

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

the patient is enrolled with the payer and has opted into the data exchange.

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

(6) *Concurrent coverage data exchange requirements.* When an enrollee has provided sufficient identifying information about concurrent payers and has opted in as described in paragraph (b)(2) of this section, an MA organization must do the following, through the API required in paragraph (b)(1) of this section:

(i) Request the enrollee's data from all known concurrent payers as described in paragraph (b)(4) of this section, and at least quarterly thereafter while the enrollee is enrolled with both payers.

(ii) Respond as described in paragraph (b)(5) of this section within 1 business day of a request from any concurrent payers. If agreed upon with the requesting payer, the MA organization may exclude any data that were previously sent to or originally received from the concurrent payer.

(7) *Patient educational resources.* Provide information to enrollees in plain language, explaining at a minimum: the benefits of Payer-to-Payer API data exchange, their ability to opt in or withdraw that permission, and instructions for doing so. The MA organization must provide the following resources:

(i) When requesting an enrollee's permission for Payer-to-Payer API data exchange, as described in paragraph (b)(2) of this section.

(ii) At least annually, in appropriate mechanisms through which it ordinarily communicates with current enrollees.

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

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§ 422.122 Prior authorization requirements.

(a) *Communicating a reason for denial.* Beginning January 1, 2026, if the MA organization denies a prior authorization request (excluding request for coverage of drugs as defined in § 422.119(b)(1)(v)), in accordance with the timeframes established in §§ 422.568(b)(1) and 422.572(a)(1), the response to the provider must include a

specific reason for the denial, regardless of the method used to communicate that information.

(b) *Prior Authorization Application Programming Interface (API).* Beginning January 1, 2027, an MA organization must implement and maintain an API conformant with § 422.119(c)(2) through (4), (d), and (e), and the standards in 45 CFR 170.215(a)(1), (b)(1)(i), and (c)(1) that—

(1) Is populated with the MA organization's list of covered items and services (excluding drugs, as defined in § 422.119(b)(1)(v)) that require prior authorization;

(2) Can identify all documentation required by the MA organization for approval of any items or services that require prior authorization;

(3) Supports a Health Insurance Portability and Accountability Act (HIPAA)-compliant prior authorization request and response, as described in 45 CFR part 162; and

(4) Communicates the following information about prior authorization requests:

(i) Whether the MA organization—

(A) Approves the prior authorization request (and the date or circumstance under which the authorization ends);

(B) Denies the prior authorization request; or

(C) Requests more information.

(ii) If the MA organization denies the prior authorization request, it must include a specific reason for the denial.

(5) In addition to the requirements of this section, an MA organization using prior authorization policies or making prior authorization decisions must meet all other applicable requirements under this part, including § 422.138 and the requirements in subpart M of this part.

(c) *Publicly reporting prior authorization metrics.* Beginning in 2026, following each calendar year that it offers an MA plan, an MA organization must report prior authorization data, excluding data on drugs as defined in § 422.119(b)(1)(v), at the MA contract level by March 31. The MA organization must make the following data from the previous calendar year publicly accessible by posting them on its website: