Medicare Part C Reporting Requirements:
Technical Specifications Document
Contract Year 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 these Technical Specifications made between Contract Year 2025 and Contract Year 2026. Please compare the two Technical Specifications documents for all the changes between the two contract years.

1. Improved formatting for accessibility.
2. Updated introduction to clarify the description of these Technical Specifications and cite additional documentation available on the Health Plan Management System (HPMS). Also clarified information on resubmission of data and due date extension requests in the introduction.
3. Removed duplicative information already listed in the Reporting Requirements document or HPMS documentation.
4. Added clarification on submitting Reporting Requirements data through either file upload or data entry.
5. Removed all references to lmi.org email boxes. All Part C Reporting Requirements inquiries should be sent to PartsCDPlanReportingAndDV@cms.hhs.gov.
6. Clarified specifications for most Reporting Requirements sections, including but not limited to:
    a. For the Organization Determinations and Reconsiderations reporting requirement section, the definitions for purposes of Medicare Advantage Organization (MAO) reporting subheading and content was removed.
    b. Clarified a note on inclusions in Element H and notes on Reporting Enrollees Who Are Unable to be Reached in the Special Needs Plans (SNPs) Care Management section.
    c. Clarified a note on enrollment and disenrollment of beneficiaries between SNP plans under the same contract in the same measurement year (MY).
    d. Added significantly greater detail to several specifications for Supplemental Benefit Utilization And Costs. Also, corrected the Plan Benefit Package (PBP) Category code number for 9d-1.

    e. Synchronized language where possible between Part C and Part D specifications for the following sections: Grievances, Organization Determinations and Reconsiderations, Employer Group Plan Sponsors, and Enrollment and Disenrollment.

7. Removed Appendix I (FAQs) and moved information from those FAQs into the specifications for relevant Reporting Requirements sections.

8. Removed Appendix II and replaced with a citation in the Payments to Provider section.

Introduction

These technical specifications supplement the Part C Reporting Requirements (OMB 0938-1054), and do not change, alter, or add to the data collection. They serve to further define data elements. The Part C Reporting Requirements document can be found at: https://www.cms.gov/medicare/enrollment-renewal/health-plans/part-c.

The purpose of these technical specifications is to help ensure a common understanding of the data to be reported by Medicare Advantage Organizations (MAOs), to assist MAOs in preparing and submitting datasets, to ensure a high level of accuracy in the data reported to CMS, and to reduce the need for MAOs to correct and resubmit data. Each Part C reporting section is listed in this document with specifications for data elements within Reporting Sections.

MAOs must report all data based on the most current Technical Specifications as of the reporting deadline, which apply for the entire reporting period.

Information relevant to Employer DBA and Legal Name, Employer Address, and Employer Tax Identification Numbers (Employer Group Plans) is proprietary information and not subject to public disclosure under provisions of the Freedom of Information Act (FOIA). An MAO may need to provide independent justification for protecting this data following a submission of a FOIA request.

File Upload Rules and Instructions

With limited exceptions, Reporting Requirements data are reported via file upload in the Health Plan Management System (HPMS) Plan Reporting User Module (PRM). Instructions for data submission are in the HPMS Plan User Manual, which is found by accessing HPMS – Quality and Performance – Plan Reporting – Documentation. Information on creation of the file upload for each section is found in the File Record Layouts for each Reporting Section. These file layouts can be found in the same location as the Plan User Manual.

For certain Reporting Requirements sections, Element A is reported via data entry into the PRM, and all following elements are reported via file upload. Details on these sections are found in the Reporting Requirements sections below.

Validation checks should be performed by MAOs prior to data submissions. When files are uploaded into the HPMS PRM, the system will perform validation checks. The list of validation checks performed for each reporting section is found in the Data Entry Edit Rules document, found in the same location as the Plan User Manual. CMS may apply new or adjust existing quality assurance checks based upon data received from MAOs.

Resubmissions

If previously submitted data are incorrect, and the reporting deadline has passed, the MAO should request the opportunity to correct and resubmit data (referred to as a resubmission) prior to the resubmission deadline. An MAO can only initiate a resubmission request after the original reporting deadline (e.g., the last Monday in February) has expired. CMS expects data to be accurate on the date of submission.

In order to accommodate data validation activities, with the exception of the Dual Eligible Special Needs Plans (D-SNP) Transmission of Admission Notifications Reporting Section, data corrections must be submitted prior to 11:59 p.m. Pacific time on March 31st, or if March 31st falls on a weekend or federal holiday, prior to 11:59 p.m. Pacific time on the preceding business day.

Data corrections for the D-SNP Transmission of Admission Notifications Reporting Section must be submitted prior to 11:59 p.m. Pacific time on May 31st, or if May 31st falls on a weekend or federal holiday, prior to 11:59 p.m. Pacific time on the preceding business day.

Instructions for how to request resubmission of data are outlined in the aforementioned HPMS Plan User Manual.

If an MAO requests a resubmission, but does not upload new data, then the original data remains submitted. HPMS will not allow the resubmission of data that are identical to the original data submission. MAOs should retain documentation supporting their 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.

Once an MAO submits a resubmission request, and CMS approves the request to resubmit, the MAO has 7 days to resubmit data, or until the resubmission deadline, whichever comes first.

Data Integrity and Outlier Notifications

After the reporting deadline has passed for a particular Reporting Section, CMS will alert MAOs regarding potential data integrity issues and/or data that has been determined to be an outlier relative to the rest of the Part C or D program. These alerts come through the Monitoring Parts C & D Reporting Web Portal. These alerts serve only to give MAOs the opportunity to correct submitted data if needed, and do not indicate that submitted data are incorrect, or that resubmissions are required. The list of data integrity and outlier checks for each reporting section can be accessed by navigating to HPMS – Quality and Performance – Plan Reporting – Documentation.

CMS may apply new or adjust existing data integrity checks and outlier threshold validations based upon data received from Sponsoring Organizations.

Questions

Questions about Part C Reporting Requirements should be sent via email to PartsCDPlanReportingAndDV@cms.hhs.gov. Please be aware immediate responses to individual questions may not always be possible due to email volume. CMS recommends plans first refer to the current Medicare Part C Reporting Requirements document or Technical Specifications for answers.

For technical assistance relevant to file formats and uploads, please contact the HPMS help desk: 1-800-220- 2028 or email: hpms@cms.hhs.gov.

