

MEDICARE PART C REPORTING REQUIREMENTS

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1054 and expires on 01/31/2028. The time required to complete this information collection is estimated to average 29 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4- 26-05, and Baltimore, Maryland 21244-1850.

Effective as of January 1, 2026

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Revision History (from Contract Year 2025 to 2026)

The following list is provided as a courtesy and includes certain changes to this document made between Contract Year (CY) 2025 and CY 2026. Please compare the documents from both years for all the changes between the two CYs.

1. Formatting changes have been made throughout the document.
2. Additional information on timely submission of data has been included in the introduction. This information used to be found in the Technical Specifications.
3. Clarification of definitions of level of data to be reported has been added to the introduction.
4. Additional information on inclusions and exclusions from Reporting Sections has been included in the introduction.
5. Clarification has been added to the introduction about terminated contracts and contracts/plans with no enrollment.
6. Additional information on Data Validation has been included in the introduction.
7. Information has been added to the introduction on CMS Analysis of Reporting Requirements data and publication of the Limited Data Set.
8. The new mailbox for questions about Part C Reporting Requirements has been added to the introduction.
9. Duplicative information has been removed, including information duplicative of the Technical Specifications.
10. Information on whether each Reporting Requirement section is to be reported as a file upload or as data entry has been removed. This information is now in Technical Specifications. Note that for CY 2026, the two D-SNP Reporting Requirement sections will now be reported via file upload.
11. Summaries describing each Reporting Requirement section have been added.
12. Minor clarifications have been made to most Reporting Requirement section's parameters table.
13. Information to clarify technical specifications for data elements and data upload specifications has been moved to the Technical Specifications.
14. Minor clarifications have been made to most Reporting Requirements sections' data elements.

Introduction

Section 1857(e)(1) of the Social Security Act (the Act) provides broad authority for the Secretary to add terms to the contracts with Medicare Advantage Organizations (MAOs), including terms that require the sponsor to provide the Secretary with information as the Secretary may find necessary and appropriate. Pursuant to our statutory authority, we codified these information collection requirements for MAOs in regulation at 42 CFR § 422.516.

42 CFR § 422.516(a) requires each MAO to have a procedure to develop, compile, evaluate, and report to the Centers for Medicare & Medicaid Services (CMS), to its enrollees, and to the general public, at the times and in the manner that CMS requires, statistics indicating the following:

- 1) The cost of its operations.
- 2) The procedures related to and utilization of its services and items.
- 3) The availability, accessibility, and acceptability of its services.
- 4) To the extent practical, developments in the health status of its enrollees.
- 5) Information demonstrating that the MAO has a fiscally sound operation.
- 6) Other matters that CMS may require.

This document lists data elements for each reporting section, reporting timeframes, deadlines, and required levels of reporting.

Timely Submission of Data

Most reporting sections will be reported annually. Reporting deadlines often occur in the subsequent calendar year. Reporting deadlines and frequencies are listed in the Reporting Requirement sections below. Data submissions are due by 11:59 p.m. Pacific Time on the date of the reporting deadline.

MAOs must report all data based on the most current Reporting Requirements documentation as of the reporting deadline. MAOs should be able to support the accuracy of their data submissions based on their understanding of the Reporting Requirements documentation. MAOs should retain documentation supporting their Health Plan Management System (HPMS) data submissions and resubmissions. MAOs must retain this complete archive for the 10-year retention period required per federal regulations and be prepared to provide the archive to CMS upon request.

Level of Data Reported

Data elements may be reported at the Plan-level, or the individual Contract-level. Contract-level reporting indicates data should be entered at the H#, S#, R#, or E# level. Plan-level reporting indicates data should be entered at the Plan Benefit Package (PBP) level (e.g., Plan 001 for contract H#, R#, S#, or E#). Plan-level reporting is necessary to conduct appropriate oversight and monitoring of some areas. Level of reporting is listed in the Reporting Requirement sections below.

Inclusions and Exclusions from Reporting

Organization types required to report data are listed in the Reporting Requirements sections below. The following organization types are excluded from reporting all Part C Reporting Requirements:

1. Demonstration Plans
2. Healthcare Prepayment Plan (HCPP) – 1833 Cost Plans
3. National PACE Plans
4. Prescription Drug Plans (PDPs)¹
5. Fallback Plans
6. Employer/Union Only Direct Contract PDPs¹
7. LI NET Sponsor Plans

Terminations

If a contract terminates before July 1 in the following year after the CY reporting period, the contract must not report data for the respective two years – the CY reporting period, and the following year.

- Example: Contract terminates June 20XX. The contract must not report CY 20XX - 1 (“CY reporting period”) or CY 20XX data (“following year”).

If a PBP (Plan) under a contract terminates at any time in the CY reporting period and the contract remains active through July 1 of the following year, the contract must report data for all PBPs, including the terminated PBP.

No Enrollment Contracts and Plans

Contracts or plans with no enrollment must not report data for any reporting section. No enrollment signifies that the contract has no enrollees for all the months within the reporting period.

Data Validation

CMS requires that sponsoring organizations (SOs) contracted to offer Medicare Part C and/or Part D benefits be subject to an independent yearly audit to validate certain data reported to CMS to determine its reliability, validity, completeness, and comparability in accordance with specifications developed by CMS.²

Reporting Sections requiring data validation are indicated in the Reporting Requirement sections below. More information about data validation can be found at <https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/part-c-and-part-d-data-validation>.

¹ Denotes that these the plans are required to report the Employer Group Plan Sponsors reporting section, because this section is reported by both Part C and Part D plans.

² See 42 CFR § 422.516(g) and § 423.514(j)

Reporting Requirements Data Analysis and Limited Data Set

CMS analyzes data submitted for accuracy and trends. In addition, certain data reported by MAOs are published annually in a Limited Data Set (LDS). More information on this LDS can be found at <https://www.cms.gov/data-research/files-order/limited-data-set-lds-files/parts-c-and-d-reporting-requirements-limited-data-set>.

Questions

Questions about Part C Reporting Requirements should be sent via email to PartsCDPlanReportingAndDV@cms.hhs.gov.

Reporting Sections

Section I. Grievances

MAOs must comply with grievance requirements for timely hearing and resolving of grievances as established in regulations at 42 CFR Part 422 Subpart M and further described in the [Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance](#).

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due Date(s)
<ul style="list-style-type: none"> - Local Coordinated Care Plan (CCP) - Medicare Savings Accounts (MSAs) - Religious Fraternal Benefit (RFB) Private Fee for Services (PFFS) - PFFS - 1876 Cost - Regional CCP - Employer/Union Only Direct Contract - PFFS - RFB Local CCP - Employer/Union Only Direct Contract Local CCP <p>Organizations should include all 800 series plans.</p> <p>Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.</p>	1/Year, Contract Level	Q1: 1/1-3/31 Q2: 4/1- 6/30 Q3: 7/1-9/30 Q4: 10/1-12/31 (Reporting at quarterly level)	First Monday of February of the following year. Data Validation required.

Data Element ID	Data Element Description
A.	Number of Total Grievances
B.	Number of Total Grievances in which timely notification was given
C.	Number of Expedited Grievances
D.	Number of Expedited Grievances in which timely notification was given
E.	Number of Dismissed Grievances

Section II. Organization Determinations & Reconsiderations

42 CFR Part 422 Subpart M outlines organization determination and reconsideration requirements for MAOs, including timeframes for handling determinations, and further described in the [Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance](#).

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due Date(s)
<ul style="list-style-type: none"> - Local CCP - MSA - RFB PFFS - PFFS - 1876 Cost - Regional CCP - Employer/Union Only Direct Contract PFFS - RFB Local CCP - Employer/Union Only Direct Contract Local CCP <p>Organizations should include all 800 series plans.</p> <p>Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.</p>	<p>1/Year, Contract Level</p>	<p>Q1: 1/1-3/31 Q2: 4/1- 6/30 Q3: 7/1-9/30 Q4: 10/1-12/31</p> <p>(Reporting at quarterly level)</p>	<p>Last Monday of February of the following year.</p> <p>Data Validation required.</p>

Subsection 1: Organization Determinations

Data Element ID	Data Element Description
A.	Total Number of Organization Determinations made
B.	Number of Organization Determinations - Withdrawn
C.	Number of Organization Determinations - Dismissals
D.	Number of Organization Determinations requested by enrollee/representative or provider on behalf of the enrollee (Services)
E.	Number of Organization Determinations submitted by Enrollee/Representative (Claims)
F.	Number of Organization Determinations requested by Non-Contract Provider (Services)
G.	Number of Organization Determinations submitted by Non-Contract Provider (Claims)

Subsection 2: Disposition – All Organization Determinations

Data Element ID	Data Element Description
A.	Number of Organization Determinations – Fully Favorable (Services) Requested by enrollee/representative or provider on behalf of the enrollee
B.	Number of Organization Determinations – Fully Favorable (Services) Requested by Non-contract Provider
C.	Number of Organization Determinations – Fully Favorable (Claims) Submitted by enrollee/representative
D.	Number of Organization Determinations – Fully Favorable (Claims) Submitted by Non-contract Provider
E.	Number of Organization Determinations – Partially Favorable (Services) Requested by enrollee/representative or provider on behalf of the enrollee
F.	Number of Organization Determinations – Partially Favorable (Services) Requested by Non-contract Provider
G.	Number of Organization Determinations – Partially Favorable (Claims) Submitted by enrollee/representative.
H.	Number of Organization Determinations – Partially Favorable (Claims) Submitted by Non-contract Provider
I.	Number of Organization Determinations – Adverse (Services) Requested by enrollee/representative or provider on behalf of the enrollee
J.	Number of Organization Determinations – Adverse (Services) Requested by Noncontract Provider
K.	Number of Organization Determinations – Adverse (Claims) Submitted by enrollee/representative
L.	Number of Organization Determinations – Adverse (Claims) Submitted by Noncontract Provider

Subsection 3: Reconsiderations

Data Element ID	Data Element Description
A.	Total number of Reconsiderations made
B.	Number of Reconsiderations - Withdrawn
C.	Number of Reconsiderations - Dismissals
D.	Number of Reconsiderations requested by or on behalf of the enrollee (Services)
E.	Number of Reconsiderations submitted by Enrollee/Representative (Claims)
F.	Number of Reconsiderations requested by Non-Contract Provider (Services)
G.	Number of Reconsiderations submitted by Non-Contract Provider (Claims)

Subsection 4: Disposition – All Reconsiderations

Data Element ID	Data Element Description
A.	Number of Reconsiderations – Fully Favorable (Services) requested by enrollee/representative or provider on behalf of the enrollee
B.	Number of Reconsiderations – Fully Favorable (Services) requested by Non-contract Provider
C.	Number of Reconsiderations – Fully Favorable (Claims) submitted by enrollee/representative
D.	Number of Reconsiderations – Fully Favorable (Claims) submitted by Non-contract Provider
E.	Number of Reconsiderations – Partially Favorable (Services) requested by enrollee/representative or provider on behalf of the enrollee
F.	Number of Reconsiderations – Partially Favorable (Services) requested by Noncontract Provider
G.	Number of Reconsiderations – Partially Favorable (Claims) submitted by enrollee/representative
H.	Number of Reconsiderations – Partially Favorable (Claims) submitted by Noncontract Provider
I.	Number of Reconsiderations – Adverse (Services) requested by enrollee/representative or provider on behalf of the enrollee
J.	Number of Reconsiderations – Adverse (Services) requested by Non-contract Provider
K	Number of Reconsiderations – Adverse (Claims) submitted by enrollee/representative
L.	Number of Reconsiderations – Adverse (Claims) submitted by Non-contract Provider

