Medicare Part D Reporting Requirements:
Technical Specifications Document
Contract Year 2026

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Revision History (from Contract Year 2025 to Contract Year 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. Indicated that all Part D 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. Synchronized language where possible between Part C and Part D specifications for the following sections: Grievances, Coverage Determinations, Redeterminations and Reopenings, Employer Group Plan Sponsors, and Enrollment and Disenrollment.
    b. Clarified the last bullet point in the Reopenings section of the Coverage Determinations, Redeterminations and Reopenings reporting requirement section.
    c. Rearranged and clarified bullet points in the Coverage Determinations, Redeterminations, and Reopenings reporting requirement section.
    d. Included an additional bullet point for Medication Therapy Management as well as updated Element R's (Method of delivery for the annual comprehensive medication review (CMR)) real-time interactive consultation options.
    e. Added specifications regarding beneficiaries participating in the Medicare Prescription Payment Plan across multiple years.

Introduction

These technical specifications supplement the Part D Reporting Requirements (OMB 0938-0992) and do not change, alter, or add to the data collection. They serve to further define data elements. The Part D Reporting Requirements document can be found at: https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/part-d-reporting-requirements.

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

Sponsors 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, Employer Tax Identification Numbers (Employer Group Plans), and Beneficiary Name is proprietary information and not subject to public disclosure under provisions of the Freedom of Information Act (FOIA). A sponsor 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 are 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, Data 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 sponsors 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 Part D Plans.

Resubmissions

If previously submitted data are incorrect, and the reporting deadline has passed, the sponsor should request the opportunity to correct and resubmit data (referred to as a resubmission) prior to the resubmission deadline. A sponsor 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 Medicare Prescription Payment Plan 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 Medicare Prescription Payment Plan 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 a sponsor 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. Sponsors should retain documentation supporting their HPMS data submissions and resubmissions. Sponsors 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 a sponsor submits a resubmission request, and CMS approves the request to resubmit, the sponsor 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 sponsors 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 sponsors the opportunity to correct submitted data if needed, and does 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 sponsors.

Questions

Questions about Part D 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 sponsors first refer to the current Medicare Part D 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. Enrollment and Disenrollment

- HPMS displays separate modules for reporting Part C and Part D Enrollment/Disenrollment data.
- Employer Group Waiver Plans (EGWPs) and all-800 series plans are waived from this reporting section. For contracts with both non-800-series and 800-series plans, data for the 800-series plan(s) may be excluded.
- For Enrollment, Elements 1.A-1.K must include all enrollments.
- Disenrollments must not be included in Enrollments.
- For Disenrollment, Elements 2.A-2.F 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 sponsor 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 II. Medication Therapy Management (MTM) Programs

- Some sponsors also offer enrollment in the MTM program to an expanded population of beneficiaries who do not meet the targeting criteria under § 423.153(d)(2).
- The data elements must be reported for all beneficiaries enrolled in the sponsors' Part D MTM program at any time in the reporting period, whether based on CMS's specifications or other plan-specific expanded targeting criteria within the reporting period. Regardless of this designation, the MTM services reported for each beneficiary (such as targeted medication review or comprehensive medication review) must have met CMS's MTM program requirements and definitions.
- Sponsors should refer to the annual MTM Program Guidance and Submission memo for information about the Part D MTM program requirements and definitions. It is posted on the CMS MTM web page at https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/medication-therapy-management.
- Sponsors should refer to the annual MTM Program Data Submission Instructions memo for information regarding MTM data file submission. It is posted on the CMS Part D Reporting Requirements web page at www.cms.gov>Medicare>Coverage>Prescription Drug Coverage Contracting>Part D Reporting Requirements
- The period of MTM eligibility and enrollment is a contract year (which aligns with the reporting period). Therefore, beneficiaries should be reported for each contract year in which they were eligible and enrolled in the contract's MTM program. A distinct MTM program enrollment date should be generated and reported for each year of enrollment.
    - Beneficiaries who were enrolled in the MTM program in the previous contract year and who again met the eligibility criteria and were enrolled in the MTM program in the current reporting period should be reported.
    - Beneficiaries who were newly targeted for eligibility (i.e., beneficiaries not enrolled in the contract's MTM program during the previous contract year) and enrolled in the MTM program for the current reporting period should be reported.
    - Beneficiaries who are deceased or were retroactively disenrolled prior to their MTM enrollment date should not be reported.
- If a beneficiary meets both sets of targeting criteria (multiple chronic diseases/multiple Part D drugs/cost threshold AND drug management program at-

risk beneficiary) as specified in § 423.153(d)(2), sponsors should report the date the beneficiary first met either set of the targeting criteria.

- Sponsors should refer to Chapter 5, Section 10.2 of the Prescription Drug Benefit Manual for a description of the types of facilities that are considered long-term care.
- For beneficiaries who opted out of the MTM program due to disenrollment from the plan, only mid-year disenrollments from the plan should be reported in Element L. Do not report end of year disenrollments (such as 12/31).
- When reporting the MTM program opt-out reason in Element L, opt-out code “03” - Request by beneficiary” includes request by beneficiary or beneficiary’s authorized representative.
- Enrolled beneficiaries may refuse or decline individual MTM services or the CMR without having to opt out (disenroll) from the MTM program. These beneficiaries should not be reported as opted out.
- Sponsors should only report MTM services provided within the reporting period. A beneficiary’s MTM service dates generally occur on or after their date of MTM program enrollment. Meaning, the MTM service dates (such as CMR date of (initial)) offer (Element N), Date(s) of CMR(s) (Element P) and Date CMR written summary in CMS standardized format was provided or sent (Element Q) must be on or after the Date of MTM program enrollment (Element H). See the following sub-bullet for exceptions:
    - If MTM follow-up services (such as CMR summary or medication therapy problem resolution) are sent or observed in the calendar year after the initial MTM service (such as CMR or medication therapy problem recommendation), elements O, P, Y, X, and Z should be reported for the year that the initial MTM service was performed and should not be reported again in the following year.

- For reporting received annual CMR with a written summary in CMS standardized format, the beneficiary must receive the CMR written summary. Therefore, returned mail does not count as a received CMR (Element O).
- The Method of delivery for the annual CMR (Element R) must include a real-time interactive consultation that is conducted In-Person; Synchronous Telehealth – telephone; Synchronous Telehealth – video conferencing; Other real-time method.
- A beneficiary is unable to accept an offer to participate in the CMR only when the beneficiary is cognitively impaired [Recipient of initial CMR (Element T)]. If the beneficiary is present during the CMR, report the beneficiary as the recipient of the CMR.

- If a CMR written summary in CMS standardized format is sent and returned, Element O should be reported as “N” and Elements P, Q, R, S, and T should still be reported based on when the CMR summary was provided/sent (even if returned) and based on when and how the interactive CMR consultation was provided. If the CMR summary is successfully re-sent (i.e. not returned a second time), Element O should be reported as “Y” and Element Q should list the date the CMR summary was first sent.
- The number of medication therapy problem recommendations made to prescriber(s) as a result of MTM services (Element W) should be reported based on the count of unique recommendations made to prescribers within the reporting period regardless of the success or result of the recommendations; it is not equal to the total number of prescribers that received medication therapy problem recommendations.
    - For example, if 3 medication therapy problem recommendations were identified for a member and were sent to the prescriber in a fax, this should be reported as 3 recommendations. If these 3 medication therapy recommendations were sent to a second prescriber, this should still be reported as 3 recommendations (not 6).
- For reporting number of communications (Element Y) and method of delivery for information (Element Z) regarding safe disposal of medications, the beneficiary must receive the information. Therefore, returned mail does not count as received.
- Safe disposal communications (Elements Y and Z) that were sent on or after the date of MTM enrollment and before the date of MTM program opt-out (if applicable) should be reported.
- When a beneficiary moves between contracts:
    - The beneficiary should be reported in the beneficiary-level files for each contract in which they were enrolled in the contract’s MTM program at any time in the reporting period. Each contract must qualify and enroll the beneficiary based on the contract’s own MTM program criteria.
    - The dates of enrollment, disenrollment elements, and other elements (such as CMRs, targeted medication reviews (TMRs), and written communications such as number of safe disposal communications) should be reported distinctly per the specific activities that occurred for the beneficiary when enrolled in the MTM program for the specific contract ID within the reporting period (contract year). For example, if the beneficiary received a CMR while enrolled in contract 1’s MTM program but did not receive a CMR while enrolled in contract 2’s MTM program, the CMR should be reported for contract 1 only.

