

(ii)(A) *Number of beneficiaries required to cover.* (1) The number of beneficiaries required to cover is calculated by multiplying the 95th percentile base population ratio by the total number of Medicare beneficiaries residing in a county.

(2) CMS uses its MA State/County Penetration data to calculate the total number of beneficiaries residing in a county.

(B) *95th percentile base population ratio.* (1) The 95th percentile base population ratio is:

(i) Calculated annually for each county type and varies over time as MA market penetration and plan enrollment change across markets; and

(ii) Represents the proportion of Medicare beneficiaries enrolled in the 95th percentile MA plan (that is, 95 percent of plans have enrollment lower than this level).

(2) CMS calculates the 95th percentile base population ratio as follows:

(i) Uses its most recent List of PFFS Network Counties to exclude any private-fee-for-service (PFFS) plans in non-networked counties from the calculation at the county-type level.

(ii) Uses its most recent MA State/County Penetration data to determine the number of eligible Medicare beneficiaries in each county.

(iii) Uses its Monthly MA Enrollment By State/County/Contract data to determine enrollment at the contract ID and county level, including only enrollment in regional preferred provider organization (RPPO), local preferred provider organization (LPPO), HMO, HMO/provider sponsored organization (POS), healthcare prepayment plans under section 1833 of the Act, and network PFFS plan types.

(iv) Calculates penetration at the contract ID and county level by dividing the number of enrollees for a given contract ID and county by the number of eligible beneficiaries in that county.

(v) Groups counties by county designation to determine the 95th percentile of penetration among MA plans for each county type.

(f) *Exception requests.* (1) An MA plan may request an exception to network adequacy criteria in paragraphs (b) through (e) of this section when either

paragraph (f)(1)(i) or (ii) of this section is met:

(i)(A) Certain providers or facilities are not available for the MA plan to meet the network adequacy criteria as shown in the Provider Supply file for the year for a given county and specialty type; and

(B) The MA plan has contracted with other providers and facilities that may be located beyond the limits in the time and distance criteria, but are currently available and accessible to most enrollees, consistent with the local pattern of care.

(ii)(A) A facility-based Institutional-Special Needs Plan (I-SNP) is unable to contract with certain specialty types required under §422.116(b) because of the way enrollees in facility-based I-SNPs receive care; or

(B) A facility-based I-SNP provides sufficient and adequate access to basic benefits through additional telehealth benefits (in compliance with §422.135) when using telehealth providers of the specialties listed in paragraph (d)(5) of this section in place of in-person providers to fulfill network adequacy standards in paragraphs (b) through (e) of this section.

(2) In evaluating exception requests, CMS considers whether—

(i) The current access to providers and facilities is different from the HSD reference and Provider Supply files for the year;

(ii) There are other factors present, in accordance with §422.112(a)(10)(v), that demonstrate that network access is consistent with or better than the original Medicare pattern of care; and

(iii) Approval of the exception is in the best interests of beneficiaries.

(iv) As applicable, the facility-based I-SNP submits:

(A) Evidence of the inability to contract with certain specialty types required under this section due to the way enrollees in facility-based I-SNPs receive care; or

(B) Substantial and credible evidence that sufficient and adequate access to basic benefits is provided to enrollees using additional telehealth benefits (in compliance with §422.135) furnished by providers of the specialties listed in paragraph (d)(5) of this section and the

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facility-based I-SNP covers out-of-network services furnished by a provider in person when requested by the enrollee as provided in § 422.135(c)(1) and (2), with in-network cost sharing for the enrollee.

(3) Any MA organization that receives the exception provided for facility-based I-SNPs must agree to offer only facility-based I-SNPs under the MA contract that receives the exception.

[85 FR 33904, June 2, 2020, as amended at 87 FR 27895, May 9, 2022; 88 FR 22330, Apr. 12, 2023; 89 FR 30819, Apr. 23, 2024; 89 FR 63827, Aug. 6, 2024]

§ 422.118 Confidentiality and accuracy of enrollee records.

For any medical records or other health and enrollment information it maintains with respect to enrollees, an MA organization must establish procedures to do the following:

(a) Abide by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. The MA organization must safeguard the privacy of any information that identifies a particular enrollee and have procedures that specify—

(1) For what purposes the information will be used within the organization; and

(2) To whom and for what purposes it will disclose the information outside the organization.

(b) Ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas.

(c) Maintain the records and information in an accurate and timely manner.

(d) Ensure timely access by enrollees to the records and information that pertain to them.

[65 FR 40323, June 29, 2000]

§ 422.119 Access to and exchange of health data and plan information.