Subsection 5: Re-Openings

Data Element ID	Data Element Description
A.	Total number of reopened (revised) decisions, for any reason
B.	Contract Number
C.	Case ID
D.	Case level (Organization Determination or Reconsideration)
E.	Date of original disposition
F.	Original disposition (Fully Favorable, Partially Favorable, or Adverse)
G.	Was the case processed under the expedited timeframe? (Y/N)
H.	Case type (Service or Claim)
I.	Status of treating provider (Contract, Non-contract)
J.	Date case was reopened
K.	Reason(s) for reopening (Clerical Error, Other Error, New and Material Evidence, Fraud or Similar Fault, or Other)
L.	Additional Information (Optional)
M.	Date of reopening disposition (revised decision)
N.	Reopening disposition (Fully Favorable; Partially Favorable, Adverse or Pending)

Section III. Employer Group Plan Sponsors

CMS regulations (42 CFR § 422.106) stipulate specific parameters for MAOs offering employer group health plans. Additional information regarding waivers can be found in Chapter 9 of the Medicare Managed Care Manual (<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c09.pdf>).

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due Date(s)
<ul style="list-style-type: none"> - Local CCP - MSA - RFB PFFS - PFFS - 1876 Cost - PDP - Regional CCP - Employer/Union Only Direct Contract PDPs - Employer/Union Only Direct Contract PFFS - RFB Local CCP - Employer/Union Only Direct Contract Local CCP <p>Organizations should include all 800 series plans and any individual plans sold to employer groups.</p> <p>Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.</p>	<p>1/Year, PBP Level</p>	<p>1/1 - 12/31 (Reporting at annual level)</p>	<p>First Monday of February of the following year.</p> <p>Data Validation not required.</p>

Data Element ID	Data Element Description
A.	Employer Legal Name
B.	Employer DBA Name
C.	Employer Federal Tax ID
D.	Employer Address
E.	Type of Group Sponsor (employer, union, trustees of a fund)
F.	Organization Type (state government, local government, publicly traded organization, privately held corporation, non-profit, church group, other)
G.	Type of Contract (insured, ASO, other)
H.	Is this a calendar year plan? (Y (yes) or N (no))
I.	If Element H is "N", provide non-calendar year start date.
J.	Current/Anticipated enrollment

Section IV. Special Needs Plans (SNPs) Care Management

Title 42, Part 422, Subpart C outlines the requirements for Part C sponsors offering Special Needs Plans, including specific timeframes, health risk assessments, and models of care.

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due Date(s)
<p>SNP PBPs under the following types:</p> <ul style="list-style-type: none"> - Local CCP - Regional CCP <p>Only SNP Plans are required to report.</p> <p>Organizations should exclude 800 series plans if they are SNPs.</p>	1/Year, PBP Level	1/1-12/31 (Reporting at annual level)	<p>Last Monday of February in the following year.</p> <p>Data Validation required.</p>

Data Element ID	Data Element Description
A.	Number of new enrollees due for an Initial Health Risk Assessment (HRA)
B.	Number of enrollees eligible for an annual reassessment HRA
C.	Number of initial HRAs performed on new enrollees
D.	Number of initial HRA refusals
E.	Number of initial HRAs not performed because SNP is unable to reach new enrollees
F.	Number of annual reassessments performed on enrollees eligible for a reassessment
G.	Number of annual reassessment refusals
H.	Number of annual reassessments where SNP is unable to reach an enrollee

Section V. Enrollment and Disenrollment

Enrollment and disenrollment requirements for Medicare Advantage (MA) and Part D plan elections are outlined at 42 CFR Part 422 Subpart B and 42 CFR Part 423 Subpart B, respectively.

For Part C reporting, MAOs offering MA-only plans (i.e., no Part D benefit) are to report enrollment, disenrollment, and reinstatement activity for these plans in this reporting section. Similarly, 1876 Cost plans are to report enrollment, disenrollment, and reinstatement activity for PBPs that do not include a Part D optional supplemental benefit. Enrollment, disenrollment, and reinstatement activity for MA prescription drug plans (MA-PDs) and 1876 Cost plan PBPs that include a Part D optional supplemental benefit must report under the appropriate section in the Part D Reporting Requirements.

For more information on these requirements, refer to the MA and Part D Enrollment and Disenrollment Guidance, available at: <https://www.cms.gov/medicare/enrollment-renewal/part-d-enrollment-eligibility>.

Organization Types Required to Report	Reporting Frequency, Level	Report Period(s)	Data Due date(s)
<ul style="list-style-type: none"> - MA-only (no Part D plans) - Local CCP - RFB PFFS - PFFS - 1876 Cost (PBPs that do not include a Part D optional supplemental benefit) - Regional CCP - RFB Local CCP 	2/Year, Contract Level	Period 1: 1/1-6/30 Period 2: 7/1- 12/31 (Reporting at bi-annual level)	Last Monday of August Last Monday of February of the following year. Data Validation is not required.

Subsection 1: Enrollment

Data Element ID	Data Element Description
A.	The total number of enrollment requests (initiated by the beneficiary or his/her authorized representative) received in the reporting period. Do not include auto/facilitated or passive enrollments, rollover transactions, or other enrollments effectuated by CMS.
B.	Of the total reported in Element A, the number of enrollment requests complete at the time of initial receipt (i.e., required no additional information from applicant or his/her authorized representative).
C.	Of the total reported in Element A, the number of enrollment requests that were not complete at the time of initial receipt and for which the sponsor was required to request additional information from the applicant (or his/her authorized representative).
D.	Of the total reported in Element A, the number of enrollment requests denied due to the sponsor's determination of the applicant's ineligibility to elect the plan (i.e., individual not eligible for an election period).
E.	Of the total reported in Element C, the number of enrollment requests received that are incomplete upon initial receipt and completed within established timeframes.
F.	Of the total reported in Element C, the number of enrollment requests denied due to the applicant or his/her authorized representative not providing information to complete the enrollment request within established timeframes.
G.	Of the total reported in Element A, the number of paper enrollment requests received.
H.	Of the total reported in Element A, the number of telephonic enrollment requests received (if sponsor offers this mechanism).
I.	Of the total reported in Element A, the number of electronic enrollment requests received via an electronic device or secure internet website (if sponsor offers this mechanism).
J.	Of the total reported in Element A, the number of Medicare Online Enrollment Center (OEC) enrollment requests received.

Subsection 2: Disenrollment

Data Element ID	Data Element Description
A.	The total number of voluntary disenrollment requests received in the reporting period. Do not include disenrollments resulting from an individual's enrollment in another plan.
B.	Of the total reported in Element A, the number of disenrollment requests completed at the time of initial receipt (i.e., required no additional information from enrollee or his/her authorized representative).
C.	Of the total reported in Element A, the number of disenrollment requests denied by the Sponsor for any reason.
D.	The total number of involuntary disenrollments for failure to pay plan premium in the specified time period.
E.	Of the total reported in Element D, the number of disenrolled individuals who submitted a timely request for reinstatement for Good Cause.
F.	Of the total reported in Element E, the number of favorable Good Cause determinations.
G.	Of the total reported in Element F, the number of individuals reinstated.

Section VI. Rewards and Incentives Programs

42 CFR § 422.134 establishes requirements for MA sponsors offering rewards and incentives programs.

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due date(s)
<ul style="list-style-type: none"> - Local CCP - MSA - RFB PFFS - PFFS - Regional CCP - Employer/Union Only Direct Contract PFFS - RFB Local CCP - Employer/Union Only Direct Contract Local CCP <p>Organizations should include all 800 series plans.</p> <p>Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.</p>	1/Year, Contract Level	1/1-12/31 (Reporting at annual level)	<p>Last Monday of February of the following year.</p> <p>Data Validation is not required.</p>

Data Element ID	Data Element Description
A.	Do you have a Rewards and Incentives Program(s)? (“Yes” or “No” only)
B.	Rewards and Incentives Program Name
C.	What health related services and/or activities are included in the program?
D.	What reward(s) may enrollees earn for participation?
E.	How do you calculate the value of the reward?
F.	How do you track enrollee participation in the program?
G.	How many enrollees are currently enrolled in the program?
H.	How many rewards have been awarded so far?

Section VII. Payments to Providers

The Department of Health and Human Services (HHS) developed the four categories of value-based payments: fee-for-service with no link to quality (Category 1); fee-for-service with a link to quality (Category 2); alternative payment models built on fee-for-service architecture (Category 3); and population-based payment (Category 4). These groupings conform to the Health Care Payment Learning & Action Network (HCPLAN) Alternative Payment Models (APM) Framework categories. For more detailed information, please refer to the LAN [APM Framework](https://hcp-lan.org/apmframework/) (<https://hcp-lan.org/apmframework/>).

CMS will collect data from MAOs about the proportion of their payments made to contracted providers based on these four categories in order to understand the extent and use of alternate payment models in the MA industry.

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due Date(s)
<ul style="list-style-type: none"> - Local CCP - PFFS - Regional CCP - RFB Local CCP 	1/Year, Contract Level	1/1-12/31 (Reporting at annual level)	Last Monday of February of the following year. Data Validation not required.

Data Element ID	Data Element Description
A.	Total dollars paid to providers (in and out of network) for Medicare Advantage enrollees.

Subsection 1: Category 1

Data Element ID	Data Element Description
B.	Total dollars paid to providers through legacy payments (including fee-for-service (i.e., payments made for units of service) that are adjusted to account for neither infrastructure investments, nor provider reporting of quality data, nor provider performance on cost and quality metrics). Also includes diagnosis-related groups that are not linked to quality and value.

Subsection 2: Category 2

Data Element ID	Data Element Description
C.	Total dollars paid to providers through fee-for-service plus pay-for-reporting payments (linked to quality).
D.	Total dollars paid to providers through fee-for-service plus pay-for-

Data Element ID	Data Element Description
	performance payments (linked to quality)
E.	Dollars paid for foundational spending to improve care (linked to quality).
F.	Total dollars paid in Category 2.

Subsection 3: Category 3

Data Element ID	Data Element Description
G.	Total dollars paid to providers through traditional shared-savings (linked to quality) payments.
H.	Total dollars paid to providers through utilization-based shared-savings (linked to quality) payments.
I.	Total dollars paid to providers through fee-for-service-based shared-risk (linked to quality) payments.
J.	Total dollars paid to providers through procedure-based bundled/episode payments (linked to quality) programs.
K.	Total dollars paid in Category 3.
L.	Total Risk-based payments not linked to quality (e.g., 3N in APM definitional framework).

Subsection 4: Category 4

Data Element ID	Data Element Description
M.	Total dollars paid to providers through condition-specific, population-based payments (linked to quality).
N.	Total dollars paid to providers through condition-specific, bundled/episode payments (linked to quality).
O.	Total dollars paid to providers through population-based payments that are NOT condition-specific (linked to quality).
P.	Total dollars paid to providers through full or percent of premium population-based payments (linked to quality).
Q.	Total dollars paid to providers through integrated finance and delivery system programs (linked to quality).
R.	Total dollars paid in Category 4.
S.	Total capitation payment not linked to quality (e.g., 4N in the APM definitional framework).

Subsection 5: Provider Data

Data Element ID	Data Element Description
T.	Total number of Medicare Advantage contracted providers
U.	Total Medicare Advantage contracted providers paid on a fee-for-service basis with no link to quality (Category 1)
V.	Total Medicare Advantage contracted providers paid on a fee-for-

