Medicare Part C Reporting Requirements

Effective January 1, 2025

**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 December 31, 2025. 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.**

**Table of Contents**

[I. GRIEVANCES 5](#_Toc169083120)

[II. ORGANIZATION DETERMINATIONS & RECONSIDERATIONS 7](#_Toc169083121)

[III. EMPLOYER GROUP PLAN SPONSORS 11](#_Toc169083122)

[IV. SPECIAL NEEDS PLANS (SNP) CARE MANAGEMENT 12](#_Toc169083123)

[V. ENROLLMENT AND DISENROLLMENT 13](#_Toc169083124)

[VI. REWARDS AND INCENTIVES PROGRAMS 15](#_Toc169083125)

[VII. PAYMENTS TO PROVIDERS 16](#_Toc169083126)

[VIII. SUPPLEMENTAL BENEFIT UTILIZATION AND COSTS 19](#_Toc169083127)

[IX. D-SNP ENROLLEE ADVISORY COMMITTEE 26](#_Toc169083128)

[X. D-SNP TRANSMISSION OF ADMISSION NOTIFICATIONS 26](#_Toc169083129)

**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. Additional Supplemental Benefits Utilization and Cost inquiries are directed to the following mailbox: <https://dpapportal.lmi.org/DPAPMailbox>.

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/  Uni on Direct Contracts; Religious Fraternal Benefit (RF B). | 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 Determination s/ Reconsiderations | CCP;  PFFS;  1876 Cost;  MSAs,  Religious Fraternal Benefit (RF B) 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. |
| 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]](#footnote-3)  1876 Cost Plans with no Part D.  800 series plans are excluded. | 2/Year Contract | 1/1-6/30, 7/1-12/31 | Last Monday of August (1/1-6/30)  Last Monday of February in the following year. (7/1-12/31) |
| VI. Rewards and Incentives Programs. | Local CCPs  MSAs  PFFS, and Regional Coordinated Care Plans (CCPs)  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  (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 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 of February in the following year. |
| IX. D-SNP Enrollee Advisory Committee | D-SNP PBPs under the following types:  01 – Local CCP  11 – Regional CCP  15 – RFB Local CCP | 1/Year PBP | 1/1-12/31 | Last Monday of February in the following year. |
| X. D-SNP Transmission of Admission Notifications | D-SNP PBPs that are not fully integrated D-SNPs or highly integrated D-SNPs, except as specified under 42 CFR 422.107(d)(2), under the following types:  01 – Local CCP  11 – Regional CCP  15 – RFB Local CCP | 1/Year PBP | 1/1-12/31 | Last Monday of April in the following year. |

**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, which expresses 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.

## GRIEVANCES

This reporting section requires an upload.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Reporting section** | **Organization Types Required to Report** | **Report Frequency Level** | **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 |

## 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 |
| 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 |
| 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) |
| 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]](#footnote-4) |
| O. | Reopening disposition (Fully Favorable; Partially Favorable, Adverse or Pending) |

## EMPLOYER GROUP PLAN SPONSORS

This reporting section requires a file 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 |

## SPECIAL NEEDS PLANS (SNP) CARE MANAGEMENT

This reporting section requires a file upload 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 a reassessment |
| 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.

## ENROLLMENT AND DISENROLLMENT

This reporting section requires a file 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 | Last Monday of August (1/1-6/30)  Last Monday of February in the following year. (7/1-12/31) |

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.

For more information on these requirements, refer to the Medicare Advantage and Part D Enrollment and Disenrollment Guidance, available at:

<https://www.cms.gov/medicare/enrollment-renewal/part-d-enrollment-eligibility>.

For questions specific to enrollment/disenrollment requirements please contact the following mailbox: [https://enrollment.lmi.org/deepmailbox](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fenrollment.lmi.org%2Fdeepmailbox&data=05%7C01%7CJeffrey.Maready%40cms.hhs.gov%7C8c0e73087ed24da3a96408db86d5e26a%7Cfbdcedc170a9414bbfa5c3063fc3395e%7C0%7C0%7C638252025402358097%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=F8wGeKEL83s9pLSYeczbnPKjAh3hf2v6Ob5fkjDlbGc%3D&reserved=0).

| **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. |

## REWARDS AND INCENTIVES PROGRAMS

This is partial data entry and a file upload into HPMS at the Contract level.

|  |  |  |  |
| --- | --- | --- | --- |
| **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  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 | 1/1-12/31 | 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 the program? [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] |

## 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  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 dollars paid to providers (in and out of network) for Medicare Advantage enrollees in [CY 20XX] or most recent 12 months. | | | |
| **Category 1** | | | | |
| B. | 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. | | | |
| **Category 2** | | | | |
| C. | Total dollars paid to providers through fee-for-Service plus pay-for-reporting payments (linked to quality) in [CY 20XX] or most recent 12 months. | | | |
| D. | 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. | | | |
| E. | Dollars paid for foundational spending to improve care (linked to quality) in [CY 20XX] or most recent 12 months. | | | |
| F. | Total dollars paid in Category 2 in [CY 20XX] or most recent 12 months. | | | |
| **Category 3** | | | | |
| G. | Total dollars paid to providers through traditional shared-savings (linked to quality) payments in [CY 20XX] or most recent 12 months. | | | |
| H. | Total dollars paid to providers through utilization-based shared-savings (linked to quality) payments in [CY 20XX] or most recent 12 months. | | | |
| I. | Total dollars paid to providers through fee-for-service-based shared-risk (linked to quality) payments in [CY 20XX] or most recent 12 months. | | | |
| J. | Total dollars paid to providers through procedure-based bundled/episode payments (linked to quality) programs [CY 20XX] or most recent 12 months. | | | |
| K. | Total dollars paid in Category 3 in [CY 20XX] or most recent 12 months. | | | |
| L. | Total Risk-based payments not linked to quality (e.g., 3N in APM definitional framework) | | | |
| **Category 4** | | | | |
| M. | Total dollars paid to providers through condition-specific, population-based payments (linked to quality) in [CY 20XX] or most recent 12 months. | | | |
| N. | Total dollars paid to providers through condition-specific, bundled/episode payments (linked to quality) in [CY 20XX] or most recent 12 months. | | | |
| O. | Total dollars paid to providers through population-based payments that are NOT condition-specific (linked to quality) in [CY 20XX] or most recent 12 months. | | | |
| P. | Total dollars paid to providers through full or percent of premium population-based payments (linked to quality) in [CY 20XX] or most recent 12 months. | | | |
| Q. | Total dollars paid to providers through integrated finance and delivery system programs (linked to quality) in [CY 20XX] or most recent 12 months. | | | |
| R. | Total dollars paid in Category 4 in [CY 20XX] or most recent 12 months. | | | |
| S. | Total capitation payment not linked to quality (e.g., 4N in the APM definitional framework) | | | |
| **Provider Data** | | | | |
| T. | Total number of Medicare Advantage contracted providers | | | |
| U. | Total Medicare Advantage contracted providers paid on a fee-for-service basis with no link to quality (category 1) | | | |
| V. | Total Medicare Advantage contracted providers paid on a fee-for-service plus pay-for-reporting payments (linked to quality) | | | |
| W. | Total Medicare Advantage contracted providers paid on a fee-for-service plus pay-for-performance payments (linked to quality) | | | |
| X. | Total Medicare Advantage contracted providers paid on a fee-for-service basis  with a link to quality (category 2) | | | |
| Y. | Total Medicare Advantage contracted providers paid based on alternative payment models built on a fee-for-service architecture (Category 3) | | | |
| Z. | Total Medicare Advantage contracted providers paid through traditional shared-savings (linked to quality) | | | |
| AA. | Total Medicare Advantage contracted providers paid through utilization-based shared-savings (linked to quality) | | | |
| BB. | Total Medicare Advantage contracted providers paid through fee-for-service-based shared-risk (linked to quality) | | | |
| CC. | Total Medicare Advantage contracted providers paid through procedure-based bundled/episode payments (linked to quality) | | | |
| DD. | Total Medicare Advantage contracted providers paid based risk-based payments not linked to quality (e.g., 3N in the APM definitional framework) | | | |
| EE. | Total Medicare Advantage contracted providers paid based on population-based (category 4) | | | |
| FF. | Total Medicare Advantage contracted providers paid through condition-specific, population-based payments (linked to quality) | | | |
| GG. | Total Medicare Advantage contracted providers paid through condition-specific, bundled/episode payments (linked to quality) | | | |
| HH. | Total Medicare Advantage contracted providers paid through population-based payments that are NOT condition-specific (linked to quality) | | | |
| II. | Total Medicare Advantage contracted providers paid through full or percent of premium population-based payments (linked to quality) | | | |
| JJ. | Total Medicare Advantage contracted providers paid through integrated finance and delivery system programs (linked to quality) | | | |
| KK. | 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 enrollees in an accountable care arrangements. Metrics are linked to quality)** | | | | |
| LL. | Total Medicare Advantage covered lives in [CY 20XX] or most recent 12 months. | | | |
| MM. | 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)]. | | | |
| **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)** | | | | |
| NN. | 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)]. | | | |

## SUPPLEMENTAL BENEFIT UTILIZATION AND COSTS

This reporting section requires a file 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  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** |
| *Inpatient Hospital Services* | |
| 1a1 | Additional Days for Inpatient Hospital-Acute |
| 1a2 | Non-Medicare-covered Stay for Inpatient Hospital-Acute |
| 1a3 | Upgrades for Inpatient Hospital-Acute |
| 1a-B | Inpatient Hospital – Acute Services (For B-Only Plans) |
| 1b1 | Additional Days for Inpatient Hospital Psychiatric |
| 1b2 | Non-Medicare-covered Stay for Inpatient Hospital Psychiatric |
| 1b-B | Inpatient Psychiatric Hospital Services (For B-Only Plans) |
| *Skilled Nursing Facility Services* | |
| 2-1 | Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF) |
| 2-3a | SNF – Waiver of 3 Day Hospital Stay |
| 2-B | SNF Care (For B-Only Plans) |
| *Cardiac and Pulmonary Rehabilitation Services* | |
| 3-1 | Additional Cardiac Rehabilitation Services |
| 3-2 | Additional Intensive Cardiac Rehabilitation Services |
| 3-3 | Additional Pulmonary Rehabilitation Services |
| 3-4 | Additional Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD) Services |
| *Worldwide Emergency/Urgent Coverage* | |
| 4c1 | Worldwide Emergency Coverage |
| 4c2 | Worldwide Urgent Coverage |
| 4c3 | Worldwide Emergency Transportation |
| *Health Care Professional Services* | |
| 7b1 | Routine Chiropractic Care |
| 7b2 | Chiropractic – Other Service |
| 7f | Routine Foot Care |
| *Outpatient Blood Services* | |
| 9d | Three (3) Pint Deductible Waived |
| *Transportation Services* | |
| 10b1 | Transportation Services to Plan-Approved Health-related Location |
| 10b2 | Transportation Services to Any Health-related Location |
| *Other Supplemental Services* | |
| 13a | Acupuncture Treatments |
| 13b | Over-the-Counter (OTC) Items |
| 13c | Meal Benefits |
| 13d | Other 1 |
| 13e | Other 2 |
| 13f | Other 3 |
| 13g | Dual Eligible SNPs with Highly Integrated Services |
| *Preventive and Other Defined Supplemental Services* | |
| 14b | Annual Physical Exam |
| 14c1 | Health Education |
| 14c2 | Nutritional/Dietary Benefit |
| 14c3 | Additional Smoking and Tobacco Cessation Counseling |
| 14c4a | Fitness Benefit – Physical Fitness\* |
| 14c4b | Fitness Benefit – Memory Fitness\* |
| 14c4c | Fitness Benefit – Activity Tracker\* |
| 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 (PERS) |
| 14c12 | Medical Nutrition Therapy (MNT) |
| 14c13 | Post Discharge In-home Medication Reconciliation |
| 14c14 | Re-admission Prevention |
| 14c15 | Wigs for Hair Loss Related to Chemotherapy |
| 14c16 | Weight Management Programs |
| 14c17 | Alternative Therapies |
