

a requirement to read promotional material or agree to receive future communications from the organization making the documentation available;

(1) API syntax, function names, required and optional parameters supported and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns;

(2) The software components and configurations an application must use in order to successfully interact with the API and process its response(s); and

(3) All applicable technical requirements and attributes necessary for an application to be registered with any authorization server(s) deployed in conjunction with the API.

(e) *Denial or discontinuation of access to the API.* An MA organization may deny or discontinue any third party application's connection to the API required under paragraph (a) of this section if the MA organization:

(1) Reasonably determines, consistent with its security risk analysis under 45 CFR part 164 subpart C, that allowing an application to connect or remain connected to the API would present an unacceptable level of risk to the security of protected health information on the MA organization's systems; and

(2) Makes this determination using objective, verifiable criteria that are applied fairly and consistently across all apps and developers through which parties seek to access electronic health information, as defined in 45 CFR 171.102, including but not limited to, criteria that rely on automated monitoring and risk mitigation tools.

(f) *Reporting on Patient Access API usage.* Beginning in 2026, by March 31 following any calendar year that it offers an MA plan, an MA organization must report to CMS the following metrics, in the form of aggregated, de-identified data, for the previous calendar year at the contract level in the form and manner specified by the Secretary:

(1) The total number of unique enrollees whose data are transferred via the Patient Access API to a health app designated by the enrollee.

(2) The total number of unique enrollees whose data are transferred more

than once via the Patient Access API to a health app designated by the enrollee.

(g) *Enrollee resources regarding privacy and security.* An MA organization must provide in an easily accessible location on its public website and through other appropriate mechanisms through which it ordinarily communicates with current and former enrollees seeking to access their health information held by the MA organization, educational resources in non-technical, simple and easy-to-understand language explaining at a minimum:

(1) General information on steps the individual may consider taking to help protect the privacy and security of their health information including factors to consider in selecting an application including secondary uses of data, and the importance of understanding the security and privacy practices of any application to which they will entrust their health information; and

(2) An overview of which types of organizations or individuals are and are not likely to be HIPAA covered entities, the oversight responsibilities of the Office for Civil Rights (OCR) and the Federal Trade Commission (FTC), and how to submit a complaint to:

(i) The HHS Office for Civil Rights (OCR); and

(ii) The Federal Trade Commission (FTC).

(h) *Applicability.* An MA organization must comply with the requirements of this section beginning in paragraphs (a) through (e) and (g) of this section beginning January 1, 2021, unless otherwise specified, and with the requirements in paragraph (f) of this section beginning in 2026, with regard to data:

(1) With a date of service on or after January 1, 2016; and

(2) That are maintained by the MA organization.

[85 FR 25632, May 1, 2020, as amended at 89 FR 8974, Feb. 8, 2024]

§ 422.120 Access to published provider directory information.

(a) An MA organization must implement and maintain a publicly accessible, standards-based Application Programming Interface (API) that is

conformant with the technical requirements at § 422.119(c), excluding the security protocols related to user authentication and authorization and any other protocols that restrict the availability of this information to particular persons or organizations, the documentation requirements at § 422.119(d), and is accessible via a public-facing digital endpoint on the MA organization's website.

(b) The API must provide a complete and accurate directory of—

(1) The MA plan's network of contracted providers, including names, addresses, phone numbers, and specialties, updated no later than 30 calendar days after the MA organization receives provider directory information or updates to provider directory information; and

(2) For an MA organization that offers an MA-PD plan, the MA-PD's pharmacy directory, including the pharmacy name, address, phone number, number of pharmacies in the network, and mix (specifically the type of pharmacy, such as "retail pharmacy") updated no later than 30 calendar days after the MA organization receives pharmacy directory information or updates to pharmacy directory information.

(c) This section is applicable beginning January 1, 2021.

[85 FR 25633, May 1, 2020]

§ 422.121 Access to and exchange of health data for providers and payers.

(a) *Application programming interface to support data exchange from payers to providers—Provider Access API.* Beginning January 1, 2027, an MA organization must do the following:

(1) *API requirements.* Implement and maintain an application programming interface (API) conformant with all of the following:

(i) Section 422.119(c)(2) through (4), (d), and (e).

(ii) The standards in 45 CFR 170.215(a)(1), (b)(1)(i), (c)(1), and (d)(1).

(2) *Provider access.* Make the data specified at § 422.119(b) with a date of service on or after January 1, 2016, excluding provider remittances and enrollee cost-sharing information, that are maintained by the MA organization

available to in-network providers via the API required in paragraph (a)(1) of this section no later than 1 business day after receiving a request from such a provider, if all the following conditions are met:

(i) The MA organization authenticates the identity of the provider that requests access and attributes the enrollee to the provider under the attribution process described in paragraph (a)(3) of this section.

