

---

# Issue Brief

FEDERAL ISSUE BRIEF



*Analysis provided for MHA by Larry Goldberg, Goldberg Consulting*

## CMS Finalizing Interoperability and Prior Authorization Rule

The Centers for Medicare & Medicaid Services (CMS) are issuing a final rule regarding Interoperability and Prior Authorization.

Through the provisions in the rule, 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 Qualified Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FfEs), (collectively "impacted payers") are required to implement and maintain certain Health Level 7® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) application programming interfaces (APIs) to improve the electronic exchange of health care data, as well as to streamline prior authorization processes.

To encourage providers to adopt electronic prior authorization processes, the rule also adds a new measure for Merit-based Incentive Payment System (MIPS) eligible clinicians under the Promoting Interoperability performance category of MIPS, as well as for eligible hospitals and critical access hospitals (CAHs), under the Medicare Promoting Interoperability Program.

The final rule is at the **Federal Register** office for publication on February 8. A copy of the 728-page document is available at: <https://public-inspection.federalregister.gov/2024-00895.pdf>.

### Comments

CMS posted a version of the rule on January 17 on its website. That version was 822 pages. We are using the **Federal Register** copy of 728 pages for the material that follows.

The rule is both complex and intense. It includes what was proposed, comments received, responses and final action sections. To understand the final action sections, one needs to first understand what was proposed and second the changes CMS is making in this final rule.

According to CMS, most of the rule relates to payers.

We are taking a different approach in analyzing the rule. We are providing a section-by-section table of contents. This should help in deciding which material maybe applicable to you.

Page numbers of the rule are provided in red.

### Medicare Fee-for-Service Implementation of Final Policies (Page 20)

Although these requirements do not directly pertain to Medicare FFS, CMS says "it wants to ensure that people with Medicare can benefit from the policies in this rule, regardless of their coverage or delivery system. CMS intends for the Medicare FFS program to be a market leader on data exchange, including through the Provider Access, Payer-to-Payer, and Prior Authorization APIs."

"Providers can use the Prior Authorization API to determine whether a specific payer requires prior authorization for a certain item or service, thereby easing one of the major points of administrative burden in the existing prior authorization process."

---

## Effective Dates

For the Provider Access API policy, CMS is finalizing compliance dates in 2027 (by January 1, 2027, for MA organizations and state Medicaid and CHIP FFS programs; by the rating period beginning on or after January 1, 2027 for Medicaid managed care plans and CHIP managed care entities; and for plan years beginning on or after January 1, 2027 for QHP issuers on the FFEs).

## Table of Contents -- Interoperability and Prior Authorization Rule

### I. Background, Summary of Provisions, and Terms (Page 3)

- A. Purpose and Background
- B. Summary of Major Provisions (Page 5)
- C. Specific Terms Used in this Final Rule (Page 12)
- D. Global Comments (Page 17)
  - 1. Medicare Fee-for-Service Implementation of Final Policies (Page 18)
  - 2. Compliance Dates and Enforcement (Page 18)
  - 3. Exclusion of Drugs (Page 25)
  - 4. Impacted Payers (Page 29)
  - 5. Withdrawal of Proposed Rule (Page 33)
  - 6. National Directory of Healthcare (Page 33)

### II. Provisions of the Proposed Rule and the Analysis of and Responses to Public Comments

- A. Patient Access API (Page 36)
  - 1. Background
  - 2. Enhancing the Patient Access API (Page 36)
    - a. Prior Authorization Information (Page 42)
      - i. Compliance Dates (Page 47)
      - ii. Data Content (Page 50)
      - iii. Timeline for Data Sharing (Page 60)
      - iv. Length of Prior Authorization Data Availability (Page 64)
    - b. Interaction with HIPAA Right of Access Provisions (Page 68)
    - c. Patient Access API Metrics (Page 71)
      - i. Reporting Level (Page 75)
      - ii. Annual Reporting (Page 78)
      - iii. Public Reporting (Page 79)
      - iv. Other Metrics (Page 80)
    - d. Patient Access API Amendments (Page 81)
    - e. Medicaid Expansion CHIP Programs (Page 83)
    - f. Specific CHIP-related Regulatory Framework (Page 83)
  - 3. Other Requests for Comment (Page 84)
  - 4. Final Action (Page 86)
  - 5. Statutory Authorities for the Patient Access API Policies (Page 88)
    - a. MA Organizations (Page 88)
    - b. Medicaid and CHIP (Page 90)
    - c. Qualified Health Plan Issuers on the Federally-Facilitated Exchanges (Page 95)
- B. Provider Access API (Page 97)
  - 1. Background
  - 2. Requirements for Payers: Provider Access API for Individual Patient Information (Page 99)
    - a. General Comments (Page 105)
    - b. Compliance Dates (Page 106)
    - c. Identifying Providers and Networks (Page 109)
    - d. Provider Adoption and Use (Page 113)
    - e. Data Content (Page 123)
    - f. Provider Remittances and Cost-Sharing Information (Page 128)

- g. Prior Authorization Data (Page 131)
- h. Data Availability (Page 135)
- i. Response Timeframe for Requested Data (Page 137)
- j. Interaction with HIPAA Privacy, Security, and Administrative Transaction Rules (Page 141)
- k. Technical and Standards Considerations (Page 144)
- l. Interaction with ONC Policies (Page 148)
- m. Interaction with Trusted Exchange Framework and Common Agreement (Page 149)
- n. Federal Matching Funds for State Medicaid and CHIP FFS Expenditures on Implementation of the Provider Access API (Page 151)
- o. Medicaid Expansion CHIP (Page 151)
- 3. Additional Requirements for the Provider Access API (Page 151)
  - a. Attribution (Page 151)
  - b. Opt-Out
    - 1. General Comments on Opt-Out (Page 168)
    - ii. Interaction with HIPAA (Page 171)
    - iii. Interaction with Health Information Exchanges (Page 174)
    - iv. Opt-Out Process Design (Page 177)
    - v. Opt-Out Timeframes (Page 181)
  - c. Patient Educational Resources Regarding the Provider Access API (Page 181)
    - i. Dissemination (Page 183)
    - ii. Content (Page 184)
  - d. Provider Resources Regarding the Provider Access API (Page 188)
    - i. Dissemination (Page 189)
    - ii. Content (Page 189)
- 4. Extensions, Exemptions, and Exceptions (Page 192)
- 5. Final Action (Page 194)
- 6. Statutory Authorities for Provider Access API (Page 197)
  - a. Medicare Advantage Organizations (Page 197)
  - b. Medicaid and CHIP (Page 199)
  - c. Qualified Health Plan Issuers on the Federally-Facilitated Exchanges (Page 202)
- C. Payer-to-Payer API (Page 204)
  - 1. Background
  - 2. Proposal to Rescind the CMS Interoperability and Patient Access Final Rule Payer to Payer Data Exchange Policy (Page 214)
  - 3. Payer to Payer Data Exchange on FHIR (Page 216)
    - a. Payer-to-Payer API Technical Standards
    - b. Payer-to-Payer API Data Content Requirements (Page 227)
      - i. Data Content
      - ii. Provider Remittances and Patient Cost-Sharing (Page 235)
      - iii. Prior Authorization Data (Page 236)
      - iv. Duration of Prior Authorization Data to be Exchanged (Page 241)
      - v. Considering Prior Authorizations from Another Payer (Page 243)
  - c. Identifying Previous and Concurrent Payers and Opt-In (Page 245)
    - i. Process Timing (Page 245)
    - ii. Gathering Previous and Concurrent Payer Information (Page 251)
    - iii. Currently Enrolled Patients (Page 257)
    - iv. Opt-In (Page 257)
  - d. Requesting Data Exchange from a Patient's Previous/Concurrent Payer(s) and Responding to such a Request (Page 268)
    - i. Timeframe for Requesting Data (Page 268)
    - ii. Additional Data Exchange (Page 273)
    - iii. Authorization and Authentication Protocols (Page 275)
    - iv. Attestation (Page 277)
    - v. Timeframe for Responding to a Request (Page 279)
    - vi. Payers Not Subject to this Regulation (Page 281)
  - e. Ongoing Data Exchange Requirements for Concurrent Coverage (Page 284)
    - i. Concurrent Coverage Data Exchange
    - ii. Concurrent Payer Exchange Timeframe (Page 286)

- f. Data Incorporation and Maintenance (Page 288)
          - i. Data Incorporation
          - ii. Data Retention (Page 293)
        - g. Patient Education Resources (Page 295)
  - 4. Payer to Payer Data Exchange in Medicaid and CHIP (Page 300)
    - a. Inclusion of Medicaid and CHIP Fee-for-Service
    - b. Medicaid and CHIP – Seeking Permission Using an Opt-In Approach in the Payer-to-Payer API (Page 301)
    - c. Federal Matching Funds for State Medicaid and CHIP Expenditures on Implementation Payer to Payer Data Exchange (Page 312)
    - d. Medicaid Expansion CHIP (Page 312)
  - 5. Extensions, Exemptions, and Exceptions (Page 312)
  - 6. Final Action (Page 315)
  - 7. Statutory Authorities for Payer-to-Payer Data Exchange Proposals (Page 319)
    - a. MA Organizations (Page 319)
    - b. Medicaid and Children’s Health Insurance Program (Page 322)
    - c. Qualified Health Plan Issuers on the Federally-Facilitated Exchanges (Page 327)
- D. Prior Authorization API and Improving Prior Authorization Processes (Page 329)
  - 1. Background
    - a. Compliance Dates (Page 334)
  - 2. Requirement to Implement an API for Prior Authorization (Page 337)
    - a. Prior Authorization API
    - b. FHIR Implementation Guides (Page 342)
    - c. Implementation, Automation, and Other General Considerations for the Prior Authorization API and Processes (Page 349)
    - d. Implementation Timing Considerations (Page 359)
    - e. Existing Prior Authorization Standards: HIPAA Exceptions for Testing New Standards (Page 362)
    - f. Federal Matching Funds for State Medicaid and CHIP Fee-for-Service Programs’ Expenditures on Implementation of the Prior Authorization API (Page 371)
    - g. Medicaid Expansion CHIP (Page 371)
  - 3. Requirement for Payers to Provide Reason for Denial of Prior Authorizations and Notifications (Page 371)
    - a. Background on Providing a Reason for Denial of Prior Authorization (Page 371)
    - b. Denial Reason and Denial/Decision Codes (Page 372)
    - c. Existing Notice Requirements to Communicate Prior Authorization Denial Information – By Program (Page 380)
      - i. Denial Notice Requirements (Page 381)
      - ii. Notice and Payer Communications (Page 385)
  - 4. Requirements for Prior Authorization Decision Timeframes and Communications (Page 388)
    - a. Impact of Delays in Prior Authorization Decisions: Background of Decision Timeframes
    - b. Standard and Expedited Prior Authorization Requests and Decision Timeframes (Page 388)
    - c. Decision Timeframes for Standard and Expedited Prior Authorization Requests (Page 392)
    - d. Operational Topics (Page 406)
  - 5. Requirements for Timing of Notifications Related to Prior Authorization Decisions (Page 409)
    - a. Medicare Advantage Organizations
    - b. Medicaid Fee-for-Service, Including Beneficiary Notice and Fair Hearings (Page 412)
    - c. Medicaid Managed Care (Page 418)
    - d. CHIP Fee-for-Service and Managed Care (Page 420)
  - 6. Extensions, Exemptions, and Exceptions (Page 423)
  - 7. Public Reporting Requirements for Prior Authorization Metrics (Page 424)
    - a. Reporting Prior Authorization Metrics (Page 426)
    - b. Publication of Prior Authorization Metrics (Page 439)
    - c. Types of Prior Authorization Metrics (Page 440)
  - 8. “Gold-Carding” Programs for Prior Authorization (Page 441)
  - 9. Final Action (Page 444)

