Medicare Part C Reporting Requirements

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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. 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.

Reporting Section	Organization Types Required to Report	Report Frequency Level	Report Period (s)	Data Due Date (s)
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	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.

[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)
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.

I. 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

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

Data Element ID	Data Element Description
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

Data Element ID	Data Element Description
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)

Data Element ID	Data Element Description
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]
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 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

IV. 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.

V. 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.

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 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]

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 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)].

VIII. 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	1/year; PBP	1/1-12/31	Last Monday in February of the following calendar year

Contracts should also report this measure, regardless of organization type.			

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?

Data Element ID	Data Element Description
	(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

Data Element ID	Data Element Description
	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

IX. 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)

X. 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	1/Year PBP	1/1-12/31	Last Monday of April in the following year.

15 – RFB Local CCP			

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.