Reporting Sections

Section I. Grievances

- For an explanation of Medicare Part C Grievance Procedures, refer to CMS Regulations and Guidance: 42 CFR Part 422, Subpart M, and the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance via the CMS website: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index.html.
- Report grievances based on the date the MAO provided the enrollee with its decision (regardless of when the request was received). Include grievances filed by the enrollee or his or her representative.
- If an enrollee files a grievance and then files a subsequent grievance on the same issue prior to the organization's decision or deadline for decision notification (whichever is earlier), report as one grievance.
- If an enrollee files a grievance and then files a subsequent grievance on the same issue after the organization's decision or deadline for decision notification (whichever is earlier), report as separate grievances.
- If an enrollee files a grievance about multiple issues during a call or in writing, report as separate grievances.
- If an extension is requested after the required time frame for decision making has elapsed, the decision is considered non-timely and should not be counted in Element B.
- For Element E, dismissed grievances, report grievances received but the MAO did not process them because they did not meet the requirements for valid grievances.
- Report a grievance as either a Part C or Part D grievance, depending on the MAO's process used to investigate and resolve the grievance. Where a clear distinction is not available, report cases as Part C grievances.
- Report grievances filed by beneficiaries previously enrolled, even if they are no longer enrolled by the time of notification. The MAO is still responsible for investigating, resolving and reporting the grievance.
- Report expedited grievances as part of the total number of grievances and the total number of timely notifications.

Do Not Report:

- Complaints Tracking Module (CTM) records as grievance logs. The CTM complaint process is separate and distinct from the MAO's procedures for handling enrollee grievances.
- Grievances filed by non-enrollees, including prospective enrollees.
- Grievances related to services or items only covered under the MAO's Medicaid benefits and never covered by Medicare and not covered as a supplemental Medicare benefit (such as Medicaid home- and community-based long-term services and supports).
- General inquiries or questions that do not include a complaint.
- Withdrawn grievances.
- Dismissed grievances in the total number of grievances.
- Complaints made to providers that are not filed with the MAO.

Section II. Organization Determinations & Reconsiderations

- For an explanation of organization determinations, reconsiderations, and re-openings procedures, refer to CMS regulations 42 CFR Part 422, Subpart M, and the 'Parts C & D Enrollee Grievances Organization/Coverage Determinations, and Appeals Guidance via the CMS website: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG. For information on the integrated appeals process, refer to the Addendum to the Part C &D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans: https://www.cms.gov/files/document/dsnppartscdgrievancesdeterminationsappealsguidanceaddendum.pdf.

General

- To ensure consistent reporting by all MAOs, CMS has included data fields to report partially favorable decisions and expects decisions that are partially favorable to be reported as such.
- Data elements that state "provider on behalf of an enrollee" refer to contract providers. Non-contract providers have their own reporting elements.
- Report completed organization determinations and reconsiderations (i.e., MAO has notified enrollee of its pre-service decision or adjudicated a claim) during the reporting period, regardless of when the request was received.
- Withdrawn and dismissed coverage requests are not included in the total number of coverage requests. Instead, withdrawn coverage requests (which are dismissed as a result of a withdrawal request) and dismissed coverage requests are distinct data elements.

Report:

- Completed organization determinations and reconsiderations (i.e., MAO has notified enrollee of its pre-service decision or adjudicated a claim submitted by the enrollee or non-contract provider) during the reporting period, regardless of when the request was received. MAOs are to report organization determinations or reconsiderations where a substantive decision has been made, as described in this section and processed in accordance with the organization determination and reconsideration procedures described under 42 C.F.R. Part 422, Subpart M.
- Pre-service organization determination and reconsideration requests submitted by the enrollee, enrollee's representative, or contract provider on behalf of the enrollee, and requests from non-contract providers.
- Requests for payment of a Part B drug submitted by the enrollee or non-contract provider are reportable as organization determinations or reconsiderations.

- MAOs are to report fully favorable, partially favorable, and adverse service and payment requests (organization determinations and reconsiderations)
- A request for payment, other than a contract provider, as a separate and distinct organization determination, even if a pre-service request for that same item or service was also processed.
- Prior authorization request and a post-service payment request for the same service if the enrollee or a non-contract provider submits the payment request; this is not considered duplicative.
- Decisions made by delegated entities, such as an external, contracted entity responsible for organization determinations (e.g., claims processing and preservice decisions) or reconsiderations.
- A denial of a Medicare request for coverage (payment or provision) of an item or service as either partially favorable or adverse, regardless of whether Medicaid payment or provision ultimately is provided, in whole or in part, for that item or service. However, D-SNPs that are applicable integrated plans as defined in 42 CFR § 422.561 should report a request for a Medicare item or service based on the outcome of applying both Medicare and Medicaid coverage criteria.
- Denials based on exhaustion of Medicare benefits.

Do Not Report:

- Independent Review Entity (IRE) decisions.
- Claims payment or appeals from contract providers that are governed under the contractual arrangement between the MAO and its contract providers.
- An appeal by an enrollee (or other party) of the MAO's dismissal of a coverage determination.
- A decision by the MAO to uphold or reverse its dismissal of an organization determination as a result of an enrollee (or other party) appealing a dismissal.
- MAO decisions regarding a request to vacate a dismissal.
- Re-openings requested or completed by the IRE, Administrative Law Judge (ALJ), or Appeals Council.
- Concurrent reviews during hospitalization that do not result in organization determinations.
- Concurrent reviews of Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) care that do not result in organization determinations.

- Duplicate payment requests concerning the same service or item. MAOs should exclude duplicate claim submissions (e.g., a request for payment concerning the same service) and claims returned to a provider/supplier due to error (e.g., claim submissions or forms that are incomplete, invalid or do not meet the requirements for a Medicare claim).
- Payment requests returned to a provider/supplier in which a substantive decision (fully favorable, partially favorable, or adverse) has not been made – e.g., payment requests or forms are incomplete, invalid, or do not meet the requirements for a Medicare claim (e.g., due to a clerical error).
- Part B drugs that are paid or denied at the pharmacy and point-of-sale Part B drug claim rejections are not reportable as organization determinations. If the MAO subsequently processes an organization determination, this should be reported under Element "E" subsection #1.
- A Quality Improvement Organization (QIO) review of an individual's request to continue Medicare-covered services (e.g., a SNF stay) and any related claims/requests to pay for continued coverage based on such QIO decision.
- A service only covered under the MAO's Medicaid benefits and never covered by Medicare and not covered by the MAO as a supplemental Medicare benefit (such as Medicaid home-and community-based long-term services and supports).

