

Medicare Part C Reporting Requirements

Effective January 1, 2024

**Prepared by: Centers for Medicare & Medicaid Services
Center for Medicare
Medicare Drug Benefit and C&D Data Group**

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1054 and expires on October 31, 2024. The time required to complete this information collection is estimated to average 42 hours per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4- 26-05, and Baltimore, Maryland 21244-1850.

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Background and Introduction

CMS has authority to establish reporting requirements for Medicare Advantage Organizations (MAOs) as described in 42CFR §422.516 (a). Pursuant to that authority, each MAO must have an effective procedure to develop, compile, evaluate, and report information to CMS in the time and manner that CMS requires. Additional regulatory support for the Medicare Part C Reporting Requirements is also found in the Final Rule entitled “Medicare Program; Revisions to the Medicare Advantage and Prescription Drug Program” (CMS 4131-F).

All Part C Reporting Requirements documents will be posted at: [Centers for Medicare & Medicaid Services Part C Reporting Requirements website](#). CMS believes providing these separate instructions will better serve the organizations reporting these data, while satisfying the Paperwork Reduction Act requirements.

Organizations for which these specifications apply are required to collect these data. Reporting will vary depending on the plan type and reporting section. Most reporting sections will be reported annually. Effective January 1, 2024 a new reporting section, Supplemental Benefit Utilization and Costs, has been added to the Part C Reporting Requirements.

The following data elements listed directly below are considered proprietary, and CMS considers these as not subject to public disclosure under provisions of the Freedom of Information Act (FOIA): *

- Employer DBA and Legal Name, Employer Address, Employer Tax Identification Numbers (Employer Group Sponsors)

*Under FOIA, Plans may need to independently provide justification for protecting these data if a FOIA request is submitted.

In order to provide guidance to Part C Sponsors on the actual process of entering reporting requirements data into the Health Plan Management System, a separate Health Plan Management System (HPMS) Plan Reporting Module (PRM) User Guide may be found on the PRM start page.

Exclusions from Reporting

National PACE Plans and 1833 Cost Plans are excluded from reporting all Part C Reporting Requirements reporting sections.

Overview of the parameters for current Part C Reporting Requirements reporting sections.

| Reporting Section | Organization Types Required to Report | Report Frequency Level | Report Period (s) | Data Due date (s) |
|---|--|-------------------------------|--|---|
| I. Grievances | Coordinated Care Plans (CCPs); Private Fee-For-Service Plans (PFFS); 1876 Cost; Medicare Savings Accounts (MSAs) (includes all 800 series plans); Employer/ Union Direct Contracts; Religious Fraternal Benefit (RFB). | 1/Year Contract | 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (reporting will include each quarter) | First Monday of February in the following year. Validation required. |
| II. Organization Determinations/ Reconsiderations | CCP; PFFS; 1876 Cost; MSAs, Religious Fraternal Benefit (RFB) PFFS; (includes all 800 series plans), Employer/Union Direct Contracts should also report this section regardless of organization type. | 1/Year Contract | 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (reporting will include each quarter) | Last Monday of February in the following year. Validation required. |
| III. Employer Group Plan Sponsors | CCP; PFFS; 1876 Cost; MSA (includes 800 series plans and any individual plans sold to employer groups), Employer/Union Direct Contracts should also report this section, regardless of organization type. | 1/Year PBP | 1/1-12/31 | First Monday of February in the following year. |

| Reporting Section | Organization Types Required to Report | Report Frequency Level | Report Period (s) | Data Due date (s) |
|--|---|-------------------------------|--------------------------|---|
| IV. Special Needs Plans (SNP) Care Management | Local CCP; Regional CCP, RFB Local CCP with SNPs. Excludes 800 series plans if they are SNPs. | 1/Year PBP | 1/1-12/31 | Last Monday of February in the following year. Validation required. |
| V. Enrollment/Disenrollment | MAOs offering MA only (no Part D) plans. ¹ 1876 Cost Plans with no Part D. 800 series plans are excluded. | 2/Year Contract | 1/1-6/30, 7/1-12/31 | For 1/1-6/30, last Monday of August. For 7/1-12/31, last Monday of February in the following year. |
| VI. Rewards and Incentives Programs. | Local CCPs MSAs PFFS, and Regional Coordinated Care Plans (CCPs) MMP's 800 series plans are included. | 1/Year Contract | 1/1-12/31 | Last Monday of February in the following year. |
| VII. Payments to Providers | Local CCP Regional CCP RFB Local CCP PFFS MMP (excludes 800 series plans) | 1/Year Contract | 1/1-12/31 | Last Monday of February in the following year. |
| VIII. Supplemental Benefit Utilization and Costs | 01 – Local CCP 02 – MSA 03 – RFB PFFS 04 – PFFS 05 – MMP 06 – 1876 Cost 11 – Regional CCP 12-14 – ED-PFFS 13-15 – RFB Local CCP | 1/Year PBP | 1/1-12/31 | Last Monday of February in the following year. Validation required on select elements; see technical specifications for further information. |