Data Element ID	Data Element Description
	service plus pay-for-reporting payments (linked to quality)
W.	Total Medicare Advantage contracted providers paid on a fee-for-service plus pay-for-performance payments (linked to quality)
X.	Total Medicare Advantage contracted providers paid on a fee-for-service basis with a link to quality (Category 2)
Y.	Total Medicare Advantage contracted providers paid based on alternative payment models built on a fee-for-service architecture (Category 3)
Z.	Total Medicare Advantage contracted providers paid through traditional shared savings (linked to quality)
AA.	Total Medicare Advantage contracted providers paid through utilization-based shared-savings (linked to quality)
BB.	Total Medicare Advantage contracted providers paid through fee-for-service-based shared-risk (linked to quality)
CC.	Total Medicare Advantage contracted providers paid through procedure-based bundled/episode payments (linked to quality)
DD.	Total Medicare Advantage contracted providers paid through risk-based payments not linked to quality (e.g., 3N in the APM definitional framework)
EE.	Total Medicare Advantage contracted providers paid through population-based payments (Category 4)
FF.	Total Medicare Advantage contracted providers paid through condition-specific, population-based payments (linked to quality)
GG.	Total Medicare Advantage contracted providers paid through condition-specific, bundled/episode payments (linked to quality)
HH.	Total Medicare Advantage contracted providers paid through population-based payments that are NOT condition-specific (linked to quality)
II.	Total Medicare Advantage contracted providers paid through full or percent of premium population-based payments (linked to quality)
JJ.	Total Medicare Advantage contracted providers paid through integrated finance and delivery system programs (linked to quality)
KK.	Total Medicare Advantage contracted providers paid based on capitation with no link to quality (e.g., Category 4N in the APM definitional framework)

Subsection 6: PCP/PCG-Focused Accountable Care Metrics

(Metrics below apply to the number of MA plan enrollees in an accountable care arrangement. Metrics are linked to quality.)

Data Element ID	Data Element Description
LL.	Total Medicare Advantage covered lives.
MM.	Total number of Medicare Advantage health plan enrollees attributed / aligned / assigned / empaneled to a Primary Care Provider (PCP) or Primary Care Group (PCG) participating in a TCOC Category 3 or 4 accountable care APM of six months or longer. [This does NOT include health plan enrollees attributed / aligned / assigned / empaneled to a PCP or PCG, who are paid based on capitation with no link to quality (4N)].

Subsection 7: Non-PCP/PCG-Focused Accountable Care Metric

(Metrics below apply to the number of MA plan enrollees in an accountable care arrangement. Metrics are linked to quality.)

Data Element ID	Data Element Description
NN.	Total number of Medicare Advantage health plan enrollees attributed / aligned / assigned / empaneled to non-PCPs (i.e., specialists) participating in a TCOC Category 3 or 4 accountable care APM (e.g., shared savings with upside risk only) of six months or longer. [This does NOT include health plan enrollees attributed / aligned / assigned / empaneled to a non-PCP/PCG provider, who are paid based on capitation with no link to quality (4N)].

Section VIII. Supplemental Benefit Utilization and Costs

42 CFR § 422.102 provides MAO requirements for mandatory and optional supplemental benefits, and special supplemental benefits for the chronically ill (SSBCI). Refer to the Technical Specifications for a list of the Supplemental Benefit PBP Category Codes. The Data Elements listed below must be reported for all PBP Category Codes. Any MAO that offers any of these supplemental benefits (as they noted in the PBP they submitted to CMS for the CY) is required to report this section, whether or not any beneficiaries utilized the benefit.

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data due date(s)
<ul style="list-style-type: none"> - Local CCP - MSA - RFB PFFS - PFFS - 1876 Cost - Regional CCP - Employer/Union Only Direct Contract PFFS - RFB Local CCP - Employer/Union Only Direct Contract Local CCP <p>Organizations should include all 800 series plans.</p> <p>Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.</p>	1/Year, PBP Level	1/1-12/31 (Reporting at annual level)	<p>Last Monday in February of the following year</p> <p>Data Validation is not required.</p>

Data Element ID	Data Element Description
A.	Contract ID
B.	PBP ID
C.	PBP Category
D.	Supplemental benefit name, if the PBP Category (Element C) has an "Other" designation (PBP categories: 7b2, 13d, 13e, 13f, 13i11 through 13i15, and 17a2). The text entered for Element D should be the supplemental benefit name that the

