Medicare Part D Plan Reporting Requirements:
Technical Specifications Document
Contract Year 2014

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Introduction

The Part D Plan Reporting Requirements document provides a description of the reporting sections, reporting timeframes and deadlines, and specific data elements for each reporting section. The document has completed OMB review and approval in compliance with the Paper Reduction Act of 1995, and its OMB control number is #0938-0992. The document is located in HPMS under "In the News", and posted on the CMS website.

For CY2014, numerous revisions were made to the Part D Plan Reporting Requirements.

Data Elements were revised or removed for the following reporting sections:

- Medicare Therapy Management (MTM) Programs,
- Grievances,
- Coverage Determinations and Redeterminations,
- Employer/Union-Sponsored Group Health Plan Sponsors, and
- Plan Oversight of Agents

The final CY2014 Reporting Requirements incorporates all of these changes. These technical specifications supplement the Part D Plan Reporting Requirements, and do not change, alter, or add to the data collection described above. They serve to further define data elements and alert Sponsors to how CMS will review and analyze these data.

The purposes of these technical specifications are to help assure a common understanding of the data to be reported by Sponsors, to assist Sponsors in preparing and submitting datasets, to ensure a high level of accuracy in the data reported to CMS, and to reduce the need for Sponsors to correct and resubmit data.

Each Part D reporting section is listed in this document with information regarding the following subjects.

A. Data element definitions - details for each data element reported to CMS, including examples, methods for calculations, and how various data elements are associated.

B. QA checks/Thresholds - procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

C. Edits and Validation Checks - validation checks that should be performed by each Part D Sponsor prior to data submission.

D. Analysis- how CMS will evaluate reported data, as well as how other data sources may be monitored.

E. Notes - additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

General Information

Level of Data to be Reported

The level of reporting for each reporting section is specified in the reporting requirements document and within each reporting section in HPMS. Sponsor-level reporting indicates data may be submitted from an organization that is associated with more than one CMS-issued Part D contract. Contract-level reporting indicates data should be entered at the H#, S#, R#, or E# level. Plan-level reporting indicates data should be entered at the PBP level, (e.g. Plan 001 for contract H#, R#, S#, or E). Plan-level reporting is necessary to conduct appropriate oversight and monitoring of some areas.

A summary of the reporting level required for each reporting section is below.

REPORTING REQUIREMENT SECTION	LEVEL OF REPORTING
Enrollment and Disenrollment	Contract
Retail, Home Infusion, and Long Term Care Pharmacy Access	Contract (Section I) Plan (Sections II and III)
Medication Therapy Management (MTM) Programs	Contract
Prompt Payment by Part D Sponsors	Contract
Grievances	Contract
Coverage Determinations and Redeterminations	Contract
Long-Term Care (LTC) Utilization	Contract
Fraud, Waste and Abuse Compliance Programs	Contract
Employer/Union-Sponsored Group Health Plan Sponsors	Plan
Plan Oversight of Agents	Contract

Timely submission of data

Compliance with these reporting requirements is a contractual obligation of all Part D Sponsors. Compliance requires that the data not only be submitted in a timely manner, but that they also are accurate. Data submissions are due by 11:59 p.m. Pacific time on the date of the reporting deadline.

Please note the quarterly reports are now due annually and will be available in HPMS on or after 12/29/2014. Sponsors should generate these reports at the end of each quarter of the contract year and hold them for the annual submission.

Only data that reflect a good faith effort by a Sponsor to provide accurate responses to Part D reporting requirements will count as data submitted in a timely manner. Sponsors must not submit “placeholder” data (e.g., submitting the value “0” in reporting fields in HPMS). Sponsors can expect CMS to rely more on compliance notices and enforcement actions in response to reporting requirement failures. Therefore, CMS may issue warning notices or requests for corrective action plans to non-compliant Sponsors. Should the non-compliance persist, CMS may impose intermediate sanctions (e.g., suspension of marketing and enrollment activities) or civil monetary penalties pursuant to Subpart O of 42 C.F.R. Part 423 or contract termination pursuant to Subpart K of 42 C.F.R. Part 423.

If previously submitted data are incorrect, Part D Sponsors should request the opportunity to correct and resubmit data. Part D Sponsors are, responsible for correcting previously submitted data if it is determined the data were erroneous. If CMS changes the technical specifications during the contract year, which requires a change in reporting methodology, CMS is requiring that reports be regenerated for the prior reporting periods for Part D reporting. In order to accommodate data validation activities, data corrections may only be submitted until March 31st following the last quarter or end of year reporting deadline.

Once a reporting deadline has passed, CMS requires the Part D Sponsor to submit a formal request to resubmit any data. HPMS designates this request as a Request Resubmission. Requests for resubmissions will only be approved for 7 days from the date the request is reviewed and approved by CMS. Sponsors should not submit requests to resubmit data until they have data available to submit. Data submitted after the given reporting period deadline shall be considered late, and may not be incorporated within CMS data analyses and reporting. HPMS will not allow the resubmission of data that are identical to the original data submission.

CMS tracks resubmissions, including the number of resubmissions after the deadline. Failure to resubmit after requesting a resubmission is considered as overdue. CMS expects that data are accurate on the date they are submitted. Data resubmissions may only be submitted until March 31st following the last quarter or end of year reporting deadline. CMS urges Plans to store revised data for CMS auditors and data validation reviewers. Plans should retain documentation supporting their reported data.

The following steps must be followed by a Part D Sponsor to request resubmission:

1. On the HPMS Part D Plan Reporting Start Page, click the Resubmission Request link.
2. Select/complete the following:
    a. Reporting section (e.g. Redeterminations);
    b. Time period (e.g., 1st quarter 2014);
    c. Select contracts or plans, depending on reporting level; and
    d. The reason for the resubmission request.
3. CMS will review the information provided and either accept or reject the request for resubmission.

General Data Entry Rules

HPMS will not allow the entry of greater than sign (>); less than sign (<); or semi-colon (;) in any data entry field or uploaded file.
Unless otherwise noted,

- the entry of a zero is allowed,
- the entry of a negative is not allowed, and
- decimals are not allowed.

General Data File Upload Rules

Please note that each time a data file submission is made, the previously submitted file will be ignored, regardless if the second file submission successfully passes validation.

Exclusions from Reporting

The Part D reporting requirements apply to Part D Sponsors offering the Part D benefit, including PDPs and MA-PDs. They do not apply to MA only Plans. Data relating to Part B claims are excluded from these Part D reports, unless otherwise specified (e.g., Coverage Determinations and Redeterminations reporting). MA Organizations and Medicare Cost Plans that offer Part D benefits will be required to comply with all reporting requirements contained herein, with the exception of the Employer/Union-Sponsored Group Health Plan Sponsors reporting section, and the Plan Oversight of Agents reporting section. PACE Organizations are excluded from these Part D reporting requirements. Contracts that terminate during the reporting period are also excluded from these reporting requirements.

Medicare/Medicaid Plans (MMP) offering Part D benefits will be required to comply with all reporting requirements contained herein, with the exception of the Retail, Home Infusion and Long-Term Care Pharmacy Access, and Employer/Union-Sponsored Group Health Plan Sponsors reporting sections.

Based on the information in the Reporting Requirements document and these Technical Specifications, Plans/Sponsors should report data based on interpretation of these documents and be able to support their reporting decisions.

Contracts with no enrollment have the option of reporting for the following sections: Enrollment/Disenrollment; Grievances; Coverage Determinations and Redeterminations; LTC Utilization; Employer/union-Sponsored Group Health Plan Sponsors.

A contract is considered to have no enrollment if the contract has no enrollees for all months within the reporting period. If a contract has any enrollees during the reporting period, it is NOT considered to have no enrollment.

General questions about Part D reporting requirements should be sent via email to: partd-planreporting@cms.hhs.gov.

I. Enrollment and Disenrollment

A. Data element definitions – details for each data element reported to CMS, including examples, methods for calculations, and how various data elements are associated.

1. Enrollment

Data elements to be entered into the HPMS at the CMS Contract level:

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of enrollment requests received.	The total number of enrollment requests received in the specified time period.	• Field type: Number. • Note – this element is based on initial receipt date, not effective date.
B.	Total number of enrollment requests complete at the time of initial receipt (i.e. required no additional information from applicant or his/her authorized representative).	Of the total reported in A, the number of enrollment requests complete at the time of initial receipt (i.e. required no additional information from applicant or his/her representative).	• Field type: Number. • Is a subset of A.
C.	Total number of enrollment requests for which the Sponsor was required to request additional information from the applicant (or his/her representative).	Of the total reported in A, the number of enrollment requests for which the Sponsor was required to request additional information from the applicant (or his/her representative). Do not report as a distinct enrollment request information received from an applicant in response to a request for information necessary to complete an enrollment request.	• Field type: Number. • Is a subset of A.
D.	Total number of enrollment requests denied due to the Sponsor's	Of the total reported in A, the number of enrollment requests denied due to the Sponsor's determination of the applicant's ineligibility to elect	• Field type: Number. • Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
	determination of the applicant's ineligibility to elect the plan (i.e. individual not eligible for an election period).	the plan (i.e. individual not eligible for an election period.)	
E.	Number of incomplete enrollment requests received that are completed within established timeframes.	Of the total reported in C, the number of incomplete enrollment requests received that are incomplete upon initial receipt and completed within established timeframes.	• Field type: Number. • Is a subset of C.
F.	Number of enrollment requests denied due to the applicant or his/her authorized representative not providing information to complete the enrollment request within established timeframes.	Of the total reported in C, the number of enrollment requests denied due to the applicant or his/her authorized representative not providing information to complete the enrollment request within established timeframes.	• Field type: Number. • Is a subset of C.
G.	Number of paper enrollment requests received.	Of the total reported in A, the number of paper enrollment requests received.	• Field type: Number. • Is a subset of A.
H.	Number of telephonic enrollment requests received (if offered).	Of the total reported in A, the number of telephonic enrollment requests received (if Sponsor offers this mechanism).	• Field type: Number. • Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
I.	Number of internet enrollment requests received via plan website (if offered).	Of the total reported in A, the number of internet enrollment requests received via plan website (if Sponsor offers this mechanism).	• Field type: Number. • Is a subset of A.
J.	Number of Online Enrollment Center (OEC) enrollment requests received.	Of the total reported in A, the number of Medicare Online Enrollment Center (OEC) enrollment requests received.	• Field type: Number. • Is a subset of A.
K.	Number of enrollment requests effectuated by sales persons (as defined in Chapter 3 of the Medicare Managed Care Manual).	Of the total reported in A, the number of enrollment requests effectuated by sales persons (as defined in Chapter 3 of the Medicare Managed Care Manual).	• Field type: Number. • Is a subset of A. • For stand-alone PDPs only.
L.	Number of enrollment transactions submitted using the SEP Election Period code “S” related to creditable coverage.	Of the total reported in A, the number of enrollment transactions submitted using the SEP Election Period code “S” for individuals who involuntarily lose creditable coverage or who were not adequately informed of a loss of creditable coverage or that they never had creditable coverage.	• Field type: Number. • Is a subset of A.
M.	Number of enrollment transactions submitted using the SEP Election Period code “S” related to SPAP.	Of the total reported in A, the number of enrollment transactions submitted using the SEP Election Period code “S” for individuals who belong to a Qualified SPAP or who lose SPAP eligibility.	• Field type: Number. • Is a subset of A.
N.	Number of enrollment	Of the total reported in A, the number of enrollment	• Field type: Number. • Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
	transactions submitted using the SEP Election Period code "S" that coordinates with the Medicare Advantage Disenrollment Period.	transactions submitted using the SEP Election Period code "S" that coordinates with the Medicare Advantage Disenrollment Period.	• For stand-alone PDPs only.
O.	Number of enrollment transactions submitted using the SEP Election Period code "S" for individuals affected by a contract nonrenewal, plan termination or service area reduction.	Of the total reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" for individuals affected by a contract nonrenewal, plan termination or service area reduction.	• Field type: Number. • Is a subset of A.

2. Disenrollment

Data elements to be entered into the HPMS at the CMS Contract level:

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of voluntary disenrollment requests received in the specified time period.	The total number of voluntary disenrollment requests received in the specified time period.	• Field type: Number. • Note – this element is based on initial receipt date, not effective date.

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of disenrollment requests complete at the time of initial receipt (i.e. required no additional information from enrollee or his/her authorized representative).	Of the total reported in A, the number of disenrollment requests complete at the time of initial receipt (i.e. required no additional information from enrollee or his/her representative).	• Field type: Number. • Is a subset of A.
C.	Total number of disenrollment requests denied by the Sponsor for any reason.	Of the total reported in A, the number of disenrollment requests denied by the Sponsor for any reason.	• Field type: Number. • Is a subset of A.

B. QA checks/Thresholds - procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.
   - CMS' outlier notifications serve only to give Part D sponsors the opportunity to correct submitted data if needed, and does not indicate that submitted data are incorrect, or that resubmissions are required.
   - The percent of enrollment requests denied by the contract will be examined for outlier data. After accounting for the number of enrollment requests filed, contracts with values above the 95th percentile for their contract type will be flagged as outliers.
   - The percent of disenrollment requests denied by the contract will be examined for outlier data. After accounting for the number of disenrollment requests files, contracts with values above the 95th percentile for their contract type will be flagged as outliers.
   - CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from Part D Plans.

C. Edits and Validation Checks - validation checks that should be performed by each Part D Sponsor prior to data submission.
   - N/A.

D. Analysis- how CMS will evaluate reported data, as well as how other data sources may be monitored.
   - To be determined.

E. Notes – additional clarifications to a reporting section.

1. EGWPs and all-800 series plans are waived from this reporting section. For contracts with both non 800-series and 800-series plans, data for the 800-series plan(s) may be excluded.
2. Data are based on enrollment requests or submitted transactions. Auto-assignments should not be included in these data.
3. Reporting should include all enrollment requests received during the period, including those which may subsequently "fail" after the period, and/or reporting deadline.
4. Enrollment/disenrollment cancellations should not be included in this reporting.
5. Voluntary disenrollment TRCs should not be included in this reporting.
6. HPMS displays one module for reporting both Part C and Part D Enrollment/Disenrollment data.

II. Retail, Home Infusion, and Long Term Care Pharmacy Access

A. Data element definitions – details for each data element reported to CMS, including examples, methods for calculations, and how various data elements are associated.

I. Retail Pharmacy Access, Home Infusion (HI), and Long Term Care (LTC) Pharmacy Access: Three data files to be uploaded through the HPMS at the CMS Part D Contract level.