¹ MA only. MAPD and PDPs report under Part D.

| Reporting Section | Organization Types Required to Report | Report Frequency Level | Report Period (s) | Data Due date (s) |
|-------------------|--|------------------------|-------------------|-------------------|
| | <p>Organizations should include all 800 series plans.</p> <p>Employer/Union Direct Contracts should also report this measure, regardless of organization type.</p> | | | |

REPORTING SECTIONS

Grievances

According to MMA statute, all Medicare Advantage organizations must provide meaningful procedures for hearing and resolving grievances between enrollees, and the organization or any other entity or individual through which the organization provides health care services under any MA plan it offers. A grievance is any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of an MA organization's or provider's operations, activities, or behavior, regardless of whether remedial action is requested. MA organizations are required to notify enrollees of their decision no later than 30 days after receiving their grievance based on the enrollee's health condition. An extension up to 14 days is allowed if it is requested by the enrollee, or if the organization needs additional information and documents that this extension is in the interest of the enrollee. An expedited grievance that involves refusal by a MA organization to process an enrollee's request for an expedited organization determination or reconsideration requires a response from the MA organization within 24 hours.

I. GRIEVANCES

This reporting section requires an upload.

| Reporting section | Organization Types Required to Report | Report FrequencyLevel | Report Period (s) | Data Due date (s) |
|-------------------|--|---------------------------|---|---|
| Grievances | 01 – Local CCP 02 – MSAs 03- Religious Fraternal Benefit (RFB PFFS) 04- Private Fee for Services (PFFS) 06 – 1876 Cost 11 – Regional CCP 14 – Employee Union Direct (ED)-PFFS 15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type. | 1/Year /Contract level | 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (reporting will include each quarter) | First Monday of February in the following year. Validation required. |
| Data Element ID | Data Element Description | | | |
| A. | Number of Total Grievances | | | |
| B. | Number of Total Grievances in which timely notification was given | | | |
| C. | Number of Expedited Grievances | | | |
| D. | Number of Expedited Grievances in which timely notification was given | | | |
| E. | Number of Dismissed Grievances | | | |

II. ORGANIZATION DETERMINATIONS & RECONSIDERATIONS

This section requires a file upload.

| Organization Types Required to Report | Reporting Frequency Level | Report Period (s) | Data Due date(s) |
|--|---------------------------|---|--|
| 01 – Local CCP 02 –MSA 03– RFB PFFS 04 - PFFS 06 – 1876 Cost 11 – Regional CCP 14 – ED-PFFS 15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type. | 1/Year Contract | 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (reporting will include each quarter) | Last Monday of February in the following year. Validation required. |

| Data Element ID | Data Element Description |
|----------------------|--|
| Subsection #1 | ORGANIZATION DETERMINATIONS |
| A. | Total Number of Organization Determinations Made in the Reporting Period Above |
| B. | Number of Organization Determinations - Withdrawn |
| C. | Number of Organization Determinations - Dismissals |
| D. | Number of Organization Determinations requested by enrollee/representative or provider on behalf of the enrollee (Services). |
| E. | Number of Organization Determinations submitted by Enrollee/Representative (Claims). |
| F. | Number of Organization Determinations requested by Non-Contract Provider (Services). |
| G. | Number of Organization Determinations submitted by Non-Contract Provider (Claims). |
| Subsection #2 | DISPOSITION – ALL ORGANIZATION DETERMINATIONS |
| A. | Number of Organization Determinations – Fully Favorable (Services) Requested by enrollee/representative or provider on behalf of the enrollee. |
| B. | Number of Organization Determinations – Fully Favorable (Services) Requested by Non-contract Provider. |

