

2024 Approved Document

Medicare-Medicaid Plans (MMP) removed from applicable organization types required to report Part C reporting requirements.

Supplemental Benefits Reporting Section-CY
2025 PBP service categories

Supplemental Benefits Reporting Section-Service
Area-Related Services

Supplemental Benefits Reporting Section-Data
element ID and data element description

Supplemental Benefits Reporting Section-Data
element ID and data element description

Supplemental Benefits Reporting Section-Data
element ID and data element description

Supplemental Benefits Reporting Section-Data
element ID and data element description

None

Updated: February 2024

None

None

Organization Determination is a plan's response to a request for coverage (payment or provision) of an item, service, or Part B drug, including auto-adjudicated claims, service authorizations which include prior-authorization (authorization that is issued prior to the services being rendered), concurrent authorization (authorization that is issued at the time the service is being rendered), post authorization (authorization that is issued after the service has been rendered), and requests to continue previously authorized ongoing courses of treatment. It includes pre-service organization determination requests submitted by the enrollee, enrollee's representative, contract provider on behalf of the enrollee and requests from non-contract providers. It does not include claims payment requests from contract providers that are governed by the contractual arrangement between the MAO and its contract providers

Reconsideration is a plan's review of an adverse or partially favorable organization determination as defined in 42 CFR § 422.580

Do Not Report: Data from Medicare/Medicaid Programs (MMPs) organizations

HRA Reporting Timeline: There are situations when a new enrollee who has remained enrolled in the SNP for 365 days after the date of the initial HRA, will be counted in both data elements A and B. because the he/she is a new enrollee (A) and an enrollee eligible for an annual reassessment (B).

Enrollees who were previously in a Medicare-Medicaid Plan and received an initial or annual HRA that were cross walked to a D-SNP within the MAO after the end of a Financial Alignment Demonstration will not need to participate in a second initial HRA. They should be included in element B.

If eligibility records received after completion of the HRA indicate the member was never enrolled in the plan, do not count this member as a new enrollee and do not count the HRA

For Dual Eligible SNPs (D-SNPs) only, CMS will accept a Medicaid HRA that is performed by the same organization (or an affiliate under the same parent organization) within 90 days before or after the effective date of Medicare enrollment as meeting the Part C obligation to perform an HRA.

Questions have arisen regarding how to report data elements in this reporting section when enrollees disenroll and then re-enroll, either in the same SNP or a different one (different organization or sponsor) within the measurement year. When a member disenrolls from one SNP and enrolls into another SNP (a different sponsor or organization), the member should be counted as a “new enrollee” for the receiving plan.

When a member enrolls, disenrolls, and re-enrolls, into any SNP under the same contract number, the previous HRA is still considered valid and can continue to be used as long as it is not more than 365 days old. Even if the member is re-enrolling into the same plan, the individual would still not be counted more than once in any category.

As noted in the table for Element ID A, column “inclusions,” SNPs should include members who disenrolled from and re-enrolled into the same plan if an initial HRA was not performed prior to disenrollment. When this occurs, SNPs should calculate the member's eligibility date starting from the date of re-enrollment.

HHS developed the four categories of value-based payments: fee-for-service with no link to quality (category 1); fee-for-service with a link to quality (category 2); alternative payment models built on fee-for-service architecture (category 3); and population-based payment (category 4).

Category four includes population-based payment arrangements to include some payment is not directly triggered by service delivery so volume is not linked to payment. Under these arrangements, clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., greater than a year). For detailed information regarding these categories, please refer to the Alternative Payment Model (APM) Framework: <https://hcp-lan.org/apm-refresh-white-paper/>.
None

01- Local CCP 04 - PFFS 05 - MMP 11- Regional
CCP 15 - RFB Local CCP

HHS developed the four categories of value-based payments: fee-for-service with no link to quality (category 1); fee-for-service with a link to quality (category 2); alternative payment models built on fee-for-service architecture (category 3); and population-based payment (category 4).

None

Total dollars paid to providers (in and out of network) for Medicare Advantage enrollees in [CY 20XX] or most recent 12 months. Total Medicare Advantage payment made to contracted providers

Total dollars paid to providers through legacy payments (including fee-for-service (i.e., payments made for units of service) in [CY 20XX] or most recent 12 months that are adjusted to account for neither infrastructure investments, nor provider reporting of quality data, nor provider performance on cost and quality metrics). ,Also includes diagnosis-related groups that are not linked to quality and value, or capitation without quality components) in [CY 20XX] or most recent 12 months.Total Medicare Advantage payment made on a fee-for-service basis with no link to quality (category 1)

Total dollars paid to providers through fee-for-Service plus pay-for-performance payments (linked to quality) in [CY 20XX] or most recent 12 months.Total Medicare Advantage payment made on a fee-for-service basis with a link to quality (category 2)

F. Total dollars paid to providers through traditional shared-savings (linked to quality) payments in [CY 20XX] or most recent 12 months.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)

L. Total dollars paid to providers through condition-specific, population-based payments (linked to quality) in [CY 20XX] or most recent 12 months. Total Medicare Advantage payment made using population-based payment (category 4)

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 risk-based payments not linked to quality (e.g., 3N in the APM definitional framework)

N. Total Medicare Advantage contracted providers paid based on capitation with no link to quality (e.g., category 4N in the APM definitional framework)

PCP/PCG-Focused Accountable Care Metrics (metrics below apply to the number of MA plan members in an accountable care arrangements. Metrics are linked to quality)

Total number of Medicare Advantage health plan members

attributed/aligned/assigned/empaneled to a Primary Care Provider (PCP) or Primary Care Group (PCG) participating in a TCOC Category 3 or 4 accountable care APM of six months or longer in [CY 20XX] or most recent 12 months.

[This does NOT include health plan enrollees members

attributed/aligned/assigned/empaneled to a PCP or PCG, who are paid based on capitation with no link to quality (4N)].

Non-PCP/PCG-Focused Accountable Care Metric
(metrics below apply to the number of MA plan
members in an accountable care arrangements.
Metrics are linked to quality)

Total number of Medicare Advantage health plan
members

attributed/aligned/assigned/empaneled to non-
PCPs (i.e., specialists) participating in a TCOC
Category 3 or 4 accountable care APM (e.g.,
shared savings with upside risk only) of six
months or longer in [CY 20XX] or most recent 12
months. [This does NOT include health plan
members

attributed/aligned/assigned/empaneled to a
non-PCP/PCG provider, who are paid based on
capitation with no link to quality (4N)].

Fee-for-service with no link to quality (category
1); Fee-for-service with a link to quality (category
2); Alternative payment models built on fee- for-
service architecture (category 3); Population-
based payment (category 4) For additional
guidance regarding the four (4) categories of
payment, we ask that you refer to the Learning
Action Network Definitional.

For data elements F – J, how do we report if a
provider is paid using multiple payment
arrangements that fit under multiple categories?

For data elements F and J are we to report by
individual providers or by contracts (which
include groups with one or more providers)

For data elements A – E, are we to report
payments made to providers in 2024 based on
services rendered in 2023?

For data elements A – E, do payments refer to
the total calculated allowed amount or actual
payments to providers?

Supplemental benefits reporting section, PBP
categories and Supplemental Benefit names
updated

Supplemental benefits reporting section,
headers updated

Supplemental benefits reporting section, Dental categories

Section V. Enrollment and Disenrollment

Tech Specs: Section III. Enrollment and Disenrollment

Payments to Providers- Data element W added

Payments to Providers- Data element CC added

FAQ- new FAQ questions added for the payments to providers section.

2025 60-Day Document	Type of Change	Reason for Change
Deleted	Update	The MMP plan type is terminating at the end of CY 2025, as CMS transitions the FAI demonstrations to D-SNP models.
Updated throughout the reporting section to accurately represent the CY 2025 PBP service categories and titles.	Update	The CY 2025 PBP categories are updated to reflect additional services and recategorizations, including dental and OTC hearing services.
Removed the visitor/travel program and out-of-network categories to include as reported PBP elements. These elements are now provided as new data elements provided by the plan.	Update	This change will allow CMS to more accurately see how the benefits are being offered and utilized based on their network status.
Added Contract ID and PBP ID as two data elements that must be included. Subsequent renumbering throughout the chart as a result.	New	Clarification
Supplemental Benefits Reporting Section - Element F- network type (in-network, out-of-network (for PPO), out-of-network (for HMO-POS), and visitor/travel)	Update	Removed as part of the PBP elements, and now must be reported separately.
Supplemental Benefits Reporting Section - Element N -The total out-of-pocket cost for enrollees.	New	New Part C Reporting Requirement to clarify that plan cost sharing may vary depending on the type of supplemental benefit.
Supplemental Benefits Reporting Section - Element O - The median out-of-pocket cost for enrollees.	New	New Part C Reporting Requirement to clarify that plan cost sharing may vary depending on the type of supplemental benefit.
D-SNP Enrollee Advisory Committee	New	New Part C Reporting Requirement
Updated: January 2025	Update	Year changed to reflect updates being made to current version.
D-SNP Transmission of Admission Notifications	New	New Part C Reporting Requirement

Addition of Withdrawn Grievances to Do Not Report section	New	Clarification
Addition of : "Applicable integrated plans report integrated organization determinations per 42 CFR § 422.631."	Update	Clarification
Addition of: "Applicable integrated plans report integrated reconsiderations per 42 CFR § 422.633."	Update	Clarification
Deleted	Update	The MMP plan type is terminating at the end of CY 2025, as CMS transitions the FAI demonstrations to D-SNP models.
There are situations when a new enrollee who has remained enrolled in the SNP for 365 days after the date of the initial HRA, will be counted in both data elements A and B. because the individual is a new enrollee (A) and an enrollee eligible for an annual reassessment (B).	Update	Clarification
Enrollees who were previously in a Medicare-Medicaid Plan and received an initial or annual HRA that were cross walked to a D-SNP within the MAO after the end of a Financial Alignment Initiative demonstration will not need to participate in a second initial HRA. They should be included in element B.	Update	Clarification

If eligibility records received after completion of the HRA indicate the individual was never enrolled in the plan, do not count this individual as a new enrollee and do not count the HRA	Update	Clarification
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For dual eligible SNPs (D-SNPs) only, CMS will accept a Medicaid HRA that is performed by the same organization (or an affiliate under the same parent organization) within 90 days before or after the effective date of Medicare enrollment as meeting the Part C obligation to perform an HRA, if the HRA meets the requirements at 42 CFR § 422.101(f).	Update	Clarification
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Questions have arisen regarding how to report data elements in this reporting section when enrollees disenroll and then re-enroll, either in the same SNP or a different one (different organization or sponsor) within the measurement year. When an individual disenrolls from one SNP and enrolls into another SNP (a different sponsor or organization), the individual should be counted as a “new enrollee” for the receiving plan.	Update	Clarification
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When an individual enrolls, disenrolls, and re-enrolls, into any SNP under the same contract number, the previous HRA is still considered valid and can continue to be used as long as it is not more than 365 days old. Even if the individual is re-enrolling into the same plan, the individual would still not be counted more than once in any category.	Update	Clarification
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As noted in the table for Element ID A, column "inclusions," SNPs should include individuals who disenrolled from and re-enrolled into the same plan if an initial HRA was not performed prior to disenrollment. When this occurs, SNPs should calculate the member's eligibility date starting from the date of re-enrollment.	Update	Clarification
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HHS developed the four categories of value-based payments: fee-for-service with no link to quality (category 1); fee-for-service with a link to quality (category 2); alternative payment models built on fee-for-service architecture (category 3); and population-based payment (category 4). These groupings conform to the Health Care Payment Learning & Action Network (HCPLAN) Alternative Payment Models (APM) Framework categories. For more detailed information, please refer to the LAN APM Framework (<https://hcp-lan.org/apm-framework/>).

Update

Clarification

Category four includes population-based payment arrangements to include some payment is not directly triggered by service delivery so volume is not linked to payment. Under these arrangements, clinicians and organizations . responsible for the care of a beneficiary for a long period (e.g., greater than a year).

Update

Clarification

CMS will also collect data on the number of lives MA organizations have attributed, aligned, assigned, empaneled, or otherwise associated with accountable care arrangements. Under such arrangements providers have accountability for quality and total cost of care for a period of at least six months (i.e. a longitudinal, aligned care relationship between the beneficiary and clinician/provider). For additional detail on the definition of these concepts, please see LAN Guidance on Measuring Covered Lives in Accountable Care APM Arrangements and APM Data Collection Tool found here (<https://hcp-lan.org/data-collection-process/#1601909304600-3b650088-e3e1>).

New

New Part C Reporting Requirement

01 - Local CCP 04- PFF 11-Regional CCP 15 - RFB Local CCP removed 05-MMP from chart

Update

The MMP plan type is terminating at the end of CY 2025, as CMS transitions the FAI demonstrations to D-SNP models.

HHS developed the four categories of value-based payments: fee-for-service with no link to quality (category 1); fee-for-service with a link to quality (category 2); alternative payment models built on fee-for-service architecture (category 3); and population-based payment (category 4). These groupings conform to the Health Care Payment Learning & Action Network (HCPLAN) Alternative Payment Models (APM) Framework categories. For more detailed information, please refer to the LAN APM Framework (https://hcp-lan.org/apm-framework/).	Update	Clarification
For additional details on the definitions in this section, please see Appendix 2: Measuring Covered Lives in Accountable Care		New Part C Reporting Requirement
Total dollars paid to providers (in and out of network) for Medicare Advantage members/enrollees in [CY 20XX] or most recent 12 months.	Update	Clarification/consistency
Total dollars paid to providers through legacy payments (including fee-for-service (i.e., payments made for units of service) in [CY 20XX] or most recent 12 months that are adjusted to account for neither infrastructure investments, nor provider reporting of quality data, nor provider performance on cost and quality metrics). Also includes diagnosis-related groups that are not linked to quality and value in [CY 20XX] or most recent 12 months.	Update	Clarification/consistency
Total dollars paid to providers through fee-for-Service plus pay-for-performance payments (linked to quality) in [CY 20XX] or most recent 12 months.	update	Clarification/consistency
D. Total dollars paid to providers through traditional shared-savings (linked to quality) payments in [CY 20XX] or most recent 12 months.	Update	Clarification/consistency

K. Total Risk-based payments not linked to quality (e.g., 3N in APM definitional framework)	Update	consistency
F. Total dollars paid to providers through condition-specific, population-based payments (linked to quality) in [CY 20XX] or most recent 12 months.Total Medicare Advantage payment made using population-based payment (category 4)	Update	consistency
S. Total number of Medicare Advantage contracted providers	Update	consistency
T. Total Medicare Advantage contracted providers paid on a fee-for-service basis with no link to quality (category 1)	Update	consistency
U. Total Medicare Advantage contracted providers paid on a fee-for-service basis with a link to quality (category 2)	Update	consistency
V. Total Medicare Advantage contracted providers paid based on alternative payment models built on a fee-for-service architecture (category 3)	Update	consistency
Z. Total Medicare Advantage contracted providers paid based risk-based payments not linked to quality (e.g., 3N in the APM definitional framework)	Update	consistency
FF. Total Medicare Advantage contracted providers paid based on capitation with no link to quality (e.g., category 4N in the APM definitional framework)	Update	consistency
PCP/PCG-Focused Accountable Care Metrics (metrics below apply to the number of MA plan enrollees in an accountable care arrangements. Metrics are linked to quality)	Update	consistency
Total number of Medicare Advantage health plan enrollees attributed/aligned/assigned/empaneled to a Primary Care Provider (PCP) or Primary Care Group (PCG) participating in a TCOC Category 3 or 4 accountable care APM of six months or longer in [CY 20XX] or most recent 12 months. [This does NOT include health plan enrollees attributed/aligned/assigned/empaneled to a PCP or PCG, who are paid based on capitation with no link to quality (4N)]	Update	clarification

Non-PCP/PCG-Focused Accountable Care Metric (metrics below apply to the number of MA plan enrollees in an accountable care arrangements. Metrics are linked to quality)	Update	consistency
Total number of Medicare Advantage health plan enrollees attributed/aligned/assigned/empaneled to non-PCPs (i.e., specialists) participating in a TCOC Category 3 or 4 accountable care APM (e.g., shared savings with upside risk only) of six months or longer in [CY 20XX] or most recent 12 months. [This does NOT include health plan enrollees attributed/aligned/assigned/empaneled to a non-PCP/PCG provider, who are paid based on capitation with no link to quality (4N)].	Update	consistency
Fee-for-service with no link to quality (category 1); Fee- for-service with a link to quality (category 2); Alternative payment models built on fee- for-service architecture (category 3); Population-based payment (category 4) For additional guidance regarding the four (4) categories of payment, we ask that you refer to the Learning Action Network Definitional Framework white paper.	correction	accuracy
For data elements S – FF, how do we report if a provider is paid using multiple payment arrangements that fit under multiple categories?	update	consistency
For data elements S. and FF. are we to report by individual providers or by contracts (which include groups with one or more providers)?	Update	consistency
For data elements A. – R., are we to report payments made to providers in 20XX based on services rendered in the prior year?	Update	consistency
For data elements A. – R., do payments refer to the total calculated allowed amount or actual payments to providers?	Update	consistency
Several PBP categories and supplemental benefit category names have been updated to match what the PBP in HPMS lists for these benefits (e.g. 1a2 Inpatient Acute Non-Medicare Covered Stay is now 1a2 Non-Medicare covered Stay for Inpatient Hospital-Acute)	Update	Accuracy, the PBP categories and Supplemental Benefit names are being updated to match the PBP submissions in HPMS
The headers have been updated to match the PBP submission in HPMS	New	Accuracy

These categories have been updated to match the new dental categories in the HPMS submission for the PBP	New	New Part C Reporting Requirement, Accuracy
Updated reference to Enrollment/Disenrollment guidance, added URL	Update	accuracy
Updated reference to Enrollment/Disenrollment guidance, added URL	Update	accuracy
Missing data element added on 9.27	Update	New Part C Reporting Requirement
Missing data element added on 9.27	Update	New Part C Reporting Requirement
11 new FAQ questions added to provide definitions and clarifications.	Update	clarification

Burden Change

Decrease

Increase

Increase

Increase

Increase

Increase

Increase

Increase

None

Increase

None

None

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None

None

None

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