Data Element ID	Data Element Description
	plan submitted in the PBP for the CY of the reporting period.
E.	How is the supplemental benefit offered? (Mandatory, Optional, Uniformity Flexibility, SSBCI, not offered) If the same supplemental benefit (as identified by a specific PBP Category) is offered in multiple ways (e.g., as an optional benefit, and also as SSBCI), report Elements F-P for each offering type separately.
F.	Network type (in-network, out-of-network (for PPO), out-of-network (for HMO-POS), Visitor/travel, Other). If "Other", specify further in Element M, e.g., full network for PFFS plan. Similar to Element E, if the same supplemental benefit (as identified by a specific PBP Category in Element C) is offered in more than one network type (e.g., as both in-network and out-of-network (for PPO)), report Elements G-P for each network type separately.
G.	The unit of utilization used by the plan when measuring utilization. For example, admissions, visits, procedures, trips, or purchases. This list of examples is not exhaustive. Only one unit of utilization is allowed per PBP Category.
H.	The number of enrollees ever eligible for the benefit during the reporting period.
I.	The number of enrollees who utilized the benefit at least once.
J.	The total instances of utilizations among eligible enrollees.
K.	The median number of utilizations among enrollees who utilized the benefit at least once.
L.	The total net amount incurred by the plan to offer the benefit.
M.	The type of payment arrangement(s) the plan used to implement the benefit. The plan may use the categories CMS provides in the Payments to Providers section of the Part C Reporting Requirements. Alternatively, the plan may use other phrases or provide a brief description if its payment arrangement does not neatly fall into one of those categories.
N.	How the plan accounts for the cost of the benefit, including how the plan determines and measures administrative costs, costs to deliver, and any other costs the plan captures.
O.	The total out-of-pocket-cost for enrollees who utilized the benefit.
P.	The median out-of-pocket cost for enrollees.

Section IX. D-SNP Enrollee Advisory Committee

42 CFR § 422.107(f) establishes requirements for Enrollee Advisory Committees for any MAO offering one or more D-SNPs in a state.

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due Date(s)
D-SNP PBPs under the following types: <ul style="list-style-type: none"> - Local CCP - Regional CCP 	1/Year, PBP Level	1/1-12/31 (Reporting at annual level)	Last Monday of February of the following year. Data Validation is not required.

Data Element ID	Data Element Description
A.	Does the D-SNP share an enrollee advisory committee (EAC) with other D-SNP(s)? (“Yes” or “No” only)
B.	Provide the total number of D-SNP EAC meetings held during the measurement year.
C.	List the dates during the measurement year when the D-SNP EAC met.
D.	Were interpreter services offered for each D-SNP EAC meeting? (“Yes” or “No” only)
E.	Were auxiliary aids and services offered for each D-SNP EAC meeting? (“Yes” or “No” only)

Section X. D-SNP Transmission of Admission Notifications

42 CFR § 422.107(d) establishes requirements for any D-SNP that is not a fully integrated or highly integrated D-SNP (i.e., FIDE SNP or HIDE SNP), except as specified at 42 CFR § 422.107(d)(2) or as required by a State Medicaid Agency Contract, to notify the State Medicaid agency or designate of hospital and skilled nursing facility admissions for at least one group of high-risk full benefit dually eligible individuals.

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due Date(s)
D-SNP PBPs that are not fully integrated D-SNPs or highly integrated D-SNPs, except as specified under 42 CFR 422.107(d)(2) or as required by a state Medicaid Agency Contract, under the following types: <ul style="list-style-type: none"> - Local CCP - Regional CCP 	1/Year, PBP Level	1/1-12/31 (Reporting at annual level)	Last Monday of April of the following year. Data Validation is not required.

Data Element ID	Data Element Description
A.	Provide the total number of hospital admissions and skilled nursing facility (SNF) admissions during the measurement year among the group(s) of high risk full-benefit dually eligible individuals designated in the D-SNP's state Medicaid agency contract.
B.	Of the total reported in Element A, provide the total number of admission notifications that the D-SNP transmitted to the state or state designated entity during the measurement year.