| Data Element ID | Data Element Description |
|------------------------|--|
| C. | Number of Organization Determinations – Fully Favorable (Claims) Submitted by enrollee/representative. |
| D. | Number of Organization Determinations – Fully Favorable (Claims) Submitted by Non-contract Provider. |
| E. | Number of Organization Determinations – Partially Favorable (Services) Requested by enrollee/representative or provider on behalf of the enrollee. |
| F. | Number of Organization Determinations – Partially Favorable (Services) Requested by Non-contract Provider. |
| G. | Number of Organization Determinations – Partially Favorable (Claims) Submitted by enrollee/representative. |
| H. | Number of Organization Determinations – Partially Favorable (Claims) Submitted by Non-contract Provider. |
| I. | Number of Organization Determinations – Adverse (Services) Requested by enrollee/representative or provider on behalf of the enrollee. |
| J. | Number of Organization Determinations – Adverse (Services) Requested by Non-contract Provider. |
| K. | Number of Organization Determinations – Adverse (Claims) Submitted by enrollee/representative. |
| L. | Number of Organization Determinations – Adverse (Claims) Submitted by Non-contract Provider. |
| Subsection #3: | RECONSIDERATIONS |
| A. | Total number of Reconsiderations Made in Reporting Time Period Above. |
| B. | Number of Reconsiderations - Withdrawn |
| C. | Number of Reconsiderations - Dismissals |
| D. | Number of Reconsiderations requested by or on behalf of the enrollee (Services). |
| E. | Number of Reconsiderations submitted by Enrollee/Representative (Claims). |
| F. | Number of Reconsiderations requested by Non-Contract Provider (Services). |
| G. | Number of Reconsiderations submitted by Non-Contract Provider (Claims) |
| Subsection #4: | DISPOSITION – ALL RECONSIDERATIONS |
| A. | Number of Reconsiderations – Fully Favorable (Services) requested by enrollee/representative or provider on behalf of the enrollee. |
| B. | Number of Reconsiderations – Fully Favorable (Services) requested by Non-contract Provider. |

| Data Element ID | Data Element Description |
|------------------------|---|
| C. | Number of Reconsiderations – Fully Favorable (Claims) submitted by enrollee/representative. |
| D. | Number of Reconsiderations – Fully Favorable (Claims) submitted by Non-contract Provider. |
| E. | Number of Reconsiderations – Partially Favorable (Services) requested by enrollee/representative or provider on behalf of the enrollee. |
| F. | Number of Reconsiderations – Partially Favorable (Services) requested by Non-contract Provider. |
| G. | Number of Reconsiderations – Partially Favorable (Claims) submitted by enrollee/representative. |
| H. | Number of Reconsiderations – Partially Favorable (Claims) submitted by Non-contract Provider |
| I. | Number of Reconsiderations – Adverse (Services) requested by enrollee/representative or provider on behalf of the enrollee |
| J. | Number of Reconsiderations – Adverse (Services) requested by Non-contract Provider. |
| K | Number of Reconsiderations – Adverse (Claims) submitted by enrollee/representative |
| L. | Number of Reconsiderations – Adverse (Claims) submitted by Non-contract Provider. |
| Subsection #5: | RE-OPENINGS |
| A. | Total number of reopened (revised) decisions, for any reason, in Time Period Above |
| | For each case that was reopened, the following information will be uploaded in a data file: |
| B. | Contract Number |
| C. | Plan ID |
| D. | Case ID |
| E. | Case level (Organization Determination or Reconsideration) |
| F. | Date of original disposition |
| G. | Original disposition (Fully Favorable, Partially Favorable, or Adverse) |
| H. | Was the case processed under the expedited timeframe? (Y/N) |
| I. | Case type (Service or Claim) |

| Data Element ID | Data Element Description |
|------------------------|--|
| J. | Status of treating provider (Contract, Non-contract) |
| K. | Date case was reopened |
| L. | Reason(s) for reopening (Clerical Error, Other Error, New and Material Evidence, Fraud or Similar Fault, or Other) |
| M. | Additional Information (Optional) |
| N. | Date of reopening disposition (revised decision) ² |
| O. | Reopening disposition (Fully Favorable; Partially Favorable, Adverse or Pending) |

² The date of disposition is the date the required written notice of a revised decision was sent per 405.982