| 14c18 | Therapeutic Massage |
| 14c19 | Adult Day Health Services |
| 14c20 | Home-Based Palliative Care |
| 14c21 | In-Home Support Services |
| 14c22a | Support for Caregivers of Enrollees – Respite Care\* |
| 14c22b | Support for Caregivers of Enrollees – Caregiver Training\* |
| 14c22c | Support for Caregivers of Enrollees – Other\* |
| *Dental* | |
| 16b1 | Oral Exams |
| 16b2 | Dental X-Rays |
| 16b3 | Other Diagnostic Dental Services |
| 16b4 | Prophylaxis (cleaning) |
| 16b5 | Fluoride Treatment |
| 16b6 | Other Preventive Dental Services |
| 16c1 | Restorative Services |
| 16c2 | Endodontics |
| 16c3 | Periodontics |
| 16c4 | Prosthodontics, removable |
| 16c5 | Maxillofacial Prosthetics |
| 16c6 | Implant Services |
| 16c7 | Prosthodontics, fixed |
| 16c8 | Oral and Maxillofacial Surgery |
| 16c9 | Orthodontics |
| 16c10 | Adjunctive General Services |
| *Eye Exams/Eyewear* | |
| 17a1 | Routine Eye Exams |
| 17a2 | Other Eye Exam Services |
| 17b1 | Contact Lenses |
| 17b2 | Eyeglasses (Lenses and Frames) |
| 17b3 | Eyeglass Lenses |
| 17b4 | Eyeglass Frames |
| 17b5 | Eyewear Upgrades |
| *Hearing Exams/Hearing Aids* | |
| 18a1 | Routine Hearing Exams |
| 18a2 | Fitting/Evaluation for Hearing Aid |
| 18b1 | Prescription Hearing Aids (All Types) |
| 18b2 | Prescription Hearing Aids – Inner Ear |
| 18b3 | Prescription Hearing Aids – Outer Ear |
| 18b4 | Prescription Hearing Aids – Over the Ear |
| 18c | OTC Hearing Aids |
| *Medicare covered services offered as POS or V/T* | |
| VT | Visitor/Travel Program (Medicare Covered benefits)\* |
| POS | Point of Service (Medicare Covered benefits)\* |
|  |  |
| *Non-Primarily Health Related Benefits\*\** | |
| 13i1 | Food and Produce |
| 13i2 | Meals (Beyond limited basis) |
| 13i3 | Pest Control |
| 13i4 | Transportation for Non-Medical Needs |
| 13i5 | Indoor Air Quality Equipment and Services |
| 13i6 | Social Needs Benefit |
| 13i7 | Complementary Therapies |
| 13i8 | Services Supporting Self-Direction |
| 13i9 | Structural Home Modifications |
| 13i10 | General Supports for Living |
| 13i-11 | Non-Primarily Health Related Benefits for the Chronically Ill Other 1 |
| 13i-12 | Non-Primarily Health Related Benefits for the Chronically Ill Other 2 |
| 13i-13 | Non-Primarily Health Related Benefits for the Chronically Ill Other 3 |
| 13i-14 | Non-Primarily Health Related Benefits for the Chronically Ill Other 4 |
| 13i-15 | Non-Primarily Health Related Benefits for the Chronically Ill Other 5 |

\*Benefit category code has been defined for purposes of collecting these data for the Part C Reporting Requirements. These codes are not part of the CY 2025 Plan Benefit Package (PBP).