- 
10. Statutory Authorities to Require Improvements in Prior Authorization Processes, Decision and Notification Timeframe Policies (Page 446)
    - a. Medicare Advantage
    - b. Medicaid (Page 450)
      - i. Prior Authorization API (Page 452)
      - ii. Requirement for Payers to Provide Specific Reason for Denial of Prior Authorizations (Page 452)
      - iii. Requirements for Prior Authorization Decision Timeframes, Notifications Related to Prior Authorization Decision Timeframes, and Amendments to Existing Medicaid Fair Hearings and Appeals Regulations (Page 453)
      - iv. Public Reporting of Prior Authorization Metrics (Page 455)
    - c. CHIP (Page 456)
    - d. Qualified Health Plan Issuers on the Federally-Facilitated Exchanges (Page 459)
  - E. Extensions, Exemptions, and Exceptions and Federal Matching Funds for Medicaid and CHIP (Page 461)
    1. Background
    2. Extensions, Exemptions, and Exceptions (Page 461)
      - a. Extensions and Exemptions for State Medicaid and CHIP Fee-for-Service
      - b. Exception for Qualified Health Plan Issuers on the Federally-Facilitated Exchanges (Page 473)
    3. Federal Matching Funds for State Medicaid and CHIP Expenditures on Implementation of the Provider Access, Payer-to-Payer, and Prior Authorization APIs (Page 477)
    4. Medicaid Expansion CHIP (Page 481)
    5. Final Action (Page 482)
  - F. Electronic Prior Authorization Measures for the Merit-based Incentive Payment System Promoting Interoperability Performance Category and the Medicare Promoting Interoperability Program (Page 486)
    1. Background
    2. Electronic Prior Authorization (Page 487)
      - a. Measure Specifications (Page 506)
      - b. Prior Authorization API Functionality (Page 521)
      - c. Measure Exclusions (Page 531)
      - d. Office of the National Coordinator for Health Information Technology Health IT Certification Program (Page 533)
      - e. Other Considerations (Page 533)
    3. Final Action (Page 539)
  - G. Interoperability Standards for APIs (Page 544)
    1. Background
    2. Modifications to Required Standards for APIs (Page 545)
      - a. HL7 FHIR and Technical Readiness (Page 547)
      - b. Additional Implementation Guide Discussion (Page 567)
      - c. Using Updated Versions of Required Standards (Page 568)
    3. Recommended Standards to Support APIs (Page 576)
      - a. Recommending vs. Requiring Implementation Guides (Page 576)
      - b. Implementation Guide Maturity (Page 582)
      - c. Authentication and Authorization (Page 592)
    4. Required Standards and Recommended Implementation Guides to Support APIs (Page 594)
    5. Final Action (Page 598)

### **III. Collection of Information Requirements (Page 600)**

### **IV. Regulatory Impact Analysis (Page 628)**

### **Summary of Major Provisions**

The material that follows is basically from CMS' fact sheet on this rule.

---

### **Patient Access API**

CMS is requiring impacted payers to add information about prior authorizations (excluding those for drugs) to the data available via that Patient Access API. This requirement must be implemented by January 1, 2027.

To assess Patient Access API usage, beginning January 1, 2026, CMS is requiring impacted payers to report annual metrics to CMS about Patient Access API usage.

### **Provider Access API**

To facilitate care coordination and support movement toward value-based payment models, CMS is requiring that impacted payers implement and maintain a Provider Access API to share patient data with in-network providers with whom the patient has a treatment relationship. Impacted payers will be required to make the following data available via the Provider Access API: individual claims and encounter data (without provider remittances and enrollee cost-sharing information); data classes and data elements in the United States Core Data for Interoperability (USCDI); and specified prior authorization information (excluding those for drugs).

CMS is also requiring impacted payers to maintain an attribution process to associate patients with in-network or enrolled providers with whom they have a treatment relationship and to allow patients to opt-out of having their data available to providers under these requirements. Impacted payers will be required to provide plain language information to patients about the benefits of API data exchange with their providers and their ability to opt out.

These requirements must be implemented by January 1, 2027.

### **Payer-to-Payer API**

To support care continuity, CMS is requiring that impacted payers implement and maintain a Payer-to-Payer API to make available claims and encounter data (excluding provider remittances and enrollee cost-sharing information), data classes and data elements in the USCDI and information about certain prior authorizations (excluding those for drugs). Impacted payers are only required to share patient data with a date of service within five years of the request for data.

CMS is also finalizing an opt-in process for patients to provide permission under these requirements. Impacted payers are required to provide plain-language educational resources to patients that explain the benefits of the Payer-to-Payer API data exchange and their ability to opt-in.

These requirements must be implemented by January 1, 2027.

### **Prior Authorization API**

CMS is requiring impacted payers to implement and maintain a Prior Authorization API that is populated with its list of covered items and services, can identify documentation requirements for prior authorization approval, and supports a prior authorization request and response. These Prior Authorization APIs must also communicate whether the payer approves the prior authorization request (and the date or circumstance under which the authorization ends), denies the prior authorization request (and a specific reason for the denial), or requests more information. This requirement must be implemented beginning January 1, 2027.