III. EMPLOYER GROUP PLAN SPONSORS

This reporting section requires an upload.

| Organization Types Required to Report | Report Frequency/Level | Report Period (s) | Data Due date (s) |
|--|------------------------|-------------------|---|
| 01 – Local CCP 02 – MSA 04 – PFFS 06 – 1876 Cost 11 – Regional CCP 14 – ED-PFFS Organizations should include all 800 series plans and any individual plans sold to employer groups. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type. | 1/year PBP | 1/1 - 12/31 | First Monday of February in the following year. |

| Data Element ID | Data Element Description |
|-----------------|---|
| A. | Employer Legal Name |
| B. | Employer DBA Name |
| C. | Employer Federal Tax ID |
| D | Employer Address |
| E. | Type of Group Sponsor (employer, union, trustees of a fund) |
| F. | Organization Type (State Government, Local Government, Publicly Traded Organization, Privately Held Corporation, Non-Profit, Church Group, Other) |
| G. | Type of Contract (insured, ASO, other) |
| H. | Is this a calendar year plan? (Y (yes) or N (no)) |
| I. | If data element #H is a "N", provide non-calendar year start date. |
| J. | Current/Anticipated Enrollment |

IV. SPECIAL NEEDS PLANS (SNPs) CARE MANAGEMENT

This reporting section requires direct data entry into HPMS.

| Organization Types Required to Report | Report Frequency Level | Report Period (s) | Data Due date (s) |
|---|------------------------|-------------------|--|
| SNP PBPs under the following types: 01 – Local CCP 11 – Regional CCP 15 – RFB Local CCP Organizations should exclude 800 series plans if they are SNPs. | 1/Year PBP | 1/1-12/31 | Last Monday of February in the following year. Validation required. |

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

Notes:

If a new enrollee does not receive an initial HRA within 90 days of enrollment that enrollee's annual HRA is due to be completed within 365 days of enrollment. A new enrollee who receives an HRA within 90 days of enrollment is due to complete a reassessment HRA no more than 365 days after the initial HRA was completed.

V. ENROLLMENT AND DISENROLLMENT

This reporting section requires an upload into HPMS.

| Organization Types Required to Report | Reporting Frequency Level | Report Period | Data Due date (s) |
|--|---------------------------|------------------------------|---|
| MAOs offering MA- only (no Part D) plans 1876 Cost Plans (PBPs that do not include a Part D optional supplemental benefit.) | 2/Year Contract | 1/1 - 6/30 7/1 – 12/31 | For 1/1-6/30, last Monday of August. For 7/1-12/31, last Monday of February in the following year |

CMS provides guidance for MAOs and Part D sponsors' processing of enrollment and disenrollment requests.

CMS will collect data on the elements for these requirements, which are otherwise not available to CMS, in order to evaluate the sponsor's processing of enrollment, disenrollment and reinstatement requests in accordance with CMS requirements.

Note: Both Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Manual outline the enrollment and disenrollment periods (Section 30) enrollment (Section 40) and disenrollment procedures (Section 50) for all Medicare health and prescription drug plans.

For questions specific to enrollment/disenrollment requirements please contact the following mailbox: <https://enrollment.lmi.org/deepmailbox>.

| Data Element ID | Data Element Description |
|------------------------|---|
| Subsection #1 | Enrollment |
| A. | The total number of enrollment requests (i.e., requests initiated by the beneficiary or his/her authorized representative) received in the specified time period. Do not include auto/facilitated or passive enrollments, rollover transactions, or other enrollments effectuated by CMS. |
| B. | 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 authorized representative). |
| C. | 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). |
| D. | 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 the plan (i.e., individual not eligible for an election period). |
| E. | Of the total reported in C, the number of incomplete enrollment request received that are incomplete upon initial receipt and completed within established timeframes. |
| F. | 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. |
| G. | Of the total reported in A, the number of paper enrollment requests received. |
| H. | Of the total reported in A, the number of telephonic enrollment requests received (if sponsor offers this mechanism). |
| I. | Of the total reported in A, the number of electronic enrollment requests received via an electronic device or secure internet website (if sponsor offers this mechanism). |
| J. | Of the total reported in A, the number of Medicare Online Enrollment Center (OEC) enrollment requests received. |
| Subsection #2 | Disenrollment |
| A. | The total number of voluntary disenrollment requests received in the specified time period. Do not include disenrollments resulting from an individual's enrollment in another plan. |
| B. | 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 authorized representative). |
| C. | Of the total reported in A, the number of disenrollment requests denied by the Sponsor for any reason. |
| D. | The total number of involuntary disenrollments for failure to pay plan premium in the specified time period. |
| E. | Of the total reported in D, the number of disenrolled individuals who submitted a timely request for reinstatement for Good Cause. |
| F. | Of the total reported in E, the number of favorable Good Cause determinations. |
| G. | Of the total reported in F, the number of individuals reinstated. |

