

Payer to Payer Access API Guide



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Preface

Purpose and Scope

The CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) requires CMS-regulated payers to build and maintain a Payer to Payer API to enable the data exchange between Responding/Old Payer and a Requesting/New Payer. The Requesting/ Responding Payers can also act as concurrent Payers. FHIR System will be acting as the Requesting/New Payer in the Payer-to-Payer Requestor Flow and as Responding/Old Payer in the Payer-to-Payer Responder Flow.

The CMS Prior Authorization Rule (CMS-0057) limits the data to be exchanged via Payer-to-Payer APIs to Five years prior to the date of the request. Members are by default considered as opted-out of Payer to Payer API and Members have also been given provision to opt-in. The Requesting payers must request a patient's data from a patient's previous/concurrent payer(s) no later than one week after the start of coverage provided the patient has opted in. Responding/Old Payer must respond with the required data within one business day of receiving the request from the Requesting/New Payer.

This rule has emphasized that the Payer to Payer API must enable data exchange between Responding/Old Payer and a Requesting/New Payer that includes:

- Claims and encounter data (excluding Provider remittances and patient cost-sharing information), and
- Prior authorization requests and decisions (excluding those for drugs and those that were denied).

This document describes Acentra's Interoperability Solution that supports the new CMS mandate.

Document Conventions

This document uses the following conventions:

- The term "you" refers to the application owners who use this document.
- Italicized portions of the URLs represent placeholders for adding tenant-specific details.
- Hyperlink names appear in bold fonts.

Audience Requirements

This document is intended for third-party application owners or developers who need to know how to connect their applications to Acentra's Payer to Payer Access API, and for payers implementing the API to provide data to third-party applications via the API.

Chapter 1 – Overview

The Acentra Interoperability Solution is engineered to support the business and technical requirements defined in the CMS mandate (CMS Final Rule 0057 F). The solution leverages Da Vinci Payer Data Exchange 2.1.0 - STU 2.1 as anchors in conjunction with data exchange standards, such as HL7® Fast Healthcare Interoperability Resources (FHIR®), United States Core Data and Interoperability (USCDI), and CMS recommended Implementation Guides (IGs).

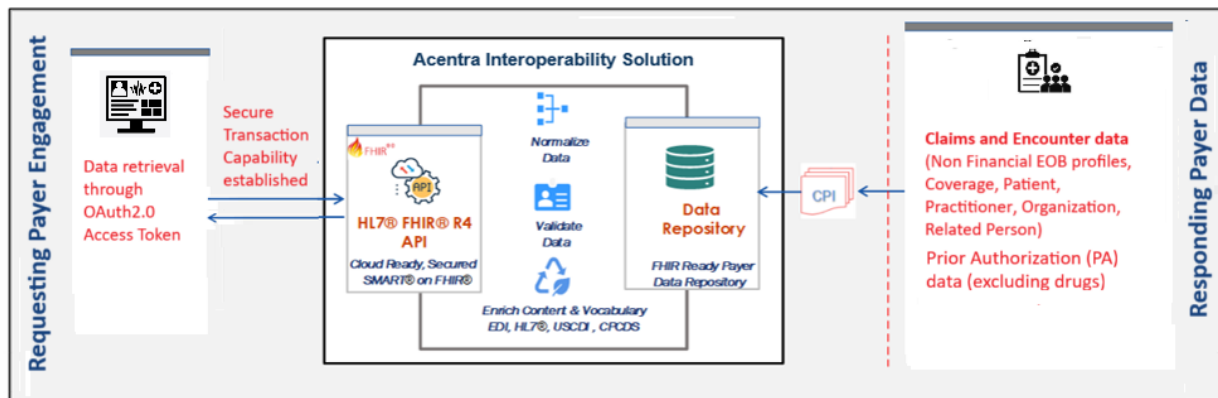


Figure 1 provides a diagram of the overall solution.

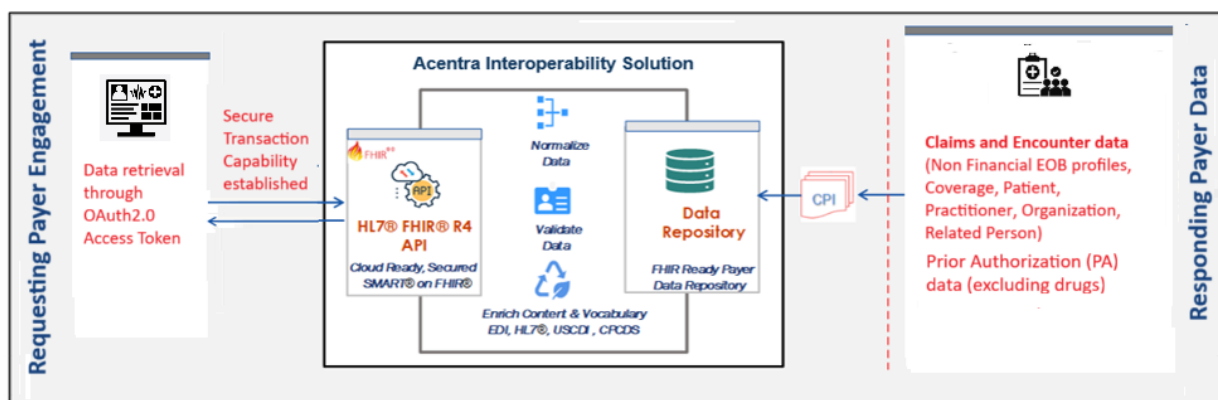


Figure 1. Acentra Interoperability Solution (Payer to Payer API Responder Flow)

Table 1 describes the features of the components of the Acentra Interoperability Solution.

Table 1. Payer to Payer Access API Solution Components

Component	Features
Mapper	Enables translation of Payer data to a Common Payer Interface (CPI), leveraging pre-built data intake templates.

Component	Features
	Streamlines the data mapping for payers by utilizing standardized business attributes with lineage across C4BB profiles, the PDex Prior Authorization profile and related frameworks leveraging industry standards to support seamless data access for Payers. Normalizes and enriches the data before loading to the FHIR Ready Payer Data Repository (FPDR).
Data Repository	Responder Flow: FHIR FPDR integrated with the CPI enables inter-related models for storing and retrieving data via logical views for Explanation of Benefits (EOBs). Data will be loaded from the payer Systems on a defined cadence and supplemented with the historical data necessary to meet the data availability requirement. The Provider, Organization, and Member and Consent data will be loaded daily, the Claims information will be loaded once every week after the RA Cycle is completed, and the Prior Authorization data will be loaded after Claims. Requestor Flow: Data received from each of the Responding Payer will be stored in FHIR Ready Payer Data Repository (FPDR) with corresponding Payer ID.
FHIR Adapter	Facilitates the retrieval of data from FPDR and integrates with the FHIR Server.
FHIR Server	Implements a RESTful FHIR API service that delivers standardized responses based on the CMS-mandated CARIN IG for Blue Button®, Da Vinci PDex Prior Authorization profiles, HReX Parameters - Member Match Response Profile, PDex \$multi-member-match response Profile for Data Export and Member Match operations accordingly. The API integrates SMART® on FHIR for secure authentication and authorization, ensuring controlled access of data exchange between Requesting Payer and Responding Payers. FHIR API endpoint of the Responding/Old Payer must be known by the Requesting/New Payer to enable data exchange through Payer to Payer API.
SMART on FHIR Module	Secures the Payer to Payer Access API by implementing the CMS-recommended standalone launch authorization sequence based on the OAuth 2.0 standard, as part of the SMART on FHIR framework. Enables federated authentication with identity Providers (IdPs) that support OAuth 2.0 or SAML 2.0 protocols, ensuring secure and seamless access for authorized Payers. Establishes a Secure Transaction Capability between the requesting Payer and responding Payer using mTLS secure connection to perform OAuth2.0 Dynamic Client Registration to acquire OAuth2.0 client credentials. Client credentials are used to acquire OAuth2.0 token.

1.1 Data Flow

The finalized claims and encounter data (excluding Provider remittances and patient cost-sharing information), beneficiary demographic data, and Prior authorization requests and

decisions (excluding those for drugs) are extracted from the Responding Payer Systems into the pre-defined CPI data intake templates.

The extracted data files will be sent to the Acentra Interoperability Solution using Secure File Transfer Protocol (SFTP) and will be imported into the FHIR-ready Payer Data Repository (FPDR) using the Mapper. Figure 2 depicts a high-level data flow.

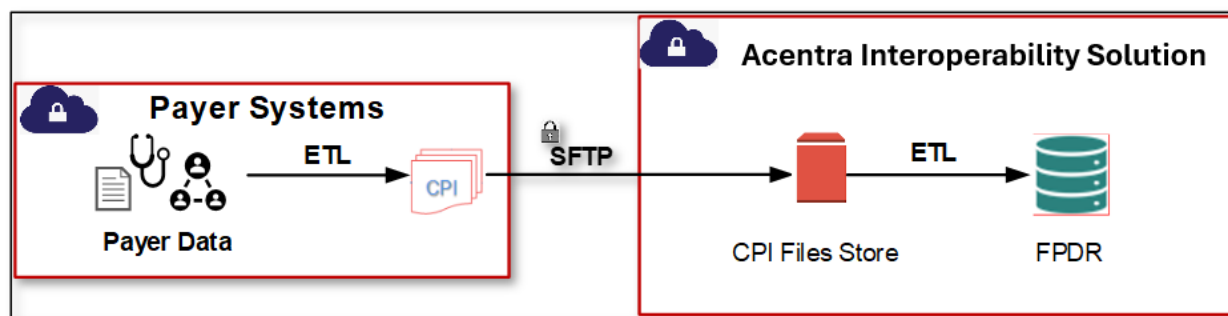


Figure 2. Payer to Payer Access API – Data Flow – Payer Systems to FPDR (Responder Flow)

As part of this process, Acentra’s Interoperability Solution normalizes, validates, and enriches the claims and encounter data, beneficiary demographic data, beneficiary Consent data, and Prior Authorization data to make it FHIR-ready for third-party apps. The EOB resources combine key information from a claim, a claim response, and prior authorization and provide comprehensive information on the services rendered to a patient by their Provider. Claims will be loaded into the product within a day after they are finalized. Prior Authorization data will be loaded into the product once they are submitted.

Chapter 2 – Payer to Payer Access API

2.1 Responder Overview

Payer to Payer Access API facilitates the secure movement of data from Responding/Old Payer System to authorized Requesting/New Payer system accessible via authorized third-party consumer applications. The FHIR System will be acting as a Responding/Old Payer in the Payer-to-Payer Responder Flow. The Payer to Payer Access API leverages the CMS-recommended Da Vinci Payer Data Exchange (PDex) Implementation Guide (IG) and CARIN for Blue Button (C4BB) Implementation Guide (IG) along with the Common Payer Consumer Data Set (CPCDS) as anchors, in conjunction with data exchange standards, such as HL7 FHIR, United States Core Data and Interoperability (USCDI), and SMART on FHIR Application Launch Framework (Standalone Sequence).

Acentra's Interoperability Solution ensures that the data in transit and at rest is encrypted. A secure connection between the Requesting/New Payers and Responding/Old Payers must be established via mTLS to perform OAuth2.0 Dynamic Client Registration, through which the authorized Requesting/New Payer acquires OAuth2.0 client credentials. These client credentials are then used to obtain an OAuth 2.0 access token. In addition to the Client Credentials flow, the product also supports Private Key JWT client authentication, which can be enabled based on configuration.

Even after authentication, the SMART on FHIR authorization enforces that only requests carrying a valid OAuth 2.0 access token will be given the appropriate access for data retrieval.

2.1.1 Member Match Operation

Member match requests will be received from the authorized Requesting Payer using HREx Member Match Request Profile for **Single Member Request** and PDex Multi-Member-Match request profile for **Bulk Member Request**.



Provides important information the user needs to observe or act upon. Acentra prefers bulk member match requests to contain up to 1,000 member records per request to optimize processing efficiency.

The request will include Patient Demographics, Consent and Coverage Information. The FHIR system must support \$member-match-request and \$bulk-member-match-request to process Member match operation request. There is a configuration in place to define the maximum number of members allowed per group. By default, the configuration will support up to 500 members per group. A configurable setting is available to define the maximum number of members permitted within a group. By default, the system is configured to support up to 500 members per group.

The Requesting Payer is mandated to provide the Member ID of the patient and patient demographic information such as First Name, Last Name, and Date of Birth as input parameters, which will be stored in FPDR.

Member Matching Logic

The Member matching logic should be driven entirely by configuration thereby allowing FHIR Product or Projects to add, remove, or modify matching attributes without any code changes. Attributes to be used by the Member matching algorithm to match the patient in the responding Payer's system will be defined by configuration. The Member Match Logic can be performed successfully in the FHIR system only when an exact match is found.

- The default attributes used for Member matching in FHIR product are Given Name (First Name + Middle Name), Family Name (Last Name), and Date of Birth (DOB). These attributes must be used together to perform an exact match.
- **Member Match Logic:** Given Name (First Name + Middle Name) + Family Name (Last Name) + Date of Birth (DOB).
- **Default Configuration:** FirstName,MiddleName,LastName,BirthDate
- At the Project level, additional attributes such as Member ID and Gender may be included in the configuration as needed.
 - Additional Configuration for Project:
Gender,FirstName,MiddleName,LastName,BirthDate,MemberIdntfr

When a unique Member match is found in the Responding/Old Payer's system, the match is considered valid. For Bulk Member request, if no match is found, or multiple matches are found in the Responding/Old Payer's system, the match is considered invalid. Member Match Logic and Group assignment process are common for both Single Member Request and Bulk Member Request.

Payer-Specific Groups

The FHIR system must create three groups every time for each incoming request for each Requesting Payer. Members must be assigned to any one of the groups.

- **Matched Group** - Members who are matched and have provided consent (Opt in) for data sharing.
- **Non-matched Group** - Members whose identities could not be matched (No match or multiples matches) in the Responding/Old Payer system.
- **Consent Constrained Group** - Members who are matched but have opted out of data sharing.

When a unique Member match is found in the Responding/Old Payer System, the Member's consent for each matched member must be evaluated to sort them into appropriate Payer-specific groups.

Member Match Response:

The FHIR product supports both **synchronous** and **asynchronous** processing for bulk Member Match requests. The processing mode is determined based on the configured Member thresholds and the presence of the Prefer: respond-async header. The maximum Member limits for both processing modes are configurable.

For Group creation response for requests containing up to 500 (configurable) members, the system supports synchronous processing by default and asynchronous processing when the Prefer: respond-async header is included.



When a group creation request contains 500 member IDs or fewer, the FHIR system shall create the Group synchronously and return the response in the same transaction.

For Group Creation Response for Requests containing more than 500 (configurable) members, the system supports asynchronous processing only, and the Prefer: respond-async header is required.



If a request includes more than 500 member IDs and does not specify the Prefer: respond-async header, or if it attempts synchronous processing, the FHIR system will reject the request and return an HTTP 422 (Unprocessable Entity) response with a configurable error message such as:
The submitted bulk FHIR request exceeds the allowed limit. Synchronous requests support up to 500 resources, while asynchronous requests support up to 1,500 resources. Please reduce the request size or submit the request using asynchronous processing and try again.

Member match response will be sent back to the Requesting Payer using the HReX Member Match Response Profile for **Single Member response**, and the PDex \$Multi-member-match response profile for **Bulk Member Response**. The response will include three parameter bundles, each representing one of the following groups - Matched Group, Consent Constrained Group, and Non-matched Group.

2.1.2 Data Export Operation

When the Requesting Payer is requesting data, the System must validate in FPDR whether the Member has provided consent for the data exchange for the Requesting Payer. The Payer's FHIR server processes the data export request, excluding the Member's data who have opted out for a specific Payer.

In a Single Member Request, the Requesting Payer uses the Member ID returned during the \$member-match operation to invoke Data Retrieval Process. In a Bulk Member Request, the Requesting payer uses the Group ID of the Matched Members returned during the \$Bulk-member-match operation to initiate asynchronous generation of a requested export dataset.



Bulk Data Export requests must include the Prefer: respond-async header and be processed using the asynchronous workflow.

The FHIR system supports sending either an absolute or relative polling URL in the content location for the requesting payer to poll the status of export request based on the configuration.

As per the CMS 0057-F rule, the Payers are restricted from sharing the quantity of items or services used under a prior authorization via the Payer-to-Payer API. In addition, Prior authorizations with a denied or rejected status must not be shared.

The FHIR system makes one or more exported files available to the Requesting Payer. Based on configuration, either a secure pre-signed download URL or a file retrieval API endpoint is provided in the completion response

2.1.2 Configuration

- Configuration flags have been implemented in Payer-to-Payer access API to perform certain validation checks when the configuration flag is set to "Yes". The System must bypass the validation checks when the configuration flag is set to "No" and directly sends the response data to the requesting Payer.
- Table 2 demonstrates the System behavior based on the configuration in Payer to Payer Access API.

Table 2. Configuration in Payer to Payer Access API

Configuration in Payer to Payer Access API	When Configuration Flag is “Yes”	When Configuration Flag is “No”
Inclusion of Other Payer Data into API responses	Response must include both current Payer data and other Payer (external) data.	Response must include only current Payer data.
Group creation and validation	The System performs the following validation: • All Group creation and validation checks. • All Member validation and Member consent validation checks.	The System bypasses Group creation and validation check and directly sends the export response data to the Requesting Payer. Other assumptions: • Our FHIR system will not perform Member Match Operation and Member consent checks. • If a Member Match operation request is received while group creation and validation are disabled, the System must return an OperationOutcome indicating that “Member match cannot be performed when group creation and validation are disabled”. • During a data export request, the Requesting Payer must send the Group ID, and the Member IDs associated with the group and the request will be processed as per the defined business rules. • If the request contains only the Group ID (without Member IDs), the System must generate an OperationOutcome indicating that “Member details are required when group validation is disabled”.
MEMBER_MATCH_VALIDATION	Default value is “FirstName,LastName,Middle Name,BirthDate”.	Additional values like MemberIdtfr, Gender will also support.
Polling URL Format	The system returns relative polling URL in the content location header.	The system returns complete absolute polling URL in the content location header.
File Retrieval Method	The system sends a pre-signed download URL.	The system sends a file retrieval API endpoint.

2.1.3 Payer to Payer Access API (Responder flow) Documentation

Error! Reference source not found.3 provides links to the online documentation for the Payer to Payer Access API (Responder Flow).

Table 3. Online Documentation – Payer to Payer Access API (Responder Flow)

Function	Online Documentation
IG References	Payer to Payer Exchange IG (Single Member) https://build.fhir.org/ig/HL7/davinci-epdx/payertopayerexchange.html#payer-to-payer-exchange-single-member Payer to Payer Exchange IG (Bulk Member) https://build.fhir.org/ig/HL7/davinci-epdx/payertopayerbulkexchange.html#payer-to-payer-exchange-bulk
Claims and Encounters Data	HL7.FHIR.US.CARIN-BB\Artifacts Summary - FHIR v4.0.1 CARIN Consumer Directed Payer Data Exchange IG Non-Financial (Basis) Profiles Inpatient Institutional Basis Profile Outpatient Institutional Basis Profile Professional NonClinician Basis Profile Oral Basis Profile Pharmacy Basis Profile
Prior Authorization Data	PDex Prior Authorization Profile
Search Parameters	 Payer%20to%20Paye r%20Access%20API-S
Error Codes	 FHIR-Error%20Codes _Payer-to-Payer%20A

2.2 Requestor Overview

The Payer to Payer Access API facilitates the secure transfer of data from a Responding/Old Payer System to an authorized Requesting/New Payer system, which can be accessed via

authorized third-party consumer applications. The FHIR System will act as the New/Requesting Payer in the Payer-to-Payer Requestor Flow. The Requesting Payer (FHIR System) must successfully complete the registration/onboarding process with the identified prior or concurrent Payer's system to initiate a member match request.

A secure connection will be established using OAuth 2.0 and mTLS protocols to acquire OAuth2.0 client credentials, which will then be used to obtain an OAuth2.0 Access token for an authorized Requesting Payer (FHIR System).

The FHIR system supports valid OAuth token acquisition from the Responding Payer's authorization server either through Client Credentials or Private Key JWT Authentication method based on the configuration before invoking any Responding Payer API Endpoint.

FHIR API endpoint of the Responding/Old Payer must be known by the New/Requesting Payer (our FHIR System) prior to initiating the data request.

The Acentra Interoperability Solution is engineered to support the business and technical requirements defined in the CMS mandate (CMS Final Rule 0057 F). The solution leverages Da Vinci Payer Data Exchange 2.1.0 - STU 2.1 as anchors in conjunction with data exchange standards, such as HL7® Fast Healthcare Interoperability Resources (FHIR®), United States Core Data and Interoperability (USCDI), and CMS recommended Implementation Guides (IGs).

Figure 3 provides a diagram of the overall solution.

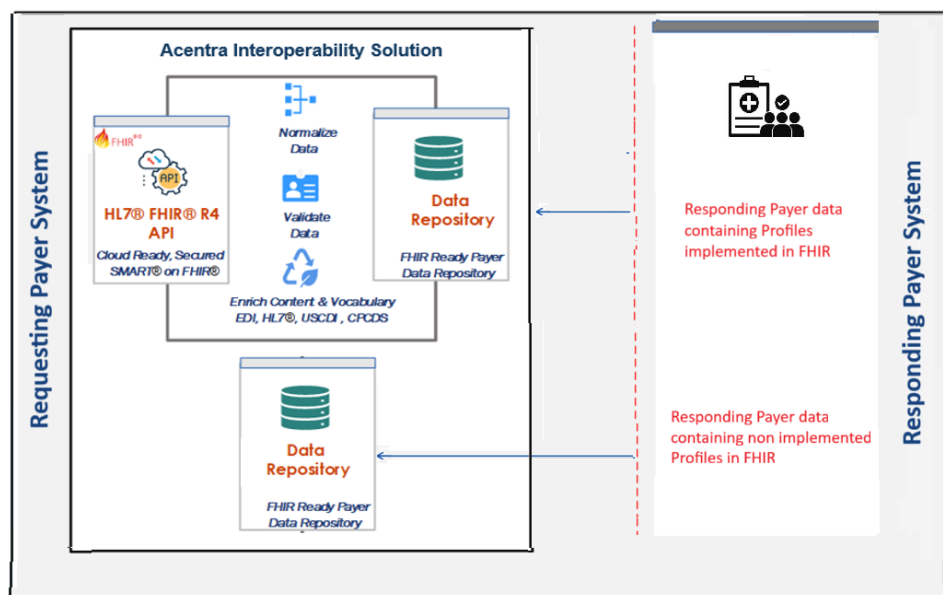


Figure 3. Acentra Interoperability Solution (Payer to Payer API Requestor Flow)

2.2.1 Member Information Management

Consent Information

- The source system will capture the **Member Consent** information and previous **Coverage** information for each unique payer through the **CPI-Consent Layout** and **Member Consent API**. It will include distinct Consent and Coverage records corresponding to the number of Payers with which the Member is associated. The data will be stored in FPDR database.
- Consent information for each Member will be extracted from the Source system through the exclusive Consent Segment 5 (CNS0005) – **CPI-MEMBER-PAYER-TO-PAYER-CONSENT-INFO** of the Consent CPI Layout to enable sharing of healthcare information with other organizations through Payer to Payer API.
- Since Members are Opted Out by default for Payer-to-Payer Access API, if the value of the data element CONSENT-PROVISION-TYPE in the **CPI-MEMBER-PAYER-TO-PAYER-CONSENT-INFO** segment is either “null” or “deny”, then the system should consider the Member as Opted Out for Payer to Payer(P2P) Data Exchange and store **MEMBER-PAYER-CONSENT-STATUS** as active in FPDR.

Previous Coverage Information

- Previous/concurrent coverage information for each Member will be extracted from the Source system through the exclusive Consent segment CNS0004 – **CPI-MEMBER-PRIOR-HEALTH-PLAN-COVERAGE-INFO**, based on HReX Coverage Profile in the Consent CPI Layout. This segment can be repeated based on the number of previous or concurrent coverages the member had with the previous Payers.
- Since Payer-to-Payer API supports Concurrent Payers, a **Concurrent Flag** has been introduced to indicate whether an Old Payer is also a Concurrent Payer. If the Concurrent Flag is set to Y, then the System should initiate the Member processing and data export process to that Payer every three months including the “since” parameter from the last data received date. Provided that the “To date” element from the **CPI-MEMBER-PRIOR-HEALTH-PLAN-COVERAGE-INFO** segment remains active within the last three months, the System should continue to request data.

2.2.2 Automated Member Processing and Grouping:

Upon receiving Member extracts from the source system, an automated scheduled job triggered daily will identify and consolidate the list of all Members associated for each Responding Payer (Old/Concurrent Payer) and process the data for the Member Match Operation.

For each Old/Concurrent Payer, if our FHIR system (Requesting payer) has not been on-boarded and registered with each Responding Payer (Old/Concurrent payer), the Payer Onboarding process must be initiated (Refer to the [Payer Onboarding and Registration](#) section).

The following steps to be repeated for each Member associated with the Responding Payer:

- Step 1: For each Member, Opt-In Consent Status per associated Payer must be determined to proceed with further steps.
- Step 2: For each valid Member-Payer combination, the Audit Table must be evaluated to determine if export data is stored in the FPDR under the appropriate data model in the data export process.
- Step 3: The Member extract must be validated for the presence of mandatory Data Elements to proceed with the Member Match request.
- Step 4: Once these validations are complete for each Member, the Member Match request profile (Single or bulk) should be finalized based on the group size:
 - If the group contains only one member, a Single Member Match operation should be invoked.
 - If the group contains multiple members, a Bulk Member Match operation must be invoked.

2.2.3 Member Match Operation (Single and Bulk Member)

Member Match Request

As a Requesting/New Payer, our FHIR system should send the Member match request to the Responding/Old Payer in the following ways:

- Single Member Request
- Bulk Member Request

The FHIR system should build the Single Member request based on the mandatory parameters using the input parameter profile - HRex Parameters - Member Match Request Profile. The FHIR system should build the Bulk Member request based on the mandatory parameters using the input parameter profile - HRex Parameters - Member Match Request Profile. The mandatory parameters include - Member's Demographic Information, Member's Coverage Information, and Member's Consent information.

For a State FHIR server supporting multiple participating payers, our product supports the Requesting Payer system sending a **target organization context**, thereby enabling the State FHIR server to route the request to the intended Responding Payer based on the configuration.

Member Match Response

As a Requesting/New Payer, our FHIR System will receive the Member match response in two ways:

- Single Member Response
- Bulk Member Response

The Requesting/New Payer (our FHIR system) will receive the unique member identifier (UMB) of the matched member from the Responding Payer system as Single Member Response conforming to the HRex Parameters - Member Match Response Profile. The Requesting/New

Payer (our FHIR system) supports receiving the Bulk Member response through the profile-PDex \$multi-member-match response using either a **synchronous** or an **asynchronous** processing model which is determined based on the configuration.

Acentra's FHIR system supports receiving either an absolute or relative polling URL based on the Polling URL Format Configuration to determine the status of the Asynchronous Bulk Member Match request and to retrieve the results.

The response contains three parameter bundles, each representing a group:

- Matched Group
- Non-matched Group
- Consent Constrained Group (not applicable for requestor flow)

Requesting Payer will leverage the Group ID and the Member ID of the matched members received from the Responding/Old payer to initiate a FHIR \$export operation.

2.2.4 Data Export Operation and Response Processing (Single and Bulk Members)

Data Export Process

The Requesting Payer (our FHIR system) uses the Member ID returned during the \$member-match operation to invoke Data Retrieval Process for Single Member. The Requesting Payer (our FHIR system) uses the Group ID of the Matched Members received from the old/target Payer during the \$Bulk-member-match operation to initiate the asynchronous generation of a requested export dataset for Bulk Members. If an old Payer is also a Concurrent Payer, the Concurrent Flag will be set to "Y", and the System should initiate the data export process to that Payer every three months including the "since" parameter from the last data received date. Provided that the "To date" element from the CPI-MEMBER-PRIOR-HEALTH-PLAN-COVERAGE-INFO segment remains active within the last three months, the System should continue to request data.

Data Export Response Process

The Requesting/New Payer (our FHIR system) will receive the data export responses after the data export operation which will be updated in Audit table.

Acentra's FHIR system supports receiving either an absolute or relative URL based on the Polling URL Format Configuration to determine the status of bulk export operation and to retrieve the results.

When the status of export operation is completed, Acentra's FHIR system downloads the generated Bulk Data files using either a secure pre-signed download URL or a file retrieval API endpoint URL supplied by the responding payer system.

The JSON files will be processed, and the validated data will be stored in the FPDR based on the Resource types.

2.2.5 Configuration

Table 4 demonstrates the Requesting Payer System behavior based on the configuration in Payer to Payer Access API.

Table 4. Configuration in Payer to Payer Access API

Configuration in Payer to Payer Access API	When Configuration Flag is “Yes”	When Configuration Flag is “No”
Inclusion of Target Payer Context	The system includes the target organization identifier as a query parameter in the request URL to identify the intended Responding Payer.	The system calls the bulk member match endpoint without the target organization query parameter.
Member Match Request (Sync/Async)	The system shall invoke the member match request synchronously.	The system shall invoke the member match request asynchronously by including Prefer: respond-async header in the request.
Polling URL Format	The system supports receiving relative polling URL.	The system supports receiving absolute polling URL
File Retrieval Method	The system expects a pre-signed download URL after the status of export operation is completed.	The system expects a file retrieval API endpoint URL after the status of export operation is completed .

2.2.6 Payer to Payer Access API (Requestor flow) Documentation

Error! Reference source not found.5 provides links to online documentation for the Payer to Payer Access API (Requestor flow).

Table 5. Online Documentation – Payer to Payer Access API (Requestor flow)

Online Documentation – Payer to Payer Access API (Requestor flow)	Online Documentation
IG References	Payer to Payer Exchange IG (Single Member) https://build.fhir.org/ig/HL7/davinci-epdx/payertopayerexchange.html#payer-to-payer-exchange-single-member Payer to Payer Exchange IG (Bulk Member)

Online Documentation – Payer to Payer Access API (Requestor flow)	Online Documentation
	https://build.fhir.org/ig/HL7/davinci-epdx/payertopayerbulkexchange.html#payer-to-payer-exchange-bulk

2.3 FHIR Server Sandbox Environment

Acentra's Interoperability Solution's Sandbox Environment provides a synthetic but reliable dataset for Claims and Encounters to help facilitate testing of the Payer-to-Payer Access API. The Sandbox dataset represents real data and ensures consistency across the dataset.

Detailed information about Acentra's Interoperability Solution Sandbox Environment can be found at <https://sandbox.mhbapp.com/index.html>. The site includes information for contacting Acentra to register your application.

As shown in Figure 4, the Acentra Sandbox FHIR server documentation portal provides all the required information for the third-party app developers to register their app and connect and access the Sandbox FHIR server for Payer-to-Payer Access API.

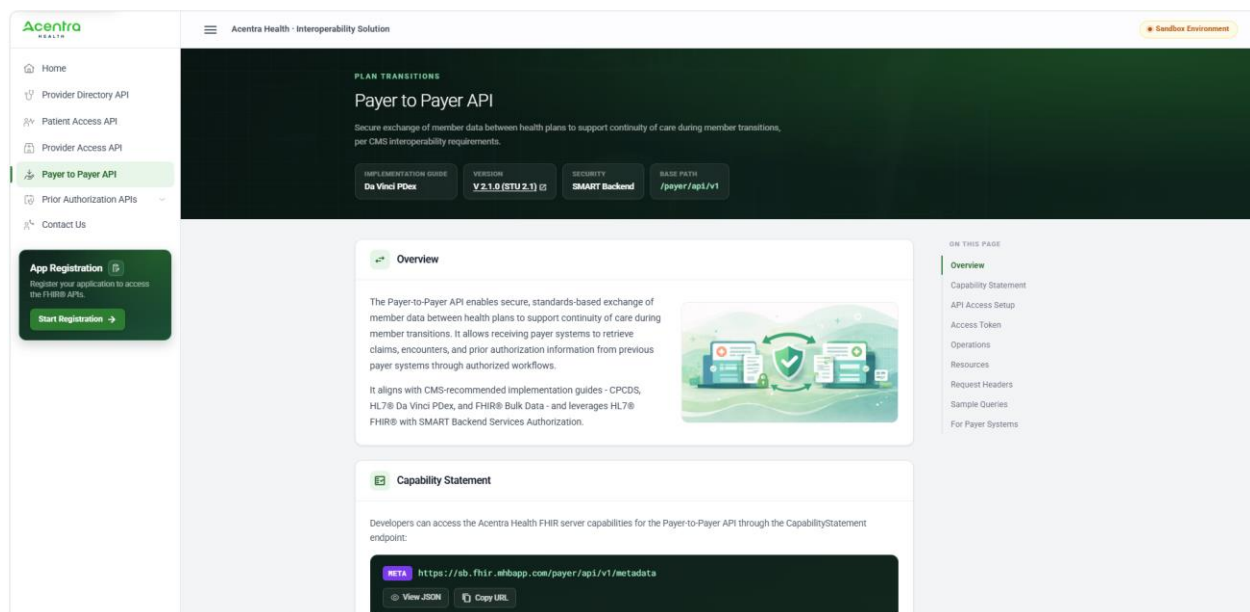


Figure 4. Acentra Sandbox Environment – Online Developer Documentation

2.4 Accessing the Sandbox Environment

Before you can access the Payer to Payer API, you will need to register your application with Acentra's Sandbox Environment.



Refer to the Sandbox FHIR server documentation information at <https://sandbox.mhbapp.com/index.html>

2.5 Base URLs

Three types of FHIR server URLs are provided below for Payer to Payer API.

- Acentra Sandbox
- UAT
- Production

Table 6 provides the base URLs for the FHIR server for the Payer to Payer API. Please note that the base URLs are not accessible via browser and are meant to be accessed programmatically.

Table 6. Base URLs for Payer to Payer Access API

Environment	Base URL Payer to Payer Access API (<i>base_url_pra</i>)
Acentra Sandbox	https://sb.fhir.mhbapp.com/payer/api/v1/
UAT	<a href="https://<<tenant-id>>.np.fhir.mhbapp.com/payer/api/v1/">https://<<tenant-id>>.np.fhir.mhbapp.com/payer/api/v1/
Production	<a href="https://<<tenant-id>>.fhir.mhbapp.com/payer/api/v1/">https://<<tenant-id>>.fhir.mhbapp.com/payer/api/v1/

2.6 Capability Statement

The capability statement describes the set of capabilities (behaviors) implemented by the FHIR Server; for example, it describes the enabled profiles, interactions, and search parameters and provides information about the authorization and token endpoints.

The FHIR server capabilities for Payer to Payer Access API can be accessed using the Capability Statement endpoint: https://<<base_url_p2p>>/metadata.

Please refer to Table 5 for the base URLs for Payer to Payer Access API. For example - the sandbox environment capability URL will be: <https://sb.fhir.mhbapp.com/payer/api/v1/metadata>.

2.7 Resources

The Acentra Interoperability Solution's Payer to Payer Access API supports the resources listed in Table 8.

Table 7. Member Match API and URLs for Payer to Payer Access API

Member Match API	URL
Single Member Match	https://[base_url]/Patient/\$member-match
Bulk Member Match	https://[base_url]/Group/\$bulk-member-match

Table 8. Resources and URLs for Payer to Payer Access API (Single Data Export)

Resources	URL
Practitioner	https://[baseURL]/Patient/[id]/\$everything?_typeFilter=Practitioner
	https://[baseURL]/Patient/[id]/\$everything?_type=Practitioner&patient=[id]
	https://[baseURL]/Patient/[id]/\$everything?_since=[date]&_typeFilter=Practitioner&patient=[id]
	https://[baseURL]/Patient/[id]/\$everything?_until=[date]&exportType=hl7.fhir.us.davinci-pdex%23provider-snapshot&_typeFilter=Practitioner&patient=[id]
Patient	https://[baseURL]/Patient/[id]/\$everything
	https://[baseURL]/Patient/[id]/\$everything?_typeFilter=Patient
	https://[baseURL]/Patient/[id]/\$everything?_type=Patient
	https://[baseURL]/Patient/[id]/\$everything?_since=[date]&_typeFilter=Patient
	https://[baseURL]/Patient/[id]/\$everything?_until=[date]&exportType=hl7.fhir.us.davinci-pdex%23provider-snapshot&_typeFilter=Patient
	https://[baseURL]/Patient/[id]/\$everything?_typeFilter=Patient?_include=Patient:provider
	https://[baseURL]/Patient/[id]/\$everything?_typeFilter=Patient?_include=Patient:insurer
Organization	https://[baseURL]/Patient/[id]/\$everything?_type=Organization
	https://[baseURL]/Patient/[id]/\$everything?_typeFilter=Organization
	https://[baseURL]/Patient/[id]/\$everything?_typeFilter=Organization&_since=[date]&patient=[id]
	https://[baseURL]/Patient/[id]/\$everything?_typeFilter=Organization&patient=[id]&_until=[date]&exportType=hl7.fhir.us.davinci-pdex%23provider-snapshot
	https://[baseURL]/Patient/[id]/\$everything?_typeFilter=Organization?_include=Organization:insurer&patient=[id]
Coverage	https://[baseURL]/Patient/[id]/\$everything?_type=Coverage
	https://[baseURL]/Patient/[id]/\$everything?_typeFilter=Coverage
	https://[baseURL]/Patient/[id]/\$everything?_typeFilter=Coverage&_since=[date]

