**FAQS ABOUT CMS INTEROPERABILITY AND PATIENT ACCESS FINAL RULE (CMS-9115-F) PAYER-TO-PAYER DATA SHARING REQUIREMENT**

[Publication Date]

Set out below are frequently asked questions (FAQs) regarding how the Centers for Medicare & Medicaid Services (CMS) is exercising its discretion in how it enforces the payer-to-payer data exchange provisions (85 FR 25564-25569) of the CMS Interoperability and Patient Access final rule (CMS-9115-F, 85 FR 25510, May 1, 2020). These FAQs have been prepared by the CMS Office of Burden Reduction & Health Informatics (OBRHI) Health Informatics and Interoperability Group (HIIG), and are published to address stakeholder questions and promote compliance.

**Q1: What is the payer-to-payer data exchange requirement?**

On May 1, 2020, CMS published the CMS Interoperability and Patient Access final rule (CMS-9115-F) to establish policies that advance interoperability and patient access to health information. The rule required Medicare Advantage (MA) organizations, Medicaid managed care plans, Children's Health Insurance Program (CHIP) managed care entities, and Qualified Health Plan (QHP) issuers on the Federally-facilitated Exchanges (FFEs) (collectively referred to as "impacted payers") to facilitate enhanced data sharing by exchanging data with other payers at the patient's request, starting January 1, 2022 or for plan or policy years beginning on or after January 1, 2022, as applicable.[1] CMS also required these impacted payers to incorporate and maintain the data they receive through this payer-to-payer data exchange into the enrollee's record, with the goal of increasing transparency for patients, promoting better coordinated care, reducing administrative burden, and enabling patients to establish a collective patient healthcare record as they move throughout the healthcare system. [2] These policies are collectively referred to as the "payer-to-payer data exchange requirement."

**Q2: Will CMS enforce the payer-to-payer data exchange requirements on January 1, 2022 as finalized in the CMS Interoperability and Patient Access final rule?**

No. CMS is exercising its discretion in how it enforces the payer-to-payer data exchange provisions (85 FR 25564-25569) of the CMS Interoperability and Patient Access final rule (CMS-9115-F). As a matter of enforcement discretion, CMS will not take action to enforce compliance with these specific provisions until future rulemaking is finalized. CMS's decision to exercise enforcement discretion for the payer-to-payer policy until future rulemaking is finalized does not affect any other existing regulatory requirements and implementation timelines finalized in the CMS Interoperability and Patient Access rule finalized on May 1, 2020.

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[1] 42 CFR §§ 422.119(f); 438.62(b)(1)(vi); 457.1216 (which requires compliance with § 438.62); and 45 CFR § 156.221(f)

[2] 42 CFR §§ 422.119(h); 438.62(b)(1)(vii); 457.1216 (which requires compliance with § 438.62); and 45 CFR § 156.221(h)(2)

CMS continues to encourage impacted payers that have already developed Fast Healthcare Interoperability Resources (FHIR)-based application programming interface (API) solutions to support payer-to-payer data exchange to continue to move forward with implementation and make this functionality available on January 1, 2022 in accordance with the CMS Interoperability and Patient Access final rule policies. However, for those impacted payers that are not capable of making the data available in a FHIR-based API format, we believe this enforcement discretion will alleviate industry tension regarding implementation; avoid the risk of discordant, non-standard data flowing between payers; provide time for data standards to mature further through constant development, testing, and reference implementations; and allow payers additional time to implement more sophisticated payer-to-payer data exchange solutions.

**Q3: Why is CMS exercising enforcement discretion for the payer-to-payer data exchange provisions of the CMS Interoperability and Patient Access final rule (CMS-9115-F)?**

In the CMS Interoperability and Patient Access final rule, CMS did not require a specific mechanism for the payer-to-payer data exchange. Rather, CMS required impacted payers to receive data in whatever format it was sent and send data in the form and format it was received, which ultimately complicated implementation by requiring payers to accept data in different formats.

Since the rule was finalized in May 2020, multiple impacted payers have indicated to CMS that the lack of technical specifications for the payer-to-payer data exchange requirement is creating challenges for implementation, which may lead to differences in implementation across industry, poor data quality, operational challenges, and increased administrative burden. Differences in implementation approaches may create gaps in patient health information that conflict directly with the intended goal of interoperable payer-to-payer data exchange.

After listening to stakeholder concerns about implementing the payer-to-payer data exchange requirement and considering the potential for negative outcomes that impede, rather than support, interoperable payer-to-payer data exchange, CMS is exercising enforcement discretion to delay the payer-to-payer data exchange requirement until future rulemaking is finalized.