VI. REWARDS AND INCENTIVES PROGRAMS

This is a partial data entry into HPMS and upload.

| Organization Types Required to Report | Report FrequencyLevel | Report Period(s) | Data Due date (s) |
|---|-----------------------|------------------|--|
| 01- Local CCP 02- MSA 03- RFB PFFS 04- PFFS 05- MMP 11- Regional CCP 14- ED-PFFS 15 - RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contractsshould also report this reporting section, regardless of organizationtype. | 1/Year Contract | 1/1-12/31 | Last Monday of February in following year. |

A plan user needs to select "Yes" or "No" for data element A. on the edit page. If the plan user selected "No," no upload is necessary. If the plan user selects "Yes," then the user will be required to upload additional information in accordance with the file record layout.

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

VII. PAYMENTS TO PROVIDERS

This reporting section requires a file upload.

Collecting these data will help to inform us as we determine how broadly MA organizations are using alternative payment arrangements. See Technical Specs for additional information.

| Organization Types Required to Report | Report Frequency Level | Report Period (s) | Data Due Date (s) |
|---|------------------------|-------------------|--|
| 01 – Local CCP 04 - PFFS 05 – MMP ³ 11 – Regional CCP 15 – RFB Local CCP | 1/Year Contract | 1/1-12/31 | Last Monday of February in the following year. |

| Data Element ID | Data Element Description |
|-----------------|---|
| A. | Total Medicare Advantage payment made to contracted providers. |
| B. | Total Medicare Advantage payment made on a fee-for-service basis with no link to quality (category 1). |
| C. | Total Medicare Advantage payment made on a fee-for-service basis with a link to quality (category 2). |
| D. | Total Medicare Advantage payment made using alternative payment models built on fee-for-service architecture (category 3). |
| E. | Total Risk-based payments not linked to quality (e.g., 3N in APM definitional framework). |
| F. | Total Medicare Advantage payment made using population-based payment (category 4). |
| G. | Total capitation payment not linked to quality (e.g., 4N in the APM definitional framework). |
| H. | Total number of Medicare Advantage contracted providers. |
| I. | Total Medicare Advantage contracted providers paid on a fee-for-service basis with no link to quality (category 1). |
| J. | Total Medicare Advantage contracted providers paid on a fee-for-service basis with a link to quality (category 2). |
| K. | Total Medicare Advantage contracted providers paid based on alternative payment models built on a fee-for-service architecture (category 3). |
| L. | Total Medicare Advantage contracted providers paid based on risk-based payments not linked to quality (e.g., 3N in the APM definitional framework). |
| M. | Total Medicare Advantage contracted providers paid based on population-based (category 4). |
| N. | Total Medicare Advantage contracted providers paid based on capitation with no link to quality (e.g., category 4N in the APM definitional framework). |

³ MMPs should report for all APMs not just Medicare APMs.

VIII. Supplemental Benefit Utilization and Costs

This reporting section requires an upload.

| Organization Types Required to Report | Report Frequency Level | Report Period(s) | Data due date(s) |
|--|------------------------|------------------|--|
| 01 – Local CCP 02 – MSA 03 – RFB PFFS 04 – PFFS 05 – MMP 06 – 1876 Cost 11 – Regional CCP 12-14 – ED-PFFS 13-15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this measure, regardless of organization type. | 1/year; PBP | 1/1-12/31 | Last Monday in February of the following calendar year |