Resources	URL
	https://[baseURL]/Patient/[id]/\$everything?patient=[id]&_typeFilter=Coverage&_until=[date]&exportType=hl7.fhir.us.davinci-pdex%23provider-snapshot https://[baseURL]/Patient/[id]/\$everything?_typeFilter=Coverage?include=Coverage:payor&patient=[id]
RelatedPerson	https://[baseURL]/Patient/[id]/\$everything?patient=[id]&_typeFilter=RelatedPerson https://[baseURL]/Patient/[id]/\$everything?_type=RelatedPerson&patient=[id] https://[baseURL]/Patient/[id]/\$everything?_since=[date]&_typeFilter=RelatedPerson&patient=[id] https://[baseURL]/Patient/[id]/\$everything?_until=[date]&exportType=hl7.fhir.us.davinci-pdex%23provider-snapshot&_typeFilter=RelatedPerson&patient=[id] https://[baseURL]/Patient/[id]/\$everything?_typeFilter=RelatedPerson?include=RelatedPerson:patient&patient=[id]
Prior Authorization	https://[baseURL]/Patient/[id]/\$everything?patient=[date]&_typeFilter=ExplanationOfBenefit?use=preauthorization https://[baseURL]/Patient/[id]/\$everything?patient=[date]&_typeFilter=ExplanationOfBenefit?use=preauthorization%26service-date=ge[date] https://[baseURL]/Patient/[id]/\$everything?patient=[id]&_typeFilter=ExplanationOfBenefit?use=preauthorization%26_lastUpdated=[date] https://[baseURL]/Patient/[id]/\$everything?patient=[date]&_typeFilter=ExplanationOfBenefit?use=preauthorization&_since=[date] https://[baseURL]/Patient/[id]/\$everything?_typeFilter=ExplanationOfBenefit?use=preauthorization&_until=[date]&exportType=hl7.fhir.us.davinci-pdex%23provider-snapshot https://[baseURL]/Patient/[id]/\$everything?_typeFilter=ExplanationOfBenefit?use=preauthorization&_until=[date]&exportType=hl7.fhir.us.davinci-pdex%23provider-download https://[baseURL]/Patient/[id]/\$everything?_typeFilter=ExplanationOfBenefit?use=preauthorization&_until=[date]&exportType=hl7.fhir.us.davinci-pdex%23provider-delta
ExplanationOfBenefit	https://[baseURL]/Patient/[id]/\$everything?_type=ExplanationOfBenefit https://[baseURL]/payer/Patient/[id]/\$everything?_typeFilter=ExplanationOfBenefit https://[baseURL]/Patient/[id]/\$everything?_since=[date]&_typeFilter=ExplanationOfBenefit https://[baseURL]/Patient/[id]/\$everything?_until=[date]&exportType=hl7.fhir.us.davinci-pdex%23provider-snapshot&_typeFilter=ExplanationOfBenefit https://[baseURL]/Patient/[id]/\$everything?_typeFilter=ExplanationOfBenefit?include=ExplanationOfBenefit:patient https://[baseURL]/Patient/[id]/\$everything?_typeFilter=ExplanationOfBenefit?include=ExplanationOfBenefit:provider

Resources	URL
	https://[baseURL]/Patient/[id]/\$everything?patient=[id]&_typeFilter=ExplanationOfBenefit?_include=ExplanationOfBenefit:insurer
	https://[baseURL]/Patient/[id]/\$everything?_typeFilter=ExplanationOfBenefit?_include=ExplanationOfBenefit:care-team
	https://[baseURL]/Patient/[id]/\$everything?_typeFilter=ExplanationOfBenefit?_include=ExplanationOfBenefit:coverage

Bulk Data Export

Table 9. Resources and URLs for Payer to Payer Access API (Bulk Data Export)

Resources	URL
Practitioner	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[id]&_typeFilter=Practitioner
	https://[baseURL]/Group/[id]/\$davinci-data-export?_type=Practitioner&patient=[id]
	https://[baseURL]/Group/[id]/\$davinci-data-export?_since=[date]&_typeFilter=Practitioner&patient=[id]
	https://[baseURL]/Group/[id]/\$davinci-data-export?_until=[date]&exportType=hl7.fhir.us.davinci-pdex%23provider-snapshot&_typeFilter=Practitioner&patient=[id]
Patient	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[id]
	https://[baseURL]/Group/[id]/\$davinci-data-export?_typeFilter=Patient&patient=[id]
	https://[baseURL]/Group/[id]/\$davinci-data-export?_type=Patient&patient=[id]
	https://[baseURL]/Group/[id]/\$davinci-data-export?_since=[date]&_typeFilter=Patient&patient=[id]
	https://[baseURL]/Group/[id]/\$davinci-data-export?_until=[date]&exportType=hl7.fhir.us.davinci-pdex%23provider-snapshot&_typeFilter=Patient&patient=[id]
	https://[baseURL]/Group/[id]/\$davinci-data-export?_typeFilter=Patient?_include=Patient:provider&patient=[id]
	https://[baseURL]/Group/[id]/\$davinci-data-export?_typeFilter=Patient?_include=Patient:insurer&patient=[id]
Organization	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[id]&typeFilter=Organization
	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[id]&_type=Organization

Resources	URL
	https://[baseURL]/Group/[id]/\$davinci-data-export?_typeFilter=Organization&patient=[id]
	https://[baseURL]/Group/[id]/\$davinci-data-export?_typeFilter=Organization&_since=[date]&patient=[id]
	https://[baseURL]/Group/[id]/\$davinci-data-export?_typeFilter=Organization&patient=[id]&_until=[date]&exportType=hl7.fhir.us.davinci-pdex%23provider-snapshot
	https://[baseURL]/Group/[id]/\$davinci-data-export?_typeFilter=Organization?include=Organization:insurer&patient=[id]
Coverage	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[id]&_type=Coverage
	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[id]&_typeFilter=Coverage
	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=2023120&_typeFilter=Coverage&_since=[date]
	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[id]&_typeFilter=Coverage&_until=[date]&exportType=hl7.fhir.us.davinci-pdex%23provider-snapshot
	https://[baseURL]/Group/[id]/\$davinci-data-export?_typeFilter=Coverage?include=Coverage:payor&patient=[id]
RelatedPerson	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[id]&_typeFilter=RelatedPerson
	https://[baseURL]/Group/[id]/\$davinci-data-export?_type=RelatedPerson&patient=[id]
	https://[baseURL]/Group/[id]/\$davinci-data-export?_since=[date]&_typeFilter=RelatedPerson&patient=[id]
	https://[baseURL]/Group/[id]/\$davinci-data-export?_until=[date]&exportType=hl7.fhir.us.davinci-pdex%23provider-snapshot&_typeFilter=RelatedPerson&patient=[id]
	https://[baseURL]/Group/[id]/\$davinci-data-export?_typeFilter=RelatedPerson?_include=RelatedPerson:patient&patient=[id]
Prior Authorization	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[date]&_typeFilter=ExplanationOfBenefit?use=preauthorization
	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[date]&_typeFilter=ExplanationOfBenefit?use=preauthorization%26service-date=ge[date]