- Required File Format is ASCII File - Tab Delimited.
- The file name extension should be ".TXT"
- File name=Pharmacies_ (RT, HI or LTC)_(CONTRACTNAME)_(CONTRACTYEAR).txt
- Replacing '(RT, HI or LTC) with the corresponding type of pharmacies
- Pharmacies_(RT)_(CONTRACTNAME)_(CONTRACTYEAR).txt
- Pharmacies_ (HI)_(CONTRACTNAME)_(CONTRACTYEAR).txt
- Pharmacies_ (LTC)_(CONTRACTNAME)_(CONTRACTYEAR).txt
- And also replacing (CONTRACTNAME)' with the Part D Contract's name, and CONTRACTYEAR) with the year.
- Plans are required to submit data for their entire service area, even if there are no HI and/or LTC pharmacies in specific territories/states.

Retail Record Layout

Field Name	Field Type	Maximum Field Length	Field Description	Sample Field Value(s)
NPI_Number	CHAR Always Required	Exactly 10	Indicate the contracted Retail pharmacy NPI number (exactly 10 digits).	1234567809
Pharmacy_Name	CHAR Always Required	150	Provide the name of the Retail pharmacy.	CVS Pharmacy
Pharmacy_Street_Address	CHAR Always Required	150	Enter the street address of the pharmacy.	1212 North Luther Street
Pharmacy_City_Address	CHAR Always Required	75	Enter the city in which the pharmacy is located.	Wichita
Pharmacy_State_Address	CHAR Always Required	2	Enter the state abbreviation in which the pharmacy is located.	MO

Field Name	Field Type	Maximum Field Length	Field Description	Sample Field Value(s)
Pharmacy_Zip_Address	CHAR Always Required	Exactly 5 or Exactly 10	Enter the pharmacy's zip code.	22203 or 22203-1234
Pharmacy_Network_Type_PN	CHAR Always Required	1	Is the pharmacy network preferred?	P = Preferred N = Non-Preferred
Chain_YN	CHAR Always Required	1	Is the pharmacy a chain?	N = No Y = Yes
Independent_YN	CHAR Always Required	1	Is the pharmacy independent?	N = No Y = Yes
Group_Purchasing_YN	CHAR Always Required	1	Does the pharmacy allow group purchasing?	N = No Y = Yes

Home Infusion Record Layout

Field Name	Field Type	Maximum Field Length	Field Description	Sample Field Value(s)
NPI Number	CHAR Always Required	Exactly 10	Indicate the contracted Home Infusion pharmacy NPI number (exactly 10 digits).	1234567809
Pharmacy_Name	CHAR Always Required	150	Provide the name of the Home Infusion pharmacy.	CVS Pharmacy
Pharmacy_Street_Address	CHAR Always Required	150	Enter the street address of the pharmacy.	1212 North Luther Street
Pharmacy_City_Address	CHAR Always Required	75	Enter the city in which the pharmacy is located.	Wichita
Pharmacy_State_Address	CHAR Always	2	Enter the state abbreviation in	MO

Field Name	Field Type	Maximum Field Length	Field Description	Sample Field Value(s)
	Required		which the pharmacy is located.	
Pharmacy_Zip_Address	CHAR Always Required	Exactly 5 or Exactly 10	Enter the pharmacy's zip code.	22203 or 22203-1234
States_Licensed	CHAR Always Required	No Limit	Enter the states in which the pharmacy is licensed. Use the state abbreviation. This field should be comma-delimited; state abbreviations should be separated with a comma. Please note: the contract must have at least one pharmacy licensed in each state that is covered in the contract's service area.	MA, VA, KS
Pharmacy_Network_Type_PN	CHAR Always Required	1	Is the pharmacy network preferred?	P = Preferred N = Non-Preferred
Chain_YN	CHAR Always Required	1	Is the pharmacy a chain?	N = No Y = Yes
Independent_YN	CHAR Always Required	1	Is the pharmacy independent?	N = No Y = Yes
Group_Purchasing_YN	CHAR Always Required	1	Does the pharmacy allow group purchasing?	N = No Y = Yes

LTC Pharmacy Record Layout

Field Name	Field Type	Maximum Field Length	Field Description	Sample Field Value(s)
NPI Number	CHAR Always Required	Exactly 10	Indicate the contracted LTC pharmacy NPI number (exactly 10 digits).	1234567809
Pharmacy_Name	CHAR Always Required	150	Provide the name of the LTC pharmacy.	CVS Pharmacy
Pharmacy_Street_Address	CHAR Always Required	150	Enter the street address of the pharmacy.	1212 North Luther Street
Pharmacy_City_Address	CHAR Always Required	75	Enter the city in which the pharmacy is located.	Wichita
Pharmacy_State_Address	CHAR Always Required	2	Enter the state abbreviation in which the pharmacy is located.	MO
Pharmacy_Zip_Address	CHAR Always Required	Exactly 5 or Exactly 10	Enter the pharmacy's zip code.	22203 or 22203-1234

Field Name	Field Type	Maximum Field Length	Field Description	Sample Field Value(s)
States_Licensed	CHAR Always Required	No Limit	Enter the states in which the pharmacy is licensed. Use the state abbreviation. This field should be comma-delimited; state abbreviations should be separated with a comma. Please note: the contract must have at least one pharmacy in each state that is covered in the contract's service area.	MA, VA, KS
Pharmacy_Network_Type_PN	CHAR Always Required	1	Is the pharmacy network preferred?	P = Preferred N = Non-Preferred
Chain_YN	CHAR Always Required	1	Is the pharmacy a chain?	N = No Y = Yes
Independent_YN	CHAR Always Required	1	Is the pharmacy independent?	N = No Y = Yes
Group_Purchasing_YN	CHAR Always Required	1	Does the pharmacy allow group purchasing?	N = No Y = Yes

II. Sponsors receiving pharmacy access waivers: Data elements to be entered into the HPMS at the Plan (PBP) level for only those MA-PD and Cost Plans that own and operate their own pharmacies and have received a waiver of the any willing pharmacy requirement.

Element Letter	Element Name	Definition	Allowable Values
A.	Number of prescriptions provided by all pharmacies owned and operated	The number of prescriptions provided in the time period by all pharmacies owned and operated.	• Is mutually exclusive. • Field type: Number.
B.	Number of prescriptions provided at all pharmacies contracted	The number of prescriptions provided in the time period at all pharmacies contracted.	• Is mutually exclusive. • Field type: Number.

III. Sponsors receiving pharmacy access waivers: Data elements to be entered into the HPMS at the Plan (PBP) level for only those MA-PD and cost plans that own and operate their own retail pharmacies and have received a waiver of the retail pharmacy convenient access standards. These plans are not exempt from reporting Retail Pharmacy Access listed above.

Element Letter	Element Name	Definition	Allowable Values
A.	Number of prescriptions provided by retail pharmacies owned and operated	The number of prescriptions provided in the time period by retail pharmacies owned and operated.	• Is mutually exclusive. • Field type: Number.
B.	Number of prescriptions provided at all retail pharmacies contracted	The number of prescriptions provided in the time period at all retail pharmacies contracted.	• Is mutually exclusive. • Field type: Number.

B. QA checks/Thresholds - procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS' outlier notifications serve only to give Part D sponsors the opportunity to correct submitted data if needed, and does not indicate that submitted data are incorrect, or that resubmissions are required.

- The number of contracted retail pharmacies reported for this reporting section will be combined with data from the Pharmacy Support of Electronic Prescribing reporting section to determine outliers for the percent of retail pharmacies enabled to receive electronic prescribing.
- CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from Part D Plans.

C. Edits and Validation Checks - validation checks that should be performed by each Part D Sponsor prior to data submission.
   - For section I (HI and LTC pharmacy reporting), the States Licensed field must include ALL states in the plan's service area for the HI and LTC data file uploads.
   - For section I (Retail, HI and LTC pharmacy reporting), a contract with both employer-only (800 series) market portions of its service area and individual market plans serving the total or part of its service area, will be required to report data only for the states in the individual plans' active service area. A contract with an entirely employer-only (800 series) or an entirely individual market service area will be required to report data for all states in its active service area.

D. Analysis- how CMS will evaluate reported data, as well as how other data sources may be monitored.
   - CMS will evaluate to ensure access standards are met.

E. Notes – additional clarifications to a reporting section.
   1. Employer groups are not exempt from this reporting section.
   2. The Retail, HI and LTC pharmacy network templates can be found in the HPMS reporting module, under Documentation -> Download File Templates.
   3. The download entitled Beneficiary Count Data is a national file used for PDP and MA-PD sponsors, and is updated annually. The file is posted on the Prescription Drug Contracting section of CMS' website in January. To locate the file on the web, go to http://www.cms.gov/PrescriptionDrugCovContra/04_RxContracting_ApplicationGuidance.asp and click on the application guidance link on the left side navigation bar.

III. Medication Therapy Management (MTM) Programs

1. Data element definitions – details for each data element reported to CMS, including examples, methods for calculations, and how various data elements are associated.

    - A data file containing the following fields for targeted beneficiaries enrolled in the contract's Medication Therapy Management (MTM) program at any time in the reporting period will be uploaded using Gentran or Connect Direct:
    - You must not include additional information outside of what is dictated in the record layout.
    - You must not include a header row.
    - Submissions that do not strictly adhere to the record layout will be rejected.

    Important notes and clarifications are provided below in E. Notes.

Beneficiaries Eligible for MTM Record Layout

Element Letter	Field Name	Field Type	Field Length	Start Position	End Position	Field Description
A.	Contract Number	CHAR REQUIRED	5	1	5	The Contract Number (e.g., H1234, S1234) for your organization.
B.	HICN or RRB Number	CHAR REQUIRED	12	6	17	For each distinct beneficiary identified to be eligible for MTM (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, provide the unique number that the Social Security Administration assigns to each Medicare beneficiary, which is the Health Insurance Claim number (HICN). For Railroad Retirement Board (RRB) beneficiaries, provide the RRB number in this field instead of the

Beneficiaries Eligible for MTM Record Layout						
Element Letter	Field Name	Field Type	Field Length	Start Position	End Position	Field Description
						HICN. Distinct beneficiaries should only be reported once per file. If the beneficiary's HICN changed during the reporting period, only report the most current HICN.
C.	Beneficiary first name	CHAR REQUIRED	30	18	47	For each beneficiary eligible for MTM, the first name of the beneficiary identified to be eligible for MTM in the reporting period.
D.	Beneficiary middle initial	CHAR OPTIONAL	1	48	48	For each beneficiary eligible for MTM, the middle initial of the beneficiary identified to be eligible for MTM in the reporting period.
E.	Beneficiary last name	CHAR REQUIRED	30	49	78	For each beneficiary eligible for MTM, the last name of the beneficiary identified to be eligible for MTM in the reporting period.
F.	Beneficiary date of birth	DATE REQUIRED	8	79	86	For each beneficiary eligible for MTM, the date of birth for the beneficiary identified to be eligible for MTM in the reporting period (CCYYMMDD, e.g., 19400130).
G.	Met the specified targeting criteria per CMS – Part D requirements	CHAR REQUIRED	1	87	87	For each beneficiary eligible for MTM, indicate if the beneficiary met the specified targeting criteria per CMS – Part D requirements at any time in the reporting

Beneficiaries Eligible for MTM Record Layout						
Element Letter	Field Name	Field Type	Field Length	Start Position	End Position	Field Description
						period. This should be Y (yes) or N (no).
H.	Beneficiary identified as cognitively impaired at time of Comprehensive Medication Review (CMR) offer or delivery of CMR	CHAR REQUIRED	1	88	88	For each beneficiary eligible for MTM, indicate if the beneficiary was identified as being cognitively impaired at time of comprehensive medication review (CMR) offer or delivery of CMR. This should be Y (yes), N (no), or U (unknown).
I.	Date of MTM program enrollment	DATE REQUIRED	8	89	96	For each beneficiary identified to be eligible for the MTM program in the reporting period, enter the date they were automatically enrolled within the reporting period (CCYYMMDD, e.g., 20140102).
J.	Date met the specified targeting criteria per CMS – Part D requirements	DATE Conditionally REQUIRED (if element G is 'Yes')	8	97	104	For each beneficiary identified to be eligible for MTM, enter the date the beneficiary met the specified targeting criteria per CMS – Part D requirements within the reporting period (CCYYMMDD, e.g. 20140102). *This date must be provided if the beneficiary met the specified targeting criteria per CMS – Part D requirements. Leave blank if beneficiary was*

Beneficiaries Eligible for MTM Record Layout						
Element Letter	Field Name	Field Type	Field Length	Start Position	End Position	Field Description
						enrolled based upon other expanded, plan-specific targeting criteria. This date may be the same as date of MTM program enrollment, or different if the beneficiary was first enrolled based on other expanded plan-specific targeting criteria and then met the targeting criteria per CMS – Part D requirements later in the reporting period.
K.	Date MTM program opt-out, if applicable	DATE Conditionally REQUIRED	8	105	112	For each beneficiary who opted-out of the MTM program, enter the date the beneficiary opted-out within the reporting period (CCYYMMDD, e.g., 20140130). *The date must be provided if the beneficiary opted out of MTM.*
L.	Reason participant opted-out of MTM program (Death; Disenrollment from Plan; Request by beneficiary; or Other). Required if Date of MTM Opt-out is applicable.	CHAR Conditionally REQUIRED (If element K is provided)	2	113	114	For each beneficiary with a disposition status of opted out of MTM program, the reason must be provided. Reasons for opting out must be one of the following: 01 - Death; 02 - Disenrollment from Plan; 03 - Request by beneficiary; or 04 - Other. If Date MTM opt-out is

Beneficiaries Eligible for MTM Record Layout						
Element Letter	Field Name	Field Type	Field Length	Start Position	End Position	Field Description
						provided, then Reason participant Opted-out of MTM program is required.
M.	Offered annual comprehensive medication review (CMR)	CHAR REQUIRED	1	115	115	For each beneficiary enrolled in MTM program, indicate if the beneficiary was offered a CMR per CMS – Part D requirements within the reporting period. This should be Y (yes) or N (no).
N.	If offered a CMR, date of (initial) offer	DATE Conditionally REQUIRED (If element M is provided)	8	116	123	For each beneficiary enrolled in MTM program who was offered a CMR per CMS – Part D requirements, enter the date of the CMR offer within the reporting period (CCYYMMDD, e.g. 20140601). *The date must be provided if the beneficiary was offered a CMR.*
O.	Received annual CMR with written summary in CMS standardized format	CHAR REQUIRED	1	124	124	For each beneficiary enrolled in MTM program, indicate if the beneficiary received an annual CMR per CMS – Part D requirements with written summary in CMS standardized format within the reporting period. This should be Y (yes) or N (no).
P.	Number of CMRs received with written summary in	NUMERIC REQUIRED	2	125	126	For each beneficiary enrolled in MTM program, indicate the number of CMRs received per CMS –

Beneficiaries Eligible for MTM Record Layout						
Element Letter	Field Name	Field Type	Field Length	Start Position	End Position	Field Description
	CMS standardized format.					Part D requirements with written summary in CMS standardized format within the reporting period. This is a numeric field. If the beneficiary received no CMRs per CMS – Part D requirements with written summary in CMS standardized format, then enter 0.
Q.	Date(s) of CMR(s) with written summary in CMS standardized format.	DATE Conditionally REQUIRED (If element O is 'Yes')	8	127	134	For each beneficiary enrolled in MTM program who received an annual CMR per CMS – Part D requirements with written summary in CMS standardized format, enter the date of the CMR within the reporting period. This is a date field (CCYYMMDD, e.g. 20140615). *The date must be provided if the beneficiary received an annual CMR per CMS – Part D requirements with written summary in CMS standardized format.* If more than 1 CMR is received, up to 5 dates will be allowed. In the case of multiple CMRs for a beneficiary, the plan

Beneficiaries Eligible for MTM Record Layout						
Element Letter	Field Name	Field Type	Field Length	Start Position	End Position	Field Description
						should always report the first and last CMR dates, and then choose other CMR dates based upon the significance of the CMR purpose or findings.
	Date(s) of CMR(s) with written summary in CMS standardized format, second date of CMR.	DATE Conditionally REQUIRED (If element O is 'Yes' and element P is greater than 1)	8	135	142	For each beneficiary enrolled in MTM program who received an annual CMR per CMS – Part D requirements with written summary in CMS standardized format, enter the date of the CMR. This is a date field (CCYYMMDD, e.g. 20140615). *The date must be provided if the beneficiary received an annual CMR per CMS – Part D requirements with written summary in CMS standardized format.* If more than 1 CMR is received, up to 5 dates will be allowed. In the case of multiple CMRs for a beneficiary, the plan should always report the first and last CMR dates, and then choose other CMR dates based upon the significance of the CMR purpose or

Beneficiaries Eligible for MTM Record Layout						
Element Letter	Field Name	Field Type	Field Length	Start Position	End Position	Field Description
						findings.
	Date(s) of CMR(s) with written summary in CMS standardized format, third date of CMR.	DATE Conditionally REQUIRED (If element O is 'Yes' and element P is greater than 2)	8	143	150	For each beneficiary enrolled in MTM program who received an annual CMR per CMS – Part D requirements with written summary in CMS standardized format, enter the date of the CMR within the reporting period. This is a date field (CCYYMMDD, e.g. 20140615). *The date must be provided if the beneficiary received an annual CMR per CMS – Part D requirements with written summary in CMS standardized format.* If more than 1 CMR is received, up to 5 dates will be allowed. In the case of multiple CMRs for a beneficiary, the plan should always report the first and last CMR dates, and then choose other CMR dates based upon the significance of the CMR purpose or findings.
	Date(s) of CMR(s) with written	DATE Conditionally REQUIRED	8	151	158	For each beneficiary enrolled in MTM program who received

Beneficiaries Eligible for MTM Record Layout						
Element Letter	Field Name	Field Type	Field Length	Start Position	End Position	Field Description
	summary in CMS standardized format, fourth date of CMR.	(If element O is 'Yes' and element P is greater than 3)				an annual CMR per CMS – Part D requirements with written summary in CMS standardized format, enter the date of the CMR within the reporting period. This is a date field (CCYYMMDD, e.g. 20140615). *The date must be provided if the beneficiary received an annual CMR per CMS – Part D requirements with written summary in CMS standardized format.* If more than 1 CMR is received, up to 5 dates will be allowed. In the case of multiple CMRs for a beneficiary, the plan should always report the first and last CMR dates, and then choose other CMR dates based upon the significance of the CMR purpose or findings.
	Date(s) of CMR(s) with written summary in CMS standardized format, fifth date of CMR.	DATE Conditionally REQUIRED (If element O is 'Yes' and element P is greater than 4)	8	159	166	For each beneficiary enrolled in MTM program who received an annual CMR per CMS – Part D requirements with written summary in CMS standardized format, enter the date

Beneficiaries Eligible for MTM Record Layout						
Element Letter	Field Name	Field Type	Field Length	Start Position	End Position	Field Description
						of the CMR within the reporting period. This is a date field (CCYYMMDD, e.g. 20140615). *The date must be provided if the beneficiary received an annual CMR per CMS – Part D requirements with written summary in CMS standardized format.* If more than 1 CMR is received, up to 5 dates will be allowed. In the case of multiple CMRs for a beneficiary, the plan should always report the first and last CMR dates, and then choose other CMR dates based upon the significance of the CMR purpose or findings.
R.	Method of delivery for the annual CMR	CHAR Conditionally REQUIRED (If element O is 'Yes')	2	167	168	For each beneficiary enrolled in the MTM program that received the annual CMR within the reporting period, indicate the method of delivery for the annual CMR. The method of delivery must be one of the following: 01 – Face-to-face; 02 – Telephone; 03 – Telehealth consultation (e.g. video-conference); or

Beneficiaries Eligible for MTM Record Layout						
Element Letter	Field Name	Field Type	Field Length	Start Position	End Position	Field Description
						04 – Other *If beneficiary received an annual CMR per CMS – Part D requirements with written summary in CMS standardized format, then method of delivery of the annual CMR is required.* If more than one CMR is received, report the method of delivery for the initial CMR.
S.	Qualified Provider who performed the initial CMR	CHAR Conditionally REQUIRED (If element O is 'Yes')	2	169	170	For each beneficiary enrolled in the MTM program that received an *annual CMR per CMS – Part D requirements with written summary in CMS standardized format.* Indicate the Qualified Provider who performed the CMR. Qualified Provider must be identified by one of the following: 01 – Physician; 02 – Registered Nurse; 03 – Licensed Practical Nurse; 04 – Nurse Practitioner; 05 – Physician's Assistant; 06 – Local Pharmacist; 07 – LTC Consultant Pharmacist; 08 – Plan Sponsor Pharmacist;

Beneficiaries Eligible for MTM Record Layout						
Element Letter	Field Name	Field Type	Field Length	Start Position	End Position	Field Description
						09 – Plan Benefit Manager (PBM) Pharmacist; 10 – MTM Vendor Local Pharmacist; 11 – MTM Vendor In-house Pharmacist; 12 – Hospital Pharmacist; 13 – Pharmacist – Other; 14 – Other *If beneficiary received the annual CMR, then the Qualified Provider who performed the initial CMR is required.* If more than one CMR is received, report the Qualified Provider who performed the initial CMR.
T.	Recipient of CMR	CHAR Conditionally REQUIRED (If element O is 'Yes')	2	171	172	For each beneficiary enrolled in MTM, indicate the recipient of the annual CMR per CMS – Part D requirements with written summary in CMS standardized format within the reporting period. Plans should report the recipient of the CMR interaction and not the recipient of the CMR documentation. The recipient of the CMR must be identified by one of the following: 01 – Beneficiary 02 – Beneficiary's

Beneficiaries Eligible for MTM Record Layout						
Element Letter	Field Name	Field Type	Field Length	Start Position	End Position	Field Description
						prescriber 03 – Caregiver 04 – Other authorized individual *If the annual CMR was provided for the beneficiary, then the recipient of the CMR is required.* If more than one CMR is received, report the recipient of the initial CMR.
U.	Number of targeted medication reviews	NUMERIC REQUIRED	2	173	174	For each beneficiary enrolled in MTM, indicate the number of targeted medication reviews conducted per CMS – Part D requirements within the reporting period. This is a numeric field. If the beneficiary had no targeted medication reviews, enter 0.
V.	Number of drug therapy problem recommendations made to beneficiary's prescriber(s) as a result of MTM services	NUMERIC REQUIRED	2	175	176	For each beneficiary enrolled in MTM, indicate the number of drug therapy problem recommendations made to beneficiary's prescriber(s) as a result of MTM services. For reporting purposes, a recommendation is defined as a suggestion to take a specific course of action related to the beneficiary's drug therapy.

Beneficiaries Eligible for MTM Record Layout						
Element Letter	Field Name	Field Type	Field Length	Start Position	End Position	Field Description
						If the same recommendation is made to multiple prescribers or repeated on multiple dates, then that recommendation should only be counted and reported once. Examples include, but are not limited to, Needs additional therapy; Unnecessary drug therapy; Dosage too high; Dosage too low; More effective drug available; Adverse drug reaction; or Medication Non-compliance/Non-adherence. This is a numeric field. If the beneficiary had no drug therapy problem recommendations made to prescriber(s) as a result of MTM services, enter 0.
W.	Number of drug therapy problem resolutions resulting from recommendations made to beneficiary's prescriber(s) as a result of MTM recommendations	NUMERIC REQUIRED	2	177	178	For each beneficiary enrolled in MTM, indicate the number of drug therapy problem resolutions resulting from recommendations made to beneficiary's prescriber(s) as a result of MTM services. For reporting purposes, a resolution is defined as a change or variation from the beneficiary's previous drug therapy. Examples include, but

Beneficiaries Eligible for MTM Record Layout						
Element Letter	Field Name	Field Type	Field Length	Start Position	End Position	Field Description
						are not limited to, Initiate drug; Change drug (such as product in different therapeutic class, dose, dosage form, quantity, or interval); Discontinue or substitute drug (such as discontinue drug, generic substitution, or formulary substitution); Medication compliance/ adherence. This is a numeric field. If the beneficiary had no drug therapy problem resolutions made as a result of MTM recommendations, enter 0.
X.	Topics discussed with the beneficiary during the CMR	CHAR Conditionally REQUIRED (If element O is 'Yes')	75	179	253	For each beneficiary enrolled in MTM, enter the topics discussed with the beneficiary during the CMR, including the medication or care issue to be resolved or behavior to be encouraged. These are the descriptions of the topics listed on the beneficiary's written summary in CMS standardized format in the Medication Action Plan under 'What we talked about'.

Beneficiaries Eligible for MTM Record Layout						
Element Letter	Field Name	Field Type	Field Length	Start Position	End Position	Field Description
						Required if received annual CMR. If element O is 'Yes', then this should not be null. If more than 1 topic discussed, up to 5 topics will be allowed to be reported.
	Topics discussed with the beneficiary during the CMR	CHAR Conditionally REQUIRED (If element O is 'Yes')	75	254	328	For each beneficiary enrolled in MTM, enter the topics discussed with the beneficiary during the CMR, including the medication or care issue to be resolved or behavior to be encouraged. These are the descriptions of the topics listed on the beneficiary's written summary in CMS standardized format in the Medication Action Plan under 'What we talked about'. Required if received annual CMR. If element O is 'Yes', then this element should not be null. If more than 1 topic discussed, up to 5 topics will be allowed to be reported.

Beneficiaries Eligible for MTM Record Layout						
Element Letter	Field Name	Field Type	Field Length	Start Position	End Position	Field Description
	Topics discussed with the beneficiary during the CMR	CHAR Conditionally REQUIRED (If element O is 'Yes')	75	329	403	For each beneficiary enrolled in MTM, enter the topics discussed with the beneficiary during the CMR, including the medication or care issue to be resolved or behavior to be encouraged. These are the descriptions of the topics listed on the beneficiary's written summary in CMS standardized format in the Medication Action Plan under 'What we talked about'. Required if received annual CMR. If element O is 'Yes', then this element should not be null. If more than 1 topic discussed, up to 5 topics will be allowed to be reported.
	Topics discussed with the beneficiary during the CMR	CHAR Conditionally REQUIRED (If element O is 'Yes')	75	404	478	For each beneficiary enrolled in MTM, enter the topics discussed with the beneficiary during the CMR, including the medication or care issue to be resolved or behavior to be encouraged. These are the

Beneficiaries Eligible for MTM Record Layout						
Element Letter	Field Name	Field Type	Field Length	Start Position	End Position	Field Description
						descriptions of the topics listed on the beneficiary's written summary in CMS standardized format in the Medication Action Plan under 'What we talked about'. Required if received annual CMR. If element O is 'Yes', then this element should not be null. If more than 1 topic discussed, up to 5 topics will be allowed to be reported.
	Topics discussed with the beneficiary during the CMR	CHAR Conditionally REQUIRED (If element O is 'Yes')	75	479	553	For each beneficiary enrolled in MTM, enter the topics discussed with the beneficiary during the CMR, including the medication or care issue to be resolved or behavior to be encouraged. These are the descriptions of the topics listed on the beneficiary's written summary in CMS standardized format in the Medication Action Plan under 'What we talked about'. Required if received annual CMR.

Beneficiaries Eligible for MTM Record Layout						
Element Letter	Field Name	Field Type	Field Length	Start Position	End Position	Field Description
						If element O is 'Yes', then this element should not be null. If more than 1 topic discussed, up to 5 topics will be allowed to be reported.

2. QA checks/Thresholds - procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.
    - CMS' outlier notifications serve only to give Part D sponsors the opportunity to correct submitted data if needed, and does not indicate that submitted data are incorrect, or that resubmissions are required.
    - The percent of eligible MTM program enrollees who opted out of an MTM program will be examined for outlier data.
    - The percent of MTM program enrollees who received a CMR with written summary in CMS standardized format will be examined for outlier data. Dates of enrollment and opt-out will be considered.
    - CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from Part D Plans.

3. Edits and Validation Checks - validation checks that should be performed by each Part D Sponsor prior to data submission.
    - See column "Field Type" for data fields that are conditionally required.

4. Analysis- how CMS will evaluate reported data, as well as how other data sources may be monitored.
    - CMS will also evaluate the percent of beneficiaries that opt-out of MTM.
    - CMS will evaluate the percent of beneficiaries who are offered and receive a comprehensive medication review with written summary in CMS standardized format.
    - CMS will evaluate initial MTM outcomes, as reported as drug therapy problem recommendations and drug therapy problem resolutions.

5. Notes - additional clarifications to a reporting section.
    1. Sponsors should refer to the annual Guidance and Submission memo for more information about the Part D MTM program requirements and definitions. It is posted on the CMS MTM web page at www.cms.gov > Medicare > Prescription Drug Contracting > Medication Therapy Management.

2. Sponsors should not wait for program acceptance (such as a returned enrollment mailing or affirmation via the phone) from the beneficiary to enroll them in the MTM program or offer the required minimum MTM services.
3. All distinct beneficiaries identified to be eligible for MTM (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 are reported. The reported beneficiaries must receive MTM services within the reporting period that meet or exceed CMS' MTM program requirements.
4. The drug costs used to determine if the total annual cost of a beneficiary's covered Part D drugs is likely to equal or exceed the specified annual cost threshold for MTM program eligibility includes the ingredient cost, dispensing fee, sales tax, and vaccine administration fee, if applicable. This projection may be based on claims within the reporting period or based on historical claims from the previous contract year.
5. The period of MTM eligibility and enrollment is a contract year (which aligns with the reporting period); therefore eligibility, enrollment, etc. are counted and reported distinctly for each contract year. A beneficiary may be reported for multiple program years if they re-qualify for MTM each year.
    - At the start of each contract year, beneficiaries who were enrolled in the MTM program in the previous contract year and again meet the eligibility criteria for the contract year within the reporting period (re-qualify) should be automatically enrolled in MTM and reported.
    - Also, beneficiaries who are newly targeted for eligibility and automatically enrolled in the MTM program for the contract year within the reporting period are reported. Only activities that occurred in the contract year in the reporting period that meet or exceed CMS' MTM requirements should be reported.
    - Beneficiaries who no longer meet the eligibility criteria for the MTM program for the contract year within the reporting period would no longer be enrolled in the MTM program and would no longer be reported. Any activities that occurred in the contract year in the reporting period when they are no longer enrolled would not be reported. Only activities that occurred in the contract year in the reporting period that meet or exceed CMS' MTM requirements should be reported.
6. A targeted beneficiary should only be reported once per contract year per contract file. If the beneficiary's HICN changed during the reporting period, only report the most current HICN.
7. If a beneficiary is deceased prior to their MTM eligibility date, the plan should not report the beneficiary.
8. For Date of MTM program opt-out (element K) and Reason participant opted-out of MTM program (element L), sponsors should not count and report a member as having disenrolled from the plan with an opt-out date of 12/31 simply because it is the end of the year and the beneficiary will no longer be enrolled in the plan for the following year. A 12/31 disenrollment date should only be counted and reported if the member truly disenrolled from the plan on 12/31. In addition, lack of response from the beneficiary should not be counted as an opt-out as eligible beneficiaries should be automatically enrolled.
9. Sponsors should refer to Chapter 5, Section 10.2 of the Prescription Drug Benefit Manual for a description of the types of facilities which are considered LTC.

10. The CMR may be performed with the beneficiary's prescriber, caregiver, or other authorized individual if a beneficiary is offered the annual CMR and is unable to accept the offer to participate (cognitively impaired). Sponsors should be able to present documentation or rationale for these determinations.
11. Only the activities that were completed within the reporting period should be reported. However, drug therapy problem resolutions that are observed in the year after the reporting period but before the reporting deadline for the reporting period that are a result of MTM recommendations made in the reporting period may be reported.
12. For all targeted beneficiaries, including beneficiaries in a LTC setting, upon their enrollment in the MTM program, sponsors are required to perform targeted medication reviews (TMRs) at least quarterly with follow-up interventions when necessary, offer the CMR, and offer interventions for both beneficiaries and prescribers.
13. Sponsors should refer to the 2014 MTM Program Guidance and Submission memo for more information about required MTM services and the definition for a CMR. Only CMRs that meet CMS – Part D requirements should be reported, which is:
    - an interactive, person-to-person, or Telehealth medication review and consultation of the beneficiary's medications (including prescriptions, over-the-counter (OTC) medications, herbal therapies, and dietary supplements), and
    - performed in real-time by a pharmacist or qualified provider with the beneficiary (or their authorized representative), and
    - with a written summary of the results of the review provided to the targeted individual in CMS' standardized format.
14. Offers for a CMR may be delivered by spoken conversations, voicemails, messages left on answering machines, or welcome letters that include a clear offer to the CMR. For reporting CMR offers, the beneficiary must receive the offer. Therefore, returned mail or incorrect phone numbers do not count as an offer.
15. CMS requires that sponsors perform TMRs for all targeted beneficiaries enrolled in the MTM program, no less often than quarterly as of the date of enrollment in the MTM program. Part D sponsors must assess the findings of these reviews to determine if a follow-up intervention is necessary and if the intervention is warranted for the beneficiary and/or prescriber.
16. The enrolled beneficiaries may refuse or decline individual MTM services without having to opt-out (disenroll) from the program. These beneficiaries should not be reported as opt-out from the MTM program. For example, if an enrolled beneficiary declines the annual CMR or another follow-up intervention, the sponsor should still offer drug therapy problem recommendations to the prescriber and perform targeted medication reviews at least quarterly to assess medication use on an on-going basis.
17. The number of drug therapy problem recommendations made to prescriber(s) as a result of MTM services (element V) is 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 drug therapy problem recommendations.

- For example, if 3 drug 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 drug therapy recommendations were sent to a second prescriber, this should still be reported as 3 recommendations (not 6).

18. Drug therapy problem resolutions resulting from recommendations made to the beneficiary's prescriber(s) as a result of MTM services (element W) include, but are not limited to, the examples listed above (Initiate drug; change drug (such as product in different therapeutic class, dose, dosage form, quantity, or interval); Discontinue or substitute drug (such as discontinue drug, generic substitution, therapeutic substitution, or formulary substitution); Medication compliance/adherence)). Sponsors should not limit data reported to the examples provided. Sponsors should retain documentation supporting the number of drug therapy problem resolutions reported to CMS. If the resolution was observed in the calendar year after the current reporting period and before the reporting deadline, but was the result of a MTM intervention and drug therapy problem recommendation made within the current reporting period, the change may be reported for the current reporting period. However, this change to drug therapy cannot be reported again in the following reporting period.
19. Topics discussed with the beneficiary during the CMR (element X) should include each topic that was included in the 'What we talked about' field in the Medication Action Plan (MAP) of the CMR summary in standardized format. If the MAP contained more than 5 topics, report the 5 most important topics. Additional information about the standardized format, including instructions and FAQs, is available on the CMS website at: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM.html.
20. When a beneficiary moves between contracts:
    - The beneficiary would be included in the beneficiary level files and reported for each contract in which they were eligible for the MTM program and automatically enrolled. The new contract must re-qualify the beneficiary for the MTM program and must retarget the beneficiary based on the contract's MTM program criteria.
    - The dates of enrollment, disenrollment elements, and other elements would differ depending on the specific activity that occurred for the beneficiary when enrolled in the MTM program for the specific contract ID within the reporting period (contract year).
    - Each contract would treat their enrollment/TMRs/CMRs/etc. individually for the beneficiary. If a beneficiary received a CMR in Contract 1 and not Contract 2, it would be reported in Contract 1.
21. In the case when a beneficiary enrolls in a Part D contract and is eligible for their MTM program, disenrolls from the plan, and re-enrolls in the same Part D contract and their MTM program:
    - One beneficiary record would be included in the beneficiary level files reported for the Contract.
    - If there is a gap in MTM program enrollment of 60 days or less, report the initial date of MTM program enrollment, no date of MTM program opt-out, and other applicable elements for activity across all MTM program enrollment periods within the reporting period.

- If there is a gap in MTM program enrollment of more than 60 days, report the last date of MTM program enrollment and other applicable elements for activity in the last MTM program enrollment period within the reporting period.

22. 'CMR date of (initial) offer' (element N) and 'Date(s) of CMR(s) with written summary in CMS standardized format' (element Q) must be after the 'Date of MTM program enrollment' (element I). The 'Date of MTM program enrollment' could be:
    - The date the beneficiary was enrolled based on the targeting criteria per CMS – Part D requirements. In this case, the 'Date of MTM program enrollment' would equal the 'Date met the specified targeting criteria per CMS – Part D requirements'.
    - The date the beneficiary was enrolled based on expanded, other plan-specific targeting criteria. In this case, the "Date met the specified targeting criteria per CMS – Part D requirements' would be after the 'Date of MTM program enrollment' or blank of the beneficiary was only eligible based on expanded, other plan-specific targeting criteria.

    In any case, the beneficiary has to be enrolled in the MTM program before any MTM services would occur.
23. 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 enrollees via e-mail to: partd-planreporting@cms.hhs.gov.

IV. Prompt Payment by Part D Sponsors

NOTE: EFFECTIVE JANUARY 2014, THIS REPORTING SECTION IS BEING SUSPENDED FROM THE 20 14 PART D REPORTING REQUIREMENTS.

A. Data element definitions - details for each data element reported to CMS, including examples, methods for calculations, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of paid claims.	The total number of paid claims.	• Field type: Number.
B.	Total number of paid electronic claims.	The total number of paid electronic claims.	• Field type: Number. • Is a subset of A.
C.	Total number of paid non-electronic claims.	The total number of paid non-electronic (e.g. paper) claims.	• Field type: Number. • Is a subset of A.
D.	Total number of paid electronic claims which were not paid timely.	The total number of paid electronic claims which were not paid timely, according to appropriate time-periods.	• Field type: Number. • Is a subset of B.
E.	Number of paid non-electronic claims which were not paid timely.	The total number of paid non-electronic claims which were not paid timely, according to appropriate time-periods.	• Field type: Number. • Is a subset of C.

B. QA checks/Thresholds - procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS' outlier notifications serve only to give Part D sponsors the opportunity to correct submitted data if needed, and does not indicate that submitted data are incorrect, or that resubmissions are required.
- The percent of paid claims that were electronic will be examined for outlier data. After accounting for the total number of paid claims, contracts with values below 95% will be flagged as outliers.
- The percent of total claims, electronic claims and non-electronic claims paid late will be examined for outlier data. Contracts with values above 5% on any of these measures will be flagged as outliers.
- CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from Part D Plans.

C. Edits and Validation Checks - validation checks that should be performed by each Part D Sponsor prior to data submission.
    - The total number of paid claims (Element A) should equal the sum of paid electronic and non-electronic claims (Element B+C).

D. Analysis- how CMS will evaluate reported data, as well as how other data sources may be monitored.
    - To be determined.

E. Notes - additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
    1. A clean claim that is paid within the required 14 days when the claim was submitted electronically) or 30 days (when the claim was submitted non-electronically) is counted as being paid promptly, regardless of whether it is subsequently reversed.
    2. A clean claim that is not paid within the required 14 days (when the claim was submitted electronically) or 30 days (when the claim was submitted non-electronically) is late regardless of any future reversals of that claim.
    3. A clean claim that is not paid prior to the reversal and the reversal occurred prior to the 14th day when the claim was submitted electronically) or the 30th day (when the claim was submitted non-electronically) should not be counted as a clean claim.
    4. This reporting includes only Part D covered claims.

V. Grievances

A. Data element definitions – details for each data element reported to CMS, including examples, methods for calculations, and how various data elements are associated.

Data elements to be uploaded into HPMS at the Contract level:

Grievances Data File Record Layout

Required File Format = ASCII File - Tab Delimited
Do not include a header record
Filename extension should be ".TXT"
There can be multiple records per plan.

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
Contract_Number	CHAR Required	5 Exactly	Provide the CMS issued contract number. (Note: The system shall validate the contract number is valid.)	H1234
Tot_Griev_Tot_Num	NUM Required	12	Enter the Total Number of Grievances.	123456789012
Tot_Griev_Timely_Notice__Given_Num	NUM Required	12	Enter the Number of grievances in which timely notification was given.	123456789012
Num_Expedited_Griev_Tot_Num	NUM Required	12	Enter the Number of Expedited Grievances.	123456789012
Num_Expedited_Griev_Timely_Notice__Given_Num	NUM Required	12	Enter the Number of Expedited Grievances in which timely notification was given.	123456789012
Enrollment_Disenrollment_Griev_Tot_Num	NUM Required	12	Enter the Total Number of Enrollment/Disenrollment Grievances.	123456789012
Enrollment_Disenrollment_Griev_Timely_Notice__Given_Num	NUM Required	12	Enter the Number of Enrollment/Disenrollment grievances in which timely notification was given.	123456789012
Plan_Bene_Griev_Tot_Num	NUM Required	12	Enter the Total Number of Plan Benefit Grievances.	123456789012
Plan_Bene_Griev_Timely_Notice__Given_Num	NUM Required	12	Enter the Number of Plan Benefit Grievances in which timely notification was given.	123456789012
Pharmacy_Access_Griev_Tot_Num	NUM Required	12	Enter the Total Number of Pharmacy Access Grievances.	123456789012
Pharmacy_Access_Griev_Timely_Notice__	NUM Required	12	Enter the Number of Pharmacy Access Grievances	123456789012

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
Given_Num			in which timely notification was given.	
Marketing_Griev_Tot_Num	NUM Required	12	Enter the Total Number of Marketing Grievances.	123456789012
Marketing_Griev_Timely_Notice__Given_Num	NUM Required	12	Enter the Number of Marketing Grievances in which timely notification was given.	123456789012
Customer_Serv_Griev_Tot_Num	NUM Required	12	Enter the Total Number of Customer Service Grievances.	123456789012
Customer_Serv_Griev_Timely_Notice__Given_Num	NUM Required	12	Enter the Number of Customer Service Grievances in which timely notification was given.	123456789012
Coverage_Determ_Griev_Tot_Num	NUM Required	12	Enter the Total Number of Coverage Determination and Redetermination Process Grievances.	123456789012
Coverage_Determ_Griev_Timely_Notice__Given_Num	NUM Required	12	Enter the Number of Coverage Determination and Redetermination Process Grievances in which timely notification was given.	123456789012
Quality_Care_Griev_Tot_Num	NUM Required	12	Enter the Total Number of Quality of Care Grievances.	123456789012
Quality_Care_Griev_Timely_Notice__Given_Num	NUM Required	12	Enter the Number of Quality of Care Grievances in which timely notification was given.	123456789012
CMS_Issue_Griev_Tot_Num	NUM Required	12	Enter the Total Number of Grievances related to “CMS Issues.”	123456789012
CMS_Issue_Griev_Timely_Notice__Given_Num	NUM Required	12	Enter the Number of Grievances related to “CMS Issues” in which timely notification was given.	123456789012
Other_Griev_Tot_Num	NUM Required	12	Enter the Total Number of Other Grievances.	123456789012
Other_Griev_Timely_Notice_Given_Num	NUM Required	12	Enter the Number of Other grievances in which timely notification was given.	123456789012

B. QA checks/Thresholds - procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.
    - CMS' outlier notifications serve only to give Part D sponsors the opportunity to correct submitted data if needed, and does not indicate that submitted data are incorrect, or that resubmissions are required.
    - The percent of beneficiaries filing grievances will be examined for outlier data. After accounting for enrollment, plans with values above the 95th percentile for their plan type or below the 5th percentile for their plan type will be flagged as outliers.
    - The percent of grievances for which the plan provided timely notification of its decision will be examined for outlier data. All plans with values below the 5th percentile for their plan type will be flagged as outliers.
    - CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from Part D Plans.