The data elements listed below must be reported for each of the following supplemental benefits:

| PBP Category | Supplemental Benefit |
|--|--|
| <i>Inpatient Hospital Services</i> | |
| 1a | Inpatient Acute Additional days |
| 1a | Inpatient Acute Non-Medicare-Covered Stay |
| 1a | Inpatient Acute Upgrades |
| 1b | Inpatient Hospital – Acute Services (For B-Only Plans) |
| 1b | Inpatient Psychiatric Additional Days |
| 1b | Inpatient Psychiatric Non-Medicare-Covered Stay |
| 1b | Inpatient Psychiatric Hospital Services (For B-Only Plans) |
| <i>Skilled Nursing Facility Services</i> | |
| 2 | SNF Additional Days Beyond Medicare-Covered |
| 2 | SNF Non-Medicare-Covered Stay |
| 2 | SNF – Waive Hospital Stay |
| 2 | SNF – Waive Hospital Stay, 3 days |
| 2 | SNF Care (For B-Only Plans) |

| PBP Category | Supplemental Benefit |
|---|---|
| <i>Cardiac Rehabilitation Services</i> | |
| 3-1 | Additional Cardiac Rehabilitation Services |
| 3-2 | Additional Pulmonary Rehabilitation Services |
| 3-3 | Additional Intensive Cardiac Rehabilitation Services |
| 3-4 | Additional Supervised Exercise Therapy for Peripheral Artery Disease Services |
| <i>Worldwide Coverage; Visitor Travel</i> | |
| 4c | Worldwide Emergency Coverage |
| 4c | Worldwide Emergency Transportation |
| 4c | Worldwide Urgent Coverage |
| <i>Professional Services</i> | |
| 7b | Routine Chiropractic Care |
| 7b | Chiropractic – Other Service |
| 7f | Routine Foot Care |
| <i>Outpatient Hospital Services</i> | |
| 9d | Three (3) Pint Deductible Waived |
| <i>Transportation</i> | |
| 10b | Transportation to Plan-approved Location |
| 10b | Transportation to Any Health-related Location |
| <i>Other Services</i> | |
| 13a | Acupuncture Treatments |
| 13b | Over-the-Counter (OTC) Items |
| 13c | Meals |
| 13d | Other 1 |
| 13e | Other 2 |
| 13f | Other 3 |
| 13g | Dual Eligible SNPs with Highly Integrated Services |
| <i>Preventive Services</i> | |
| 14b | Annual Physical Exam |
| 14c1 | Health Education |
| 14c2 | Nutritional/Dietary Benefit |

| PBP Category | Supplemental Benefit |
|------------------------|--|
| 14c3 | Additional Smoking and Tobacco Cessation Counseling |
| 14c4 | Fitness Benefit – Physical Fitness |
| 14b4 | Fitness Benefit – Memory Fitness |
| 14c4 | Fitness Benefit – Activity Tracker |
| 14c5 | Enhanced Disease Management |
| 14c6 | Telemonitoring Services |
| 14c7 | Remote Access Technologies – Nursing Hotline |
| 14c7 | Remote Access Technologies – Web/Phone-based Technologies |
| 14c8 | Home and Bathroom Safety Devices and Modifications |
| 14c9 | Counseling Services |
| 14c10 | In-Home Safety Assessment |
| 14c11 | Personal Emergency Response System (PRS) |
| 14c12 | Medical Nutrition Therapy (MNT) |
| 14c13 | Post Discharge In-home Medication Reconciliation |
| 14c14 | Re-admission Prevention |
| 14c15 | Wigs for Hair Loss Related to Chemotherapy |
| 14c16 | Weight Management Programs |
| 14c17 | Alternative Therapies |
| 14c18 | Therapeutic Massage |
| 14c19 | Adult Day Health Services |
| 14c20 | Home-Based Palliative Care |
| 14c21 | In-Home Support Services |
| 14c22 | Support for Caregivers of Enrollees – Respite Care |
| 14c22 | Support for Caregivers of Enrollees – Caregiver Training |
| 14c22 | Support for Caregivers of Enrollees - Other |
| <i>Dental Services</i> | |
| 16a | Oral Exams |
| 16a | Prophylaxis (Cleaning) |
| 16a | Dental X-Rays |
| 16a | Fluoride Treatment |
| 16b | Dental Non-Routine Services |
| 16b | Dental Diagnostic Services |
| 16b | Dental Restorative Services |
| 16b | Endodontics |
| 16b | Periodontics |
| 16b | Extractions |
| 16b | Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services |
| <i>Vision Services</i> | |
| 17a | Routine Eye Exams |
| 17a | Eye Exams – Other Service |
| 17b | Contact Lenses |