Resources	URL
	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[id]&_typeFilter=ExplanationOfBenefit?use=preauthorization%26_lastUpdated=[date]
	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[date]&_typeFilter=ExplanationOfBenefit?use=preauthorization&_since=[date]
	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[id]&_typeFilter=ExplanationOfBenefit?use=preauthorization&_until=[date]&exportType=hl7.fhir.us.davinci-pdex%23provider-snapshot
	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[id]&_typeFilter=ExplanationOfBenefit?use=preauthorization&_until=[date]&exportType=hl7.fhir.us.davinci-pdex%23provider-download
	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[id]&_typeFilter=ExplanationOfBenefit?use=preauthorization&_until=[date]&exportType=hl7.fhir.us.davinci-pdex%23provider-delta
ExplanationOfBenefit	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[id]&_type=ExplanationOfBenefit
	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[id]&_typeFilter=ExplanationOfBenefit
	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[id]&_since=[date]&_typeFilter=ExplanationOfBenefit
	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[id]&_until=[date]&exportType=hl7.fhir.us.davinci-pdex%23provider-snapshot&_typeFilter=ExplanationOfBenefit
	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[id]&_typeFilter=ExplanationOfBenefit?_include=ExplanationOfBenefit:patient
	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[id]&_typeFilter=ExplanationOfBenefit?_include=ExplanationOfBenefit:provider
	https://[baseURL]/Group/[id]/\$davinci-data-export?patient=[id]&_typeFilter=ExplanationOfBenefit?_include=ExplanationOfBenefit:insurer

2.7.1 Member Match Input Parameters

Single Member Match

URL: [https://\[base_url\]/Patient/\\$member-match](https://[base_url]/Patient/$member-match)

Method: POST

Table 10. Single Member Match Input Parameters

Name	Description	Input type
MemberPatient	HRex Patient containing member demographics.	JSON Body
Consent	Represents a member's consent to the sharing of their healthcare information to requesting Payers.	JSON Body
CoverageToMatch	Details of responding/old health plan coverage provided by the member, typically from their health plan coverage card.	JSON Body
CoverageToLink	Details of new health plan coverage, provided by the Requesting/New Payer based upon the member's enrollment.	JSON Body

Bulk Member Match

URL: [https://\[base_url\]/Group/\\$bulk-member-match](https://[base_url]/Group/$bulk-member-match)

Method: POST

Table 11. Bulk Member Match Input Parameters

Name	Description	Input type
MemberPatient	HRex Patient containing member demographics.	JSON Body
Consent	Represents a member's consent to the sharing of their healthcare information to requesting Payers.	JSON Body
CoverageToMatch	Details of responding/old health plan coverage provided by the member, typically from their health plan coverage card.	JSON Body

2.7.2 Single Data Export Parameters

Table 12 provides the list of supported parameters for Export Operation of a Single member.

Table 12. Single Data Export Parameters

Parameters	Description	Scenarios
start	The date range relates to service start date - e.g. all records relating to care provided in a certain date range.	YYYY-MM-DD – Format to be used for input
end	The date range relates to service end date - e.g. all records relating to care provided in a certain date range.	YYYY-MM-DD – Format to be used for input
_since	Return resources which have undergone changes after the supplied _since time.	YYYY-MM-DD – Format to be used for input
_type	Returns resources of the specified resource type(s).	[baseURL]/payer/Patient/[id]/\$everything?_type=Coverage
_count	To return the results through the specified page counts.	[baseURL]/payer/Patient/[id]/\$everything?_count=2

2.7.3 Bulk Data Export Search Parameters:

Table 12 provides a list of search parameters that can be used as bulk data export parameters.

Table 13. Bulk Data Export Parameters

S.No	Parameter	Description	Scenarios
1	patient	To retrieve data for specific members of the Group.	Patient ID to be passed mandatorily with Group ID in input.
2	since	To be used for resource requests when the full history is not required to limit data.	YYYY-MM-DD – Format to be used for input.
3	until	Response includes resources updated before the specified time. Mostly used with the <i>hl7.fhir.us.davinci-pdex#provider-snapshot</i> exportType to retrieve member data for a specific period.	YYYY-MM-DD – Format to be used for input.
4	_type	This enables providers to only retrieve the resource types they are interested in seeing. Resource types that can be used in this parameter - Patient, Practitioner, ExplanationOfBenefit, Coverage, Organization, RelatedPerson.	Example: [base]/Group/[id]/\$davinci-data-export?_type=Patient,Coverage.
5	_typeFilter	Specifies a search URL that can be used to narrow the results for one or	Can be used in conjunction with the _type parameter specifying the elements to limit the resource types as

S.No	Parameter	Description	Scenarios
		more of the resource types being exported. When constructing search queries to incorporate into a <code>_typeFilter</code>, Search parameters supported by the relevant profiles from the Pdex or CARIN Blue Button IGs SHALL be followed.	well as to specific search sets within one or more of the resource types. To support multiple <code>typeFilters</code>, separate them by a comma. Examples: <code>[base]/Group/[id]/\$davinci-data-export?_typeFilter=Coverage?status=active</code> <code>[base]/Group/[id]/\$davinci-data-export?_typeFilter=ExplanationOfBenefit&use=preauthorization</code> <code>[base]/Group/[id]/\$davinci-data-export?_typeFilter=ExplanationOfBenefit&use=claim</code> <code>[base]/Group/[id]/\$davinci-data-export?_typeFilter=ExplanationOfBenefit&use=claim, preauthorization</code>
6	exportType	The exportType parameter specifies the purpose of the export and SHALL have one of the following values: 1) <code>hl7.fhir.us.davinci-pdex#provider-delta</code> 2) <code>hl7.fhir.us.davinci-pdex#provider-download</code> 3) <code>hl7.fhir.us.davinci-pdex#provider-snapshot</code>	The <code>hl7.fhir.us.davinci-pdex#provider-delta</code> option SHALL be used when the provider is retrieving new, or updated data that will be stored as part of the patient record. The <code>hl7.fhir.us.davinci-pdex#provider-download</code> option SHALL be used when the provider is retrieving data that will be stored as part of the patient record. The <code>hl7.fhir.us.davinci-pdex#provider-snapshot</code> value SHOULD be used when a provider wants to download data for viewing.

2.8 Request Headers

All requests for Payer to Payer Access API resources require the headers outlined in Table 14.

Table 14. Request Headers

Headers	Values
content-type	application/json
accept	application/json
authorization	Bearer <<PayerID>>

Chapter 3 – Connecting to the Payer to Payer Access API

The Requesting/New Payer must initiate the onboarding and registration process with each identified Payer associated with Members who have opted for Payer-to-Payer data exchange.

