchange Purpose and follow TEFCA policies for consent, patient access, minimum necessary, and auditing.

3 CMS ALIGNED NETWORKS (ANs)

Networks aligned to CMS goals and criteria that enable coordinated exchange and use of data for outcomes.



CMS Aligned Networks Use Cases (Ecosystem Categories)

Patient Access	Easy, secure access to data via APIs & apps
Provider Workflow Enablement	Reduced burden, integrated digital tools
Health System Transformation	Interoperable, coordinated care delivery
Digital Health Innovation	Innovation, pilots & digital solutions
Improved Outcomes	Better outcomes through data-driven care
Lower Costs	Efficiency, reduced waste & total cost
Trust & Transparency	Data trust, consent, reporting transparency

ANs align to CMS priorities, data sharing criteria, and governance commitments to drive outcomes at scale.

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Looking ahead

Early value signals



Convergence priority vs. divergence acceptance

2 to 3 year future vision



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