| PBP Category | Supplemental Benefit |
|---|---|
| 17b | Eyeglasses (Lenses and Frames) |
| 17b | Eyeglass Frames |
| 17b | Eyeglass Lenses |
| 17b | Eyewear Upgrades |
| <i>Hearing Services</i> | |
| 18a | Routine Hearing Exams |
| 18a | Fitting/Evaluation for Hearing Aid |
| 18b | Hearing Aids (All Types) |
| 18b | Hearing Aids – Inner Ear |
| 18b | Hearing Aids – Outer Ear |
| 18b | Hearing Aids – Over the Ear |
| <i>Service Area-Related Services</i> | |
| V/T | Visitor/Travel Program – US and its territories |
| V/T | Visitor/Travel Program – Other |
| OON | Out-of-network Services |
| <i>Supplemental Benefits for the Chronically Ill (SSBCIs)</i> | |
| 13i | Food and Produce |
| 13i | Meals (Beyond limited basis) |
| 13i | Pest Control |
| 13i | Transportation for Non-Medical Needs |
| 13i | Indoor Air Quality Equipment and Services |
| 13i | Social Needs Benefit |
| 13i | Complementary Therapies |
| 13i | Services Supporting Self-Direction |
| 13i | Structural Home Modifications |
| 13i | General Supports for Living |
| 13i-O | Non-Primarily Health Related Benefits for the Chronically Ill Other 1 |
| 13i-O | Non-Primarily Health Related Benefits for the Chronically Ill Other 2 |
| 13i-O | Non-Primarily Health Related Benefits for the Chronically Ill Other 3 |
| 13i-O | Non-Primarily Health Related Benefits for the Chronically Ill Other 4 |
| 13i-O | Non-Primarily Health Related Benefits for the Chronically Ill Other 5 |

The following data elements must be reported:

| Data Element ID | Data Element Description | [INTERNAL: How will the element be reported?] |
|------------------------|---------------------------------|--|
| A. | PBP Category | A PBP category value from table above |

| | | |
|----|--|---|
| B. | Supplemental benefit name, if “Other” (13d, 13e, 13f, or 13i-O), or if name otherwise differs from values provided above. | Narrative (max. 180 characters) |
| C. | How is the supplemental benefit offered? (Mandatory, Optional, Uniformity Flexibility, SSBCI, not offered) If the same supplemental benefit (as identified by a specific PBP Category) is offered in multiple ways (e.g., as an optional benefit, and also as an SSBCI), please report Data Elements C-J for each offering type separately. | One of the following values: M, O, UF, SSBCI, n/a |
| D. | The unit of utilization used by the plan when measuring utilization (e.g., admissions, visits, procedures, trips, purchases). | Narrative (max. 90 characters) |
| E. | The number of enrollees eligible for the benefit | A number |
| F. | The number of enrollees who utilized the benefit at least once | A number |
| G. | The total instances of utilizations among eligible enrollees | A number |
| H. | The median number of utilizations among enrollees who utilized the benefit at least once | A number |
| I. | The total net amount incurred by plan to offer the benefit. NOTE: When computing this amount, report the net amount spent rather than the gross amount allocated. For example, if the MA plan allocated \$1000 for the enrollee to use for certain dental services, but the enrollee used only \$250, then the MA plan must include only that \$250 in computing the total amount to report under this data element. Similarly, if the MA plan implements the benefit through a PMPM arrangement, and the MA plan recoups some of that amount for any reason, the MA plan must include only the amount spent rather than the | Dollar amount |

| | | |
|----|--|------------------------------------|
| | allocated PMPM amount. | |
| J. | <p>The type of payment arrangement(s) the plan used to implement the benefit. The plan may use the categories CMS provides in the Payments to Providers section of the Part C Reporting Requirements. Alternatively, the plan may use other phrases or provide a brief description if its payment arrangement does not neatly fall into one of those categories.</p> | Narrative (maximum 180 characters) |
| K. | <p>How the plan accounts for the cost of the benefit, including how the plan determines and measures administrative costs, costs to deliver, and any other costs the plan captures.</p> <p>NOTE: CMS will not voluntarily release data collected under this element to the public, either individually or in the aggregate. This information will inform future development of cost reporting data elements in these reporting requirements and may inform how CMS requires cost reporting in other contexts.</p> | Narrative (maximum 500 characters) |
| L. | The total out-of-pocket-cost per utilization for enrollees | Dollar amount |