In response to feedback received on multiple rules, extensive stakeholder outreach, and to further promote efficiency in the prior authorization process, HHS will be announcing the use of enforcement

---

discretion for the Health Insurance Portability and Accountability Act of 1996 (HIPAA) X12 278 prior authorization transaction standard. Covered entities that implement an all-FHIR-based Prior Authorization API pursuant to the CMS Interoperability and Prior Authorization final rule that do not use the X12 278 standard as part of their API implementation will not be enforced against under HIPAA Administrative Simplification, thus allowing limited flexibility for covered entities to use a FHIR-only or FHIR and X12 combination API to satisfy the requirements of the CMS Interoperability and Prior Authorization final rule. Covered entities may also choose to make available an X12-only prior authorization transaction. HHS will continue to evaluate the HIPAA prior authorization transaction standards for future rulemaking.

### ***Improving Prior Authorization Processes***

**Prior Authorization Decision Timeframes:** CMS is requiring impacted payers (excluding QHP issuers on the FFEs) to send prior authorization decisions within 72 hours for expedited (i.e., urgent) requests and seven calendar days for standard (i.e., non-urgent) requests.

**Provider Notice, Including Denial Reason:** Beginning in 2026, impacted payers must provide a specific reason for denied prior authorization decisions, regardless of the method used to send the prior authorization request. Such decisions may be communicated via portal, fax, email, mail, or phone. As with all policies in this final rule, this provision does not apply to prior authorization decisions for drugs. This requirement is intended to both facilitate better communication and transparency between payers, providers, and patients, as well as improve providers' ability to resubmit the prior authorization request, if necessary. Some impacted payers are also subject to existing requirements to provide information about denials to providers, patients, or both through notices. These existing notices are often required in writing, but nothing in this final rule changes these existing requirements.

**Prior Authorization Metrics:** CMS is requiring impacted payers to publicly report certain prior authorization metrics annually by posting them on their website.

These operational or process-related prior authorization policies are being finalized with a compliance date starting January 1, 2026, and the initial set of metrics must be reported by March 31, 2026.

### ***Electronic Prior Authorization Measure for MIPS Eligible Clinicians and Eligible Hospitals and Critical Access Hospitals (CAHs)***

CMS is adding a new measure, titled "Electronic Prior Authorization," to the Health Information Exchange (HIE) objective for the MIPS Promoting Interoperability performance category and the Medicare Promoting Interoperability Program. MIPS eligible clinicians will report the Electronic Prior Authorization measure beginning with the Calendar Year (CY) 2027 performance period/CY 2029 MIPS payment year and eligible hospitals and CAHs beginning with the CY 2027 EHR reporting period. This will be an attestation measure, for which the MIPS eligible clinician, eligible hospital, or CAH reports a yes/no response or claims an applicable exclusion, rather than the proposed numerator/denominator.

To successfully report the Electronic Prior Authorization measure:

MIPS eligible clinicians must attest "yes" to requesting a prior authorization electronically via a Prior Authorization API using data from certified electronic health record technology (CEHRT) for at least one medical item or service (excluding drugs) ordered during the CY 2027 performance period or (if applicable) report an exclusion.

Eligible hospitals and CAHs must attest "yes" to requesting a prior authorization request electronically via a Prior Authorization API using data from CEHRT for at least one hospital discharge and medical

---

item or service (excluding drugs) ordered during the 2027 EHR reporting period or (if applicable) report an exclusion.

### **Required Standards and Recommended Implementation Guides (IGs) for APIs**

The required standards and implementation specifications in this final rule include the following:

United States Core Data for Interoperability (USCDI)  
HL7® Fast Healthcare Interoperability Resources (FHIR®) Release 4.0.1  
HL7 FHIR US Core Implementation Guide (IG) Standard for Trial Use (STU) 3.1.1  
HL7 SMART Application Launch Framework Implementation Guide Release 1.0.0  
FHIR Bulk Data Access (Flat FHIR) (v1.0.0: STU 1)  
OpenID Connect Core 1.0

For information on which required standards and implementation specifications apply to each API, see Table H3 below.