(a) *Application Programming Interface to support MA enrollees.* A Medicare Advantage (MA) organization must implement and maintain a standards-based Application Programming Interface (API) that permits third-party applications to retrieve, with the approval and at the direction of a current individual

MA enrollee or the enrollee's personal representative, data specified in paragraph (b) of this section through the use of common technologies and without special effort from the enrollee.

(b) *Accessible content.* (1) An MA organization must make the following information accessible to its current enrollees or the enrollee's personal representative through the API described in paragraph (a) of this section:

(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;

(iii) All data classes and data elements included in a content standard in 45 CFR 170.213 that are maintained by the MA organization no later than 1 business day after the MA organization receives the data; and

(iv) Beginning January 1, 2027, the information in paragraph (b)(1)(iv)(A) of this section about prior authorizations for items and services (excluding drugs, as defined in paragraph (b)(1)(v) of this section), according to the timelines in paragraph (b)(1)(iv)(B) of this section.

(A) The prior authorization request and decision, including all of the following, as applicable:

(1) The prior authorization status.

(2) The date the prior authorization was approved or denied.

(3) The date or circumstance under which the prior authorization ends.

(4) The items and services approved.

(5) If denied, a specific reason why the request was denied.

(6) Related structured administrative and clinical documentation submitted by a provider.

(B) The information in paragraph (b)(1)(iv)(A) of this section must—

(1) Be accessible no later than 1 business day after the MA organization receives a prior authorization request;

(2) Be updated no later than 1 business day after any status change; and

(3) Continue to be accessible for the duration that the authorization is active and at least 1 year after the prior authorization's last status change.

(v) Drugs are defined for the purposes of paragraph (b)(1)(iv) of this section as any and all drugs covered by the MA organization, including any products that constitute a Part D drug, as defined by §423.100 of this chapter, and are covered under the Medicare Part D benefit.

(2) In addition to the information specified in paragraph (b)(1) of this section, an MA organization that offers an MA-PD plan must make the following information accessible to its enrollees through the API described in paragraph (a) of this section:

(i) Data concerning adjudicated claims for covered Part D drugs, including remittances and enrollee cost-sharing, no later than one (1) business day after a claim is adjudicated; and,

(ii) Formulary data that includes covered Part D drugs, and any tiered formulary structure or utilization management procedure which pertains to those drugs.

(c) *Technical requirements.* An MA organization implementing an API under paragraph (a) of this section:

(1) Must implement and maintain API technology conformant with 45 CFR 170.215(a)(1), (b)(1)(i), (c)(1), and (e)(1);

(2) Must conduct routine testing and monitoring, and update as appropriate, to ensure the API functions properly, including assessments to verify that the API is fully and successfully implementing privacy and security features such as, but not limited to, those required to comply with HIPAA privacy and security requirements in 45 CFR parts 160 and 164, 42 CFR parts 2 and 3, and other applicable law protecting the privacy and security of individually identifiable data;

(3) Must comply with the content and vocabulary standard requirements in paragraphs (c)(3)(i) and (ii) of this section, as applicable to the data type or data element, unless alternate standards are required by other applicable law:

(i) Content and vocabulary standards at 45 CFR 170.213 where such standards

are applicable to the data type or element, as appropriate; and

(ii) Content and vocabulary standards at 45 CFR part 162 and §423.160 of this chapter where required by law or where such standards are applicable to the data type or element, as appropriate.

(4) May use an updated version of any standard or all standards required under paragraph (c)(1) or (3) of this section, where:

(i) Use of the updated version of the standard is required by other applicable law; or

(ii) Use of the updated version of the standard is not prohibited under other applicable law, provided that:

(A) For content and vocabulary standards other than those at 45 CFR 170.213, the Secretary has not prohibited use of the updated version of a standard for purposes of this section or 45 CFR part 170;

(B) For standards at 45 CFR 170.213 and 45 CFR 170.215, the National Coordinator has approved the updated version for use in the ONC Health IT Certification Program; and

(C) Using the updated version of the standard, implementation guide, or specification does not disrupt an end user's ability to access the data specified in paragraph (b) of this section or §§422.120, 422.121, and 422.122 through the required APIs.

(d) *Documentation requirements for APIs.* For each API implemented in accordance with paragraph (a) of this section, an MA organization must make publicly accessible, by posting directly on its website or via publicly accessible hyperlink(s), complete accompanying documentation that contains, at a minimum the information listed in this paragraph. For the purposes of this section, "publicly accessible" means that any person using commonly available technology to browse the internet could access the information without any preconditions or additional steps, such as a fee for access to the documentation; a requirement to receive a copy of the material via email; a requirement to register or create an account to receive the documentation; or