- The Requesting/New Payer System connecting to the FHIR Server must first register as a FHIR enabled third-party application.
- During registration, the Requesting/New Payer System must provide its public key in the form of a JSON Web Key (JWK) to enable secure authentication with the Responding/Old Payer's FHIR Authorization Server.
- A Secure Transaction Capability between the Requesting/New Payer System and the Responding/Old Payer's FHIR Authorization Server must be established using mTLS, ensuring encrypted and secure data exchange.
- Once registration is successfully completed, the Requesting/New Payer System will be issued a "Client ID" along with other required configuration and access details which will be shared by Responding/Old Payer.
- The Requesting/New Payer System must generate a JSON Web Token (JWT) signed using its registered private key. This JWT is used to authenticate the Requesting/New Payer system and will be included in the request for an access token.
- After obtaining authentication, the Requesting/New Payer System must request an access token by sending an HTTP POST request to the Responding/Old Payer's FHIR Authorization Server token endpoint.
- Upon successful validation, the Requesting/New Payer System obtains an access token via OAuth 2.0 framework with SMART on FHIR authorization using asymmetric keys.
- Once authenticated and authorized, the FHIR API endpoint of the Responding/old payer will be known by the new/requesting Payer, therefore the Requesting/New Payer System can:
 - Perform single-member requests to retrieve data for an individual member.
 - Perform bulk-member requests to retrieve data for multiple members, as permitted by the Responding/old payer.

3.1 Requestor Flow - Payer Onboarding and Registration process

The Requesting Payer (our FHIR server) must initiate the onboarding and registration process with an external responding payer's sandbox environment via FHIR enabled third-party application. It is mandatory step to retrieve member information who have opted in for Payer-to-Payer data exchange from prior and concurrent payers.

- During registration, the Requesting Payer (our FHIR server) must provide its public key in the form of a JSON Web Key (JWK) to enable secure authentication with the external responding payer system.
- A Secure Transaction Capability between the Requesting Payer (our FHIR server) and the external responding payer system must be established using mTLS, ensuring encrypted and secure data exchange.
- Once onboarding and registration process is successfully completed and approved, the Requesting Payer (our FHIR server) will be issued a unique “Client ID” along with other required configuration and access details which will be shared by external responding payer system.
- The “Assigned Payer ID”, “Client ID” and “approved scopes” obtained from the external responding payer system shall be manually updated in the FHIR Admin Portal. These external responding payer details will be maintained in the external payer registrations list.
- The Requesting Payer (our FHIR server) must generate a JSON Web Token (JWT) signed using its registered private key. This JWT is used to authenticate the Requesting Payer (our FHIR server) and will be included in the request for an access token.
- After obtaining authentication, the Requesting Payer (our FHIR server) must request an access token by sending an HTTP POST request to the external responding payer’s FHIR Authorization Server token endpoint.
- Upon successful validation, the Requesting Payer (our FHIR server) obtains an access token via OAuth 2.0 framework with SMART on FHIR authorization using asymmetric keys.
- Once authenticated and authorized, the FHIR API endpoint of the external responding payer will be known by the Requesting Payer (our FHIR server), therefore the Requesting Payer (our FHIR server) can:
 - Perform single-member requests to retrieve data for an individual member.
 - Perform bulk-member requests to retrieve data for multiple members, as permitted by the external responding payer system.

Chapter 4 – Third-Party App Registration

4.1 Acentra Sandbox Environment

The Acentra Sandbox Environment is available for third-party app owners to perform connectivity and testing. The third-party app owners can reach out to Acentra directly or via payer organization to register their app. If the payer organization approves the request, then Acentra will provide access. In cases where the third-party app reaches out to Acentra directly, it will be Acentra discretion to approve or deny the request.

4.2 Environments

In the Acentra Interoperability Solution, the intake process collects the registration and attestation information from the third-party app owner and sends it to the authorized personnel from the payer organization (or Tenant). The payer organization uses the information provided by Acentra to conduct third-party app verification.

If approved, the payer organization notifies Acentra and Acentra will issue credentials (client-id/secret) to the third-party app owners for the appropriate environment: Production. If the app registration is not approved, then the payer organization notifies the app owner directly and conveys the decision to Acentra. A graphic of this process is shown in Figure 8.

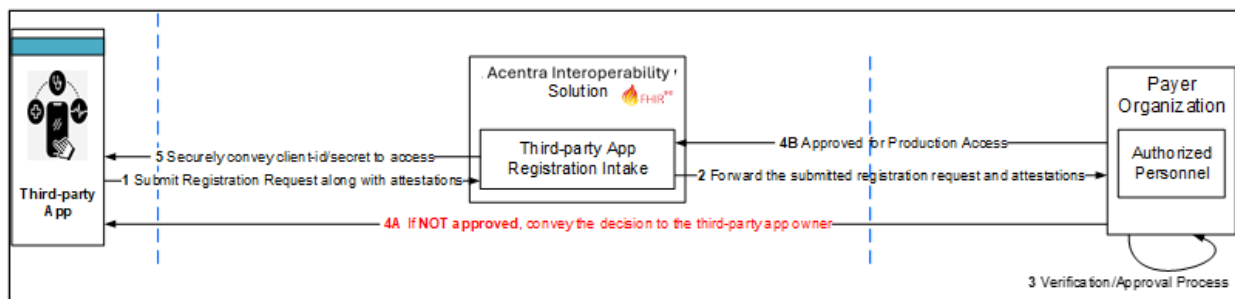


Figure 4. Third-Party App Registration Process

Chapter 5 – Glossary

This section provides definitions for document-specific terms in the following format. Entries are in alphabetical order, and items beginning with numbers will come first.

Table 15. Glossary

Term	Definition
Application Programming Interface	An interface that defines interactions between multiple software applications.
CARIN	A non-partisan, multi-sector alliance focused on providing digital health information to consumers. Also known as CARIN Alliance.
Acentra Interoperability Solution	A solution created to support the business and technical requirements defined in the CMS mandate, CMS Final Rule 0057-F.
Payer Organization	A business entity that adjudicates and renders payment for health care claims, including pharmacy claims. Examples include Medicare, state Medicaid programs, and commercial insurance carriers. In this document, "Tenant" is also used to indicate the Payer Organization in relation to the environment.
Sandbox	An environment containing hardware, instrumentation, simulators, software tools, and other support. Also known as a "test bed".
Tenant	See "Payer Organization".
Third-Party App	An application or program that is neither Acentra nor the Washington State Health Care Authority, that has authorized access via the API for the purpose of delivering data to authorized users (Payers).

Chapter 6 – Acronyms

This section provides definitions for document-specific terms in the following format: Entries are listed in alphabetical order, and items beginning with numbers will come first.

Table 16. Acronyms

Acronym	Definition
API	Application Programming Interface
CMS	Centers for Medicare & Medicaid Services
CPI	Common Payer Interface
EDI	Electronic Data Interchange
EOB	Explanation of Benefits
FHIR	Fast Healthcare Interoperability Resources
FPDR	FHIR Ready Payer Data Repository
HIPAA	Health Insurance Portability and Accountability Act
ID	Identification
IG	Implementation Guide
JWK	JSON Web Key
JWT	JSON Web Token
mTLS	Mutual Transport Layer Security
O.Auth 2.0	Open Authorization 2.0 protocol
OIDC	Open ID Connect
REST	Representational State Transfer
SAML	Security Assertion Markup Language
SFTP	Secure File Transfer Protocol
SMART	Substitutable Medical Applications and Reusable Technologies
STU	Standard for Trial Use
UI	User Interface
URL	Uniform Resource Locator

Acronym	Definition
USCDI	United States Core Data and Interoperability
PDex	Payer Data Exchange
TEFCA	Trusted Exchange Framework and Common Agreement
UDAP	Unified Data Access Profiles
UMB	Unique Member identifier