C. Edits and Validation Checks - validation checks that should be performed by each Part D Sponsor prior to data submission.
    - Plans should validate that the total number of grievances (1st element) is equal to the sum of the total number of grievances for each category excluding expedited grievances.
    - Plans should validate that the total number of timely notifications is equal to the sum of the total number of timely notifications for each category excluding expedited grievances.

D. Analysis- how CMS will evaluate reported data, as well as how other data sources may be monitored.
    - The total grievance rate per 1,000 enrollees is equal to the sum of the total number of grievances divided by average enrollments, multiplied by 1,000.

$$\left[\text{Total Grievance Rate per 1,000 enrollees }\right] = \frac{\text{Total \# Grievances}}{\text{Avg. Enrollment}} \times 1{,}000$$

    - The grievance rate by category per 1,000 enrollees is equal to the sum of the grievance element divided by average enrollment, multiplied by 1,000.

$$\left[\text{ Grievance Rate by Category per 1,000 enrollees }\right] = \frac{\text{Grievance Element}}{\text{Avg. Enrollment}} \times 1{,}000$$

    - CMS will order plans based on rates of grievances per 1,000 enrollees and determine the percentile ranking.
    - CMS will also correlate grievances with complaints in the CMS complaints tracking module (CTM).

E. Notes – additional clarifications to a reporting section.
    1. Grievances can be filed either orally or in writing. Sponsors should refer to 42 CFR §423.564 and Chapter 18, Sections 10 and 20 of the Prescription Drug

Benefit Manual for additional information regarding procedures for handling Part D grievances.

2. An enrollee's request for a coverage determination or a redetermination for drug coverage is not considered a grievance.
3. Complaints received by 1-800 Medicare or recorded only in the CTM are excluded from these data; however, complaints filed separately as grievances with the plan are included in this reporting.
4. Sponsors should report expedited grievances in 2 elements: the total number of expedited grievances, as well as in the appropriate grievance category. For example, if an enrollee files an expedited grievance because the plan denied their request for an expedited coverage determination, that grievance should be reported both as an "Expedited Grievance" and also as a "Coverage Determination and Redetermination Process" grievance.
5. Sponsors should conduct the appropriate outreach/investigation to determine which plan a grievance should be reported under. In rare instances where a Sponsor is unclear which plan the grievance pertains to, the sponsor should assign the grievance to its plan with the highest enrollment.
6. Grievances are categorized by the type of grievance as determined by the plan, and reported based on the grievance decision date.
7. A grievance decision (disposition) is timely when the sponsor appropriately notifies the enrollee of the decision no later than 30 calendar days from receipt of the grievance (24 hours for expedited grievances), or as expeditiously as the enrollee's health condition requires.
8. In the event that a beneficiary files multiple grievances during a reporting period, plans should consider the following:
    - If a beneficiary files a grievance and then files a grievance again on the same issue, prior to the Plan's decision or the deadline for decision notification (whichever is earlier), then that should only be counted as one grievance.
    - If a beneficiary files a grievance and then files a subsequent grievance on the same issue after the Plan's decision or deadline for decision notification (whichever is earlier), then that counts as a separate grievance.
    - If a beneficiary files a grievance about two different issues, then they are counted as separate grievances.
9. MA-PDs should report a grievance as either a Part C or Part D grievance, depending on the process the plan used to investigate/resolve the grievance. For most complaints or grievances, a plan will be able to determine which is more applicable. For the minority of cases where a clear distinction is not available for a MA-PD, cases should be reported as Part C grievances and therefore should be excluded from Part D reporting.
10. If a grievance is resolved within the reporting period for a member that has disenrolled from a plan and enrolled in a new plan, then the member's new plan should report the grievance regardless of where the grievance originated if they actually resolve the grievance.
11. The "CMS Issues" grievance category is meant to identify those grievances that are related to issues outside of the Plan's direct control and where the plan cannot take further action without assistance from CMS. This same type of categorization is used in the Complaint Tracking Module (CTM) and allows

CMS to exclude complaints when calculating a contract's complaint rate by enrollment. Examples include instances where a beneficiary seeks a Special Enrollment Period that is not explicitly outlined in CMS enrollment guidance, or a beneficiary who has lost coverage due to an erroneous loss of Part A/B entitlement. Please refer to Attachment B—CTM Exclusion List in the 2014 Star Ratings Technical Notes for more information.

12. Plans will be allowed to submit grievances reports in HPMS on or around 12/29/2014.

VI. Coverage Determinations and Redeterminations

A. Data element definitions – details for each data element reported to CMS, including examples, methods for calculations, and how various data elements are associated.

1. Coverage Determinations and Exceptions
Data elements to be entered into HPMS at the Contract level:

Element Letter	Element Name	Definition	Allowable Values
A.	Number of Pharmacy Transactions	The total number of pharmacy transactions during the reporting period.	• Field type: Number. • Part D Sponsors should report the total number of pharmacy transactions for Part D drugs by fill date (not batch date), including approved, rejected, and those with final disposition of reversed. CMS understands these numbers may include multiple transactions for the same prescription drug claim. • Multiple transactions for the same claim should be counted individually.
B.	Number of Pharmacy Transactions rejected due to non-formulary status	Of the total reported in A, the number of pharmacy transactions rejected due to non-formulary status.	• Field type: Number. • Is a subset of A. • Part D Sponsors should report the total number of pharmacy transactions, excluding those rejections due to early refills. CMS understands these numbers may include multiple transactions for the same prescription drug claim. • Multiple transactions for the same claim should be counted

Element Letter	Element Name	Definition	Allowable Values
			individually. • Rejections due to early refills are excluded.
C.	Number of Pharmacy Transactions rejected due to prior authorization (PA) requirements	Of the total reported in A, the number of pharmacy transactions rejected due to prior authorization (PA) requirements.	• Field type: Number. • Is a subset of A. • Part D Sponsors should report the total number of pharmacy transactions, excluding those rejections due to early refills. CMS understands these numbers may include multiple transactions for the same prescription drug claim. • Multiple transactions for the same claim should be counted individually. • Rejections due to early refills are excluded.
D.	Number of Pharmacy Transactions rejected due to step therapy requirements	Of the total reported in A, the number of pharmacy transactions rejected due to step therapy requirements.	• Field type: Number. • Is a subset of A. • Part D Sponsors should report the total number of pharmacy transactions, excluding those rejections due to early refills. CMS understands these numbers may include multiple transactions for the same prescription drug claim. • Multiple transactions for the same claim should be counted individually. • Rejections due to early refills are excluded.
E.	Number of Pharmacy Transactions rejected due to quantity limits	Of the total reported in A, the number of pharmacy transactions rejected due to quantity limits (QL) requirements based on CMS	• Field type: Number. • Is a subset of A. • Part D Sponsors should report the total number of pharmacy

Element Letter	Element Name	Definition	Allowable Values
	(QL) requirements based on CMS approved formulary	approved formulary.	transactions, excluding safety edits and those rejections due to early refills. CMS understands these numbers may include multiple transactions for the same prescription drug claim. • Multiple transactions for the same claim should be counted individually. • Safety edits and rejections due to early refills are excluded.
F.	Did the plan have high cost edits for compounds in place during the time period above?	Indicate if the plan had high cost edits for compounds in place in the reporting period.	• Field type: Character. • Part D Sponsors should indicate if the plan had high cost edits for compounds in place in the reporting period. This should be Y (yes) or N (no).
G.	If yes to element F, the cost threshold used	If yes to element F, indicate the cost threshold used.	• Field type: Number (Conditional). • Includes 2 decimal places. • Part D Sponsors should indicate the cost threshold used if the plan had high cost edits for compounds in place in the reporting period.
H.	Did the plan have high cost edits for non-compounds in place during the time period above?	Indicate if the plan had high cost edits for non-compounds in place in the reporting period.	• Field type: Character. • Part D Sponsors should indicate if the plan had high cost edits for non-compounds in place in the reporting period. This should be Y (yes) or N (no).

Element Letter	Element Name	Definition	Allowable Values
I.	If yes to element H, the cost threshold used	If yes to element H, indicate the cost threshold used.	• Field type: Number (Conditional). • Part D Sponsors should indicate the cost threshold used if the plan had high cost edits for non-compounds in place in the reporting period.
J.	Number of claims rejected due to high cost edits for compounds	Of the total reported in A, the total number of claims rejected by the plan due to high cost edits for compounds.	• Field type: Number. • Is a subset of A. • Part D Sponsors should report the total number of claims rejected by the plan due to high cost edits for compounds. CMS understands these numbers may include multiple transactions for the same prescription drug claim. • Multiple transactions for the same claim should be counted individually.
K.	Number of claims rejected due to high cost edits for non-compounds	Of the total reported in A, the total number of claims rejected by the plan due to high cost edits for non-compounds.	• Field type: Number. • Is a subset of A. • Part D Sponsors should report the total number of claims rejected by the plan due to high cost edits for non-compounds. CMS understands these numbers may include multiple transactions for the same prescription drug claim. • Multiple transactions for the same claim should be counted individually.

Element Letter	Element Name	Definition	Allowable Values
L.	Total number of coverage determinations decisions made in the reporting period.	The total number of coverage determinations decisions made by the plan in the reporting period.	• Field type: Number. • Is based on the date the decision was made. • Should not include requests that were withdrawn by the requestor or dismissed by the plan. • Should include favorable, partially favorable, and adverse decisions.
M.	Number of exception decisions made in the reporting period.	The total number of exception decisions made by the plan in the reporting period.	• Field type: Number. • Is a subset of L. • Is based on the date the decision was made. • Should include favorable, partially favorable, and adverse decisions.
N.	Number of coverage determinations decisions processed timely in the reporting period.	The number of coverage determinations decisions made by the plan that were processed timely by the plan in the reporting period.	• Field type: Number. • Is a subset of L. • See 11th, 12th, 13th, and 14th notes below for definition of a timely coverage determination.
O.	Number of coverage determinations decisions that were fully favorable in the reporting period.	The number of coverage determinations decisions made by the plan that were fully favorable in the reporting period.	• Field type: Number. • Is a subset of L.
P.	Number of coverage determinations decisions that were partially favorable in the reporting period.	The number of coverage determinations decisions made by the plan that were partially favorable in the reporting period.	• Field type: Number. • Is a subset of L.

Element Letter	Element Name	Definition	Allowable Values
Q.	Number of coverage determinations decisions that were adverse in the reporting period.	The number of coverage determinations decisions made by the plan that were adverse in the reporting period.	• Field type: Number. • Is a subset of L.
R.	Number of requests for coverage determinations that were withdrawn in the reporting period.	The total number of requests for coverage determinations that were withdrawn in the reporting period.	• Field type: Number.
S.	Number of requests for coverage determinations that were dismissed in the reporting period.	The total number of requests for coverage determinations that were dismissed in the reporting period.	• Field type: Number.

2. Redeterminations
Data elements to be entered into HPMS at the Contract level:

Element Letter	Element Name	Definition	Allowable Values
A.	Number of redeterminations made in the reporting period	Indicate the total number of redetermination decisions made by the plan in the reporting period.	• Field type: Number. • Should not include requests that were withdrawn by the requestor or dismissed by the plan. • Is based on date the redetermination decision was made during the reporting time-period. • Should include all decisions (fully favorable, partially favorable, and

Element Letter	Element Name	Definition	Allowable Values
			adverse).
B.	Number of redeterminations that were processed timely	Of the total reported in A, indicate the number of redetermination decisions made by the plan that were processed timely in the reporting period.	• Field type: Number. • Is a subset of A. See 22nd, 23rd, and 24th notes below regarding definition of a timely redetermination.
C.	Number of redeterminations that were fully favorable	Of the total reporting in A, indicate the number of redetermination decisions made by the plan that were fully favorable in the reporting period.	• Field type: Number. • Is a subset of A.
D.	Number of redeterminations that were partially favorable	Of the total reported in A, indicate the number of redetermination decisions made by the plan that were partially favorable in the reporting period.	• Field type: Number. • Is a subset of A.
E.	Number of redeterminations that were adverse	Of the total reporting in A, indicate the number of redetermination decisions made by the plan that were adverse in the reporting period.	• Field type: Number. • Is a subset of A.
F.	Number of requests for redeterminations that were withdrawn in the reporting period	The total number of requests for redeterminations that were withdrawn in the reporting period.	• Field type: Number.
G.	Number of requests for redeterminations that were dismissed in the reporting period	The total number of requests for redeterminations that were dismissed in the reporting period.	• Field type: Number.

3. Reopenings

Data elements to be entered into HPMS at the Contract level:

Element Letter	Element Name	Definition	Allowable Values

Element Letter	Element Name	Definition	Allowable Values
A.	Number of reopened (revised) decisions in the reporting period	Indicate the total number of reopened (revised) decisions made by the plan, for any reason, in the reporting period.	• Field type: Number.

Data elements to be uploaded into HPMS at the Contract level:

Element Letter	Element Name	Definition	Allowable Values
B.	For each case that was reopened: 1. Contract Number, 2. Plan ID, 3. Case ID, 4. Date of original disposition, 5. Original disposition, 6. Case level, 7. Date case was reopened, 8. Reason(s) for reopening, 9. Date of reopening disposition (revised decision), 10. Reopening disposition	Provide case information for each reopened case.	• These data will be uploaded into HPMS, please refer to file layout below, "Reopenings Data – File Record Layout". • Is a subset of element 3.A.

Reopenings Data File Record Layout

(Data listed in data element B above)

Required File Format = ASCII File - Tab Delimited
Do not include a header record
Filename extension should be ".TXT"
There can be multiple records per plan.

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
Contract_Number	CHAR Required	5 Exactly	Provide the CMS issued contract number. (Note: The system shall validate the contract number is valid.)	H1234

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
Plan_ID	CHAR Required	3 Exactly	Provide the ID (with leading zeros as appropriate) of the Plan Benefit Package (PBP). (Note: The system shall validate the plan ID is valid.)	801 or 001
Case_ID	CHAR Required	150	Provide the Case ID.	
Original_Disposition_Date	CHAR Required	8	Provide the date of original disposition. The format is MMYYYY, so the sample is intended to depict June 1, 2014 (06012014). (Note: The system shall validate that the month is a value of 01 to 12 and the day is a value of 01 to 31.)	06012014
Original_Disposition	CHAR Required	1	Provide the original disposition. (Enter 1 for Fully Favorable, or 2 for Partially Favorable, or 3 for Adverse original disposition.)	1 or 2 or 3
Case_Level	CHAR Required	1	Provide case level. (Enter 1 for Coverage Determination or 2 for Redetermination).	1 or 2
Case_Reopened_Date	CHAR Required	8	Provide the date case was opened. The	06012014

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
			format is MMDDYYYY, so the sample is intended to depict June 1, 2014 (06012014). (Note: The system shall validate that the month is a value of 01 to 12 and day is a value of 01 to 31.)	
Reopening_Reason	CHAR Required	250	Provide reasons for reopening (Clerical Error, New and Material Evidence, Fraud or Similar Fault, or Other).	
Reopening Disposition_Date	CHAR Conditional Required	8	Provide the date of reopening disposition. The format is MMDDYYYY, so the sample is intended to depict June 1, 2014 (06012014). Note: 1. The system shall validate that the month is a value of 01 to 12.) 2. If “Pending” is selected for Reopening Disposition field below, please leave this field blank.	06012014
Reopening_Disposition	CHAR Required	1	Provide reopening disposition. (Enter 1 for Fully	1 or 2 or 3 or 4

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
			Favorable, or 2 for Partially Favorable, or 3 for Adverse, or 4 for Pending reopening disposition.)	

B. QA checks/Thresholds - procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.
   - CMS' outlier notifications serve only to give Part D sponsors the opportunity to correct submitted data if needed, and does not indicate that submitted data are incorrect, or that resubmissions are required.
   - The rate of exception requests per 1,000 enrollees will be examined for outlier data. After accounting for enrollment, plans with values above the 95th percentile for their plan type or below the 5th percentile for their plan type will be flagged as outliers.
   - The percent of coverage determinations requests approved by the plan will be examined for outlier data. Plans with values above the 95th percentile or below the 5th percentile for their plan type will be flagged as outliers.
   - CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from Part D Plans.
   - The rate of redeterminations per 1,000 enrollees will be examined for outlier data. After accounting for enrollment, plans with values above the 95th percentile for their plan type or below the 5th percentile for their plan type will be flagged as outliers.
   - The percent of redeterminations resulting in a full or partial reversal of the original decision will be examined for outlier data. After accounting for the number of redeterminations filed, plans with values above the 95th percentile or below the 5th percentile for their plan type will be flagged as outliers.
   - The percent of redeterminations resulting in upholding the original decision will be examined for analysis purposes.
   - The rate of reopenings per 1,000 enrollees will be examined for outlier data. After accounting for enrollment, plans with values above the 95th percentile for their plan type or below the 5th percentile for their plan type will be flagged as outliers. CMS will also identify outliers in the percent of coverage determinations and redeterminations that are reopened.

C. Edits and Validation Checks - validation checks that should be performed by each Part D Sponsor prior to data submission.
   - Confirm those data elements listed above as subsets of other elements.
   - Plans should validate that data element 1.M is less than or equal to data element 1.L.
   - Plans should validate that data elements 1.O, 1.P, and 1.Q add up to the number in data element 1.L.

- Plans should validate that data element 2.B is less than or equal to data element 2.A.
- Plans should validate that data elements 2.C, 2.D, and 2.E add up to the number in data element 2.A.
- Plans should validate for element 3.B that the Case_Reopened_Date field is later than or equal to the Original_Disposition_Date field and that Reopening_Disposition_Date field is later than or equal to Case_Reopened_Date field.
- All data elements should be positive values.

D. Analysis- how CMS will evaluate reported data, as well as how other data sources may be monitored.
   - CMS will evaluate exception rates per 1,000 enrollees and will trend rates from quarter to quarter and from previous years.
   - Rates of appeals will be calculated per 1,000 enrollees. This means the total appeal rate per 1,000 enrollees is equal to the sum of the total number of appeals divided by average enrollment, times 1,000.

$$[\text{Total Appeal Rate per 1,000 enrollees}] = \frac{\text{Total \# Appeals}}{\text{Avg. Enrollment}} \times 1{,}000$$

E. Notes – additional clarifications to a reporting section.

Pharmacy Transactions:

1. Part D Plans should include all types of quantity limit rejects in these data. (Including but not limited to claim rejections due to quantity limits or time rejections (e.g. a claim is submitted for 20 tablets/10 days, but is only approved for 10 tablets/5 days).

Coverage Determinations and Exceptions:

2. Sponsors should refer to 42 CFR §423.566, §423.568, §423.570, §423.572, §423.576, and §423.578 and Chapter 18, Sections 10, 30, 40, 50 and 130 of the Prescription Drug Benefit Manual for additional information regarding Part D coverage determinations, including exceptions.
3. If a sponsor decides not to provide or pay for a required benefit, in whole or in part, then the decision is an adverse coverage determination and the Sponsor must provide the enrollee with a written denial notice. To ensure consistent reporting by all sponsors, CMS has included data fields for plans to report partially favorable decisions and expects decisions that are only partially favorable are not reported as favorable decisions.
4. Requests for coverage determinations, including exceptions, are reported based on the decision date.
5. Coverage determination requests that relate to Part B versus Part D coverage are included in this reporting. Point of Sale (POS) claims adjudications (e.g., a rejected claim for a drug indicating a B v. D PA is required) are NOT included unless the plan subsequently processed a coverage determination. A drug that is ultimately covered under Part B should be considered for this reporting as an adverse decision under Part D.

6. Drug or classes of drugs, or their medical uses which are statutorily excluded from coverage under Part D should not be included in this reporting.
7. In the event that a beneficiary files one coverage determination request containing multiple distinct disputes (i.e., multiple drugs), plans should count each dispute as a separate request.
8. Exception requests include tiering exceptions, exceptions to a PA or other UM requirement, and requests for drugs that are not included on the plan's formulary.
9. A request for an exception to a plan's PA criteria could be processed as a coverage determination or as a redetermination, depending if the plan has received the beneficiary's initial PA request, and denied it. Plans' reporting should be based on the manner in which each request for exception to a plan's PA criteria is processed.
10. Beneficiaries who have Utilization Management (UM) requirements waived based on an exception decision made in a previous plan year or reporting period are not considered as exception requests; and therefore, should not be reported.
11. A coverage determination is timely only when the sponsor makes a decision and appropriately notifies the enrollee and physician (if applicable) of the decision within the applicable adjudication timeframe. For favorable decisions, sponsors must also authorize or provide the benefit (or payment) under dispute within the applicable adjudication timeframe. Sponsors should refer to Chapter 18, Sections 40, 50, and 130 of the Prescription Drug Benefit Manual.
12. Untimely cases forwarded to the Independent Review Entity (IRE) are included in this reporting, and should be included as untimely coverage determinations as well as adverse decisions. Sponsors should include the cases auto-forwarded to the IRE based on the date notification was sent to the member informing him/her that their case has been referred to the IRE.
13. If a sponsor does not provide notice of a coverage determination within the required timeframe, then the case must be forwarded to the IRE, and the sponsor must send a notice to the enrollee informing him or her that their case has been referred to the IRE. Sponsors should refer to Chapter 18, Sections 40.4 and 50.6 of the Prescription Drug Benefit Manual.
14. Untimely cases that were approved (fully favorable to the enrollee) and the enrollee notified within 24 hours of the expiration of the adjudication timeframe are not auto-forwarded to the IRE but should be included in element 1.N.
15. While CMS does not currently prescribe the manner in which Part D plans should process invalid or withdrawn coverage determination requests, as a best practice, we do expect plans to develop policies and procedures for processing and responding to coverage determinations that are either withdrawn by the requestor or dismissed by the plan. CMS expects that coverage requests that are withdrawn or dismissed represent a very small percentage of total Part D coverage requests a plan receives. However, these elements have been added to provide plans with a means to report requests that are received and processed but are not adjudicated as either favorable or adverse by the plan.

- Generally, a dismissal would occur when the procedural requirements for a valid request are not met and the plan is unable to cure the defect. For example, a coverage determination request is received from a purported representative of the enrollee. The plan has been unable to obtain the required documentation within a reasonable amount of time and therefore dismisses the request. Sponsors should refer to Chapter 18, section 10.4.1 for guidance on processing coverage determination, redetermination and grievance requests from enrollee representatives.
- An example of a withdrawn request: a coverage determination is requested by an enrollee for a drug that requires step therapy. Before the plan issues the coverage determination, and before the timeframe expires and the plan loses jurisdiction of the case and must forward to the IRE, the enrollee speaks to her prescriber and learns that she can take the covered alternative, then calls her plan and asks them not to process her coverage request.

CMS strongly encourages plans to document withdrawn coverage requests in their systems, including the date and the reason the request was withdrawn.

16. Plans will be allowed to submit coverage determinations reports in HPMS on or around 12/29/2014.

Redeterminations:

17. Refer to 42 CFR §423.580, §423.582, §423.584, and §423.590 and Chapter 18, Sections 10, 70 and 130 of the Prescription Drug Benefit Manual for additional information regarding Part D redeterminations.
18. Redetermination requests are reported based on the decision date.
19. Redetermination requests that relate to Part B versus Part D coverage are included in this reporting if they are processed under the plan's Part D redetermination process. Point of Sale (POS) claims adjudications (e.g., a rejected claim for a drug indicating a B v. D PA is required) are NOT included unless the plan subsequently processed a coverage determination. A drug that is ultimately covered under Part B should be considered for this reporting as an adverse decision Part D.
20. Drug or classes of drugs, or their medical uses which are statutorily excluded from coverage under Part D should not be included in this reporting.
21. In the event that a beneficiary files one redetermination request containing multiple distinct disputes (i.e., multiple drugs), plans should count each dispute as a separate request.
22. A redetermination is timely only when the sponsor makes a decision and appropriately notifies the enrollee of the decision within the applicable adjudication timeframe. For favorable decisions, sponsors must also authorize or provide the benefit (or payment) under dispute within the applicable adjudication timeframe. Sponsors should refer to Chapter 18, Sections 70 and 130 of the Prescription Drug Benefit Manual.
23. Untimely cases forwarded to the Independent Review Entity (IRE) are included in this reporting, and should be included as untimely redeterminations as well as adverse decisions. Sponsors should include the

cases auto-forwarded to the IRE based on the date notification was sent to the member informing him/her that their case has been referred to the IRE.

24. If a Sponsor does not provide notice of a decision within the required timeframe, then the case should be forwarded to the IRE, and the Sponsor must send a notice to the enrollee informing him or her that their case has been referred to the IRE. Sponsors should refer to Chapter 18, Sections 70.7.1 and 70.8.2 of the Part D Manual.
25. While CMS does not currently prescribe the manner in which Part D plans should process invalid or withdrawn redetermination requests, as a best practice, we do expect plans to develop policies and procedures for processing and responding to redetermination requests that are either withdrawn by the requestor or dismissed by the plan. CMS expects that coverage requests that are withdrawn or dismissed represent a very small percentage of total Part D coverage requests a plan receives. However, these elements were added to provide plans with a means to report requests that are received and processed but are not adjudicated as either favorable or adverse by the plan.
    - Generally, a dismissal would occur when the procedural requirements for a valid request are not met and the plan is unable to cure the defect. For example, a redetermination request is received from a purported representative of the enrollee. The plan has been unable to obtain the required documentation within a reasonable amount of time and therefore dismisses the request. Sponsors should refer to Chapter 18, section 10.4.1 for guidance on processing coverage determination, redetermination and grievance requests from enrollee representatives.
    - An example of a withdrawn request: a redetermination is requested by an enrollee for a drug that requires step therapy. Before the plan issues the redetermination, and before the timeframe expires and the plan loses jurisdiction of the case and must forward to the IRE, the enrollee speaks to her prescriber and learns that she can take the covered alternative, then calls her plan and asks them not to process her coverage request.

    CMS strongly encourages plans to document withdrawn coverage requests in their systems, including the date and the reason the request was withdrawn.
26. Plans will be allowed to submit redeterminations reports in HPMS on or around 12/29/2014.

Reopenings (Coverage Determinations and Redeterminations):

27. A reopening is a remedial action taken to change a binding determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record.
28. Plans should refer to 42 CFR §423.1978-1986 and Chapter 18, section 120 of the Medicare Prescription Drug Benefit Manual for additional information and CMS requirements related to reopenings.
29. Plan sponsors should exclude Point of Sale (POS) claims transactions which were subsequently revised for purposes of this reopening reporting element, because plans are not required to treat the presentation of a prescription at

the pharmacy counter as a request for a coverage determination. All reopened coverage determinations and redeterminations should be included.

30. The following elements are included in the data upload:
    1. Contract number
    2. Plan ID
    3. Case ID—this is the unique internal tracking number the plan assigned to the case that is being reopened.
    4. Date of original disposition—the date the plan issued the written notification to the enrollee. If the plan reopened a coverage determination, this is the date of the original coverage determination. If the plan reopened a redetermination, it is the date of the original redetermination.
    5. Original Disposition—plans should populate this field with one of the 3 selections: Fully Favorable, Partially Favorable or Adverse.
    6. Case Level—plans should populate this field with one of the 2 selections (Coverage Determination or Redetermination) based on the type of decision that was reopened. If an enrollee requests a redetermination (and the request is valid), the plan has no jurisdiction to reopen the coverage determination and must instead process the request as an appeal.
    7. Date case was reopened—plans should populate this field with the date the plan determined to reopen the original decision. This may be the same as the date of the reopening disposition.
    8. Reason for reopening—plans should populate this field with one of the following 4 selections: Clerical Error; New and Material Evidence; Fraud or Similar Fault; or Other (all reopened determinations or decisions that do not belong in the categories above).
    9. Date of reopening disposition—the date the plan revised the original disposition in its system and sent written notification to the enrollee. See 42 CFR §423.1982.
    10. Reopening disposition—plans should populate this field with one of the 4 selections: Fully Favorable, Partially Favorable, Adverse or Pending. Pending has been included for cases where the plan is still processing the reopening, i.e., the revised decision has not been issued in accordance with §423.1982).
31. For cases that are in a reopening status across multiple reporting periods, plans should report those cases in each applicable reporting period. For example, if a plan reopened a coverage determination on 3/15/2014 and sent the notice of the revised decision on 4/22/2014, that case should be reported as “pending” in the Q1 data file and then as resolved in Q2 (either Fully Favorable, Partially Favorable or Adverse).
32. Plans will be allowed to submit reopening reports in HPMS on or around 12/29/2014.

VII. Long-term Care (LTC) Utilization

A. Data element definitions – details for each data element reported to CMS, including examples, methods for calculations, and how various data elements are associated.

Data elements A, B, C and E will be entered into HPMS.
Data listed under data element D will be uploaded into HPMS, per the file layout listed below at the contract level for each state or service area.

Element Letter	Element Name	Definition	Allowable Values
A.	Number of network LTC pharmacies	The total number of network LTC pharmacies in the service area. PDPs, regional PPOs and MA-PDs will report at the Contract level.	• Field type: Number. • Count a pharmacy that is both LTC and retail in both elements A and B, and report corresponding claims/utilization specific to business lines in elements D and E. If claims/utilization cannot be split, report the pharmacy and its claims/utilization as a LTC pharmacy only (data elements A and D). • Include any LTC pharmacy that is active in the network (that is, contracted with the Part D sponsor) for 1 or more days in the reporting period. Include LTC pharmacies that do not have utilization; in element D, enter zeroes for number and cost of prescriptions.
B.	Number of network retail pharmacies	The total number of network retail pharmacies in the service area. PDPs, regional PPOs and MA-PDs will report at the Contract level.	• Field type: Number. • Count a pharmacy that is both LTC and retail in both elements A and B, and report corresponding claims/utilization specific to business lines in elements D and E. If claims/utilization cannot be split, report the pharmacy and its claims/utilization as a LTC pharmacy only (data elements A and D). • Include any retail pharmacy

Element Letter	Element Name	Definition	Allowable Values
			that is active in the network (that is, contracted with the Part D sponsor) for 1 or more days in reporting period. • Include retail pharmacies that do not have utilization.
C.	Number of beneficiaries in LTC facilities for whom Part D drugs have been provided under the Contract	The total number of distinct beneficiaries in LTC facilities for whom Part D drugs have been provided under the Contract. PDPs, regional PPOs and MA-PDs will report at the Contract level.	• Field type: Number. • Do not report beneficiaries for whom only claims for non-Part D drugs were received, e.g. excluded or OTC drugs. • Do not report beneficiaries more than once; the total number is a distinct count of beneficiaries. • Claims with patient residence code 03 may be used to identify enrollees. The LTI report may be another tool for this reporting. • Include any LTC pharmacy that is active in the network for 1 or more days in reporting period. • Include all covered enrollees, regardless of whether the LTC pharmacy is located in the service area.
D.	For each network LTC pharmacy in the service area: a. LTC pharmacy name b. LTC pharmacy NPI Number c. Contract entity name of LTC pharmacy d. Chain code of LTC pharmacy e. Number of	Non-formulary drugs are drugs that are not on a Plan's Part D formulary but approved for coverage via the exceptions process, or under the transition policy. PDPs, regional PPOs and MA-PDs will report at the Contract level.	• These data will be uploaded into HPMS, please refer to file layout below, "Long-term Care (LTC) Pharmacy Data – File Record Layout". • Is a subset of element A. • Include any LTC pharmacy that is active in the network (that is, contracted with the Part D sponsor) for 1 or more days in reporting period should be included. • Enter "Not Available" in the Chain Code field, if the pharmacy chain code is unknown or does not exist. • A formulary drug is a drug included on a Part D plan's

Element Letter	Element Name	Definition	Allowable Values
	31-day equivalent formulary prescriptions dispensed f. Number of 31-day equivalent non-formulary prescriptions dispensed g. Cost of formulary prescriptions h. Cost of non-formulary prescriptions		CMS approved formulary, including drugs with utilization management (UM) restrictions e.g. prior authorization or step therapy. • A non-formulary drug is a drug that is not included on a Part D plan's CMS approved formulary. • Report the total number of prescriptions dispensed for Part D drugs by fill date (not batch date). • Calculate the number of 31-day equivalent prescriptions by summing the days supply of all covered Part D prescriptions dispensed, and dividing by 31. • Cost of prescriptions is defined as the sum of the total ingredient cost, dispensing fee, sales tax and vaccine administration fee. The ingredient cost should reflect the Plan's negotiated price. • Include LTC pharmacies that do not have utilization; in element D, enter zeroes for number and cost of prescriptions. • Include any pharmacy that services a LTC facility. • Claims with patient residence code 03 may be used to identify LTC pharmacies.
E.	In aggregate, for all retail pharmacies in the service area: a. Number of 30-day equivalent formulary prescriptions	Non-formulary drugs are drugs that are not on a Plan's Part D formulary but approved for coverage via the exceptions process, or under the transition policy. PDPs, regional PPOs	• Is based on network retail pharmacies in the service area. • Is a subset of B. • Number of prescriptions is a numeric field, and cost of prescriptions is a currency field. • A formulary drug is a drug

Element Letter	Element Name	Definition	Allowable Values
	dispensed b. Number of 30-day equivalent non-formulary prescriptions dispensed c. Cost of formulary prescriptions d. Cost of non-formulary prescriptions	and MA-PDs will report at the Contract level.	included on a Part D plan's CMS approved formulary, including drugs with utilization management (UM) restrictions e.g. prior authorization or step therapy. • A non-formulary drug is a drug that is not included on a Part D plan's CMS approved formulary. • Report the total number of prescriptions dispensed for Part D drugs by fill date (not batch date). • Calculate the number of 30-day equivalent prescriptions is calculated by summing the days supply of all covered Part D prescriptions dispensed, and dividing by 30. • Cost of prescriptions is defined as the sum of the total ingredient cost, dispensing fee, sales tax and vaccine administration fee. The ingredient cost should reflect the Plan's negotiated price. • Include any retail pharmacy that is active in the network (that is, contracted with the Part D sponsor) for 1 or more days in reporting period.

Long-term Care (LTC) Pharmacy Utilization Data – File Record Layout
(Data listed in data element D above)

Required File Format = ASCII File - Tab Delimited
Do not include a header record
Filename extension should be ".TXT"

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
NPI_Number	NUM Required	Exactly 10	Indicate the contracted LTC pharmacy NPI number (exactly 10 digits). Enter 9999999999 if a pharmacy's NPI cannot be identified.	1234567809
Pharmacy_Name	CHAR Required	150	Provide the name of the LTC pharmacy in the service area.	ABC LTC Pharmacy
Contract_Name	CHAR Required	150	Enter the Contract entity name of the LTC pharmacy in the service area.	Health Care Pharmacies, Inc.
Chain_Code	CHAR Required	150	Enter the chain code of the LTC pharmacy in the service area.	ABC
Formulary_ Prescriptions_ Dispensed	NUM Required	7	Enter the number of 31-day equivalent formulary prescriptions for each network LTC pharmacy in the service area.	9999999
Non_Formulary_ Prescriptions_ Dispensed	NUM Required	7	Enter the number of 31-day equivalent non-formulary prescriptions for each network LTC pharmacy in the service area.	9999999
Cost_Formulary_ Prescriptions	NUM Required	11	Enter the cost of formulary prescriptions for each network LTC pharmacy in the service area. 2 decimal points are allowed.	99999999.99 or 99999999999

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
Cost_ Non_Formulary_ Prescriptions	NUM Required	11	Enter the cost of non-formulary prescriptions for each network LTC pharmacy in the service area. 2 decimal points are allowed.	99999999.99 or 99999999999

B. QA checks/Thresholds - procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.
    - CMS' outlier notifications serve only to give Part D sponsors the opportunity to correct submitted data if needed, and does not indicate that submitted data are incorrect, or that resubmissions are required.
    - CMS may apply new quality assurance checks and threshold validations based upon data received from Part D Plans.

C. Edits and Validation Checks - validation checks that should be performed by each Part D Sponsor prior to data submission.
    - CMS requires sponsors perform validation checks and edits; however, we do not specify particular checks and/or edits that must be used.

D. Analysis- steps taken by CMS to evaluate reported data, as well as how other data sources may be monitored along with these data.
    - Rates of formulary and non-formulary utilization and costs will be calculated by LTC pharmacy and entity. Retail rates will be used for comparative purposes.
    - The percent of enrollees receiving prescriptions from LTC facilities will be taken into account when identifying LTC utilization outliers.

E. Notes – additional clarifications to a reporting section.
    1. Claims from all facilities considered LTC are included, e.g. ICFMR.
    2. Claims during a transition period are included.
    3. Medicare Secondary Payer (MSP) claims are excluded.
    4. The fill date is used when reporting this section.
    5. The type of pharmacy (LTC or retail) is in accordance with the type of contract between the pharmacy and the Part D sponsor. For example, only those pharmacies with a retail contract are included in data elements B and E.
    6. For Contract_Name, the LTC pharmacy name can be entered if it is not associated with a contract entity, the LTC pharmacy name.
    7. To complete the data entry portion of this reporting section, contracts will first need to upload their LTC Pharmacy Data file. Once the file has been successfully uploaded, contracts will then be able to enter data for data elements A, B, C and E.
    8. Employer-Direct PDPs, Employer-Direct PFFS, and any other contracts that have only 800 series plans are excluded from this reporting. Contracts with

both 800-series plans and individual plans report only data for individual plans.

9. Plans must upload the LTC Utilization Pharmacy Utilization data file before entering the data entry elements into HPMS. Once the data file is successfully uploaded, HPMS will prompt the plan user to enter the data entry elements. To submit this report, plans should follow the path below:
   HPMS>Quality and Performance>Plan Reporting Module>CY2014>Uploads>Part D – LTC Utilization>Contract Number

VIII. Fraud, Waste and Abuse Compliance Programs

NOTE: EFFECTIVE JANUARY 2014, THIS REPORTING SECTION IS BEING SUSPENDED FROM THE 2014 PART D REPORTING REQUIREMENTS.

A. Data element definitions - details for each data element reported to CMS, including examples, methods for calculations, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Number of potential fraud and abuse incidents related to inappropriate billing (i.e. inadvertent billing errors, duplicate billing).	The number of potential fraud and abuse incidents related to inappropriate billing. Inappropriate billing by pharmacies is included.	• Field type: Number. • Subset of F.
B.	Number of potential fraud and abuse incidents related to providing false information.	The number of potential fraud and abuse incidents related to providing false information.	• Field type: Number. • Subset of F.
C.	Number of potential fraud and abuse incidents related to doctor shopping/drug seeking beneficiary.	The number of potential fraud and abuse incidents related to doctor shopping/drug seeking beneficiary.	• Field type: Number. • Subset of F.
D.	Number of potential fraud and abuse incidents related to attempting to steal identity/money.	The number of potential fraud and abuse incidents related to attempting to steal identity/money.	• Field type: Number. • Subset of F.
E.	Number of potential fraud and abuse incidents related to other areas not listed above.	The number of potential fraud and abuse incidents related to other areas not listed above (e.g. OIG exclusion list, and broker/ agent complaints).	• Field type: Number. • Subset of F.
F.	Total number of potential fraud and abuse incidents identified.	The total number of potential fraud and abuse incidents identified.	• Field type: Number.
G.	Number of potential incidents identified through internal efforts.	Of the total reported in F, the number identified through internal efforts.	• Field type: Number. • This is a subset of F.

Element Letter	Element Name	Definition	Allowable Values
H.	Number of potential incidents received from external sources.	Of the total reported in F, the number of incidents received from external sources. Incidents reported through the Complaints Tracking Module (CTM) or as grievances are included.	• Field type: Number. • This is a subset of F.
I.	Number of potential fraud and abuse incidents that were closed	Of the total reported in F, the number of potential fraud and abuse incidents that were closed by the Sponsor.	• Field type: Number. • This is a subset of F.
J.	Number of inquiries initiated by the Sponsor as a result of potential fraud and abuse incidents.	The number of inquiries initiated by the Sponsor as a result of potential fraud and abuse incidents.	• Field type: Number.
K.	Number of corrective actions initiated by the Sponsor as a result of potential fraud and abuse incidents.	The number of corrective actions initiated by the Sponsor as a result of potential fraud and abuse incidents.	• Field type: Number.
L.	Number of potential fraud and abuse incidents referred to CMS for action.	The number of potential fraud and abuse incidents referred to CMS for action; includes referrals to CMS staff, MEDICs, or other CMS designated program safeguard contractor.	• Field type: Number. • Is a subset of F.
M.	Number of potential fraud and abuse incidents referred to federal law enforcement for action.	The number of potential fraud and abuse incidents referred to federal law enforcement for action. This includes referrals to the OIG, FBI, DEA, and FDA.	• Field type: Number. • Is a subset of F.
N.	Number of potential fraud and abuse incidents referred to local law enforcement for action.	The number of potential fraud and abuse incidents referred to local law enforcement for action; this includes but is not limited to referrals to state, county, township, or province police.	• Field type: Number. • Is a subset of F.

Element Letter	Element Name	Definition	Allowable Values
O.	Number of potential fraud and abuse incidents referred to State Insurance Commissioners (SICs) or state licensing authorities.	The number of potential fraud and abuse incidents referred to State Insurance Commissioners (SICs) or state licensing authorities.	• Field type: Number. • Is a subset of F.

B. QA checks/Thresholds - procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.
    - CMS' outlier notifications serve only to give Part D sponsors the opportunity to correct submitted data if needed, and does not indicate that submitted data are incorrect, or that resubmissions are required.
    - CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from Part D Plans.

C. Edits and Validation Checks - validation checks that should be performed by each Part D Sponsor prior to data submission.
    - The sum of elements A, B, C, D, and E should be equal to element F.

D. Analysis- how CMS will evaluate reported data, as well as how other data sources may be monitored.
    - To be determined.

E. Notes - additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
    1. Employer Direct plan sponsors are exempt from this reporting section.
    2. Part D Sponsors may voluntarily report aggregate data related to their anti-fraud, waste and abuse activities.

IX. Employer/Union-Sponsored Group Health Plan Sponsors

A. Data element definitions - details for each data element reported to CMS, including examples, methods for calculations, and how various data elements are associated.

Employer Group Plan Sponsor Upload File Format

Required File Format = ASCII File - Tab Delimited
Do not include a header record.
Filename extension should be ".TXT"
There can be multiple records per plan.

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
Contract_Number	CHAR Required	5 Exactly	Provide the CMS issued contract number being offered to the Employer Group Plan Sponsor. (Note: The system shall validate the contract number is valid.)	H1234
Plan_ID	NUM Required	3 Exactly	Provide the ID (with leading zeros as appropriate) of the Plan Benefit Package (PBP) being offered to the Employer Group Plan Sponsor. (Note: This is a numeric field only. The system shall validate the plan ID is valid.)	801 or 001
Employer_Legal_ Name	CHAR Required	150	Provide the legal name of the Employer Group Plan Sponsor.	United Parcel Service
Employer_DBA_N ame	CHAR Optional	150	If applicable provide the doing business as (DBA) name of the Employer Group Plan Sponsor.	United Parcel Service Employees Association
Employer_Federal _Tax_ID	NUM Required	Minimum of 9, Maximum of 20	Provide the federal tax ID of the Employer Group Plan Sponsor. (Note: This is a numeric field only. This must be a minimum of 9 digits and cannot be more than 20 digits.)	223849199

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
Employer_Street_ Address	CHAR Required	150	Provide the street address of the Employer Group Plan Sponsor headquarters.	1212 North Luther Street
Employer_City_A ddress	CHAR Required	75	Provide the city in which the Employer Group Plan Sponsor headquarters is located.	Wichita
Employer_State_ Address	CHAR Required	2	Provide the state abbreviation in which the Employer Group Plan Sponsor headquarters is located. (Note: The system shall validate the state abbreviation is appropriate.)	MO
Employer_Zip_Ad dress	NUM Required	10	Provide the Employer Group Plan Sponsor headquarters' zip code. (Note: This is a numeric field only. This field must be a minimum of 5 digits and leading zeroes are required.)	00123 00123-0123 001230123
Employer_Sponso r_Type	NUM Required	1	Indicate the Employer Group Plan Sponsor Type; acceptable values provided as sample. (Note: This is a numeric field only. The system shall validate the value is 1 through 3.)	1=Employer 2=Union 3=Trustees of a Fund
Employer_Organi zation_ Type	NUM Required	1	Indicate the Employer Group Plan Organization Type; acceptable values provided as sample. (Note: This is a numeric field only. The system shall validate the value is 1 through 7.)	1=State Government 2=Local Government 3=Publicly Traded Corp. 4=Privately Held Corp. 5=Non-Profit 6=Church Group 7=Other
Employer_Contra ct_Type	NUM Required	1	Indicate the Employer Group Plan Contract	1=Insured 2=ASO

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
			Type; acceptable values provided as sample. (Note: This is a numeric field only. The system shall validate the value is 1 through 3.)	3=Other
Calendar_Year_Plan	NUM Required	1	Provide the answer whether this is a calendar year plan.	1=Yes 2=No
Non_Calendar_Year_Start_Date	NUM Required	6	Provide the non-calendar year start date if the Calendar_Year_ Plan field is "2=No." The format is MMYYYY, so the sample is intended to depict June 2014 (062014). (Note: This is a numeric field only. The system shall validate that the month is a value of 01 to 12.)	062014
Employer_Enrollment	NUM Required	7	Provide the current enrollment for the Employer Group Plan Sponsor. (Note: This is a numeric field only. Do not include commas.)	9999999

B. QA checks/Thresholds - procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.
    - CMS' outlier notifications serve only to give Part D sponsors the opportunity to correct submitted data if needed, and does not indicate that submitted data are incorrect, or that resubmissions are required.
    - CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from Part D Plans.

C. Edits and Validation Checks - validation checks that should be performed by each Part D Sponsor prior to data submission.
    - N/A.

D. Analysis- how CMS will evaluate reported data, as well as how other data sources may be monitored.
    - To be determined.

E. Notes - additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
    1. This reporting requirement applies only to individual PDPs and “800 series” PDPs offered to employers. MA-PD plans already report these data as part of the Part C reporting requirements and are therefore exempt from this Part D reporting. Individual PDPs and “800 series” PDPs that have been identified as having the same parent organization as a MA-PD plan are also exempt from this Part D reporting.
    2. HPMS displays one module for reporting both Part C and Part D Employer/Union-Sponsored Group Health Plan Sponsors data.
    3. Each Part D contract will upload a file containing plan level data.
    4. Refer to Part C Technical Specifications for additional guidance.

X. Plan Oversight of Agents

A. Data element definitions - details for each data element reported to CMS, including examples, methods for calculations, and how various data elements are associated.

1. Agent/Broker

Data elements to be uploaded into HPMS at the Contract level.

Agent/Broker Data - File Record Layout

Required File Format = ASCII File - Tab Delimited
Do not include a header record.
Filename extension should be ".TXT"
There can be multiple records per plan.

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
Contract_Number	CHAR Required	5 Exactly	Provide the CMS issued contract number being offered to the Employer Group Plan Sponsor. (Note: The system shall validate the contract number is valid.)	H1234
Agent/Broker (A/B) Type (C = Captive; E = Employed; I = Independent; N = None)	CHAR Required	1 Exactly	The type of agent/broker used for each beneficiary enrollment. (Note: The system shall validate the value is C, E, I or N.)	C = Captive E = Employed I = Independent N = None
Agent/Broker (A/B) Last Name	CHAR Required	50	If the enrollment was facilitated by an agent/broker or one was assigned after enrollment, provide the last name of the agent/broker.	Doe
Agent/Broker (A/B) First Name	CHAR Optional	50	If the enrollment was facilitated by an agent/broker or one was assigned after enrollment, provide the first name of the agent/broker (optional).	John
Agent/Broker (A/B) Middle Initial	CHAR Required	2	If the enrollment was facilitated by an agent/broker or one was assigned after enrollment, provide the middle initial of the agent/broker.	M

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
State Licensed	CHAR Required	2	Indicate the State where agent/broker is licensed. This field should be comma-delimited; state abbreviations should be separated with a comma. (Note: The system shall validate the state abbreviation is appropriate.)	MA
Agent/Broker (A/B) National Producer Number (NPN)	CHAR Required	25	The number assigned to the agent/broker in the National Insurance Producer Registry (NIPR).	1234
Plan Assigned Agent/Broker (A/B) Identification Number	CHAR Required	25	The unique identification number assigned to the agent/broker by the plan.	1234
Agent/Broker Current License Effective Date	DATE Required	10 Exactly	Indicate the date the agent/broker's current license was effective.	02/16/2014
Agent/Broker Appointment Date	DATE Required	10 Exactly	Indicate the current agent/broker appointment date. (mm/dd/yyyy)	02/16/2014
Agent/Broker Training Completion Date	DATE Required	10 Exactly	Indicate date that agent/broker has completed all annual training requirements. (mm/dd/yyyy)	02/16/2014
Agent/Broker Testing Completion Date	DATE Required	10 Exactly	Indicate date that agent/broker completed all of the annual testing requirements with a passing score. (mm/dd/yyyy)	02/16/2014
# of Agent/Broker Complaints	NUM Required	12	Indicate aggregate number of complaints against the agent (across all licensed states). If multiple lines are needed for an agent (licensed in more than one state), only fill out this data element for the first line. For example, if an agent has four complaints and is licensed in Florida and Georgia, all four complaints should be listed under the Florida line.	10

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
# of Disciplinary Actions Taken	NUM Required	12	Indicate aggregate number of disciplinary actions taken related to marketing. Examples of disciplinary actions include: retraining, verbal or written warnings, suspension, termination, etc. If multiple lines are needed for an agent (licensed in more than one state), only fill out this data element for the first line. For example, if an agent has received two disciplinary actions and is licensed in Florida and Georgia, both actions should be listed under the Florida line.	5
Termination Date (if applicable)	Date Optional	10 Exactly	If the agent/broker was terminated during the year, indicate the date of termination. (mm/dd/yyyy)	02/16/2014
Termination for cause? (Y = Yes or N = No)	CHAR Required	1 Exactly	Enter Yes if the agent/broker was terminated for cause. Enter No if the agent/broker was terminated for another reason.	Y = Yes N = No
TMO/FMO Name	CHAR Optional	250	The name of the associated Third-party Marketing Organization (TMO)/Field Marketing Organization (FMO), if applicable.	ABC Global
# of New Enrollments	NUM Required	12	Indicate number of new enrollments generated by this agent/broker for the reporting period. If more than one line is filled out because of agent being licensed in multiple states, please put enrollments in by state.	50

2. New Enrollments
Data elements to be uploaded into Gentran/Tibco at the Contract level.

New Enrollments Data - File Record Layout

Required File Format = ASCII File - Tab Delimited
Do not include a header record.
Filename extension should be ".TXT"
There can be multiple records per plan.

Element Letter	Field Name	Field Type	Field Length	Start Position	End Position	Field Description
A.	Contract Number	CHAR REQUIRED	5	1	5	Please provide the Contract Number (e.g., H1234, S1234) for your organization.
B.	Plan Number	CHAR REQUIRED	3	6	8	Please provide Plan Beneficiary Package (PBP) Number (e.g., 001).
C.	Beneficiary Last Name	CHAR REQUIRED	30	9	38	For each eligible beneficiary, please provide the last name of each beneficiary identified to be eligible in the reporting period.
D.	Beneficiary First Name	CHAR REQUIRED	30	39	68	For each eligible beneficiary, the first name of each beneficiary identified to be eligible in the reporting period.

E.	Beneficiary Middle Initial	CHAR OPTIONAL	1	69	69	For each eligible beneficiary, please provide the middle initial of each beneficiary identified to be eligible in the reporting period.
F.	Beneficiary HICN or RRB Number	CHAR REQUIRED	12	70	81	For each distinct beneficiary identified to be eligible at any time in the reporting period, please provide the unique number that the Social Security Administration assigns to each Medicare beneficiary, which is the Health Insurance Claim number (HICN). For Railroad Retirement Board (RRB) beneficiaries, provide the RRB number in this field instead of the HICN.
G.	Agent/Broker Last Name	CHAR REQUIRED	30	82	111	Please provide the assigned Agent/Broker's last name.

H.	Agent/Broker First Name	CHAR REQUIRED	30	112	141	Please provide the assigned Agent/Broker's first name.
I.	Agent/Broker Middle Initial	CHAR OPTIONAL	1	142	142	Please provide the assigned Agent/Broker's middle initial.
J.	Agent/Broker National Producer Number (NPN)	CHAR REQUIRED	25	143	167	Please provide the Agent/Broker National Producer Number (NPN).
K.	Plan Assigned Agent/Broker Identification Number	CHAR REQUIRED	25	168	192	Please provide the Plan Assigned Agent/Broker Identification Number.
L.	Enrollment Mechanism	CHAR REQUIRED	50	193	242	Provide the Enrollment Mechanism. (Plan/Plan Representative Online; CMS Online Enrollment Center; Plan Call Center; 1-800-MEDICARE; Paper Application; Auto-Assigned/Facilitated; Other).
M.	Enrollment Application Date	DATE REQUIRED	8	243	250	Provide the Enrollment Application Date (YYYYMMDD).
N.	Enrollment Effective Date	DATE REQUIRED	8	251	258	Provide the Enrollment Effective Date (YYYYMMDD).

O.	Number of Agent/Broker complaints	NUMERIC REQUIRED	3	259	261	Please provide the number of Agent/Broker complaints filed by the beneficiary in the reporting period.
P.	Number of Marketing related complaints	NUMERIC REQUIRED	3	262	264	Of the number reported in O, please provide the number of Marketing related complaints.

B. QA checks/Thresholds - procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.
    - CMS' outlier notifications serve only to give Part D sponsors the opportunity to correct submitted data if needed, and does not indicate that submitted data are incorrect, or that resubmissions are required.

C. Edits and Validation Checks - validation checks that should be performed by each Part D Sponsor prior to data submission.
    - N/A

D. Analysis- how CMS will evaluate reported data, as well as how other data sources may be monitored.
    - To be determined.

E. Notes - additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
    1. 800 series plans and employer/union group contracts are exempt from this reporting section. For contracts with both non-800 series and 800-series plans, data for the 800-series plan(s) may be excluded.
    2. Enrollment mechanism definitions for New Enrollments Data file (element L):
        - Plan/Plan Representative Online – Any enrollments received via online enrollment mechanisms created by the plan or its representatives (including third-party marketing organizations). Plans should refer to Chapter 2 section 40.1.2 of the Medicare Managed Care Manual, Chapter 3 section 40.1.2 of the Medicare Prescription Drug Benefit Manual, and section 100.3 of the Medicare Marketing Guidelines.

- Online Enrollment Center – Any enrollments received electronically via the Medicare.gov Online Enrollment Center (OEC). Plans should refer to Chapter 2 section 40.1.2 of the Medicare Managed Care Manual, Chapter 3 section 40.1.2 of the Prescription Drug Benefit Manual and section 100.3 of the Medicare Marketing Guidelines.
- 1-800-MEDICARE – Any enrollments received via 1-800-MEDICARE.
- Paper Application – Any enrollments received as paper applications.
- Auto-assigned/Facilitated – Any enrollments that are auto-assigned or facilitated.
- Other – Any enrollments that are received via other mechanisms not listed above.

3. HPMS displays one module for reporting both Part C and Part D Plan Oversight of Agents data.
4. Reporting is required regardless of the plan's enrollment status.
5. Refer to Part C Technical Specifications for additional guidance.

XI. Summary of CY2014 Part D Reporting Requirements

Section	Report Level	Frequency	Report Period(s)	Data Due date(s)
Enrollment and Disenrollment	Contract	Biannually	1/1/2014 - 6/30/2014; 7/1/2014 - 12/31/2014	8/31/2014 2/28/2015
Retail, Home Infusion, and Long-Term Care Pharmacy Access	Subsection I: Contract; Subsections II and III: PBP	Annually	Subsection I: 1/1/2014 - 3/31/2014; Subsections II and III: 1/1/2014 - 12/31/2014	Subsection I: 5/31/2014 Subsections II and III: 2/28/2015
Medication Therapy Management Programs	Contract	Annually	1/1/2014 - 12/31/2014	2/28/2015
Prompt Payment by Part D Sponsors	Suspended	Suspended	Suspended	Suspended
Grievances	Contract	Annually	1/1/2014 - 3/31/2014; 4/1/2014 - 6/30/2014; 7/1/2014 - 9/30/2014; 10/1/2014 - 12/31/2014	2/28/2015

Section	Report Level	Frequency	Report Period(s)	Data Due date(s)
Coverage Determinations and Redeterminations	Contract	Annually	1/1/2014 - 3/31/2014; 4/1/2014 - 6/30/2014; 7/1/2014 - 9/30/2014; 10/1/2014 - 12/31/2014	2/28/2015
Long-Term Care (LTC) Utilization	Contract	Biannually	1/1/2014 - 6/30/2014; 7/1/2014 - 12/31/2014	8/31/2014 2/28/2015
Fraud, Waste and Abuse Compliance Programs	Suspended	Suspended	Suspended	Suspended
Employer/Union-Sponsored Group Health Plan Sponsors	PBP	Annually	1/1/2014 - 12/31/2014	2/28/2015
Plan Oversight of Agents	Contract	Annually	01/01/2014 – 12/31/2014	02/28/2015