CMS will allow flexibility for impacted payers to use updated versions of the standards and IGs. Impacted payers may use an updated ONC-approved standard, instead of the standard specified in regulation, if the update does not disrupt end users' ability to access the required data through the API.

### **Recommended Implementation Guides**

When implementing the updated Patient Access API, the existing Provider Directory API, and the new APIs (Provider Access, Payer-to-Payer, and the Prior Authorization APIs), CMS strongly encourages impacted payers to use the following IGs, as applicable, to reduce burden and increase interoperability:

- HL7 FHIR CARIN Consumer Directed Payer Data Exchange (CARIN IG for Blue Button®) IG Version STU 2.0.0
- HL7 SMART App Launch IG Release 2.0.0 to support Backend Services Authorization
- HL7 FHIR Da Vinci Payer Data Exchange (PDex) IG Version STU 2.0.0
- HL7 FHIR Da Vinci PDex US Drug Formulary IG Version STU 2.0.1
- HL7 FHIR Da Vinci PDex Plan-Net IG Version STU 1.1.0
- HL7 FHIR Da Vinci Coverage Requirements Discovery (CRD) IG Version STU 2.0.1
- HL7 FHIR Da Vinci Documentation Templates and Rules (DTR) IG Version STU 2.0.0
- HL7 FHIR Da Vinci Prior Authorization Support (PAS) IG Version STU 2.0.1

The standards CMS is finalizing, including updated citations are as follows:

- Health Level Seven (HL7®) Fast Healthcare Interoperability Resources (FHIR®) Release 4.0.1 at 45 CFR 170.215(a)(1) (HL7 FHIR).
- HL7® FHIR® US Core Implementation Guide (IG) Standard for Trial Use (STU) 3.1.1, which expires on January 1, 2026, at 45 CFR 170.215(b)(1)(i) (US Core IG).
- HL7® SMART Application Launch Framework IG Release 1.0.0 which expires on January 1, 2026, at 45 CFR 170.215(c)(1) (SMART App Launch IG).
- FHIR® Bulk Data Access (Flat FHIR) IG v1.0.0: STU 1 at 45 CFR 170.215(d)(1) (Bulk Data Access IG).
- OpenID Connect Core 1.0, incorporating errata set 1 at 45 CFR 170.215(e)(1) (OpenID Connect Core).



