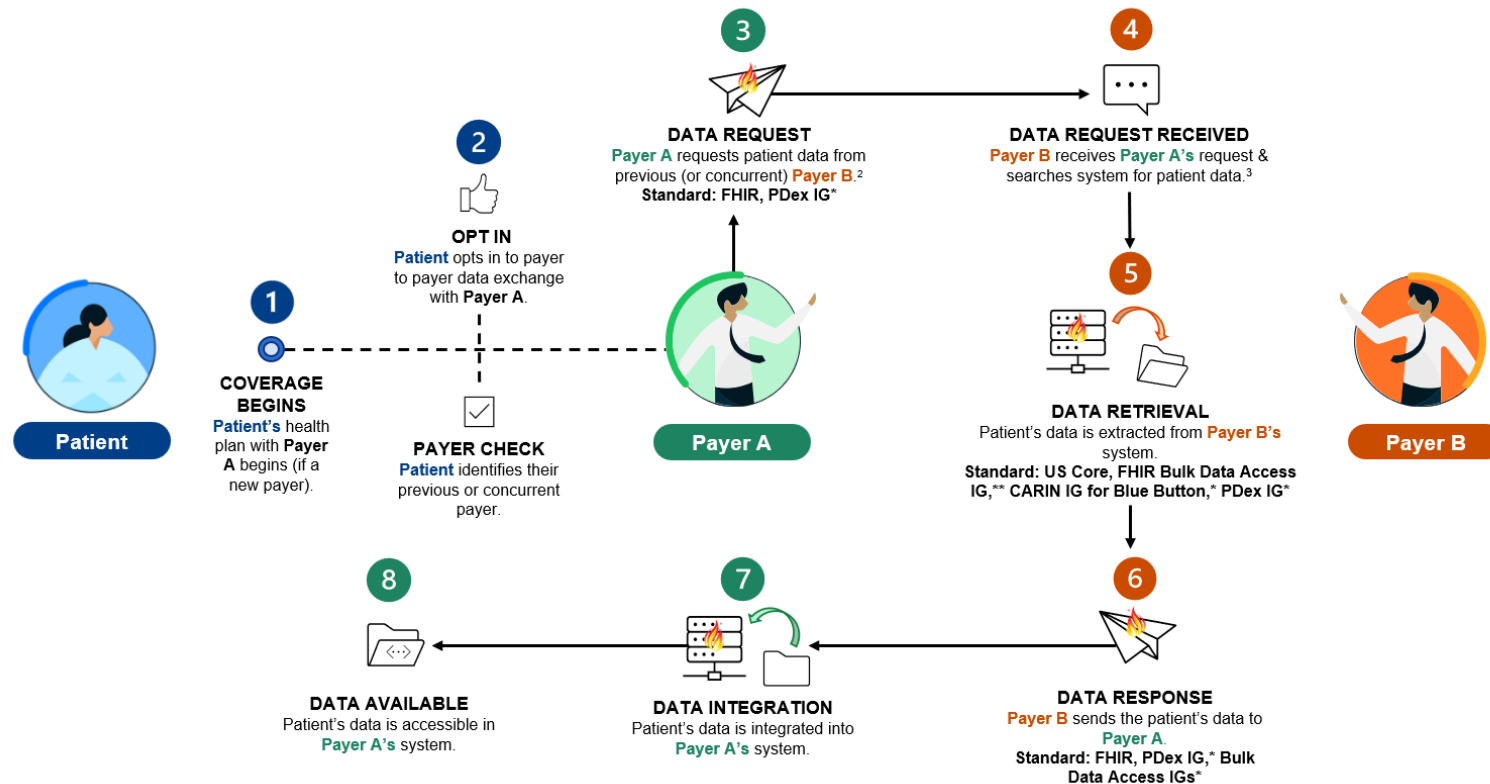


Payer-To-Payer Application Programming Interface Workflow

The 2024 CMS Interoperability and Prior Authorization final rule (CMS-0057-F) requires impacted payers¹ to implement and maintain a Payer-to-Payer Application Programming Interface (API) to make available (1) claims and encounter data (excluding provider remittances and enrollee cost-sharing information), (2) all data classes, data elements in an adopted version of the United States Core Data for Interoperability (USCDI), and (3) information about prior authorizations (excluding those for drugs and those that were denied). A workflow depicting the exchange of information between a patient's current payer and previous or concurrent payer using the required and recommended technical standards and implementation guides (IGs) is below. An asterisk (*) denotes recommended IGs.



**The FHIR Bulk Data Access IG is a required IG and used to gather data for multiple patients.

Footnotes 1-3 noted on following page.

Technical Standards and IGs

Required Standards

- **United States Core Data for Interoperability (USCDI):** USCDI is a standardized set of health data content for nationwide, interoperable health information exchange. It sets a foundation for sharing electronic health information to support patient care.
- **Health Level Seven® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®):** The FHIR standard defines how health care information can be exchanged between different computer systems regardless of how it is stored in those systems. It enables health data, including clinical and administrative data, to be quickly and efficiently exchanged.
- **HL7 FHIR US Core IG:** This IG is a set of standards that define how health care systems in the United States exchange patient data using the FHIR format. It provides common rules and data templates for essential information like medications, allergies, and lab results to ensure consistency and interoperability. It serves as the foundation for secure, standardized health data sharing across electronic health records (EHRs), apps, and payers.
- **FHIR Bulk Data Access IG:** This IG defines a standardized, FHIR-based approach to efficiently export large volumes of health data (like entire record(s) for one or more patients) from one system to another pre-authorized system, using an asynchronous process.

Recommended Standards

- **HL7 FHIR Consumer Directed Payer Data Exchange (CARIN IG for Blue Button®):** This IG uses explanation of benefits (EOB) data to enable beneficiaries to access their claims and encounter data and share that electronic information through an API.
- **HL7 Da Vinci—Payer Data Exchange (PDex) IG:** This IG facilitates the exchange of clinical and administrative information by health plans for members to authorized entities, such as their health care providers, payers that the member consents to sharing data with, or other parties based on a member's request.

Workflow Footnotes

¹ “Impacted payers” are Medicare Advantage (MA) organizations, state Medicaid and Children’s Health Insurance Program (CHIP) fee-for-service (FFS) programs, Medicaid managed care plans, CHIP managed care entities, and issuers that offer individual market Qualified Health Plans (QHPs) on the Federally-facilitated Exchanges (FFE).

² The 2024 final rule requires impacted payers, like Payer A, to request, at a minimum, patient data from the patient’s last payer and any concurrent payer(s). However, if a patient reports multiple previous payers in response to this request, the impacted payer must request the patient’s data from all the patient’s previous payers within the previous five years. Payer A must request a patient’s data from Payer B no later than one week after Payer A has sufficient identifying information and the patient has opted into the data exchange. When Payer B is a concurrent payer, Payer A must continue to request updated data from Payer B quarterly.

³ The 2024 final rule requires Payer B to respond to Payer A’s request for data when Payer B is an impacted payer.