Re-openings (Organization Determinations and Reconsiderations):

- Element A of Re-openings is reported via data entry into the HPMS PRM. All following data elements, starting with Element B, are reported via a file upload in the PRM for each case that was reopened.
- Reopened organization determinations and reconsiderations should be included, except reopened claims submitted by contract provider.
- Reopening disposition, should reflect the status of a reopened case once the MAO has notified the beneficiary of the reopening decision. For example, if an MAO reopened a coverage determination on March 15th but notified the beneficiary on April 22nd, the reopened case should be reported in Q2's file. Do not report the reopened case in Q1's file.
- If the IRE fully or partially overturns the MAO's determination, do not report the case as a reopening.

Section III. Employer Group Plan Sponsors

- HPMS displays one module for reporting both Part C and Part D Employer/Union-Sponsored Group Health Plan Sponsors data. These technical specifications apply to both MAOs and Part D sponsors (collectively referred to as plan sponsors in this section of the technical specifications).
- A Medicare Advantage Prescription Drug Plan (MA-PD) may submit Part C and Part D data in one upload; the upload file should include all applicable plan IDs for a contract.
- All employer groups that have an arrangement in place with a plan sponsor for any portion of the reporting period should be included in the file upload, regardless of enrollment. In this case, plan sponsors should use the date they have an arrangement in place with the employer group to identify the reporting year.
- Element C: Federal Tax ID is a required field in the file upload. Plan sponsors should work with their employer groups to collect this information directly. Alternatively, several commercial lookup services are available that may be used to locate this number.
- Element D: For employer groups maintaining multiple addresses with a plan sponsor, report the address from which the employer manages the human resources/health benefits.
- Element F: The employer organization type is based on how plan sponsors file their taxes. Plan sponsors that provide coverage to private market employer groups and which are subject to Mandatory Insurer Reporting (MIR) of Medicare Secondary Payer data may use the employer address and tax ID information submitted via the MIR. This information must be submitted for the purposes of the Part C and Part D reporting requirements even if the plan sponsor has sent this information to CMS previously for some other purpose.
- Element G: Type of contract (insured, ASO, other) refers to the type of contract the plan sponsor holds with the employer group that binds the organization to offer benefits to their retirees.
- Element J: Report the enrollment as of the last day of the reporting period and include all enrollments from the particular employer group into the specific PBP noted.
    - If an employer group PBP terminated prior to the reporting period ending, the PBP may still appear in HPMS, and the plan should report zero enrollments.

Section IV. Special Needs Plans (SNPs) Care Management

The period of SNPs Care Management eligibility and enrollment is a contract year (which aligns with the reporting period and measurement year (MY)).

Specifications

- Element A
  - The enrollee should be reported under this element when:
    - The enrollee has an effective enrollment date that falls within the MY and is continually enrolled for at least 90 days during the MY.
    - The enrollee has an effective enrollment date that falls within the MY, is continuously enrolled for fewer than 90 days, and completes an initial Health Risk Assessment (HRA).
    - The enrollee has an effective enrollment date that falls in the previous MY, but a 90-day deadline for initial HRA completion that falls in this MY, if no initial HRA was completed in the previous MY.
    - The initial HRA is expected to be completed within 90 days (before or after) the effective date of enrollment.
    - Includes individuals who dis-enrolled from and re-enrolled into the same plan if an initial HRA was not performed prior to disenrollment.
  - Exclude enrollees under this element when:
    - Enrollees who are continuously enrolled in a plan with a documented initial or reassessment HRA in the previous MY.
    - New enrollees who disenroll from the plan prior to the effective enrollment date or within the first 90 days after the effective enrollment date if they did not complete an initial HRA prior to disenrolling.
    - Enrollees who receive an initial or reassessment HRA and remain continuously enrolled under a MAO whose contract was part of a consolidation or merger under the same legal entity during the enrollee's continuous enrollment, where the consolidated SNP is still under the same Model of Care (MOC) as the enrollee's previous SNP.
- Element B
  - The enrollee should be reported under this element when:
    - The enrollee has been continuously enrolled for 365 days or more starting from their initial enrollment date if no initial HRA had been performed, or from the date of their previous HRA.
    - The enrollee is a new enrollee who missed the deadline to complete an initial HRA but completed a reassessment HRA by the 365-day deadline (even if the enrollee was covered for fewer than 365 days).
    - The enrollee is a new enrollee who:

        - missed the deadline to complete an initial HRA;
        - missed the deadline to complete a reassessment HRA; and
        - is enrolled for all 365 days of the MY.
    - Includes enrollees who dis-enrolled from and re-enrolled into the same plan if an initial HRA was performed within 90 days of reenrollment and the enrollee has continuously enrolled in the same plan for up to 365 days since the initial HRA.
  - Exclude enrollees under this element when:
    - New enrollees for whom the initial HRA was completed within the current MY.
    - New enrollees who miss the deadline to complete an initial HRA and have not yet completed their reassessment HRA, but whose 365-day reassessment deadline is not until the following calendar year.
    - Excludes enrollees who were not continuously enrolled in their same health plan for 365 days after their last HRA and did not receive a reassessment HRA.
- Element C
  - The enrollee should be reported under this element when:
    - Initial HRAs performed on new enrollees (as defined above in Element A) within 90 days before or after the effective date of enrollment or re-enrollment.
    - If the initial HRA is performed in the 90 days prior to the effective enrollment date, it is reported as an initial HRA in the reporting year in which the effective enrollment date falls.
    - For enrollees who dis-enrolled from and re-enrolled into the same plan, includes HRAs (initial or reassessment) performed during their previous enrollment if the HRAs are not more than 365 days old.
  - Exclude enrollees under this element when an HRA is performed after the first 90 days of enrollment.
- Element D
  - The enrollee should be reported under this element when:
    - Initial HRAs not performed on new enrollees within 90 days (before or after) the effective date of enrollment due to enrollee refusal and for which the SNP has documentation of enrollee refusal.
  - Exclude enrollees under this element when initial HRAs were not performed, for which there is no documentation of enrollee refusal.
- Element E
  - The enrollee should be reported under this element when:

        - Initial HRAs not performed on new enrollees within 90 days (before or after) the effective date of enrollment due to the SNP being unable to reach (UTR) new enrollees and for which the SNP has documentation showing that the enrollee did not respond to the SNP's attempts to reach them.
        - Documentation must show that a SNP representative made at least 3 attempts to reach the enrollee (not including any automated phone calls) and sent a follow-up letter in its attempts to reach the enrollee.
    - Exclude enrollees under this element when initial HRAs are not performed where the SNP does not have documentation showing that the enrollee did not respond to the SNP's attempt to reach them.
- Element F
    - The enrollee should be reported under this element when:
        - Reassessments performed within 365 days of last HRA (initial or reassessment HRA) on eligible enrollees.
        - It also includes "first time" assessments occurring within 365 days of initial enrollment on individuals continuously enrolled up to 365 days from enrollment date without having received an initial HRA.
        - Note: When an initial assessment is performed in the 90 days prior to the effective enrollment date, the first annual reassessment must be completed no more than 365 days after the initial HRA.
    - Exclude enrollees under this element when a reassessment HRA is completed past the 365-day deadline.
- Element G
    - The enrollee should be reported under this element when annual reassessments not performed due to enrollee refusal and for which the SNP has documentation of enrollee refusal.
    - Exclude enrollees under this element when annual reassessment is not performed, for which there is no documentation of enrollee refusal.
- Element H
    - The enrollee should be reported under this element when:
        - Annual reassessments not performed due to the SNP's inability to reach enrollees and for which the SNP has documentation showing that the enrollee did not respond to the plan's attempts to reach them.
        - Documentation must show that a SNP representative made at least 3 attempts to reach the enrollee (not including any automated phone calls) and sent a follow-up letter in its attempts to reach the enrollee. Refer to Title 42, Part 422.101(f)(1)(iv)(A) outlines the requirements

for Part C sponsors offering Special Needs Plans, including specific timeframes, health risk assessments, and models of care.

  - Exclude enrollees under this element when annual reassessment is not performed, for which the SNP does not have documentation showing that the enrollee did not respond to the SNP's attempts to reach them. Required documentation of SNP's attempts to contact the enrollee show that the SNP made at least 3 phone calls and sent a follow-up letter in it is attempts to reach the enrollee.

HRA Reporting Timeline:

- CMS's requirements specify there should be no more than 365 days between HRAs for SNP enrollees.
- Per 42 CFR 422.101(f)(1)(i), SNPs must, with respect to each individual enrolled and within 90 days (before or after) of the effective date of enrollment for all new enrollees, conduct a comprehensive initial health risk assessment (HRA).
- If a new enrollee does not receive an initial HRA within 90 days of enrollment, then that enrollee's annual HRA is due to be completed within 365 days of enrollment.
- A new enrollee who receives an HRA within 90 days of enrollment is due to complete a reassessment HRA no more than 365 days after the initial HRA was completed.
- Initial HRAs conducted prior to the effective enrollment date are counted as initial HRAs in the year in which the effective enrollment date falls. For example, an initial HRA performed on November 23, 20XX for an enrollee with an effective date of enrollment of January 1, 20XX + 1 would be counted as an initial HRA in 20XX + 1.
- If the initial HRA is not completed within 90 days before or after the effective enrollment date, the SNP will be deemed non-compliant with this requirement.
- If there is no HRA occurring within 90 days (before or after) of the effective enrollment date, the SNP is to complete an HRA as soon as possible. In this case, the HRA would be considered a reassessment.
- The count for the 365-day cycle period for the HRA begins with the day after the date the previous HRA was completed for the enrollee. Likewise, SNPs are required to conduct an initial HRA within 90 days before or after a beneficiary's effective enrollment date. That means that the effective enrollment date (EED) is considered day 0, and the next day would be considered day 1 of the 90-day timeline.
- All annual reassessment HRAs are due to occur within 365 days of the last HRA. Thus, when an initial HRA is performed in the 90 days prior to an effective enrollment date that falls in the beginning of a calendar year, in order to comply with

the requirement to perform the annual reassessment within 365 days of the last assessment, the first annual reassessment will be due within the same MY as the initial HRA.

- There are situations when a new enrollee who has remained enrolled in the SNP for 365 days after the date of the initial HRA will be counted in both Elements A and B, because the individual is a new enrollee (A) and an enrollee eligible for an annual reassessment (B).
    - Example: The effective enrollment date is January 1, 2026 and the initial HRA was completed in November 2025. The annual reassessment will be due in November 2026. The initial HRA and the annual reassessment HRA will both be reported for 2026 and the enrollee will be counted as both a new enrollee and as an enrollee eligible for annual reassessment.
- An HRA may be reported before an individualized care plan (ICP) is completed.
- Any HRA completed after the 365-day completion period is considered non-compliant for reporting purposes. However, the non-compliant HRA does reset the 365-day compliance period to complete the next HRA. Note, the only event that changes a reassessment deadline is the completion of an HRA. This is long standing guidance we have provided to the plans through correspondence.
    - Example: A plan fails to complete an HRA for an enrollee by the 5/15/2026 completion deadline. The plan also fails to complete an HRA for the enrollee during MY 2024 and 2025. However, the plan is able to complete an HRA on 2/2/2027. This HRA would be considered late since it was completed well after the due date of 5/15/2026. However, the HRA completed on 2/2/2027 would establish a new completion timeline for the enrollee. If the plan completed a second HRA within 365 days of 2/2/2027, for example 5/1/2027, then the plan could report the HRA as a completed reassessment for MY 2026 (using the example completion date of 5/1/2026).

Multiple events during a Measurement Year:

- A plan's reporting should be based on the enrollee's most recent HRA activity.
- An enrollee cannot be counted more than once in the same data element for the same plan in the same MY. All applicable events for an enrollee should be reported separately as applicable. Examples:
    - If an enrollee completes more than one reassessment HRA during the MY, the plan should only count the most recent reassessment HRA completed for Element F.

    - An enrollee completes two reassessment HRAs after the plan records two refusals and an UTR during the same MY. The plan should only count and report one HRA under Element F, one refusal under Element G, and the UTR under Element H.

Eligibility Determination:

- A SNP should not perform, or report on, an HRA if the beneficiary is not yet determined to be eligible to enroll in the SNP.
- If eligibility records received after completion of the HRA indicate the individual was never enrolled in the plan, do not count this individual as a new enrollee and do not count the HRA.

Reporting Enrollees Who Are Unable to be Reached:

- **NOTE:** CMS will treat the lack of an HRA as being due to the enrollee's refusal or because the SNP could not reach the enrollee after reasonable attempts if the following conditions are met:
    - The enrollee did not respond to at least 3 attempts to reach the enrollee (not including any "automated" phone calls) and a follow-up letter from the SNP where all the efforts were to solicit participation in the HRA.
    - None of the efforts to solicit participation were automated calls ("robo" or "blast" calls). Allowable means of outreach for the attempts to reach enrollees include non-automated phone calls, text messaging, and electronic medical record messages. Attempts must be made by a SNP representative so that when an enrollee is reached, it is possible to perform the HRA at that time.
    - Documentation of the enrollee's refusal and/or the SNP's inability to reach the enrollee is available at any time for CMS to determine health plan compliance with Part C reporting requirements.

What Constitutes a Completed HRA:

- Only completed HRAs that comprise direct beneficiary and/or caregiver input will be considered valid for reporting. For example, HRAs only using claims and/or other administrative data should not be counted/reported. For Elements C and F, CMS requires only completed assessments. This reporting section excludes cancelled enrollments.
- A cancelled enrollment is one that never becomes effective.
    - Example: An individual submits an enrollment request to enroll in Plan A on March 25th for an effective date of April 1st. Then, on March 30th, the

individual contacts Plan A and submits a request to cancel the enrollment. Plan A cancels the enrollment request per our instructions in Chapter 2 of the Medicare Advantage Enrollment and Disenrollment, and the enrollment never becomes effective.

- The date the HRA is completed by the MAO is the completed date of the HRA.

D-SNP Enrollees and Medicaid HRAs:

- For dual eligible SNPs (D-SNPs) only, CMS will accept a Medicaid HRA that is performed by the same organization (or an affiliate under the same parent organization) within 90 days before or after the effective date of Medicare enrollment as meeting the Part C obligation to perform an HRA, if the HRA meets the requirements at 42 CFR § 422.101(f).

Re-enrollment and Disenrollment:

- If a beneficiary disenrolls from one SNP and enrolls into another SNP under a different contract, sponsor, or parent organization, the beneficiary should be counted as a "new enrollee" for the receiving plan.
- Enrollees who received an initial HRA and remain continuously enrolled under a MAO that was part of a consolidation or merger within the same MAO or parent organization will not need to participate in a second initial HRA. This guidance also applies to enrollees who were cross walked from a non-renewing D-SNP PBP under a broader MA contract to a D-SNP-only contract per 42 CFR § 422.107(e).
- A beneficiary who changes between SNP plans under the same contract in the same MY should only be counted in one PBP's data. Example - Plan 001 provides the HRA for a beneficiary, then the beneficiary enrolls into Plan 002 under the same contract. For reporting purposes, Plan 001 can count the HRA as being provided. Plan 002 should not count the HRA for their enrollee. It may use the HRA's date to determine when the beneficiary is due for their next HRA. ***Even if the individual is re-enrolling into the same contract, the individual would still not be counted more than once in any data element or PBP.***
- SNPs should include beneficiaries who disenrolled from and re-enrolled into the same plan if an initial HRA was not performed prior to disenrollment. When this occurs, SNPs should calculate the enrollee's eligibility date starting from the date of re-enrollment.

Section V. Enrollment and Disenrollment

- HPMS displays separate modules for reporting Part C and Part D Enrollment/Disenrollment data.
- For Enrollment, Elements 1.A-1.J must include all enrollments.
- Disenrollments must not be included in Enrollments.
- For Disenrollment, Elements 2.A-2.D, must include all voluntary disenrollment transactions.
- Data are based on beneficiary-initiated enrollment and disenrollment requests or submitted transactions. Auto-assignments and other CMS-initiated actions should not be included in these data.
- Reporting should include all enrollment and disenrollment requests received during the reporting period, including those which may subsequently “fail” after the reporting period, and/or reporting deadline.
- Enrollment/disenrollment requests for which a timely cancellation request is received should not be included in this reporting.
- Voluntary disenrollments for which the MAO is notified solely via Daily Transaction Reply Report (DTRR), instead of via receipt of a member's disenrollment request, should not be included in this reporting.
- Reporting for Enrollment Element C (Total 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 representative)) should include all forms of potential contact.

Section VI. Rewards And Incentives Programs

- An MAO user needs to select "Yes" or "No" for Element A on the HPMS file upload page. If the MAO user selected "No," no file upload is necessary. If the MAO user selects "Yes," then the user will be required to upload additional information in accordance with the file record layout.
- Currently Enrolled (Element G) means as of December 31 of the current reporting period, and the number of rewards made “so far” (Element H) means awards made at any time up until December 31 of the current reporting period.

Section VII. Payments To Providers

- Data elements may include decimal values up to two decimal places.
- For information on measuring covered lives in accountable care and definitions of terms, refer to Appendix B of the Health Care Payment Learning and Action Network (HCPLAN) 2024 Methodology and Results Report at https://hcp-lan.org/wp-content/uploads/2025/08/2024-HCPLAN-Methodology-Report.pdf and the Guidance for Covered Lives document at https://hcp-lan.org/workproducts/APM-Measurement/Guidance-for-measuring-covered-lives.pdf

- MAOs will report on the proportion of payments made to contracted providers based on the HHS-developed four categories of value-based payment:
  - 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).
  - For additional guidance regarding the four (4) categories of payment and their subcategories, refer to page 8 of the HCPLAN 2024 Methodology and Results Report.
- For the purposes of the Payments to Providers Part C reporting requirements, contracted providers include both physicians and clinicians. Payments for administrative services and payments to hospitals, facilities, pharmacies, or labs are not to be reported.
- For Element E, refer to page 29 of the HCPLAN 2024 Methodology and Results Report for more information.
- For all Elements (B-S and U-KK), when a provider is paid using multiple payment arrangements that fall into more than one category, the MAO should report total dollars paid to that provider under the category that represents the dominant payment arrangement.
- For Elements T–KK, reporting should be done by contracts (which include groups with one or more providers). A provider group that is under contract with a plan counts as one contracted provider, and an individual provider under contract also counts as one contracted provider.

- For Elements A–S, report payments made to providers in based on the year payment was made, regardless of when services were furnished. If a service was rendered the year before the reporting period, but the payment was made during the year of the reporting period, then it should be reported for that reporting period.
- For Elements A–S, payments refer to the total actual payments made to contracted providers based on the aforementioned categories of value-based payment.
- MAOs should report the total dollars (actual payment), which includes the base payment plus any incentive, such as a bonus for performance (P4P), savings that were shared with providers, etc.
- MAOs should report shared savings or capitation without links to quality. Risk-based payment with no link to quality (should be reported under Element L, and capitation with no link to quality (classified as 4N in the Alternative Payment Model (APM) Framework by HCPLAN) should be reported under Element S.
- Elements B-S are subsets of Element A. However, it is possible that there are some forms of payments that would not fit into Elements B-S and therefore the sum of B-S can be less than A.
- For Element A, which includes both in-network and out-of-network payments, MAOs should report payments in categories 1–4 (Elements B–S) using only in-network payments. As a result, Element A may be greater than the sum of Elements B through S.
- Element L is not a subset of Element K. They are both different categories of payment as noted in the referenced APM Framework.
- Element S is not a subset of Element R. They are both different categories of payment, as noted in the referenced APM Framework.
- Elements U through JJ (excluding Element DD) are subsets of Element T. However, it is possible that there are some forms of payments that would not fit into Elements U through JJ (excluding Element DD). Hence, the sum of Elements U through JJ (excluding Element DD) can be less than T.
- Elements DD is not a subset of Element Y. They are both different categories of payment as noted in the referenced APM definitional network. For detailed information regarding these categories, refer to the APM Framework.
- Element KK is not a subset of Element EE. They are both different categories of payment as noted in the referenced APM definitional network. For detailed information regarding these categories, refer to the APM Framework.

- The total payment cannot be less than the sum of payments by category, but the sum of the payments by category can be less than or equal to the total payment.

Section VIII. Supplemental Benefit Utilization and Costs

PBP Category Codes

Data elements must be reported for each of the following supplemental benefits:

Inpatient Hospital Services

PBP Category	Supplemental Benefit
1a1	Additional Days for Inpatient Hospital-Acute
1a2	Non-Medicare-covered Stay for Inpatient Hospital-Acute
1a3	Upgrades for Inpatient Hospital-Acute
1a-B	Inpatient Hospital – Acute Services (For B-Only Plans)
1b1	Additional Days for Inpatient Hospital Psychiatric
1b2	Non-Medicare-covered Stay for Inpatient Hospital Psychiatric
1b-B	Inpatient Psychiatric Hospital Services (For B-Only Plans)

Skilled Nursing Facility

PBP Category	Supplemental Benefit
2-1	Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)
2-3	SNF – Waiver of 3 Day Hospital Stay*
2-B	SNF Care (For B-Only Plans)

Cardiac and Pulmonary Rehabilitation Services

PBP Category	Supplemental Benefit
3-1	Additional Cardiac Rehabilitation Services
3-2	Additional Intensive Cardiac Rehabilitation Services
3-3	Additional Pulmonary Rehabilitation Services
3-4	Additional Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD) Services

Worldwide Emergency/Urgent Coverage

PBP Category	Supplemental Benefit
4c1	Worldwide Emergency Coverage
4c2	Worldwide Urgent Coverage
4c3	Worldwide Emergency Transportation

Health Care Professional Services

PBP Category	Supplemental Benefit
7b1	Routine Chiropractic Care
7b2	Chiropractic – Other Service
7f	Routine Foot Care

Outpatient Blood Services

PBP Category	Supplemental Benefit
9d-1	Three (3) Pint Deductible Waived*

Transportation Services

PBP Category	Supplemental Benefit
10b1	Transportation Services - Plan-Approved Health-related Location
10b2	Transportation Services - Any Health-related Location

Other Supplemental Services

PBP Category	Supplemental Benefit
13a	Acupuncture Treatments
13b	Over-the-Counter (OTC) Items
13c	Meal Benefit
13d	Other 1
13e	Other 2
13f	Other 3
13g	Dual Eligible SNPs with Highly Integrated Services

Preventive and Other Defined Supplemental Services

PBP Category	Supplemental Benefit
14b	Annual Physical Exam
14c1	Health Education
14c2	Nutritional/Dietary Benefit
14c3	Additional Smoking and Tobacco Cessation Counseling
14c4a	Fitness Benefit – Physical Fitness*
14c4b	Fitness Benefit – Memory Fitness*
14c4c	Fitness Benefit – Activity Tracker*
14c5	Enhanced Disease Management
14c6	Telemonitoring Services
14c7a	Remote Access Technologies – Nursing Hotline*
14c7b	Remote Access Technologies – Web/Phone-based Technologies*
14c8	Home and Bathroom Safety Devices and Modifications
14c9	Counseling Services
14c10	In-Home Safety Assessment
14c11	Personal Emergency Response System (PERS)
14c12	Medical Nutrition Therapy (MNT)
14c13	Post Discharge In-home Medication Reconciliation
14c14	Re-admission Prevention
14c15	Wigs for Hair Loss Related to Chemotherapy
14c16	Weight Management Programs
14c17	Alternative Therapies
14c18	Therapeutic Massage

PBP Category	Supplemental Benefit
14c19	Adult Day Health Services
14c20	Home-Based Palliative Care
14c21	In-Home Support Services
14c22a	Support for Caregivers of Enrollees – Respite Care*
14c22b	Support for Caregivers of Enrollees – Caregiver Training*
14c22c	Support for Caregivers of Enrollees – Other*

Dental

PBP Category	Supplemental Benefit
16b1	Oral Exams
16b2	Dental X-Rays
16b3	Other Diagnostic Dental Services
16b4	Prophylaxis (cleaning)
16b5	Fluoride Treatment
16b6	Other Preventive Dental Services
16c1	Restorative Services
16c2	Endodontics
16c3	Periodontics
16c4	Prosthodontics, removable
16c5	Maxillofacial Prosthetics
16c6	Implant Services
16c7	Prosthodontics, fixed
16c8	Oral and Maxillofacial Surgery
16c9	Orthodontics
16c10	Adjunctive General Services

Eye Exams/Eyewear

PBP Category	Supplemental Benefit
17a1	Routine Eye Exams
17a2	Other Eye Exam Services
17b1	Contact Lenses
17b2	Eyeglasses (Lenses and Frames)
17b3	Eyeglass Lenses
17b4	Eyeglass Frames
17b5	Eyewear Upgrades

Hearing Exams/Hearing Aids

PBP Category	Supplemental Benefit
18a1	Routine Hearing Exams
18a2	Fitting/Evaluation for Hearing Aid
18b1	Prescription Hearing Aids (All Types)
18b2	Prescription Hearing Aids – Inner Ear

PBP Category	Supplemental Benefit
18b3	Prescription Hearing Aids – Outer Ear
18b4	Prescription Hearing Aids – Over the Ear
18c	OTC Hearing Aids

Medicare covered services offered as POS or V/T

PBP Category	Supplemental Benefit
VT	Visitor/Travel Program (Medicare Covered benefits)*
POS	Point of Service (Medicare Covered benefits)*

*Non-Primarily Health Related Benefits***

PBP Category	Supplemental Benefit
13i1	Food and Produce
13i2	Meals (Beyond limited basis)
13i3	Pest Control
13i4	Transportation for Non-Medical Needs
13i5	Indoor Air Quality Equipment and Services
13i6	Social Needs Benefit
13i7	Complementary Therapies
13i8	Services Supporting Self-Direction
13i9	Structural Home Modifications
13i10	General Supports for Living
13i11	Non-Primarily Health Related Benefits for the Chronically Ill Other 1
13i12	Non-Primarily Health Related Benefits for the Chronically Ill Other 2
13i13	Non-Primarily Health Related Benefits for the Chronically Ill Other 3
13i14	Non-Primarily Health Related Benefits for the Chronically Ill Other 4
13i15	Non-Primarily Health Related Benefits for the Chronically Ill Other 5

*Benefit category code has been defined for purposes of collecting these data for the Part C Reporting Requirements. These codes are not part of the Plan Benefit Package (PBP) for the reporting period.

**Non-Primarily Health Related Benefits are only available as Special Supplemental Benefits for the Chronically Ill (SSBCI).

Specifications

- Report
    - Report only those supplemental benefits furnished within the contract year (CY) for which the reporting period applies.
- MAOs should report on benefits in accordance with how the PBP was submitted. If the MAO noted in the PBP that they would cover 10 supplemental benefits, the MAO must submit Reporting Requirements data for all 10 of those benefits, even if no enrollees utilized the benefits.
- MAOs must report data for all PBP category codes in the table above for each of their plans. If your PBP does not offer a PBP category, submit values for Elements A, B, C, and D, and submit NO for Element E, meaning not offered. Then, leave the remaining fields blank.
- For PBP waiver categories (i.e., 2-3 "SNF – Waiver of 3 Day Hospital Stay" and 9d-1 "Three (3) Pint Deductible Waived") MAOs should report $0 for costs, if no costs are associated with these benefits.
- When Element C is "POS" or "VT", MAOs should report on the combination of all Medicare covered services with Point of Service coverage or Visitor/Travel coverage when reporting Elements D-P. When Element C is "POS", then Element F should be "HMO-POS". When Element C is "VT", then Element F should be "VT". When Element C is a non-Medicare covered service (e.g. 17a1 (Routine Eye Exams)), then MAOs could report "HMO-POS" or "VT" in Element F if this service is covered with Point of Service coverage or Visitor/Travel coverage.
- For Part C reporting, supplemental benefits are defined as those benefits delivered (i.e., plan has provided items or services) during the reporting period, regardless of when the benefit was paid in full. However, we note that MAOs should only report on costs/utilization for services which were approved. In cases where the supplemental benefit coverage was denied, MAOs should not report on costs and utilization for that item or service.
    - A mandatory supplemental benefit is defined at 42 CFR § 422.100I(2)(i)(A) as "Services not covered by Medicare that an MA enrollee must purchase as part of an MA plan that are paid for in full, directly by (or on behalf of) Medicare enrollees, in the form of premiums or cost sharing."
    - An optional supplemental benefit is defined at 42 CFR § 422.100(c)(2)(i)(B) as "Health services not covered by Medicare that are purchased at the option of the MA enrollee and paid for in full, directly by (or on behalf of) the

Medicare enrollee, in the form of premiums or cost sharing. These services may be grouped or offered individually."

- If no beneficiaries utilized a benefit that was offered, MAOs may report zero for Elements I, J, K, L, O, and P, but submit information for other elements such as Elements M and N regarding payment arrangements and costs.
- Only report text for Element D if the PBP Category (Element C) has an "Other" designation (7b2, 13d, 13e, 13f, or 13i11, 13i12, 13i13, 13i14, 13i15, and 17a2 only).
- Do not report text for Element D (meaning leave Element D blank) if the PBP category is a value not equal to an "Other" designation (7b2, 13d, 13e, 13f, 13i11, 13i12, 13i13, 13i14, 13i15, and 17a2 only). HPMS will auto-populate the names of these PBP Categories in Element D based on what is submitted in Element C.
- If the plan does not offer one of the PBP categories (Element C) with an "Other" designation (7b2, 13d, 13e, 13f, 13i11, 13i12, 13i13, 13i14, 13i15, and 17a2 only), then report "not offered" in Element D and report "NO", meaning not offered, in Element E.
- For Element E, HPMS will accept one of the following list of values: M, O, UF, SSBCI, NO. These values have the following list of meanings:
  - Mandatory = M
  - Optional = O
  - Uniformity Flexibility = UF
  - Special Supplemental Benefits for the Chronically Ill = SSBCI
  - Not Offered = NO
- For Element F, HPMS will accept one of the following list of values: INN, OONPPO, OONHMO, VT, O. These values have the following list of meanings:
  - In-network = INN
  - Out-of-network (for PPO) = OONPPO
  - Out-of-network (for HMO-POS) = OONHMO
  - Visitor/travel = VT
  - Other = O
- Since a plan may offer a PBP category more than one way (Element E) and in more than one network type (Element F), report each element specific for the unique combination of contract/plan/PBP category/offer type/network type.

- For Element G, only submit one unit of utilization for each PBP category.
- For Element H, MAOs should include all enrollees ever eligible for this benefit during the calendar year. This number should not be a 'point-in-time' number but rather a unique count of all enrollees who were eligible for the benefit under the plan.
- Elements H, I, J, and K should be reported as discrete (whole) numbers. If the median amount calculated for Element K ends in a decimal, round to the nearest whole number. If it ends in .5 - .9, round up to the next whole number. If it ends in .1 - .4, round down to the next whole number.
- For Element L:
    - When computing this amount, report the net amount spent rather than the gross amount allocated. For example, if the plan allocated $1000 for the enrollee to use for certain dental services, but the enrollee used only $250, then the plan must include only that $250 in computing the total amount to report under this data element.
    - Similarly, if the plan implements the benefit through a capitated or per member per month (PMPM) arrangement, and the plan recoups some of that amount for any reason, the plan must include only the amount spent rather than the allocated PMPM amount. If the plan does not recoup any money, the plan may report the full PMPM cost.
    - Additionally, this measure should include direct costs only. For example, if a plan pays a PMPM cost to a vendor for a benefit, which includes an administrative cost, the plan may report the full PMPM for the year.
    - If a plan pays a flat rate or PMPM to a vendor to provide several benefits, the plan should divide the rate between the services provided. For example, if a plan pays a lump sum of $2,000 a year to cover the cost of all 16 dental benefits, the plan should report $125 for Element L for each dental benefit (2000/16=125).
- Elements L, O and P should be reported as dollar amounts. Decimals are not allowed, and values should be rounded to the nearest dollar. If the dollar amount ends in .5 - .9, round up to the next whole number. If it ends in .1 - .4, round down to the next whole number.
- For Element N, be as specific as possible in completing this narrative field. CMS has not been prescriptive in guidance to allow MAOs latitude in describing how they measure costs in the most accurate way possible. If you believe your calculation of Element L (the total net amount incurred by the plan to offer the benefit) could

benefit from explanation, include that here. CMS will take this information into account when analyzing submissions. This element should be reported for all benefits offered by the plan.

- For Element N: CMS will not voluntarily release data collected under this element to the public, either individually or in the aggregate. This information will inform future development of cost reporting data elements in these reporting requirements and may inform how CMS requires cost reporting in other contexts.
- The objective Element O is to understand the level of cost-sharing (e.g., co-pay, co-insurance) borne by enrollees within the plan. This should include the enrollees' direct financial contribution towards the benefit after the plan has covered its portion.
- Element O should be a sum of all enrollee out-of-pocket costs for a service category, broken down by Element E and F.
- Out-of-pocket costs are a portion of expenses for which the enrollee is financially responsible based on: (1) the terms of coverage in their plan and (2) to what extent, if any the enrollee utilized items and services covered by their plan. Out-of-pocket costs typically include plan-imposed cost sharing amounts (including deductibles, copayments, and coinsurance) when an enrollee utilizes a plan-covered item or service.
- CMS notes that debit cards provided to enrollees to pay for plan-covered benefits are tools to administer such benefits and not benefits themselves. Plans MUST be able to determine how benefits administered through such cards are utilized for the purposes of this reporting. If plans administer multiple benefits through a debit card, the plan must be able to break down utilization and costs by service category to ensure compliance with these Reporting Requirements.

Section IX. D-SNP Enrollee Advisory Committee

- For Element A:
    - Report "No" if only enrollees from this single D-SNP or other individuals representing those enrollees participate in the EAC
    - Report "Yes" if the MAO establishes one D-SNP EAC to represent multiple D-SNPs within a state that includes enrollees or other individuals representing those enrollees from more than one D-SNP.
- For Element B:
    - If no meetings were held, report zero (0)
    - If Element A = "No": Report the count of D-SNP EAC meetings for this individual D-SNP during the measurement year.
    - If Element A =" Yes", the MAO should designate one D-SNP to respond for all D-SNPs sharing the same EAC.
        - If this D-SNP is the designated respondent: Report the count of D-SNP EAC meetings that occurred during the measurement year.
        - If this D-SNP is NOT the designated respondent: Report "See response for [four-digit H contract number and three-digit PBP number]." For example: See response for H1234-001.
- For Element C:
    - If Element A = "No": List all D-SNP EAC meeting dates where this D-SNP's enrollees or other individuals representing those enrollees participated during the measurement year. Use MM/DD/YYYY format, separate dates with commas, and list in chronological order. For Example: 01/24/2026, 04/22/2026, 07/15/2026, 10/30/2026
    - If Element A = "Yes", the MAO should designate one D-SNP to respond for all D-SNPs sharing the same EAC.
        - If this D-SNP is the designated respondent: List all D-SNP EAC meeting dates for all participating D-SNPs during the measurement year. Use MM/DD/YYYY format, separate dates with commas, and list in chronological order. For Example: 01/24/2026, 04/22/2026, 07/15/2026, 10/30/2026
        - If this D-SNP is NOT the designated respondent: Report "See response for [H contract number-PBP number]." For example: "See response for H1234-001."
- For Element D:
    - If Element A = "No":

        - Report "Yes" when interpreter services were offered for all D-SNP EAC meetings held during the measurement year (includes when offered but not utilized)
        - Report "No" when interpreter services were not offered for one or more D-SNP EAC meetings held during the measurement year
    - If Element A = "Yes": The MAO should designate one D-SNP to respond for all D-SNPs sharing the same EAC.
        - If this D-SNP is the designated respondent: Report "Yes" when interpreter services were offered for all D-SNP EAC meetings held during the measurement year (includes when offered but not utilized). Report "No" when interpreter services were not offered for one or more D-SNP EAC meetings held during the measurement year.
        - If this D-SNP is NOT the designated respondent: Report "See response for [four-digit H contract number and three-digit PBP number]." For example: See response for H1234-001.
- For Element E:
    - If Element A = "No":
        - Report "Yes" when auxiliary aids and services were offered for all D-SNP EAC meetings held during the measurement year (includes when offered but not utilized)
        - Report "No" when auxiliary aids and services were not offered for one or more D-SNP EAC meetings held during the measurement year
    - If Element A = "Yes": The MAO should designate one D-SNP to respond for all D-SNPs sharing the same EAC.
        - If this D-SNP is the designated respondent: Report "Yes" when auxiliary aids and services were offered for all D-SNP EAC meetings held during the measurement year (includes when offered but not utilized). Report "No" when auxiliary aids and services were not offered for one or more D-SNP EAC meetings held during the measurement year.
        - If this D-SNP is NOT the designated respondent: Report "See response for [four-digit H contract number and three-digit PBP number]." For example: See response for H1234-001.

Section X: D-SNP Transmission of Admission Notifications

- For Data Element A, if an enrollee has more than one hospital and/or SNF admission during the measurement year, report all admissions. For further details regarding this notification requirement, refer to 42 § CFR 422.107(d)(1).
- For Data Element B, enter the count of notifications to the state or state-designated entity of all hospital admissions and SNF admissions for enrollees designated in the DSNP's state Medicaid agency contract for the measurement year.