Responses to Questions submitted by Da Vinci to CMS February 2021

1) The regulation states the following for MA-PD plans

“For an MA organization that offers an MA-PD plan, the MA-PD’s pharmacy directory, including the pharmacy name, address, phone number, number of pharmacies in the network, and mix (specifically the type of pharmacy, such as “retail pharmacy”) updated no later than 30 calendar days after the MA organization receives pharmacy directory information or updates to pharmacy directory information”

Regarding the number of network pharmacies and the mix of pharmacies, the PDex Plan Net resources generally do not provide for summary information. Adding summary elements for specific types of resources is problematic.

a) Rather than providing specific numbers, is it sufficient to respond with information for each pharmacy (including the type) and have the recipient determine the count and mix?

b) Alternatively, the requester could submit specific queries which would provide the desired “counts”. Will this option satisfy reporting on count and mix?

On a related point, in the rule “mix,” is qualified by “(e.g., retail pharmacy)”. That could be interpreted as retail vs inpatient, or as the pharmacy variants in NUCC Provider Taxonomy (e.g., retail vs compounding vs long term care vs others). We believe the NUCC codes will provide the most useful information. Do NUCC taxonomy codes fulfil the intent of “mix”?

Response: MA organizations that offer MA-PD plans must make available, at a minimum, pharmacy directory data and include the pharmacy name, address, phone number, number of pharmacies in the network, and mix. MA-PD plans should build a Provider Directory API that will provide information for beneficiaries to enable them to find appropriate pharmacy services. This would include the location, phone number, and the designation or type of pharmacy (e.g. retail, compounding etc) for all available pharmacies. See 85 FR 25604 and 25633.

Payers may use the taxonomy codes suggested by the Implementation Guide, if applicable, or NUCC if they determine that taxonomy is appropriate for their purposes. To the extent practicable, standardization across implementers would be appropriate.

2) The preamble to the rule mentions both “Designated Record Set” and Clinical data as defined by USCDI V1.0.

a. Is the requirement to provide clinical data as defined by the HIPAA designated record set or by ONC’s USCDI V1.0?

Response: The Interoperability and Patient Access final rule requires the minimum content to be adjudicated claims (including cost); encounters with capitated providers; provider remittances; enrollee cost-sharing; and clinical data, including laboratory results (where maintained by the payer). Payers must provide the clinical data they maintain, and over which they have control, in accordance with the standards available in the current version of the USCDI.
The USCDI v1.0 includes the required content and vocabulary standards adopted at 45 CFR 170.213, and these are the data elements that must be provided through the Patient Access API if maintained in the payers system.

The HIPAA designated record set is defined at 164.501 as (1) a group of records maintained by or for a covered entity that is: (i) the medical records and billing records about individuals maintained by or for a covered health care provider; (ii) the enrollment, payment, claims adjudication and case or medical management record systems maintained by or for a health plan; or (iii) used, in whole or in part, by or for the covered entity to make decisions about individuals. (2) The term record means any item, collection, or grouping of information that includes protected health information and is maintained, or collected, used or disseminated by or for a covered entity.

3) If a covered plan has member identifiable information that was solicited from the provider to enable reporting for HEDIS and STARS, is the information intended to be included in the Patient Access API?

   a) If the information is used for no other purpose?

   b) If the information is used to report Gaps in Care to the Provider?

   **Response:** The Interoperability and Patient Access final rule defines “maintain” to mean the payer has access to the data, control over the data, and authority to make the data available through the API (85 FR 25538). All USCDI data that the payer maintains as part of the enrollees record are to be made available via the Patient Access API. The answer to which data are to be made available depends on how each payer maintains data. It is up to each payer to evaluate how data are maintained in its systems for each enrollee. {A similar question was asked and answered in October 2020}

4) The rule requires

   “(i) Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and enrollee cost-sharing pertaining to such claims, no later than one (1) business day after a claim is processed;

   (ii) Encounter data from capitated providers, no later than one (1) business day after data concerning the encounter is received by the MA organization; and”

   a) Please define processed (e.g., when the claim is adjudicated, when the claim is paid, …)

   b) If data is received by a contracted entity for “preprocessing” but that entity does not “maintain” the information, does the one (1) business day start when the plan receives the information or when it is received by the contracted entity?

   **Response:** We finalized that payers make available through the Patient Access API, no later than one (1) business day after the information is received: (1) adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and (2) encounter data. We reiterate that this is one (1) business day after the claim is adjudicated or encounter data are received. This allows for potential delays in adjudication or processing actions before the payer has control over the data. It does not require payers to change their contractual relationships or current pre-processing procedures, though we strongly
encourage payers and vendors to work together to make patient data available in as timely a manner as possible. {Note, a similar question was asked and answered in October 2020}

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