

**MEDICARE PART C AND D
REPORTING REQUIREMENTS
DRAFT Technical Specifications
Contract Year 2027**

Effective Date: January 1, 2027

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Updated: October 2026

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Revision History (from Contract Year 2026 to Contract Year 2027)

The following list is provided as a courtesy and includes certain changes to this document made between Contract Year (CY) 2026 and CY 2027. Compare the documents from both years for all the changes between the two CYs.

1. The Part C and D Reporting Requirements Technical Specifications information for Medicare Advantage (MA) organizations and Part D plan sponsors is combined into one document.
2. Information duplicative of the CY 2027 Part C and D Reporting Requirements document or other documentation was removed.
3. Changes to data elements for CY 2027 are reflected in this document. Refer to the CY 2027 Reporting Requirements document for more information.
4. For the Enrollment and Disenrollment Reporting Section, we clarified that reporting should include all enrollment and disenrollment requests with date of receipt in the reporting period, regardless of the effective date of that enrollment or disenrollment request. We also clarified reporting of Elements E and F.
5. For the Grievances Reporting Section, we explained that a Medicare Advantage Prescription Drug Plan (MA-PD) should submit Part C and D data in one upload. Counts of grievances for each data element should include both Part C and D grievances. HPMS has combined reporting of both Part C and Part D grievances data as of CY 2027.
6. For the Part C – Organization Determinations & Reconsiderations, and Reopenings section, we clarified specifications, including reporting of withdrawn and dismissed requests, and concurrent review decisions. We clarified removal of “Pending” as a reopening disposition and clarified reporting of incomplete and completed reopenings across reporting quarters and contract years.
7. For the Part D – Coverage Determinations, Redeterminations, and Reopenings section, we clarified specifications, including reporting of withdrawn and dismissed requests. We clarified removal of “Pending” as a reopening disposition, clarified reporting of incomplete and completed reopenings across reporting quarters and contract years, and updated data element references to align with the reorganized disposition elements.
8. For the Special Needs Plans (SNPs) Care Management section, we clarified specifications. This included:
 - a. Updated reporting instructions for Elements A through H to improve clarity, reduce duplicative regulatory language, and support consistent PBP-level reporting.

- b. Added and clarified key timing terms, including Initial HRA timeframe and applicable 365-day reassessment timeframe. Clarified calendar-day counting, day 0/day 1 treatment, day 365 treatment, leap-year treatment, missed initial HRAs, late HRAs, and reassessment reset rules.
 - c. Clarified that Element A and B identify the applicable initial HRA and annual reassessment HRA populations. Added one-way alignment language so related status elements align with the appropriate population element without requiring every Element A or B enrollee to have a status element.
 - d. Clarified reporting for completed HRAs, refusals, and unable-to-reach statuses, including documentation requirements and exclusions.
 - e. Clarified that an HRA may be considered complete for reporting when received by the MA organization with any degree of enrollee- or caregiver-informed completion.
 - f. Clarified that HRA status categories are reportable events, that enrollees may not be counted more than once in the same data element for the same plan and CY, and that refusal and unable-to-reach reporting should be tied to the HRA the SNP was attempting to complete. Clarified that an unable-to-reach status is not reported under Element E or H when the HRA associated with the outreach is completed within its applicable timeframe.
 - g. Clarified reporting for enrollee movement and continuity scenarios, including re-enrollment into the same plan, movement between PBPs under the same contract, enrollment under a different contract/sponsor/parent organization, and mergers, consolidations, and crosswalks.
 - h. Standardized terminology and formatting, including use of CY, completed HRA for reporting, annual reassessment HRA, MA organization, and PBP, to improve readability.
9. For the Payments to Providers section, we added clarification on how to report on negative amounts and also provided clarification on elements U-KK.
10. For the Supplemental Benefit Utilization and Costs section, we:
- a. Clarified that if a plan did not offer any supplemental benefits for the CY, then the plan ID should not be included in reporting.
 - b. Clarified how to report certain data elements if no enrollees utilized the benefit.

- c. Added PBP Category code 14c4d “Fitness Benefit – Fitness Equipment or Kit”.
 - d. Clarified instructions for Element F and Element J. Updated instructions for Element L since it is now a limited list of answer choices. Added instructions for new Element O.
11. For the D-SNP Enrollee Advisory Committee (Part C) section, we updated all element descriptions.
12. For the D-SNP Transmission of Admission Notifications section, we added clarification on transmitting admission notifications
13. For the Medicare Prescription Payment Plan Reporting Section, we clarified that if an enrollee submits a Medicare Prescription Payment Plan election request but subsequently withdraws the request, Part D sponsors should exclude that election request from reporting.
14. For MTM, clarified that beneficiaries who are deceased prior to their MTM enrollment date should not be reported.
15. For IDUR, clarified that if a sponsor made multiple opioid safety edit submissions 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.

Introduction

These technical specifications supplement the Medicare Part C and D Reporting Requirements (OMB0938-0992) and do not change, alter, or add to the data collection. They serve to further define data elements. The Part C and D Reporting Requirements document can be found at: <https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/part-c-part-d-reporting-requirements>.

The purpose of these technical specifications is to help ensure a common understanding of the data to be reported by Medicare Advantage (MA) organizations and Part D sponsors, to assist MA organizations and Part D 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 MA organizations and Part D sponsors to correct and resubmit data. Each Part C and D reporting section is listed in this document with specifications for Data Elements within Reporting Sections.

MA organizations and Part D 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). An MA organization or Part D 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.

Validation checks should be performed by MA organizations and Part D sponsors prior to data submissions. When files are uploaded to the HPMS PRM, the system performs validation checks. The list of validation checks performed for each reporting section is 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 MA organizations and Part D sponsors.

Resubmissions

If previously submitted data are incorrect, and the reporting deadline has passed, the MA organization or Part D sponsor should request the opportunity to correct and resubmit data (referred to as a resubmission) prior to the resubmission deadline. An MA organization 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 Dual Eligible Special Needs Plans (D-SNP) Transmission of Admission Notifications Reporting Section and the Medicare Prescription Payment Plan Reporting Section, data corrections must be submitted prior to 11:59 p.m. Pacific time (PT) on March 31st, or if March 31st falls on a weekend or federal holiday, prior to 11:59 p.m. PT on the preceding business day.

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

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

If an MA organization or Part D sponsor requests a resubmission, but does not upload new data, then the original submission remains the data of record in HPMS. HPMS will not allow the resubmission of data that are identical to the original data submission. MA organizations and Part D sponsors should retain documentation supporting their HPMS data submissions and resubmissions. MA organizations and Part D 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 an MA organization or Part D sponsor submits a resubmission request, and CMS approves the request to resubmit, the MA organization or Part D 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 programs. They serve only to give sponsors 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 on data received from sponsors.

Questions

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

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 (Part C and Part D)

- A Medicare Advantage Prescription Drug Plan (MA-PD) should submit Part C and Part D data in one upload.
- For **Enrollment**, Elements A-K must include all enrollments.
- For **Enrollment**, Element C should include all forms of potential contact.
- Disenrollments must not be included in Enrollments.
- For **Disenrollment**, Elements A-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 with a date of receipt in the reporting period, regardless of the effective date of that enrollment or disenrollment request. Reporting should not include any enrollment and disenrollment requests with a date of receipt outside of the reporting period, even if the effective date of that enrollment or disenrollment request is within the reporting period. For example, an enrollment request received in December of the reporting period with an effective date in the next Contract Year should be reported. An enrollment request received in December before the start of the reporting period with an effective date within the reporting period should not be reported.
- 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.
- For Elements E and F, include **enrollment** or **disenrollment** requests counted in Element C even if the completion or denial occurred after the end of the reporting period.
- Enrollment/disenrollment requests for which a timely cancellation request is received should not be included in this reporting.
- Voluntary disenrollments for which the MA organization or Part D 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.

Section II. Grievances (Part C and Part D)

- MA-PDs should submit Part C and Part D data in one upload. Counts of grievances for each data element should include both Part C and Part D grievances.
- Report grievances based on the date the MA organization or Part D sponsor 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 MA organization's or Part D sponsor'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 MA organization's or Part D sponsor'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, report grievances that were received but not processed by the MA organization or Part D sponsor because they did not meet the requirements for a valid grievance.
- Report grievances filed by beneficiaries previously enrolled, even if they are no longer enrolled by the time of notification. The MA organization or Part D 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 MA organization's or Part D sponsor's procedures for handling enrollee grievances.
- Grievances filed by non-enrollees, including 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 MA organization or Part D sponsor.
- Grievances related to services or items only covered under the MA organization'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).

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Section III. Employer Group Plan Sponsors (Part C and Part D)

- MA-PDs should 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 an MA organization or Part D sponsor for any portion of the reporting period should be included in the file upload, regardless of enrollment. In this case, MA organizations and Part D 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. MA organizations and Part D 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 an MA organization or Part D sponsor, report the address from which the employer manages the human resources/health benefits.
- Element F: The employer organization type is based on how MA organizations and Part D sponsors file their taxes. MA organizations and Part D 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 MA organization or Part D 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 MA organization or Part D 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 Plan Benefit Package (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. Organization Determinations & Reconsiderations, and Reopenings (Part C)

For an explanation of organization determinations, reconsiderations, and reopenings 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 MA organizations, 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., MA organization 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 organization determination and reconsideration 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.
- Clarification - Withdrawn vs. Dismissed Requests:
 - Organization determinations and reconsiderations that are withdrawn by the requesting party prior to the issuance of a decision must be reported under the “Withdrawn” data element.
 - A request may only be reported as “Withdrawn” when the withdrawal is received prior to the MA organization issuing a decision.
 - Pursuant to 42 CFR Part 422, Subpart M, a plan will dismiss a request for an organization determination or reconsideration when the requesting party submits a withdrawal request. However, for reporting purposes, the MA organization will report the decision under the “Withdrawn” data element only. This means that MA organizations will never report withdrawn

organization determination or reconsideration requests under the “Dismissals” data element.

- The “Dismissals” data element includes only requests for organization determinations and reconsiderations that are dismissed for reasons other than a withdrawal request.

Example: An enrollee withdraws a request for an organization determination prior to the MA organization issuing a decision. The MA organization processes the request as a dismissal and issues a dismissal notice. For reporting purposes, the request must be reported as “Withdrawn” only.

Report:

- Completed organization determinations and reconsiderations (i.e., MA organization 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. MA organizations 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.
- MA organizations 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.

Clarification – Concurrent Reviews

- Concurrent review decisions (e.g., utilization management activities during inpatient, Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) care), including MA organization-established review dates to assess continued medical necessity, are organization determinations under 42 CFR Part 422 Subpart M.
- Concurrent review activities that do not result in a distinct fully favorable, partially favorable, or adverse decision must not be reported.
 - A concurrent review decision that results in an approval (i.e., a continuation of services) must be reported as an organization determination, even if the review was initiated by the MA organization and not in response to a new request.
 - A concurrent review decision that results in an adverse determination, including a denial, reduction, or termination of services, must be reported as an organization determination, even if the review was initiated by the MA organization and not in response to a new request.
 - Multiple concurrent review decisions issued as part of a single course of treatment must be reported as separate organization determinations.
 - A concurrent review decision that was initiated by the MA organization and not in response to a new request should be reported as a service request involving the enrollee, consistent with existing data elements for requests submitted by or on behalf of the enrollee.
 - For reporting purposes, a concurrent review decision is completed in the quarter in which the MA organization communicates the decision in accordance with the applicable notification requirements.

Example

An MA organization conducts weekly concurrent reviews of an inpatient stay to assess continued medical necessity. The enrollee's stay is approved during the first three reviews. During the fourth review, the MA organization determines that

inpatient care is no longer medically necessary and issues a termination of coverage.

For reporting purposes:

- The first three approval decisions must be reported as fully favorable organization determinations under the enrollee category.
- The termination decision must be reported as an **adverse organization determination** under the enrollee category.

Do Not Report:

- Independent Review Entity (IRE) decisions.
- Claims payment or appeals from contract providers that are governed under the contractual arrangement between the MA organization and its contract providers.
- An appeal by an enrollee (or other party) of the MA organization's dismissal of a request for coverage determination.
- A decision by the MA organization to uphold or reverse its dismissal of a request for an organization determination as a result of an enrollee (or other party) appealing a dismissal.
- MA organization decisions regarding a request to vacate a dismissal.
- Reopenings requested or completed by the IRE, Administrative Law Judge (ALJ), or Appeals Council.
- Duplicate payment requests concerning the same service or item. MA organizations 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 MA organization 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 MA organization's Medicaid benefits and never covered by Medicare and not covered by the MA organization as a supplemental Medicare benefit (such as Medicaid home-and community-based long-term services and supports).

Reopenings of Organization Determinations and Reconsiderations:

- For an explanation of reopening procedures, refer to **Section 80 (Reopening and Revising Determinations and Decisions)** of the *Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance*, as well as 42 CFR § 422.616.
- Reopened organization determinations and reconsiderations should be included, except reopened claims submitted by contract provider.
- For purposes of this reporting section, a reopening is complete when the MA organization has mailed the required written notification of the revised determination or decision to the applicable party or parties.
- An MA organization must report a reopening in the quarter in which the reopening is initiated. If the reopening is completed within the same quarter, the MA organization must report only the completed reopening.
- If the reopening has not been completed by the end of the quarter in which it was initiated, the MA organization must report the reopening once in the quarter. The MA organization must populate Elements A through J, as applicable, and leave Element K, Date of Reopening Disposition, and Element L, Reopening Disposition, blank.
- The MA organization must not repeat the same incomplete reopening in subsequent quarters solely because the reopening remains incomplete.
- If the MA organization subsequently completes the reopening by mailing the required written notification, including when completion occurs in a subsequent contract year, the MA organization must report the completed reopening once in the quarter in which notification is mailed. The completed record must use the same Contract Number, Case ID, and Date Case Was Reopened reported in the initial record. Elements A through J should remain unchanged between the initial and completed records.
- The transition to a new contract year does not create a new reopening and does not require the incomplete reopening to be reported again.

- The combination of Contract Number, Case ID, and Date Case Was Reopened identifies the same reopening across reporting periods. An MA organization should not submit more than one record for that combination in the same quarterly file.
- The later completed record is an update to the previously reported incomplete reopening and does not represent a new reopening.
- If the required written notification is never sent, the MA organization must not report an additional record in subsequent quarters.
- If the IRE fully or partially overturns the MA organization's determination, do not report the case as a reopening.
- Data Element A, Case ID is the unique internal tracking number that the MA organization assigned to the case that is being reopened. If the MA organization assigns a new case ID when it reopens a case, the MA organization should populate the case ID for the original coverage determination or redetermination in this field.
- Data Element B, Case Level (Organization Determination or Reconsideration) must align with the "Date of Original Disposition" and "Original Disposition" data elements, such that all fields reflect the same level of determination being reopened.
- Data Element C, Date of original disposition: This is the date of the original organization determination decision or the original reconsideration decision.
- Data Element H, Date Case Was Reopened, is the date the MA organization initiated the reopening. For the initial reopening record, this date must fall within the applicable reporting quarter. If the completed reopening is reported in a subsequent quarter or contract year, the MA organization must continue to report the original Date Case Was Reopened. In these circumstances, the Date Case Was Reopened may precede both the reporting quarter and the contract year in which the completed reopening is reported.
- For Data Element I, "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 changes, business configuration changes, provider updates, and other adjustments.
- Data Element K, Date of Reopening Disposition, is the date the MA organization mailed the required written notification of the revised determination or decision. For an incomplete reopening reported in the quarter in which it was initiated, this data element must be left blank. When the MA organization mails the required written notification, the MA organization must populate this data element in the completed record. The Date of Reopening Disposition must fall within the reporting quarter in which the completed record is reported.

- Data Element L, Reopening Disposition, should reflect the outcome of the revised determination or decision: Fully Favorable, Partially Favorable, or Adverse. For an incomplete reopening reported in the quarter in which it was initiated, this data element must be left blank. When the written reopening decision has been sent, the MA organization must populate this data element in the completed record. Elements K and L must either both be blank for an incomplete reopening or both be populated for a completed reopening.

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

For an explanation of coverage determinations, redeterminations, and reopenings procedures, refer to CMS regulations 42 CFR Part 423, Subpart M and U, 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 Parts 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 Part D 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.
- Except as otherwise specified under Reopening of Coverage Determinations and Redeterminations, reporting of coverage determinations and redeterminations is based on the date the enrollee or 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, 20XX, to February 28, 20XX + 1, the request/decision would only be counted in 20XX.
- Part D 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.
- Clarifications for Withdrawn vs. Dismissed Requests:

- Requests for coverage determinations and redeterminations that are withdrawn by the requesting party prior to the issuance of a decision must be reported under the “Withdrawn” data element.
- A request may only be reported as “Withdrawn” when the withdrawal is received prior to the Part D sponsor issuing a decision.
- Pursuant to 42 CFR Part 423, Subpart M, a Part D sponsor will dismiss coverage determinations and redeterminations when the requesting party submits a withdrawal request. However, for reporting purposes, the Part D sponsor will report the decision under the “Withdrawn” data element only. This means that the sponsor will never report withdrawn coverage determinations and redetermination requests under the “Dismissal” data element.
- The “Dismissals” data element includes only requests for coverage determinations and redeterminations that are dismissed for reasons other than a withdrawal request.
- Example: An enrollee withdraws a request prior to the issuance of a decision. The Part D sponsor processes the request as a dismissal and issues a dismissal notice. For reporting purposes, the request must be reported as “Withdrawn” only.

Do Not Report:

- Cases related to drugs or classes of drugs that are statutorily excluded from coverage under Part D. This exclusion is in place for reporting purposes only.
- Independent Review Entity (IRE) decisions.
- Duplicate coverage determination or redetermination requests.

Coverage Determinations and Exceptions

Report:

- A request for an exception to a Part D 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 Part D sponsor’s PA criteria is processed.
- Direct Member Reimbursements (DMRs) are considered a coverage determination request; therefore, the Part D 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 Exceptions under Subsection 1c, Elements H-K.

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

Reopenings of Coverage Determinations and Redeterminations:

- For an explanation of reopening procedures, refer to **Section 80 (Reopening and Revising Determinations and Decisions)** of the *Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance*, as well as 42 CFR Part 423 Subpart U, §423.1978 through §423.1986.
- All reopened coverage determinations and redeterminations should be included.
- For purposes of this reporting section, a reopening is complete when the Part D sponsor has mailed the required written notification of the revised coverage determination or redetermination to the enrollee or enrollee's representative, as applicable.
- A Part D sponsor must report a reopening in the quarter in which the reopening is initiated. If the reopening is completed within the same quarter, the Part D sponsor must report only the completed reopening.
- If the reopening has not been completed by the end of the quarter in which it was initiated, the Part D sponsor must report the reopening once in that quarter. The Part D sponsor must populate Elements A through H, as applicable and leave Element I, Date of Reopening Disposition and Element J, Reopening Disposition, blank.

- The Part D sponsor must not report the same incomplete reopening in subsequent quarters solely because the reopening remains incomplete.
- If the Part D sponsor subsequently completes the reopening by mailing the required written notification, including when completion occurs in subsequent contract year, the Part D sponsor must report the completed reopening once in the quarter in which notification is mailed. The completed record must use the same Contract Number, Case ID, and Case Reopened Date reported in the initial record. Elements A through H must remain consistent between initial and completed records.
- The transition to a new contract year does not create a new reopening and does not require the incomplete reopening to be reported again.
- The later completed record is an update to the previously reported incomplete reopening and does not represent a new reopening.
- The combination of Contract Number, Case ID, and Case Reopened Date identifies the same reopening across reporting periods. A Part D sponsor must not submit more than one record for the combination in the same quarterly file.
- If the required written notification is never sent, the Part D sponsor must not report an additional record in subsequent quarters.
- Data Element A, Case ID is the unique internal tracking number that the Part D sponsor assigned to the case that is being reopened. If the Part D sponsor assigns a new case ID when it reopens a case, the Part D sponsor should populate the case ID for the original coverage determination or redetermination in this field.
- Data Element B, Case Level - coverage determination or redetermination - must align with the Date of Original Disposition and Original Disposition data elements, so that all three data elements reflect the same determination level being reopened.
 - If the reopening applies to a redetermination, the Date of Original Disposition must reflect the redetermination decision date.
 - The Date of Original Disposition must not reference a prior-level determination that is not the subject of the reopening.
- Data Element C, Date of Original Disposition: This is the date of the original coverage determination decision or the date of the original redetermination decision.
- Data Element G, Case Reopened Date, is the date the Part D sponsor initiated the reopening. For initial reopening record, this date should fall within the applicable reporting quarter. If the completed reopening is reported in a subsequent quarter or contract year, the Part D sponsor must continue to report the original Case Reopened Date. In these circumstances, the Case reopened Date may precede

both the reporting quarter and the contract year in which the completed reopening is reported.

- For Data Element H, “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 changes, business configuration changes, provider updates, and other adjustments.
- Data Element I, Date of Reopening Disposition, is the date the Part D sponsor mailed the required written notification of the revised coverage determination or redetermination to the enrollee or enrollee’s representative, as applicable. For incomplete reopening reported in the quarter in which it was initiated, this data element must be left blank. When the Part D sponsor mails the required written notification, the Part D sponsor must populate this data element in the completed record. The Date of Reopening Disposition must fall within the reporting quarter in which the completed record is reported.
- Data Element J, Reopening Disposition, should reflect the revised coverage determination or redetermination: Fully Favorable, Partially Favorable, or Adverse. For an incomplete reopening reported in the quarter in which it was initiated, this data element must be left blank. When the written reopening decision has been sent to the appellant, the Part D sponsor must populate this data element in the completed record.
- Elements I and J: if the reopening is incomplete, both should remain blank. If the reopening is completed, both elements should be populated.

Section VI. Special Needs Plans (SNPs) Care Management (Part C)

Title 42, Part 422, Subpart C includes requirements applicable to sponsors offering Special Needs Plans (SNPs), including requirements related to health risk assessments (HRAs), enrollee outreach, and care management under 42 CFR § 422.101(f).

In particular, 42 CFR § 422.101(f) establishes requirements for initial and annual HRAs, outreach to enrollees, and documentation of attempts to complete HRAs. Please note that the regulations require timely HRAs to be conducted or documented outreach and refusals (as defined by 42 CFR § 422.101(f)(1)(iv)(A) through (C)) for all SNP enrollees.

The period of SNPs Care Management eligibility and enrollment is a CY (which aligns with the reporting period).

Definitions

Initial HRA timeframe means the timeframe specified at 42 CFR § 422.101(f)(1)(i).

Applicable 365-day reassessment timeframe means the 365-calendar-day timeframe used to determine when an enrollee is due for an annual reassessment HRA. The timeframe is calculated under the HRA Reporting Timeline and is based on:

- the effective enrollment date if no HRA has been completed, or
- the date of the enrollee's most recent completed HRA, whether initial or reassessment.

For re-enrollment, PBP changes under same contract, mergers, consolidations, and crosswalks, use the rules in the applicable subsection.

Specifications

- Element A
 - The enrollee should be reported under this element when:
 - The enrollee has an effective enrollment date that falls within the CY and is continuously enrolled for at least 90 days during the CY.
 - The enrollee has an effective enrollment date that falls within the CY, is continuously enrolled for fewer than 90 days, and has a reportable initial HRA status category under element C, D, or E.
 - The enrollee has an effective enrollment date that falls in the previous CY, but the initial HRA timeframe ends in this CY, if no initial HRA status category was reported in the previous CY.
 - Includes individuals who disenrolled from and re-enrolled into the same plan without a completed HRA prior to disenrollment when the

enrollee otherwise meets the Element A inclusion criteria based on the re-enrollment date. See Re-enrollment and Disenrollment subsection.

- Note: Element A reflects the population of new enrollees due for an initial HRA. Reporting an enrollee under Element A does not require the enrollee to also be reported under Element C, D, or E. However, an enrollee reported under Element C, D, or E should also be reported under Element A for the same CY and PBP when the criteria for Element C, D, or E are met.
- Exclude enrollees under this element when:
 - The enrollee is continuously enrolled in a plan with a documented initial or reassessment HRA in the previous CY.
 - New enrollees who disenroll from the plan prior to the effective enrollment date or within the first 90 days after the effective enrollment date, and no initial HRA status category is reported under Element C, D, or E before disenrollment.
 - The enrollees received an initial or reassessment HRA before a consolidation, merger, or CMS-approved crosswalk and remain continuously enrolled under the same MA organization or parent organization.
- Element B
 - The enrollee should be reported under this element when:
 - The enrollee is eligible for an annual reassessment HRA during the CY.
 - For purposes of Element B, the enrollee is eligible for an annual reassessment HRA during the CY, meaning:
 - The applicable 365-day reassessment timeframe is reached during the CY; or
 - The applicable 365-day reassessment timeframe was reached before the CY and the enrollee remains due for an annual reassessment HRA for any portion of the CY because no completed HRA had reset the reassessment timeframe.
 - The enrollee is reported under Element F, G, or H for the same CY and PBP when the criteria for Element F, G, or H are met.
 - The applicable 365-day reassessment timeframe is based on:
 - The effective enrollment date, if no HRA has been completed; or
 - The date of the enrollee's most recent completed HRA, whether initial or reassessment.

- Additional reporting rules:
 - Enrollees who missed the deadline to complete an initial or reassessment HRA remain eligible for reassessment, and should continue to be included in Element B for each CY in which they meet the Element B criteria. Enrollees should not be excluded from Element B due to missed HRA deadlines.
 - For enrollees who disenrolled and re-enrolled into the same plan, determine Element B reporting using the rules in the Re-enrollment and Disenrollment subsection.
 - For enrollees who change PBPs under the same contract, determine Element B reporting using the rules in the Same Contract – Different PBP subsection.
 - For enrollees described under Mergers, Consolidations, and Crosswalks, continuous enrollment is not interrupted solely because of consolidation, merger, or crosswalk.
 - Note: Element B reflects eligibility for an annual reassessment HRA and does not reflect whether an HRA was completed. An enrollee may be reported under Element B even if the enrollee is not reported under Element F, G or H during the CY. However, an enrollee reported under Element F, G, or H should also be reported under Element B for the same CY and PBP when the criteria for Element F, G, or H are met.
- Examples
 - Example 1: An enrollee has an effective enrollment date of 1/1/20XX but does not complete an initial HRA within the initial HRA timeframe. The enrollee remains continuously enrolled and does not complete an HRA during CY 20XX. Because the applicable 365-day reassessment timeframe is reached during CY 20XX + 1, the enrollee should be reported under Element B for CY 20XX + 1, whether the reassessment HRA is completed, refused, or not performed because the SNP is unable to reach the enrollee. The enrollee may also be reported under Element F, G, or H, as applicable.
 - Example 2: An enrollee has an effective enrollment date of 1/1/20XX, does not complete an initial HRA, and remains continuously enrolled for multiple CYs without completing an HRA. After the applicable 365-day reassessment timeframe is reached, the enrollee should continue to be reported under Element B for each CY in which the enrollee remains due for an annual reassessment HRA, unless a completed HRA resets the reassessment timeframe or the enrollee no longer meets the Element B criteria.

- Exclude enrollees under this element when:
 - The enrollee is not reported under Element F, G, or H for the same CY and PBP, and either of the following applies:
 - The applicable 365-day reassessment timeframe has not been reached by the end of the CY based on:
 - The effective enrollment date, if no HRA has been completed; or
 - The date of the enrollee's most recent completed HRA, whether initial or reassessment.
 - The enrollee did not remain continuously enrolled through the date the applicable 365-day reassessment timeframe was reached, except as specified under Re-enrollment and Disenrollment, Same Contract – Different PBP, or Mergers, Consolidations, and Crosswalks.
- Element C
 - The enrollee should be reported under this element when:
 - The enrollee is a new enrollee, as defined above in Element A, and completes an initial HRA within the initial HRA timeframe.
 - If the initial HRA is completed before the effective enrollment date, it is reported as an initial HRA in the CY in which the effective enrollment date falls.
 - For re-enrollment scenarios, see the Re-enrollment and Disenrollment subsection.
 - Exclude enrollees under this element when:
 - The HRA is completed after the initial HRA timeframe. See Element F and HRA Reporting Timeline for treatment of HRAs completed after the initial HRA timeframe.
- Element D
 - The enrollee should be reported under this element when:
 - The enrollee did not complete an initial HRA within the initial HRA timeframe because the enrollee refused to participate, and the SNP has documentation of the refusal consistent with 42 CFR § 422.101(f)(1)(iv)(C).
 - Exclude enrollees under this element when:
 - The initial HRA was not completed, and the SNP does not have documentation of the enrollee's refusal.
- Element E

- The enrollee should be reported under this element when:
 - The enrollee did not complete an initial HRA within the initial HRA timeframe because the SNP was unable to reach the enrollee, and the SNP has documentation showing that the enrollee did not respond to the SNP's attempts to reach them.
 - Documentation must demonstrate that the outreach and documentation requirements under 42 CFR § 422.101(f)(1)(iv)(A) through (C) are met.
- Exclude enrollees under this element when:
 - The initial HRA associated with the unable-to-reach outreach was completed within the initial HRA timeframe.
 - The initial HRA was not completed, and the SNP does not have documentation demonstrating compliance under 42 CFR § 422.101(f)(1)(iv)(A) through (C).
- Element F
 - The enrollee should be reported under this element when:
 - The enrollee is eligible for an annual reassessment HRA and completes the reassessment within the applicable 365-day reassessment timeframe.
 - The enrollee did not complete an initial HRA within the initial HRA timeframe, remained continuously enrolled, and completed an HRA within the applicable 365-day reassessment timeframe. The enrollee should be reported under Element F and not Element C.
 - Note: When an initial HRA is completed within the initial HRA timeframe before the effective enrollment date, the first annual reassessment must be completed no more than 365 calendar days after the initial HRA completion date.
 - Exclude enrollees under this element when:
 - The enrollee completes a reassessment HRA after the applicable 365-day reassessment timeframe. The enrollee should not be reported under Element F for the missed reassessment cycle. See HRA Reporting Timeline for treatment of HRAs completed after the 365-day reassessment timeframe.
- Element G
 - The enrollee should be reported under this element when:

- The annual reassessment HRA was not completed because the enrollee refused to participate, and the SNP has documentation of the refusal consistent with 42 CFR § 422.101(f)(1)(iv)(C).
- Exclude enrollees under this element when:
 - The annual reassessment HRA was not completed, and the SNP does not have documentation of enrollee refusal.
- Element H
 - The enrollee should be reported under this element when:
 - The annual reassessment HRA was not completed within the applicable 365-day reassessment timeframe because the SNP was unable to reach the enrollee.
 - Documentation must demonstrate that outreach and documentation requirements under 42 CFR § 422.101(f)(1)(iv)(A) through (C) are met.
 - Exclude enrollees under this element when:
 - The annual reassessment HRA associated with the unable-to-reach outreach was completed within the applicable 365-day reassessment timeframe.
 - The annual reassessment HRA was not completed for a reason other than the SNP's inability to reach the enrollee.
 - The SNP does not have documentation demonstrating compliance with 42 CFR § 422.101(f)(1)(iv)(A) through (C).
- Element I
 - Report Element I as follows:
 - Report "Y" only when the PBP had enrollment during the CY but has no reportable HRA activity for Elements A through H for the entire CY.
 - Report "N" when the PBP had enrollment during the CY and has reportable data for Elements A through H, including when the reportable value for any individual element is zero.
 - Element I is not associated with whether a contract or plan has zero enrollment.

HRA Reporting Timeline

- Initial HRA requirements must comply with 42 CFR § 422.101(f)(1)(i).
- Annual HRA requirements must comply with 42 CFR § 422.101(f)(1)(ii).

- For reporting purposes, there should be no more than 365 days between HRAs for SNP enrollees.
- If no HRA is completed within the initial HRA timeframe, the enrollee's annual reassessment HRA is due no more than 365 calendar days after the effective enrollment date.
- A new enrollee who completes an initial HRA within the initial HRA timeframe is due for a reassessment HRA no more than 365 calendar days after the initial HRA was completed.
- Initial HRAs completed before the effective enrollment date are counted as initial HRAs in the CY in which the effective enrollment date falls. For example, an initial HRA completed on November 23, 20XX for an enrollee with an effective enrollment date of January 1, 20XX + 1 would be counted as an initial HRA in 20XX + 1.
- If the initial HRA is not completed within the initial HRA timeframe, the SNP will be deemed non-compliant with this requirement.
- If no HRA is completed within the initial HRA timeframe, the SNP should complete an HRA as soon as possible. For reporting purposes, if the HRA is completed within the applicable 365-day reassessment timeframe, the enrollee should be reported under Element F, and not Element C.
- For purposes of HRA timelines, all day counts are calendar-day counts.
- For the 365-day reassessment timeframe, when an HRA has been completed, the most recent completed HRA date is day 0. The count begins on the next calendar day, which is day 1, and the 365-day reassessment timeframe is reached on day 365.
- If no HRA has been completed, the effective enrollment date is considered day 0. The count begins on the next calendar day, which is day 1, and the 365-day reassessment timeframe is reached on day 365, except as otherwise specified under Re-enrollment and Disenrollment, Same Contract – Different PBP, or Mergers, Consolidations, and Crosswalks.
- Plans should not add 365 additional days after day 1 because day 1 is included in the 365-day count.
- Leap years do not extend the 365-day reassessment timeframe. If the timeframe includes February 29, the reassessment timeframe is still reached on day 365.
- For initial HRA timeframe, the effective enrollment date is day 0, and the next calendar day is day 1.

- When an HRA has been completed, the annual reassessment HRA is due no more than 365 calendar days after the most recent completed HRA. When an initial HRA is completed within the initial HRA timeframe before the effective enrollment date, the first annual reassessment HRA is due no more than 365 calendar days after the initial HRA completion date. If the 365-day reassessment timeframe, calculated from the initial HRA completion date, is reached during the CY in which the effective enrollment date falls, the first annual reassessment HRA is due during that CY.
- There are situations when an enrollee may be reported under both Element A and Element B in the same CY because the enrollee is new for Element A purposes and the applicable 365-day reassessment timeframe is reached during the same CY for Element B purposes.
 - Example: The effective enrollment date is January 1, 20XX and the initial HRA was completed in November 20XX - 1. The initial HRA is counted in CY 20XX because the effective enrollment date falls in CY 20XX. The first annual reassessment HRA is due in November 20XX because the 365-day reassessment timeframe is measured from the initial HRA completion date. The enrollee should be reported under Element A and B for CY 20XX. The initial HRA should be reported under Element C for CY 20XX. If the annual reassessment HRA is completed, refused, or not performed because the SNP is unable to reach the enrollee, the enrollee may also be reported under Element F, G, or H, as applicable.
- An HRA may be reported before an individualized care plan (ICP) is completed.
- An HRA completed after the applicable 365-day reassessment timeframe is considered late for timing purposes. A late completed HRA resets the enrollee's next reassessment due date but does not count as a completed reassessment under Element F for the missed reassessment cycle.
 - Example: An enrollee's reassessment HRA is due on 5/15/20XX, but the plan does not complete the HRA by that date. The plan subsequently completes an HRA on 2/2/20XX + 1. The 2/2/20XX + 1 HRA is late because it was completed after the 5/15/20XX deadline. The enrollee should not be reported under Element F for this missed 5/15/20XX reassessment cycle based on the 2/2/20XX + 1 HRA. However, the 2/2/20XX + 1 HRA resets the enrollee's reassessment timeline, and the next HRA is due no more than 365 calendar days after 2/2/20XX + 1. If the plan completes another HRA on 5/1/20XX + 1, the enrollee may be reported under Element F for CY 20XX + 1.
- For purposes of determining the enrollee's next reassessment due date, the most recent completed HRA controls, regardless of whether the HRA was completed

timely. A refusal or unable-to-reach status does not reset the 365-day reassessment timeframe.

What Constitutes a Completed HRA for Reporting

- HRA content requirements must comply with 42 CFR § 422.101(f)(1)(iii). For D-SNPs that are applicable integrated plans (AIPs) as defined at 42 CFR § 422.561, HRAs must comply with 42 CFR § 422.101(f)(1)(v).
- For reporting under this section, a completed HRA must include direct enrollee and/or caregiver input. HRAs based only on claims and/or other administrative data should not be counted or reported.
- For Elements C and F, an HRA is considered complete for reporting when it is received by the MA organization with any degree of completion, provided the answers received are informed by the enrollee and/or caregiver. For example, an HRA is considered complete for reporting if the MA organization receives it with only one or two portions of the HRA tool answered by the enrollee or caregiver. However, please note that this reporting standard does not alter the comprehensive HRA content requirements at 42 CFR § 422.101(f)(1)(iii) or § 422.101(f)(1)(v) as applicable for AIP D-SNPs.
- This reporting section excludes canceled enrollments.
- A canceled 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 received by the MA organization and considered complete for reporting is the completed date of the HRA.

Multiple events during a Contract Year

- An enrollee cannot be counted more than once in the same data element for the same plan in the same CY. All applicable events for an enrollee should be reported separately when the criteria for the data element are met. Examples:
 - If an enrollee completes more than one reassessment HRA during the CY, the plan should report the enrollee only once under Element F, based on the most recent reassessment HRA completed during the CY.

- An enrollee's annual reassessment HRA is due on 8/30/20XX. The SNP completes the required outreach and sends a follow-up letter by 7/1/20XX. The HRA is completed on 8/20/20XX. Report the enrollee under Element B and F, but not under Element H, based on that outreach, because the reassessment was completed timely.
- When multiple HRA status categories occur for the same enrollee during the CY, the plan should report each applicable status category when the criteria for the data element are met. Within a single data element, the enrollee may not be counted more than once for the same plan in the same CY. For Elements E and H, do not report unable-to-reach status if the HRA associated with the outreach was completed within its applicable timeframe. Apply this rule before determining the reporting year and selecting the latest reportable status for each element.
- For purposes of this subsection, HRA status categories are reportable events and include:
 - Completed HRA for reporting, as described in What Constitutes a Completed HRA for Reporting (Elements C or F)
 - Refusal (Elements D or G)
 - Unable to be reached (Elements E or H)
- Refusal and unable-to-reach statuses should be tied to the initial or annual HRA the SNP was attempting to complete.
- For reporting purposes, a refusal or unable-to-reach status should be reported once, in the later of:
 - The CY in which the related initial HRA timeframe ends or the applicable 365-day reassessment timeframe is reached; or
 - The CY in which the enrollee refuses to participate or the SNP completes and documents the outreach and follow-up process required to report the enrollee as unable to be reached.
- Outreach attempts used to support an unable-to-reach status do not all need to occur in the same CY.
- A refusal or unable-to-reach status should not be reported before the CY in which the related initial HRA timeframe ends or the applicable 365-day reassessment timeframe is reached.
- If the SNP records more than one refusal or more than one unable-to-reach status for the same enrollee under the same data element during the CY, the SNP should report the enrollee only once under the data element, using the latest refusal or unable-to-reach status for that data element.

- This rule prevents duplicate counting within the same data element. It does not preclude reporting the same enrollee under more than one data element during the CY when the criteria and documentation requirements for each data element are met.

Reporting Enrollees Who Are Unable to be Reached

- Outreach requirements for both initial and annual HRAs must comply with 42 CFR § 422.101(f)(1)(iv)(A) through (C).
- Outreach attempts and the follow-up letter used to support unable-to-reach reporting must relate to the initial or annual HRA the SNP was attempting to complete.
- For reporting purposes, allowable non-automated outreach methods may include phone calls, text messaging, or electronic medical record messages, provided the method allows the SNP representative to perform or schedule the HRA when the enrollee is reached.
- For purposes of reporting under Elements E and H, an enrollee may be reported as unable to be reached only if the SNP has documentation showing that the enrollee did not respond after the SNP satisfied the outreach and documentation requirements under 42 CFR § 422.101(f)(1)(iv)(A) through (C).
- If the SNP reaches the enrollee before the unable-to-reach criteria are met, the enrollee should not be reported as unable to be reached for that outreach event.
- If the enrollee refuses to participate, the refusal should be reported under Element D or G, as applicable, using the refusal reporting guideline in Multiple Events During a Contract Year.
- If the enrollee agrees to participate but the HRA is not completed, the agreement alone is not a reportable HRA status. Report the enrollee under the applicable data element only if a reportable status later occurs.
- If the HRA is later completed, report the enrollee under Element C or F, as applicable. If the enrollee later refuses to participate or the SNP later satisfies the unable-to-reach criteria, report the refusal or unable-to-reach status using the reporting-year guideline in Multiple Events During a Contract Year.
- An enrollee may not be counted more than once in the same data element for the same plan in the same CY.
- Documentation supporting reporting under this subsection must be retained and made available to CMS upon request.

Eligibility Determination

- A SNP should not perform or report an HRA before the beneficiary has been determined eligible to enroll in the SNP. This does not prohibit an otherwise valid initial HRA completed before the effective enrollment date.
- 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.

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

For re-enrollment and disenrollment scenarios, reporting depends on whether the beneficiary re-enrolls into the same plan, a different plan under the same contract, or a plan under a different contract, sponsor, or parent organization.

Same Plan Re-Enrollment

- If a beneficiary disenrolls from and re-enrolls into the same plan, reporting depends on whether an HRA was previously completed:
 - If an initial HRA was not completed prior to disenrollment, the beneficiary should be treated as a new enrollee, and the initial HRA timeframe begins again from the date of re-enrollment.
 - A beneficiary enrolls in a SNP with an effective date of 1/1/20XX, but disenrolls on 2/15/20XX without completing an initial HRA. The beneficiary later re-enrolls into the same plan with an effective date of 4/1/20XX. The beneficiary should be treated as a new enrollee, and the initial HRA timeframe begins on 4/1/20XX.
 - If an HRA, whether initial or reassessment, was completed prior to disenrollment and is within 365 days of the re-enrollment date, the plan may use the previous HRA completion date to determine when the next reassessment HRA is due.