\*\*Non-Primarily Health Related Benefits are only available as Special Supplemental Benefits for the Chronically Ill (SSBCI)

**The following data elements must be reported:**

| **Data Element ID** | **Data Element Description** |
| --- | --- |
| A. | Contract ID |
| B. | PBP ID |
| C | PBP Category |
| D. | Supplemental benefit name, if “Other” (13d, 13e, 13f, or 13i-O), or if name otherwise differs from values provided above. |
| E. | 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. |
| F | Network type (in-network, out-of-network (for PPO), out-of-network (for HMO-POS), Visitor/travel, other) If “other” specify further in Data Element M, e.g. full network for PFFS plan |
| G. | The unit of utilization used by the plan when measuring utilization (e.g., admissions, visits, procedures, trips, purchases). |
| H. | The number of enrollees eligible for the benefit.  \*Plans should include all enrollees ever eligible for this benefit during the calendar year. This number should not be a ‘point-in time’ number but rather a unique count of all enrollees who were eligible for the benefit. |
| I. | The number of enrollees who utilized the benefit at least once. |
| J. | The total instances of utilizations among eligible enrollees. |
| K | The median number of utilizations among enrollees who utilized the benefit at least once. |
| L. | 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 allocated PMPM amount. |
| M. | 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. |
| N. | 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.  **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. |
| O. | The total out-of-pocket-cost for enrollees.  (Note this should be a sum of all enrollee out-of-pocket costs for a service category, broken down by the Data Element E) |
| P. | The median out-of-pocket cost for enrollees |

## D-SNP ENROLLEE ADVISORY COMMITTEE

This reporting section requires data entry into HPMS.

|  |  |  |  |
| --- | --- | --- | --- |
| **Organization Types Required to Report** | **Report Frequency Level** | **Report Period (s)** | **Data Due Date (s)** |
| D-SNP PBPs under the following types:  01 – Local CCP  11 – Regional CCP  15 – RFB Local CCP | 1/Year PBP | 1/1-12/31 | Last Monday of February in the following year. |

|  |  |
| --- | --- |
| **Data Element ID** | **Data Element Description** |
| A. | Does the D-SNP share an enrollee advisory committee (EAC) with other D-SNP(s)? (“Yes” or “No” only) |
| B. | Provide the total number of D-SNP EAC meetings held during the measurement year. |
| C. | List the dates during the measurement year when the D-SNP EAC met. |
| D. | Were interpreter services offered for each D-SNP EAC meeting? (“Yes” or “No” only) |
| E. | Were auxiliary aids and services offered for each D-SNP EAC meeting? (“Yes” or “No” only) |

## D-SNP TRANSMISSION OF ADMISSION NOTIFICATIONS

This reporting section requires data entry into HPMS.

|  |  |  |  |
| --- | --- | --- | --- |
| **Organization Types Required to Report** | **Report Frequency Level** | **Report Period (s)** | **Data Due Date (s)** |
| D-SNP PBPs that are not fully integrated D-SNPs or highly integrated D-SNPs, except as specified under 42 CFR 422.107(d)(2), under the following types:  01 – Local CCP  11 – Regional CCP  15 – RFB Local CCP | 1/Year PBP | 1/1-12/31 | Last Monday of April in the following year. |

|  |  |
| --- | --- |
| **Data Element ID** | **Data Element Description** |
| A. | Provide the total number of hospital admissions and skilled nursing facility (SNF) admissions during the measurement year among the group(s) of high risk full-benefit dually eligible individuals designated in the D-SNP’s state Medicaid agency contract. |
| B. | Of the total reported in Data Element A, provide the total number of admission notifications that the D-SNP transmitted to the state or state designated entity during the measurement year. |

1. MA only. MAPD and PDPs report under Part D. [↑](#footnote-ref-3)
2. The date of disposition is the date the required written notice of a revised decision was sent per 405.982 [↑](#footnote-ref-4)