- When a beneficiary enrolls in a Part D contract and is enrolled in their MTM program, disenrolls from the contract, and re-enrolls in the same Part D contract during the reporting period:
    - The Part D contract may re-enroll the beneficiary into the MTM program. The beneficiary does not need to be re-qualified for the MTM program again within the reporting period (contract year).
    - Report the beneficiary only once per contract file per contract year.
    - Regardless of the duration of the gap in MTM program enrollment, report the initial date of MTM program enrollment, no date of MTM program opt-out, and all other applicable elements for activity across all MTM program enrollment periods within the reporting period.
- Sponsors should not upload the MTM beneficiary-level data file if they have no MTM enrollees to report. Instead, sponsors should report that they have no MTM data to report via HPMS.
- In the rare situation where a beneficiary's Medicare Beneficiary Identifier (MBI) changes in the middle of a reporting period, a sponsor may collapse the beneficiary's reporting data into one line item using the most current MBI during the reporting period. There should not be more than one record reported for a single beneficiary (regardless of whether the records are exact duplicates).
- Element U should include the number of targeted medication reviews for all distinct beneficiaries enrolled in the contract's MTM program (either met the specified targeting criteria per CMS – Part D requirements or other expanded plan-specific targeting criteria) at any time in the reporting period, regardless of whether the review resulted in a recommendation.

Section III. Grievances

- For an explanation of Medicare Part D Grievance Procedures, refer to CMS Regulations and Guidance, refer to 42 CFR §423.564 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 contract 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 sponsor did not process them because they did not meet the requirements for valid grievances.
- MA-PDs should report a grievance as either a Part C or Part D grievance, depending on the process the sponsor used to investigate/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 sponsor 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 sponsor's procedures for handling enrollee grievances.
- Grievances filed by prospective enrollees.
- 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 sponsor.

Section IV. Improving Drug Utilization Review Controls

- Formulary-level opioid safety edits include the care coordination edit, the hard morphine milligram equivalent (MME) edit, and the opioid naïve hard edit. Sponsors must report cumulative year-to-date (YTD) data by quarter to CMS on the beneficiaries who triggered each of the opioid safety edits. For more information about Medicare Part D opioid overutilization policies refer to CMS regulations and guidance: 42 CFR § 423.153(c)(2) and https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/improving-drug-utilization-review-controls-part-d.
- If an opioid safety edit does not include a prescriber and/or pharmacy count, the sponsor should enter "0" in the appropriate elements (Elements A, B, O, and P).
- If a sponsor submitted and was approved for multiple opioid safety edits during the plan year, meaning the edit criteria changed during the reporting period, report the edit specifications in place during the majority of a reporting period (Elements A-B, M-P, and V). The other reported data (totals) should account for activity for the entire reporting period across all edit criteria in place.
- Rejected claims are counted at the unique contract, beneficiary, prescriber, pharmacy, drug (strength and dosage form), quantity, date of service (DOS) and formulary-level opioid safety edit. For example, if multiple transactions are submitted and rejected by the sponsor for the same formulary-level opioid safety edit from the same pharmacy for the same beneficiary, prescription (drug, quantity and prescriber) and DOS, this would count as one rejected claim. However, if a beneficiary attempted to fill the same prescription at 3 different pharmacies, either on the same day or on different days, and the prescription was rejected each time for the same formulary-level opioid safety edit, this would count as 3 rejected claims.
- If a claim is rejected for both a care coordination, hard MME edit, and/or an opioid naïve hard edit and an early refill edit, it should be excluded from the formulary-level opioid safety edit rejection counts.
- If a claim triggers multiple opioid safety edits, the claim and beneficiary should be reported in multiple reporting sections of the opioid safety edits. For example, a claim and beneficiary can meet the criteria for both the opioid naïve hard edit and an MME opioid safety edit and should be reported accordingly.
- If a claim override, paid claim, coverage determination request, or favorable coverage determination was initiated after the current reporting period but was the result of a claim rejection during the calendar year and within the current reporting period, it may be reported for the current reporting period. It should not be reported again in the following reporting period.

- Claims submitted and/or reversed as a result of a data entry error are not counted (e.g., wrong quantity or day supply entered). CMS does not expect sponsors to search for reversed claims due to reporting errors, but only to exclude them if they are found. The examples given are not an exhaustive list of potential data entry errors.
- For Elements F, S, X and BB, a beneficiary who is a resident of a long-term care facility, is receiving hospice, palliative or end-of-life care, has sickle cell disease, or is being treated for cancer-related pain is exempt from these safety edits. This does not include beneficiaries who are not opioid naïve; they are reported in Elements Y and CC.
- Sponsors should refer to National Council of Prescription Drug Programs (NCPDP) telecommunication standards guidance for information about response codes related to opioid safety edits: https://member.ncpdp.org/Member/media/pdf/VersionDQuestions.pdf.

Care coordination edit:

- We do not currently collect the number of beneficiaries with a care coordination edit claim rejection who requested a coverage determination for the prescription(s) subject to the edit. Care coordination edit claims overridden by the pharmacist at the pharmacy with assistance from the plan (for example, the sponsor provides an override code) should be included in Elements D, E, F, and G.
- For Elements E and J, report the first time the beneficiary meets the condition or the first time the claim is rejected.
- Report in Element K only beneficiaries with claims in Element F.
- Report in Element L only beneficiaries with claims in Element G.

Hard MME edit/opioid naïve days supply safety edit:

- The rejected claim is generally not a coverage determination and should NOT be reported as a coverage determination. However, if the enrollee, the enrollee's representative, or the enrollee's prescriber then contacts the sponsor to request coverage, that request must be processed and reported as a coverage determination.
- Count in Elements U and FF only those coverage determinations that result in favorable determinations, whether full or partial. The coverage determination should be associated with a hard MME or opioid naïve safety edit claim rejection. A favorable determination may result in the original or a modified (e.g., different daily dose, quantity, etc.) opioid prescription or a different opioid being covered.
- Report in Element DD only the beneficiaries that are included in Element Z.

Section V. Coverage Determinations, Redeterminations (including At–Risk Redeterminations under a Drug Management Program), and Reopenings

- For an explanation of coverage determinations, redeterminations, and re-openings procedures, refer to CMS regulations 42 CFR Part 423, 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 sponsors, CMS has included data fields to report partially favorable decisions and expects decisions that are partially favorable to be reported as such.
- Include requests that relate to Part B versus Part D if processed under the sponsor's Part D coverage determination or redetermination process.
- Reporting is based on the date the enrollee/enrollee's representative is notified in writing of the decision.
- In the event that a beneficiary files a request containing multiple distinct disputes (i.e., multiple drugs), each dispute should be counted as a separate request.
- Beneficiaries who have Utilization Management (UM) requirements waived based on an exception decision that cross contract years are only reported in the initial year. For example, if an approval is effective from March 1, 2025, to February 28, 2026, the request/decision would only be counted in 2025.
- Sponsors should include hospice-related coverage requests in this reporting.
- 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.
- Do not report cases related drug or classes of drugs which are statutorily excluded from coverage under Part D. This exclusion is in place for the context of reporting only.
- Do not report Independent Review Entity (IRE) decisions or duplicate requests.

Coverage Determinations and Exceptions:

Report:

- A request for an exception to a plan sponsor's prior authorization (PA) criteria as a coverage determination. Reporting should be based on the manner in which each request for exception to a sponsor's PA criteria is processed.
- Direct Member Reimbursements (DMRs) are considered a coverage determination request; therefore, the sponsor's disposition of the DMR should be reported under the appropriate coverage determination type.
- Part D opioid safety edit coverage determination exceptions should be categorized as Utilization Management (Elements G-J).

Redeterminations

Report:

- At-risk determination appeals (beneficiary-specific point-of-sale (POS) edit, or prescriber or pharmacy coverage limitation appeals, sharing information for subsequent Part D enrollments) made under a Part D drug management program should be counted as a redetermination.
- The denial of a DMR request in whole or in part may be appealed. The disposition of that DMR redetermination request should be reported under the appropriate redetermination type.

Do Not Report:

- An appeal by an enrollee (or another party) of the sponsor's dismissal of a coverage determination.
- A decision by the sponsor to uphold or reverse its dismissal of a coverage determination as a result of an enrollee (or another party) appealing a dismissal.
- Sponsor decisions regarding a request to vacate a dismissal.

Reopenings (Coverage Determinations and Redeterminations):

- All reopened coverage determinations and redeterminations should be included.
- Data Element A is reported via data entry into the HPMS PRM. All following data elements, starting with Element B1, are reported via a file upload in the PRM for each reopening.

- Data Element B2, Case ID is the unique internal tracking number that the sponsor assigned to the case that is being reopened.
- Data Element B2, if the sponsor assigns a new case ID when it reopens a case, the sponsor should populate the case ID for the original coverage determination or redetermination in this field.
- Data Element B5, Original Disposition Date: This is the date of the original coverage determination decision or the date of the original redetermination decision.
- Data Element B8, Case Reopened Date: This may be the same as the date of the reopening disposition and should fall in the quarter for which the data are being reported. If the Reopening Disposition is resolved (fully favorable, partially favorable, or adverse), the date of reopening disposition is expected to fall in the quarter for which the data is being reported.
- For Data Element B9, “Other” refers to cases that would not be considered a “clerical error”, “other error”, “new and material evidence”, “fraud or similar fault”. Examples of “other” may include policy/procedure change, business configuration change, provider update, other adjustments, etc.
- Data Element B10, Reopening Disposition Date is the date the sponsor revised the original disposition in its system and sent written notification to the enrollee. See 42 CFR §423.1982.
- Data Element B11, reopening disposition, should reflect the status of a reopened case once the plan sponsor has notified the beneficiary of the reopening decision. For example, if a plan sponsor 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.

Section VI. Employer Group Plan Sponsors

- HPMS displays one module for reporting both Part C and Part D Employer/Union-Sponsored Group Health Plan Sponsors data.
- An MA-PD plan may submit Part C and Part D data in one upload, the upload file should include all applicable plan IDs for a contract.
- Refer to Part C Technical Specifications for additional guidance: https://www.cms.gov/medicare/enrollment-renewal/health-plans/part-c.

Section VII. Medicare Prescription Payment Plan

- Refer to Medicare Prescription Payment Plan Guidance for more information and definitions of terms such as “likely to benefit.”
- All beneficiaries reported in Element A should additionally be reported in either Element B, C, or D. Some beneficiaries may be determined to be likely to benefit by multiple means. For example, a beneficiary could be determined to be likely to benefit based on prior to plan year criteria and at POS, and so would be reported in both Element B and Element D. However, that beneficiary would only be reported once in Element A.
- Part D sponsors are not required to conduct targeted outreach to beneficiaries “likely to benefit” from the program if they are already participating in the program. For example, if a beneficiary has high Calendar Year (CY) 2025 out-of-pocket costs, such that they would otherwise be identified as “likely to benefit” prior to the plan year for CY 2026 but the beneficiary is already a program participant for CY 2025, the beneficiary should not be reported in Element A or Element B.
- If a beneficiary switches between Plan Benefit Packages (PBPs) during the reporting period, they would be reported as a unique beneficiary for both PBPs even if both PBPs are administered by the same Part D sponsor. Participation in the Medicare Prescription Payment Plan ends when beneficiaries disenroll from a PBP; they may choose to elect again under the new Part D plan.
- Sponsors are required to put in place reasonable guidelines for ongoing identification of beneficiaries likely to benefit during the plan year. Element C should only include individuals identified as likely to benefit based on the sponsor’s criteria for identification of beneficiaries likely to benefit from the program and should not include individuals who are only identified as likely to benefit during the plan year through the POS notification process.
- CMS intends for each contract year of reporting to capture beneficiaries’ participation in the Medicare Prescription Payment Plan program during that individual contract year. The CY 2026 Reporting Requirements should capture activities associated with program participation in CY 2026.
    - Sponsors are required to identify beneficiaries likely to benefit from the program both prior to and during the plan year. Therefore, some beneficiaries may be identified as "likely to benefit” prior to the start of the plan year and reporting period on January 1st. All likely to benefit determinations or election requests for the CY 2026 plan year that take place before the reporting period begins on January 1, 2026, should still be reported. For example, for Element B, a beneficiary may be identified as likely to benefit based on data

from the immediately preceding plan year prior to January 1st of the current plan year. These beneficiaries should be reported in Element B. As another example, a beneficiary may submit an election request to participate in the Medicare Prescription Payment Plan program for CY 2026 after October 15, 2025, and prior to January 1, 2026. This enrollee's election request should be reported in Element E and Element F.

  - Any election requests submitted on or after October 15, 2026, for a January 1, 2027, effective date, or prior to plan year likely to benefit identification in advance of the CY 2027 plan year, should not be reported with the CY 2026 data. These election requests should be reported with CY 2027 data.
  - Any election requests submitted on or after October 15, 2026, through December 31, 2026, for participation in CY 2026 should be reported with CY 2026 data.
  - Beneficiaries who participated in the program through the end of CY 2025 and whose participation in the program was automatically renewed for CY 2026 should not be counted in Element F. Element F should report new election requests for the 2026 plan year.

- The phrase "within established timeframes" refers to the requirement that beneficiaries must provide additional documentation to make the program election request complete within 21 days of receiving a request for additional information. The election request may be denied if the sponsors do not receive the requisite information within this timeframe.
- Beneficiaries reported in Element I should also be reported in either Element G or in Element K.
- Beneficiaries reported in Element J should be reported in Element K.
- Elements L and M should include all out-of-pocket cost sharing incurred by Medicare Prescription Payment Plan participants through 12/31/2026, even if the billing and collection period extends beyond 12/31/2026. For example, if a beneficiary fills a prescription on December 12, 2026, is billed in mid-January 2027, and pays their bill in early February 2027, this amount should be included in Element L. Elements L and M must not include decimals, and all amounts should be rounded to the nearest dollar.
- Element O should include beneficiaries who are precluded in participating in the Medicare Prescription Payment Plan for 2027, as of the reporting deadline. A sponsor may only preclude an individual from opting into the Medicare Prescription Payment Plan in a subsequent year if the individual owes an overdue balance to that sponsor.

- If a beneficiary enrolls in a Part D plan and submits a Medicare Prescription Payment Plan election request but cancels their enrollment in the Part D plan prior to the effective date of plan participation, Part D plans should exclude that election request from reporting. For example, if a beneficiary enrolls in a Part D plan effective April 1, 2026 and opts into the Medicare Prescription Payment plan in March 2026 but subsequently cancels the plan taking effect April 1, 2026, the Medicare Prescription Payment Plan election request that was received in March should be excluded from Element F (as enrollment into the Part D plan ultimately was canceled).