**TABLE H3: Required Standards and Recommended Implementation Guides To Support API Implementation**

API	Required Standards*	Recommended Implementation Guides
<b>Patient Access API</b>	<p>45 CFR 170.215(a)(1) HL7 FHIR Release 4.0.1</p> <p>45 CFR 170.215(b)(1)(i) HL7 FHIR US Core IG STU 3.1.1.***</p> <p>45 CFR 170.215(c)(1) HL7 SMART Application Launch Framework IG Release 1.0.0.***</p> <p>45 CFR 170.215(e)(1) OpenID Connect Core 1.0, incorporating errata set 1</p>	<p>HL7 FHIR CARIN Consumer Directed Payer Data Exchange (CARIN IG for Blue Button®) IG STU 2.0.0. URL: <a href="http://hl7.org/fhir/us/carin-bb/history.html">http://hl7.org/fhir/us/carin-bb/history.html</a>.</p> <p>HL7 FHIR Da Vinci Payer Data Exchange (PDex) IG STU 2.0.0. URL: <a href="http://hl7.org/fhir/us/davinci-pdex/history.html">http://hl7.org/fhir/us/davinci-pdex/history.html</a>.</p> <p>HL7 FHIR Da Vinci - Payer Data Exchange (PDex) US Drug Formulary IG STU 2.0.1. URL: <a href="http://hl7.org/fhir/us/Davinci-drug-formulary/history.html">http://hl7.org/fhir/us/Davinci-drug-formulary/history.html</a>.</p>
<b>Provider Access API</b>	<p>45 CFR 170.215(a)(1) HL7 FHIR Release 4.0.1</p> <p>45 CFR 170.215(b)(1)(i) HL7 FHIR US Core IG STU 3.1.1.***</p> <p>45 CFR 170.215(c)(1) HL7 SMART Application Launch Framework IG Release 1.0.0.***</p> <p>45 CFR 170.215(d)(1) FHIR Bulk Data Access (Flat FHIR) IG (v1.0.0: STU 1)</p>	<p>HL7 FHIR CARIN Consumer Directed Payer Data Exchange (CARIN IG for Blue Button®) IG STU 2.0.0. URL: <a href="http://hl7.org/fhir/us/carin-bb/history.html">http://hl7.org/fhir/us/carin-bb/history.html</a>.</p> <p>HL7 FHIR Da Vinci Payer Data Exchange (PDex) IG STU 2.0.0. URL: <a href="http://hl7.org/fhir/us/davinci-pdex/history.html">http://hl7.org/fhir/us/davinci-pdex/history.html</a>.</p> <p>45 CFR 170.215(c)(2) HL7 SMART App Launch IG, Release 2.0.0 to support Backend Services Authorization. URL: <a href="https://hl7.org/fhir/smart-app-launch/STU2/backend-services.html">https://hl7.org/fhir/smart-app-launch/STU2/backend-services.html</a></p>
<b>Provider Directory API**</b>	<p>45 CFR 170.215(a)(1) HL7 FHIR Release 4.0.1</p> <p>45 CFR 170.215(b)(1)(i) HL7 FHIR US Core IG STU 3.1.1.***</p>	<p>HL7 FHIR Da Vinci Payer Data Exchange (PDex) Plan Net IG STU 1.1.0. URL: <a href="http://www.hl7.org/fhir/us/davinci-pdex-plan-net/history.html">http://www.hl7.org/fhir/us/davinci-pdex-plan-net/history.html</a>.</p>
<b>Payer-to-Payer API</b>	<p>45 CFR 170.215(a)(1) HL7 FHIR Release 4.0.1</p> <p>45 CFR 170.215(b)(1)(i) HL7 FHIR US Core IG STU 3.1.1.***</p> <p>45 CFR 170.215(d)(1) FHIR Bulk Data Access (Flat FHIR) IG (v1.0.0: STU 1)</p>	<p>HL7 FHIR Consumer Directed Payer Data Exchange (CARIN IG for Blue Button®) IG STU 2.0.0. URL: <a href="http://hl7.org/fhir/us/carin-bb/history.html">http://hl7.org/fhir/us/carin-bb/history.html</a>.</p> <p>HL7 FHIR Da Vinci Payer Data Exchange (PDex) IG STU 2.0.0. URL: <a href="http://hl7.org/fhir/us/davinci-pdex/history.html">http://hl7.org/fhir/us/davinci-pdex/history.html</a>.</p> <p>45 CFR 170.215(c)(2) HL7 SMART App Launch IG, Release 2.0.0 to support Backend Services Authorization. URL: <a href="https://hl7.org/fhir/smart-app-launch/STU2/backend-services.html">https://hl7.org/fhir/smart-app-launch/STU2/backend-services.html</a></p>
<b>Prior Authorization API</b>	<p>45 CFR 170.215(a)(1) HL7 FHIR Release 4.0.1</p> <p>45 CFR 170.215(b)(1)(i) HL7 FHIR US Core IG STU 3.1.1.***</p> <p>45 CFR 170.215(c)(1) HL7 SMART Application Launch Framework IG Release 1.0.0.***</p>	<p>HL7 FHIR Da Vinci - Coverage Requirements Discovery (CRD) IG STU 2.0.1. URL: <a href="http://hl7.org/fhir/us/davinci-crd/history.html">http://hl7.org/fhir/us/davinci-crd/history.html</a>.</p> <p>HL7 FHIR Da Vinci - Documentation Templates and Rules (DTR) IG STU 2.0.0. URL: <a href="http://hl7.org/fhir/us/davinci-dtr/history.html">http://hl7.org/fhir/us/davinci-dtr/history.html</a>.</p> <p>HL7 FHIR Da Vinci Prior Authorization Support (PAS) IG STU 2.0.1. URL: <a href="http://hl7.org/fhir/us/davinci-pas/history.html">http://hl7.org/fhir/us/davinci-pas/history.html</a>.</p>

---

## **Final Thoughts**

We have only one basic comment. Once again, CMS has not provided a complete table of contents. This is not helpful at all. If we can make such why can't CMS do so. The agency is always arguing to reduce burden. Yet, they are continuously failing to abide by their own standards.