- A beneficiary completes an HRA on 6/1/20XX and disenrolls from the plan on 10/1/20XX. The beneficiary re-enrolls into the same plan on 12/1/20XX. Because the prior HRA was completed within 365 days, the plan may use the 6/1/20XX HRA completion date to determine the next reassessment due date.
 - If the previous HRA is more than 365 days old at the time of re-enrollment, the enrollee is considered due for a reassessment HRA, and the plan should complete the HRA. The plan should determine Element B reporting based on the applicable 365-day reassessment timeframe and report the enrollee under Element F, G, or H, as applicable.
- This Same Plan Re-Enrollment guidance applies when there is an actual disenrollment and re-enrollment. It does not apply to enrollees who remain continuously enrolled through a consolidation, merger, or crosswalk described in the Mergers, Consolidations, and Crosswalks subsection.

Different Contract, Sponsor, Parent Organization

- Except for enrollees described under Mergers, Consolidations, and Crosswalks, 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.

Same Contract – Different PBP

- A beneficiary who changes between SNP PBPs under the same contract in the same CY should only be counted in one PBP's data for the same data element.
- The PBP that completed the HRA should report the enrollee under Element C or Element F, as applicable.
- The receiving PBP should not report the previously completed HRA but may use the HRA completion date to determine when the beneficiary is due for the next reassessment HRA.
- For Elements A and B, the MA organization should report the enrollee under only one PBP for the same data element in the same CY.
- Reporting an enrollee under Element A or Element B does not require the enrollee to also be reported under a related HRA status category during the CY.
- If a related HRA status category is reported during the CY, the MA organization should report the related population element under the same PBP that reports the related HRA status category. For Element A, related HRA status categories are Elements C, D, and E. For Element B, related HRA status categories are Elements

F, G, and H. The enrollee may not be counted more than once in the same data element in the same CY.

- For Element G, the related HRA status category should be assigned to the PBP in which the annual reassessment refusal occurred. For Element H, the related HRA status category should be assigned to the PBP that completed and documented the unable-to-be reached and follow-up process. If the refusal or unable-to-reach status is reported in a later CY under Multiple Events During a Contract Year, follow the same PBP assignment guideline.
- If no related HRA status category is reported for the enrollee during the CY, the MA organization should report Element A under the PBP in which the enrollee was enrolled when the initial HRA timeframe ended and should report Element B under the PBP in which the enrollee was enrolled when the applicable 365-day reassessment timeframe was reached. If the applicable 365-day reassessment timeframe was reached before the CY and the enrollee remains due during the CY, the MA organization should report Element B under the PBP in which the enrollee was enrolled on the first day of the CY, or on the first day the enrollee was enrolled under the contract during the CY.
 - Example: Plan 001 completes an HRA for an enrollee on 3/1/20XX. The enrollee transfers to Plan 002 under the same contract on 7/1/20XX. Plan 001 may report the enrollee under Element F. If the enrollee meets Element B criteria for the CY, the MA organization should report the enrollee under Element B in Plan 001's data. Plan 002 should not report the previously completed HRA but may use the 3/1/20XX completion date to determine when the next reassessment HRA is due.

Mergers, Consolidations, and Crosswalks

- Enrollees who remain continuously enrolled under the same MA organization or parent organization through a consolidation, merger, or crosswalk are not treated as new enrollees solely because of the consolidation, merger, or crosswalk. This guidance also applies to enrollees who were crosswalked from a non-renewing D-SNP PBP under a broader MA contract to a D-SNP-only contract per 42 CFR § 422.107(e).
- Enrollees who received an initial or reassessment HRA before the consolidation, merger, or crosswalk should not be required to participate in a second initial HRA. The surviving or receiving plan should use the most recent completed HRA date to determine when the next reassessment HRA is due.
- Enrollees who did not complete an initial HRA before the consolidation, merger, or crosswalk should be reported based on the enrollee's original effective enrollment

date, not the effective date of the consolidation, merger, or crosswalk. If the initial HRA timeframe has not ended, the surviving or receiving plan should use the remaining time in the original initial HRA timeframe.

- If the initial HRA timeframe has ended and no initial HRA was completed, the enrollee should not be reported under Element C based on the consolidation, merger, or crosswalk. The enrollee should be reported under the applicable data element based on the enrollee's status and the applicable HRA timeframe.
- Enrollees who are due or overdue for an annual reassessment HRA at the time of the consolidation, merger, or crosswalk should be reported based on the most recent completed HRA date, or the original effective enrollment date if no HRA has been completed. The consolidation, merger, or crosswalk does not reset the 365-day reassessment timeframe.

Section VII. Rewards and Incentives Programs (Part C)

- An MA organization user needs to select "Yes" or "No" for Element A on the HPMS file upload page. If the MA organization user selected "No," no file upload is necessary. If the MA organization 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 VIII. Payments to Providers (Part C)

- Decimal values are allowed only for A-S elements where payment dollar amounts are entered and may include up to two decimal places.
- Unless otherwise noted, zero entry is allowed; a negative value entry is not allowed. If the calculation results in a negative amount, report as zero.
- For more information on guidance for Covered Lives document refer to <https://hcp-lan.org/workproducts/APM-Measurement/Guidance-for-measuring-covered-lives.pdf>
- 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 Elements U–KK (provider counts), when a provider is paid using multiple payment arrangements that fall into more than one category, the MA organization should count the provider under the category that represents the provider's dominant payment arrangement. For Elements B–S (payment dollars), MA organization should report payments in the applicable payment category based on how the payments were made.
- 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.
- MA organizations 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.

- MA organizations 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, MA organizations 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 IX. Supplemental Benefit Utilization and Costs (Part C)

PBP Category Codes

Data elements must be reported for each of the following supplemental benefits that the plan indicated it would offer in the PBP:

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*
14c4d	Fitness Benefit – Fitness Equipment or Kit*
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
18b3	Prescription Hearing Aids – Outer Ear

PBP Category	Supplemental Benefit
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 III Other 1
13i12	Non-Primarily Health Related Benefits for the Chronically III Other 2
13i13	Non-Primarily Health Related Benefits for the Chronically III Other 3
13i14	Non-Primarily Health Related Benefits for the Chronically III Other 4
13i15	Non-Primarily Health Related Benefits for the Chronically III 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 III (SSBCI).

Specifications

- Report
 - Report only those supplemental benefits furnished within the contract year (CY) for which the reporting period applies.
- MA organizations should report on benefits in accordance with how the PBP was submitted. If the MA organization noted in the PBP that they would cover 10 supplemental benefits, the MA organization must submit Reporting Requirements data for all 10 of those benefits, even if no enrollees utilized the benefits.
- If a PBP did not offer any supplemental benefits for the CY, then the PBP ID should not be included in reporting.
- For PBP waiver categories (i.e., 2-3 “SNF – Waiver of 3 Day Hospital Stay” and 9d-1 “Three (3) Pint Deductible Waived”) MA organizations should report \$0 for costs, if no costs are associated with these benefits.
- 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 MA organizations should only report on costs/utilization for services which were approved. In cases where the supplemental benefit coverage was denied, MA organizations 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.”
- When Element A is “POS” or “VT”, MA organizations should report on the combination of all Medicare covered services with Point of Service coverage or Visitor/Travel coverage when reporting Elements B-N. When Element A is “POS”, then Element C should be out-of-network (for HMO-POS). When Element A is “VT”, then Element C should be Visitor/travel. When Element A is a non-Medicare covered service (e.g. 17a1 (Routine Eye Exams)), then MA organizations could report out-of-network (for HMO-POS) or Visitor/travel in Element C if this service is covered with Point of Service coverage or Visitor/travel coverage.

- If no enrollees utilized a benefit that was offered, MA organizations may report zero for Elements G, H, I, J, K, M and N, but submit information for other elements. Even if no enrollees used the benefit, report data for Element E indicating what unit of utilization would have been used to measure the benefit if a beneficiary had used it. Additionally, even if no enrollees used the benefit, report data for Element L indicating the type of payment arrangement(s) that was used to implement the benefit.
 - If a benefit had no utilization, but the MA organization still incurred a cost to offer the benefit, enter data accordingly in Elements J and K.
- Since a plan may offer a PBP category more than one way (Element B) and in more than one network type (Element C), report each element specific for the unique combination of PBP category/offer type/network type.
- For Element E, only submit one unit of utilization for each PBP category.
- For Element F:
 - Include all enrollees who were eligible per the plan's internal eligibility criteria. This should include the criteria that the plan uses to determine which enrollees meet the 3-pronged statutory chronically ill enrollee requirements¹, and any additional eligibility criteria for each benefit that allow it to meet the requirement² that the benefit has reasonable expectation of improving or maintaining the health or overall function of the enrollee. Refer to the 2027 Final Rule for additional information³.
 - 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.
- Decimals are not allowed in any numeric data elements.
 - If the median amount calculated for Element I 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.
 - Similarly, a 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 J:

¹ Refer to Section 1852(a)(3)(D)(iii) of the Social Security Act (The Act)

² Refer to Section 1852(a)(3)(D)(ii)(I) of the Act

³ Refer to 91 FR 17479 (<https://www.govinfo.gov/content/pkg/FR-2026-04-06/pdf/2026-06600.pdf>)

- 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.
- This measure should include direct costs only. If administrative costs are unable to be separated from direct costs, they may be included. For example, if a plan pays a PMPM cost to a vendor for a benefit with an undefined 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 J for each dental benefit ($2000/16=125$).
- For Element K, be as specific as possible in completing this narrative field. CMS has not been prescriptive in guidance to allow MA organizations latitude in describing how they measure costs in the most accurate way possible. If you believe your calculation of Element J 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 K: CMS will not voluntarily release data collected under this element to the public, either individually or in the aggregate.
- For Element L, if a plan uses multiple listed payment arrangements, they should enter “Hybrid” for this field. However, if the payment arrangement does not neatly fit into the first four listed options, the plan should use the “Other” response option.
- The objective of Element M 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 M should be a sum of all enrollee out-of-pocket costs for a service category, broken down by Element B and C.

- 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.
- For Element O, plans must enter a value to indicate if a benefit was administered through a debit card. For example, if a plan administered both in-network and out-of-network coverage for a Food and Produce benefit through a debit card, the plan should answer Y (yes) in two lines of data (once for in-network coverage, and once for out-of-network coverage).

Section X. D-SNP Enrollee Advisory Committee (Part C)

- 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 MA organization 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.
- Element B:
 - Is this PBP designated to respond for all D-SNPs sharing the same EAC? (Yes or No only)
 - If Element A = Yes, then is this PBP designated to respond for all D-SNPs sharing the same EAC? (Yes or No only)
 - If Element A = No, then leave Element B blank
- Element C:
 - What is the PBP designated to respond for all D-SNPs sharing the same EAC? (e.g., HXXXX-001)
 - If Element B = No, then What is the PBP designated to respond for all D-SNPs sharing the same EAC? (e.g. HXXXX-001).
 - If Element B = Yes or blank, then leave Element C blank
- Element D:
 - Provide the total number of D-SNP EAC meetings held during the measurement year.
 - If Element A = Yes and Element B = No, then all elements, including Element D below, will be left blank.
 - If Element D = 0, then leave all elements below (E-G) blank.

Section XI. D-SNP Transmission of Admission Notifications (Part C)

- 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.
- If the D-SNP did not transmit any notifications directly to the state or state-designated entity during the measurement year, report Data Element B as 0.
- If another entity (e.g., a facility) transmits admission notifications to the state on behalf of the D-SNP, the D-SNP must obtain the notification data from that entity to fulfill the reporting requirement per 42 § CFR 422.107(d)(1). Only notifications transmitted to the state or state-designated entity should be counted.
- Notifications transmitted between health plans (e.g., via SFTP between plans) that are not directed to the state or state-designated entity should not be included in the count for Data Element B.

Section XII. Medication Therapy Management Programs (Part D)

- 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 prior to their MTM enrollment date should not be reported.
 - Beneficiaries who were retroactively disenrolled prior to their MTM enrollment date and received MTM services 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 K. Do not report end of year disenrollments (such as 12/31).
- When reporting the MTM program opt-out reason in Element K, 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 M), Date(s) of CMR(s) (Element O) and Date CMR written summary in CMS standardized format was provided or sent (Element P) must be on or after the Date of MTM program enrollment (Element G). 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 N, O, W, X, and Y 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 N).
- The Method of delivery for the annual CMR (Element Q) 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 S)]. 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 N should be reported as “N” and Elements O, P, Q, R, and S 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 N should be reported as “Y” and Element P 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 V) 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 X) and method of delivery for information (Element Y) regarding safe disposal of medications, the beneficiary must receive the information. Therefore, returned mail does not count as received.
- Safe disposal communications (Elements X and Y) 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 T 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 XIII. Improving Drug Utilization Review Controls (Part D)

- 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 made multiple opioid safety edits submissions 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 CC, 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 DD.
- 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.ncdp.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 GG 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 EE only the beneficiaries that are included in Element Z.

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Section XIV. Medicare Prescription Payment Plan (Part D)

- Refer to [Medicare Prescription Payment Plan Guidance](#) for more information and definitions of terms such as “likely to benefit.”
- If an enrollee submits a Medicare Prescription Payment Plan election request but subsequently withdraws the request before the request is approved or denied, Part D sponsors should exclude that election request from reporting.
- 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) 2026 out-of-pocket costs, such that they would otherwise be identified as “likely to benefit” prior to the plan year for CY 2027 but the beneficiary is already a program participant for CY 2026, 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 2027 Reporting Requirements should capture activities associated with program participation in CY 2027.
 - 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 2027 plan year that take place before the reporting period begins on January 1, 2027, 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 2027 after October 15, 2026, and prior to January 1, 2027. This enrollee's election request should be reported in Element E and Element F.

- Any election requests submitted on or after October 15, 2027, for a January 1, 2028, effective date, or prior to plan year likely to benefit identification in advance of the CY 2028 plan year, should not be reported with the CY 2027 data. These election requests should be reported with CY 2028 data.
- Any election requests submitted on or after October 15, 2027, through December 31, 2027, for participation in CY 2027 should be reported with CY 2027 data.
- Beneficiaries who participated in the program through the end of CY 2026 and whose participation in the program was automatically renewed for CY 2027 should not be counted in Element F. Element F should report new election requests for the 2027 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 12/31/2027, even if the billing and collection period extends beyond 12/31/2027. For example, if a beneficiary fills a prescription on December 12, 2027, is billed in mid-January 2028, and pays their bill in early February 2028, 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 2028, 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, 2027 and opts into the Medicare Prescription Payment plan in March 2027 but subsequently cancels the plan taking effect April 1, 2027, 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).