(ii) The enrollee does not opt out as described in paragraph (a)(4) of this section.

(iii) Disclosure of the data is not prohibited by other applicable law.

(3) *Attribution.* Establish and maintain a process to associate enrollees with their in-network providers to enable data exchange via the Provider Access API.

(4) *Opt out and patient educational resources.* (i) Establish and maintain a process to allow an enrollee or the enrollee's personal representative to opt out of the data exchange described in paragraph (a)(2) of this section and to change their permission at any time. That process must be available before the first date on which the MA organization makes enrollee information available via the Provider Access API and at any time while the enrollee is enrolled with the MA organization.

(ii) Provide information to enrollees in plain language about the benefits of API data exchange with their providers, their opt out rights, and instructions both for opting out of data exchange and for subsequently opting in, as follows:

(A) Before the first date on which the MA organization makes enrollee information available through the Provider Access API.

(B) No later than 1 week after the coverage start date or no later than 1 week after receiving acceptance of enrollment from CMS, whichever is later.

(C) At least annually.

(D) In an easily accessible location on its public website.

(5) *Provider resources.* Provide on its website and through other appropriate provider communications, information in plain language explaining the process for requesting enrollee data using the Provider Access API required in

paragraph (a)(1) of this section. The resources must include information about how to use the MA organization's attribution process to associate enrollees with their providers.

(b) *Application programming interface to support data exchange between payers—Payer-to-Payer API.* Beginning January 1, 2027, an MA organization must do the following:

(1) *API requirements.* Implement and maintain an API conformant with all of the following:

(i) Section 422.119(c)(2) through (4), (d), and (e).

(ii) The standards in 45 CFR 170.215(a)(1), (b)(1)(i), and (d)(1).

(2) *Opt in.* Establish and maintain a process to allow enrollees or their personal representatives to opt into the MA organization's payer to payer data exchange with the enrollee's previous payer(s), described in paragraphs (b)(4) and (5) of this section, and with concurrent payer(s), described in paragraph (b)(6) of this section, and to change their permission at any time.

(i) The opt in process must be offered as follows:

(A) To current enrollees, no later than the compliance date.

(B) To new enrollees, no later than 1 week after the coverage start date or no later than 1 week after receiving acceptance of enrollment from CMS, whichever is later.

(ii) If an enrollee does not respond or additional information is necessary, the MA organization must make reasonable efforts to engage with the enrollee to collect this information.

(3) *Identify previous and concurrent payers.* Establish and maintain a process to identify a new enrollee's previous and concurrent payer(s) to facilitate the Payer-to-Payer API data exchange. The information request process must start as follows:

(i) For current enrollees, no later than the compliance date.

(ii) For new enrollees, no later than 1 week after the coverage start date or no later than 1 week after receiving acceptance of enrollment from CMS, whichever is later.

(iii) If an enrollee does not respond or additional information is necessary, the MA organization must make rea-

sonable efforts to engage with the enrollee to collect this information.

(4) *Exchange request requirements.* Exchange enrollee data with other payers, consistent with the following requirements:

(i) The MA organization must request the data listed in paragraph (b)(4)(ii) of this section through the enrollee's previous payers' API, if all the following conditions are met:

(A) The enrollee has opted in, as described in paragraph (b)(2) of this section.

(B) The exchange is not prohibited by other applicable law.

(ii) The data to be requested are all of the following with a date of service within 5 years before the request:

(A) Data specified in § 422.119(b) excluding the following:

(1) Provider remittances and enrollee cost-sharing information.

(2) Denied prior authorizations.

(B) Unstructured administrative and clinical documentation submitted by a provider related to prior authorizations.

(iii) The MA organization must include an attestation with this request affirming that the enrollee is enrolled with the MA organization and has opted into the data exchange.

(iv) The MA organization must complete this request as follows:

(A) No later than 1 week after the payer has sufficient identifying information about previous payers and the enrollee has opted in.

(B) At an enrollee's request, within 1 week of the request.

(v) The MA organization must receive, through the API required in paragraph (b)(1) of this section, and incorporate into its records about the enrollee, any data made available by other payers in response to the request.

(5) *Exchange response requirements.* Make available the data specified in paragraph (b)(4)(ii) of this section that are maintained by the MA organization to other payers via the API required in paragraph (b)(1) of this section within 1 business day of receiving a request, if all the following conditions are met:

(i) The payer that requests access has its identity authenticated and includes an attestation with the request that