

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: