MEDICARE PART D
REPORTING REQUIREMENTS

Effective as of January 1, 2026

Contents

Revision History (from Contract Year 2025 to 2026)

The following list is provided as a courtesy and includes certain changes to this document made between Contract Year (CY) 2025 and CY 2026. Please compare the documents from both years for all the changes between the two CYs.

1. Formatting changes have been made throughout the document, including listing data elements in tables instead of lists.

2. Additional information on timely submission of data has been included in the introduction. This information used to be found in the Technical Specifications.

3. Clarification of definitions of level of data to be reported has been added to the introduction.

4. Additional information on inclusions and exclusions from Reporting Sections has been included in the introduction.

5. Clarification has been added to the introduction about terminated contracts and contracts/plans with no enrollment.

6. Additional information on Data Validation has been added to the introduction.

7. Information has been added to the introduction on CMS Analysis of Reporting Requirements data and publication of the Limited Data Set.

8. The new mailbox for questions about Part D Reporting Requirements has been added to the introduction.

9. Tables describing which contracts and plan types are required to report each reporting section have been added for clarity.

10. Duplicative information has been removed, including information duplicative of the Technical Specifications.

11. Certain introductory information in each Reporting Requirements section has been removed if it was duplicative of information found in cited regulations/policy guidance.

12. Minor clarifications have been made to most Reporting Requirements sections' data elements.

Introduction

Section 1860D–12(b)(3)(D) of the Social Security Act (the Act) provides broad authority for the Secretary to add terms to the contracts with Part D sponsors, including terms that require the sponsor to provide the Secretary with information as the Secretary may find necessary and appropriate. Pursuant to our statutory authority, we codified these information collection requirements for Part D sponsors in regulation at 42 CFR §423.514.

42 CFR §423.514(a) requires each Part D sponsor to have an effective procedure to develop, compile, evaluate, and report to the Centers for Medicare & Medicaid Services (CMS), to its enrollees, and to the general public, at the times and in the manner that CMS requires, information indicating the following:

1) The cost of its operations.
2) The patterns of utilization of its services.
3) The availability, accessibility, and acceptability of its services.
4) Information demonstrating that the Part D sponsor has a fiscally sound operation.
5) Pharmacy performance measures.
6) Other matters that CMS may require.

Unless otherwise specified, drug utilization data should include all covered[1] Part D drugs, including compounded drugs.

This document lists data elements for each reporting section, reporting timeframes, deadlines, and required levels of reporting.

Timely Submission of Data

Most reporting sections will be reported annually. Reporting deadlines often occur in the subsequent calendar year. Reporting deadlines and frequencies are listed in the Reporting Requirement sections below. Data submissions are due by 11:59 p.m. Pacific Time on the date of the reporting deadline.

Part D sponsors must report all data based on the most current Reporting Requirements documentation as of the reporting deadline. Part D sponsors should be able to support the accuracy of their data submissions based on their understanding of the Reporting Requirements documentation. Sponsors should retain documentation supporting their Health Plan Management System (HPMS) data submissions and resubmissions. Sponsors must retain this complete archive for the 10-year retention period required per federal regulations and be prepared to provide the archive to CMS upon request.

[1] Covered Part D drugs as defined by Section 1860D-2(e)(2) of the Social Security Act (The Act). Drugs offered under enhanced or supplemental drug benefits by sponsors are not covered Part D drugs.

Level of Data Reported

Data elements may be reported at the Plan-level, or the individual Contract-level. Contract-level reporting indicates data should be entered at the H#, S#, R#, or E# level. Plan-level reporting indicates data should be entered at the Plan Benefit Package (PBP) level (e.g., Plan 001 for contract H#, R#, S#, or E#). Plan-level reporting is necessary to conduct appropriate oversight and monitoring of some areas. Level of reporting is listed in the Reporting Requirement sections below.

Inclusions and Exclusions from Reporting

Organization types required to report data are listed in the Reporting Requirements sections below. The following organization types are excluded from reporting all Part D Reporting Requirements:

1. Medicare Savings Accounts (MSAs)[2]
2. Demonstration Plans
3. Healthcare Prepayment Plan (HCPP) – 1833 Cost Plans
4. National PACE Plans
5. Fallback Plans

Terminations

If a contract terminates before July 1 in the following year after the CY reporting period, the contract must not report data for the respective two years – the CY reporting period, and the following year.

- Example: Contract terminates June 20XX. The contract must not report CY 20XX - 1 (“CY reporting period”) or CY 20XX data (“following year”).

If a PBP (Plan) under a contract terminates at any time in the CY reporting period and the contract remains active through July 1 of the following year, the contract must report data for all PBPs, including the terminated PBP.

No Enrollment Contracts and Plans

Contracts or plans with no enrollment must not report data for any reporting section. No enrollment signifies that the contract has no enrollees for all the months within the reporting period.

Data Validation

CMS requires that sponsoring organizations (SOs) contracted to offer Medicare Part C and/or Part D benefits be subject to an independent yearly audit to validate certain data reported to CMS to determine its reliability, validity, completeness, and comparability in accordance with specifications developed by CMS.[3]

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[2] Denotes that these the plans are required to report the Employer Group Plan Sponsors reporting section, because this section is reported by both Part C and Part D plans.
[3] See 42 CFR § 422.516(g) and § 423.514(j)

Reporting Sections requiring data validation are indicated in the Reporting Requirement sections below. More information about data validation can be found at https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/part-c-and-part-d-data-validation.

Reporting Requirements Data Analysis and Limited Data Set

CMS analyses data submitted for accuracy and trends. In addition, certain data reported by Part D Sponsors is published annually in a Limited Data Set (LDS). More information on this LDS can be found at https://www.cms.gov/data-research/files-order/limited-data-set-lds-files/parts-c-and-d-reporting-requirements-limited-data-set.

Questions

Questions about Part D Reporting Requirements should be sent via email to PartsCDPlanReportingAndDV@cms.hhs.gov.

Reporting Sections

Section I. Enrollment and Disenrollment

Enrollment and disenrollment requirements for Medicare Advantage (MA) and Part D plan elections are outlined at 42 CFR 422 Subpart B and 42 CFR 423 Subpart B, respectively.

All enrollment and disenrollment activity involving a Part D benefit (e.g., standalone prescription drug plans (PDPs), MA prescription drug plans (MA-PDs), 1876 Cost plans with Part D optional supplemental benefit) are reported via the Part D Reporting Requirements. MA Organizations and 1876 Cost plans report enrollment and disenrollment activity that does not involve a Part D benefit under the Part C Reporting Requirements.

For more information on these requirements, refer to the MA and Part D Enrollment and Disenrollment Guidance, available at: https://www.cms.gov/medicare/enrollment-renewal/part-d-enrollment-eligibility.

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due Date(s)
- Local Coordinated Care Plan (CCP) - Religious Fraternal Benefit (RFB) Private Fee for Services (PFFS) - PFFS - 1876 Cost - Prescription Drug Plans (PDPs) - Regional CCP - RFB Local CCP	2/Year, Contract Level	Period 1: 1/1-6/30 Period 2: 7/1-12/31 (Reporting at biannual level)	Period 1: Last Monday of August Period 2: Last Monday of February of the following year. Data Validation is not required.

Subsection 1: Enrollment

Data Element ID	Data Element Description
A.	The total number of enrollment requests (initiated by the beneficiary or his/her authorized representative) received in the reporting period. Do not include auto/facilitated or passive enrollments, rollover transactions, or other enrollments effectuated by CMS.
B.	Of the total reported in Element 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

Data Element ID	Data Element Description
	representative).
C.	Of the total reported in Element A, the number of enrollment requests that were not complete at the time of initial receipt and for which the sponsor was required to request additional information from the applicant (or his/her authorized representative).
D.	Of the total reported in Element 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 Element C, the number of enrollment requests received that are incomplete upon initial receipt and completed within established timeframes.
F.	Of the total reported in Element C, the number of enrollment requests denied due to the applicant or his/her authorized representative not providing the information required to complete the enrollment request within established timeframes.
G.	Of the total reported in Element A, the number of paper enrollment requests received.
H.	Of the total reported in Element A, the number of telephonic enrollment requests received (if sponsor offers this mechanism).
I.	Of the total reported in Element 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 Element A, the number of Medicare Online Enrollment Center (OEC) enrollment requests received.
K.	Of the total reported in Element A, the number of enrollment requests received from an applicant through an agent or broker.

Subsection 2: Disenrollment

Data Element ID	Data Element Description
A.	The total number of voluntary disenrollment requests received in the reporting period. Do not include disenrollments resulting from an individual's enrollment in another plan.
B.	Of the total reported in Element 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 Element A, the number of disenrollment requests that were not complete at the time of initial receipt.
D.	Of the total reported in Element A, the number of disenrollment requests denied by the Sponsor for any reason.
E.	Of the total reported in Element C, the number of disenrollment requests received that are incomplete upon initial receipt and

Data Element ID	Data Element Description
	completed within established timeframes.
F.	Of the total reported in Element C, the number of disenrollment requests denied due to the enrollee or his/her authorized representative not providing information required to complete the disenrollment request within established timeframes.
G.	The total number of involuntary disenrollments for failure to pay plan premium in the reporting period.
H.	Of the total reported in Element G, the number of disenrolled individuals who submitted a timely request for reinstatement for Good Cause.
I.	Of the total reported in Element H, the number of favorable Good Cause determinations.
J.	Of the total reported in Element I, the number of individuals reinstated.

Section II. Medication Therapy Management Programs

Per 42 CFR § 423.153(d), Part D sponsors must establish Medication Therapy Management (MTM) programs. More information about Part D MTM programs can be found at: https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/medication-therapy-management. For monitoring purposes, Part D sponsors must report data elements related to all beneficiaries enrolled in their MTM program.

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due Date(s)
All contracts identified in the approved drill down of the CY of the reporting year in the MTMP Activity Report.	1/Year, Contract Level	1/1-12/31 (Reporting at annual level)	Last Monday of February of the following year. Data Validation required.

Data Element ID	Data Element Description
A.	Contract Number.
B.	MBI Number.
C.	Beneficiary first name.
D.	Beneficiary last name.
E.	Beneficiary date of birth.
F.	Beneficiary identified as cognitively impaired at time of comprehensive medication review (CMR) offer or delivery of CMR. (Y (yes), N (no), or U (unknown)).
G.	Beneficiary in a long-term care facility at the time of the first CMR offer or delivery of CMR? (Y (yes), N (no), or U (unknown))
H.	Date of MTM program enrollment.
I.	Targeting criteria met. Required if met the specified targeting criteria per CMS – Part D requirements in § 423.153(d)(2). (Multiple chronic diseases/multiple Part D drugs/cost threshold; Drug management program at-risk beneficiary; Both; None).
J.	Date met the specified targeting criteria per CMS – Part D requirements in § 423.153(d)(2). Required if met the specified targeting criteria per CMS – Part D requirements. (May be same as Date of MTM program enrollment).
K.	Date of MTM program opt-out, if applicable
L.	Reason participant opted-out of MTM program (Death; Disenrollment from Plan; Request by beneficiary; or Other). Required if Date of MTM program opt-out is applicable.
M.	Offered annual CMR. (Y (yes) or N (no)). Required if met the

Data Element ID	Data Element Description
	specified targeting criteria per CMS – Part D requirements.
N.	If offered a CMR, date of (initial) offer.
O.	Received annual CMR with written summary in CMS standardized format. (Y (yes) or N (no)). Required if offered annual CMR.
P.	Date(s) of CMR(s). (If more than 1 CMR is received, report the date of the initial CMR.). Required if received annual CMR.
Q.	Date CMR written summary in CMS standardized format was provided or sent. (If more than 1 CMR was performed, report the date the initial CMR written summary was provided or sent.).
R.	Method of delivery for the annual CMR. (In-Person; Synchronous Telehealth – telephone; Synchronous Telehealth – video conferencing; Other real-time method). (If more than 1 CMR is received, report the method of delivery for the initial CMR). Required if received annual CMR.
S.	Qualified Provider who performed the initial CMR. (Physician; Registered Nurse; Licensed Practical Nurse; Nurse Practitioner; Physician's Assistant; Local Pharmacist; LTC Consultant Pharmacist; Plan Sponsor Pharmacist; Plan Benefit Manager (PBM) Pharmacist; MTM Vendor Local Pharmacist; MTM Vendor In-house Pharmacist; Hospital Pharmacist; Pharmacist – Other; Supervised Pharmacy Intern; or Other). Required if received annual CMR.
T.	Recipient of initial CMR. (Beneficiary, Beneficiary's prescriber; Caregiver; or Other authorized individual). Required if received annual CMR.
U.	Number of targeted medication reviews. Required if met the specified targeting criteria per CMS – Part D requirements.
V.	Date the first TMR was performed.
W.	Number of medication therapy problem recommendations made to beneficiary's prescriber(s) as a result of MTM services.
X.	Number of medication therapy problem resolutions resulting from recommendations made to beneficiary's prescriber(s) as a result of MTM recommendations.
Y.	Number of communications sent to beneficiary regarding safe disposal of medications. Required if met the specific targeting criteria per CMS – Part D requirements.
Z.	Method of delivery for information regarding safe disposal of medications (CMR; TMR; Welcome Letter; Other). If more than one communication is sent, report the method of the initial communication.

Section III. Grievances

Part D sponsors must comply with grievance requirements for timely hearing and resolving of grievances as established in the regulations at 42 CFR Part 423 Subpart M and further described in the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due Date(s)
- Local CCP - RFB PFFS - PFFS - 1876 Cost - PDP - Regional CCP - Employer/Union Only Direct Contract PDPs - Employer/Union Only Direct Contract – PFFS - RFB Local CCP - LI NET Sponsor - Employer/Union Only Direct Contract 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	Q1: 1/1-3/31 Q2: 4/1- 6/30 Q3: 7/1-9/30 Q4: 10/1-12/31 (Reporting at quarterly level)	First Monday of February of the following year. Data 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

Section IV. Improving Drug Utilization Review Controls

Part D sponsors must have concurrent drug utilization review (DUR) systems, policies, and procedures designed to ensure that a review of the prescribed drug therapy is performed before each prescription is dispensed to an enrollee in a sponsor's Part D plan, typically at the point-of-sale (POS) or point of distribution as described in 42 CFR § 423.153(c)(2). To help prevent and combat prescription opioid overuse through improved concurrent DUR, sponsors are expected to implement opioid safety edits at the POS. More information about Medicare Part D opioid overutilization policies can be found at https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/improving-drug-utilization-review-controls-part-d.

For monitoring, Part D sponsors must report cumulative YTD data by quarter to CMS on the opioid care coordination, hard MME, and the opioid naïve days supply safety edits.

Organization Types Required to Report	**Report Frequency, Level**	**Report Period(s)**	**Data Due Date(s)**
- Local CCP - RFB PFFS - PFFS - 1876 Cost - PDP - Regional CCP - Employer/Union Only Direct Contract PDPs - Employer/Union Only Direct Contract PFFS - RFB Local CCP - Employer/Union Only Direct Contract 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	Q1: 1/1-3/31 Q2: 1/1- 6/30 Q3: 1/1-9/30 Q4: 1/1-12/31 (Reporting at quarterly level)	Last Monday of February of the following year. Data Validation required.

Subsection 1: Opioid Care Coordination Safety Edit

Data Element ID	Data Element Description
A.	The prescriber count criterion used, if applicable.
B.	The pharmacy count criterion used, if applicable.
C.	The number of claims rejected due to the care coordination edit.
D.	Of the total reported in Element C, the number of claim rejections overridden by the pharmacy.
E.	Of the total reported in Element D: The number of claim rejections overridden by the pharmacy within 24 hours of the initial claim rejection.
F.	Of the total reported in Element D: The number of claim rejections overridden by the pharmacy due to an exemption.
G.	Of the total reported in Element D but not in Element F: The number of claim rejections overridden by the pharmacy as a result of prescriber consultation.
H.	Of the total reported in Element C: The number of unique beneficiaries with at least one claim rejected due to the care coordination edit.
I.	Of the total reported in Element H: The number of unique beneficiaries with at least one claim rejection overridden by the pharmacy.
J.	Of the total reported in Element H: The number of unique beneficiaries with at least one claim rejection overridden by the pharmacy within 24 hours of the initial claim rejection.
K.	Of the total reported in Element H: The number of unique beneficiaries with at least one claim rejection overridden by the pharmacy due to an exemption.
L.	Of the total reported in Element H but not in Element K: The number of unique beneficiaries with at least one claim rejection overridden by the pharmacy as a result of prescriber consultation.

Subsection 2: Hard MME Safety Edit

Data Element ID	Data Element Description
M.	Did the plan have a hard MME edit in place during the time period above? (Y (yes) or N (no)).
N.	If yes to Element M: The cumulative MME threshold used.
O.	If yes to Element M: The prescriber count criterion used, if applicable.
P.	If yes to Element M: The pharmacy count criterion used, if applicable.
Q.	If yes to Element M: The number of claims rejected due to the hard MME edit.
R.	If yes to Element M: The number of unique beneficiaries with at least one claim rejected due to the hard MME edit.
S.	If yes to Element M: Of the total reported in Element R, the

Data Element ID	Data Element Description
	number of unique beneficiaries with at least one claim rejection overridden by the pharmacy due to an exemption.
T.	If yes to Element M: Of the total reported in Element R and not in element S, the number of unique beneficiaries who requested a coverage determination for the prescription(s) subject to the edit.
U.	If yes to Element M: Of the total reported in Element T, the number of unique beneficiaries that had a favorable (either full or partial) coverage determination for the prescription(s) subject to the edit.

Subsection 3: Opioid Naïve Days Supply Safety Edit

Data Element ID	Data Element Description
V.	The look-back period used to identify an initial opioid prescription fill for the treatment of acute pain for the opioid naïve days supply edit.
W.	The number of claims rejected due to the opioid naïve days supply edit.
X.	Of the total reported in Element W: The number of rejected claims overridden by the pharmacy due to an exemption.
Y.	Of the total reported in Element W: The number of rejected claims overridden by the pharmacy because the beneficiary was not opioid naïve.
Z.	Of the total reported in Element W but not in Elements X or Y: The number of rejected claims for which up to a 7 day supply (covered by the plan) was dispensed by the pharmacy.
AA.	Of the total reported in Element W: The number of unique beneficiaries with at least one claim rejected due to the opioid naïve days supply edit.
BB.	Of the total reported in Element AA: The number of unique beneficiaries with at least one rejected claim overridden by the pharmacy due to an exemption.
CC.	Of the total reported in Element AA: The number of unique beneficiaries with at least one rejected claim overridden by the pharmacy because the beneficiary was not opioid naive.
DD.	Of the total reported in Element AA but not in Elements BB or CC: The number of unique beneficiaries for whom up to a 7 day supply (covered by the plan) was dispensed by the pharmacy.
EE.	Of the total reported in Element AA: The number of unique beneficiaries with an opioid naïve days supply edit claim rejection who requested a coverage determination for the prescription(s) subject to the edit.
FF.	Of the total reported in Element EE: The number of unique beneficiaries with an opioid naïve days supply edit claim rejection who had a favorable (either full or partial) coverage determination for the prescription(s) subject to the edit.

Section V. Coverage Determinations, Redeterminations (including At–Risk Redeterminations under a Drug Management Program), and Reopenings

The requirements relating to coverage determinations (including formulary and tier exceptions, and exceptions to established drug utilization management programs) and redeterminations, including timeframes for standard and expedited requests, are described in Title 42, Part 423, Subpart M.

For further clarity regarding specific requirements for Part D sponsors, please see https://www.cms.gov/medicare/appeals-grievances/prescription-drug.

Requirements for redeterminations of at-risk determinations made under a plan sponsor's drug management program are described at 42 CFR § 423.153(f).

Title 42, Part 423, Subpart U describes requirements for reopenings of coverage determinations and redeterminations.

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due Date(s)
- Local CCP - RFB PFFS - PFFS - 1876 Cost - PDP - Regional CCP - Employer/Union Only Direct Contract PDPs - Employer/Union Only Direct Contract PFFS - RFB Local CCP - Employer/Union Only Direct Contract 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	Q1: 1/1-3/31 Q2: 4/1- 6/30 Q3: 7/1-9/30 Q4: 10/1-12/31 (Reporting at quarterly level)	Last Monday of February of the following year. Data Validation required.

Subsection 1a: Coverage Determinations (including exceptions)

Data Element ID	Data Element Description
A.	Total Number of Coverage Determinations Processed (including exceptions)
B.	Total Number of Withdrawn Coverage Determinations
C.	Total Number of Dismissed Coverage Determinations

Subsection 1b: Disposition – Coverage Determinations (non-exceptions)

Data Element ID	Data Element Description
D.	The total number of fully favorable decisions.
E.	The total number of partially favorable decisions.
F.	The total number of adverse decisions.

Subsection 1c: Disposition – Utilization Management Exceptions

Data Element ID	Data Element Description
G.	The number of utilization management exceptions.
H.	The number of fully favorable decisions.
I.	The number of partially favorable decisions.
J.	The number of adverse decisions.

Subsection 1d: Disposition – Formulary Exceptions

Data Element ID	Data Element Description
K.	The number of formulary exceptions.
L.	The number of fully favorable decisions.
M.	The number of partially favorable decisions.
N.	The number of adverse decisions.

Subsection 1e: Disposition – Tiering Exceptions

Data Element ID	Data Element Description
O.	The number of tiering exceptions.
P.	The number of fully favorable decisions.
Q.	The number of partially favorable decisions.
R.	The number of adverse decisions.

Subsection 2a: Redeterminations including exceptions and at-risk redeterminations)

Data Element ID	Data Element Description
A.	Total Number of Redeterminations Processed (including exceptions and at- risk)
B.	Total Number of Withdrawn Redeterminations
C.	Total Number of Dismissed Redeterminations

Subsection 2b: Disposition – Redeterminations (non-exceptions)

Data Element ID	Data Element Description
D.	The total number of fully favorable decisions.
E.	The total number of partially favorable decisions.
F.	The total number of adverse decisions.

Subsection 2c: Disposition – Utilization Management Exception Redeterminations

Data Element ID	Data Element Description
G.	The number of utilization management exceptions.
H.	The number of fully favorable decisions.
I.	The number of partially favorable decisions.
J.	The number of adverse decisions.

Subsection 2d: Disposition – Formulary Exception Redeterminations

Data Element ID	Data Element Description
K.	The number of formulary exceptions.
L.	The number of fully favorable decisions.
M.	The number of partially favorable decisions.
N.	The number of adverse decisions.

Subsection 2e: Disposition – Tiering Exception Redeterminations

Data Element ID	Data Element Description
O.	The number of tiering exceptions.
P.	The number of fully favorable decisions.
Q.	The number of partially favorable decisions.
R.	The number of adverse decisions.

Subsection 2f: Disposition – At-Risk Redeterminations

Data Element ID	Data Element Description
S.	The number of at-risk exceptions.
T.	The number of fully favorable decisions.
U.	The number of partially favorable decisions.
V.	The number of adverse decisions.

Subsection 3: Reopenings

Data Element ID	Data Element Description
A.	The total number of reopened (revised) decisions, for any reason
B1.	Contract Number.
B2.	Case ID.
B3.	Case level (Coverage Determination or Redetermination).
B4.	Date of original disposition.
B5.	Original disposition (Fully Favorable, Partially Favorable, or Adverse)

Data Element ID	Data Element Description
B6.	Was case processed under expedited timeframe (Y/N)
B7.	Case type (Pre-service or Payment).
B8.	Date case was reopened
B9.	Reason(s) for reopening (Clerical Error, Other Error, New and Material Evidence, Fraud or Similar Fault, or Other)
B10.	Date of reopening disposition (revised decision).
B11.	Reopening disposition (Fully Favorable, Partially Favorable, Adverse, or Pending).

Section VI. Employer Group Plan Sponsors

The information requested is necessary for CMS to ensure that employer/union-sponsored group health plans that provide Part D benefits are properly utilizing waivers and modifications in accordance with 42 CFR § 423.458(c). Additional information regarding Part D plan waivers can be found in Chapter 12 of the Medicare Prescription Drug Benefit Manual (https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/dwnlds/r6pdbpdfpdf).

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due Date(s)
- Local CCP - MSA - RFB PFFS - PFFS - 1876 Cost - PDP - Regional CCP - Employer/Union Only Direct Contract PDPs - Employer/Union Only Direct Contract PFFS - RFB Local CCP - Employer/Union Only Direct Contract Local CCP - 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 level	1/1-12/31 (Reporting at annual level)	First Monday of February of the following year. Data Validation not required.

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)

Data Element ID	Data Element Description
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 Element H is “N", provide non-calendar year start date.
J.	Current/Anticipated enrollment

Section VII. Medicare Prescription Payment Plan

The “Medicare Prescription Payment Plan” was established by section 11202 of the Inflation Reduction Act (IRA) of 2022 (P.L. 117-169). Section 1860D-2(b)(2)(E) of the Social Security Act, as added by section 11202 of the IRA, requires all Medicare Part D sponsors to offer their Part D enrollees the option to pay their out-of-pocket (OOP) Part D drug costs through monthly payments over the course of the plan year instead of as upfront payments at the pharmacy point of sale (POS), beginning January 1, 2025.

CMS does not expect Part D plans that exclusively charge $0 cost sharing for covered Part D drugs to all plan enrollees to offer enrollees the option to pay their out-of-pocket (OOP) costs through monthly payments over the course of the plan year or otherwise comply with the requirements at 42 C.F.R § 423.137 and all applicable guidance, including the Medicare Prescription Payment Plan reporting requirements. Plans that exclusively charge $0 cost sharing for covered Part D drugs to all plan enrollees are excluded from the Medicare Prescription Payment Plan reporting section.

Organization Types Required to Report	**Report Frequency, Level**	**Report Period(s)**	**Data Due Date(s)**
- Local CCP - RFB PFFS - PFFS - 1876 Cost - PDP - Regional CCP - Employer/Union Only Direct Contract PDPs - Employer/Union Only Direct Contract PFFS - RFB Local CCP - Employer/Union Only Direct Contract 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, PBP level	1/1-12/31 (Reporting at annual level)	Last Monday of April Data Validation is not required.

Subsection 1: Likely to benefit identification

Data Element ID	Data Element Description
A.	The total number of individuals identified as likely to benefit from the Medicare Prescription Payment Plan during the reporting period through any of the following methods: prior to plan year criteria; during the plan year criteria; POS criteria (unique beneficiaries, including those who did not elect to participate in the Medicare Prescription Payment Plan).
B.	The total number of individuals identified as likely to benefit from the Medicare Prescription Payment Plan during the reporting period based on prior to plan year criteria (unique beneficiaries, including those who did not elect to participate in the Medicare Prescription Payment Plan).
C.	The total number of individuals identified as likely to benefit from the Medicare Prescription Payment Plan during the reporting period based on during the plan year criteria (unique beneficiaries, including those who did not elect to participate in the Medicare Prescription Payment Plan).
D.	The total number of individuals identified as likely to benefit from the Medicare Prescription Payment Plan during the reporting period based on POS criteria (unique beneficiaries, including those who did not elect to participate in the Medicare Prescription Payment Plan).
E.	Among individuals identified in Element A, the total number of those individuals who submitted an election request to participate in the Medicare Prescription Payment Plan during the reporting period.

Subsection 2: Election request processing

Data Element ID	Data Element Description
F.	The total number of Medicare Prescription Payment Plan election requests received during the reporting period.
G.	Of the total reported in Element F, the number of election requests that were accepted during the reporting period.
H.	Of the total reported in Element F, the number of election requests that were not complete at the time of initial receipt and for which the sponsor was required to request additional information from the applicant (or his/her representative).
I.	Of the total reported in Element H, the number of election requests received that were able to be completed within established timeframes.
J.	Of the total reported in Element H, the number of election requests denied due to the applicant or his/her authorized legal representative not providing the information required to complete the election request within established timeframes.

Data Element ID	Data Element Description
K.	Of the total reported in Element F, the number of election requests that were denied during the reporting period.

Subsection 3: Unsettled balances

Data Element ID	Data Element Description
L.	The collected Medicare Prescription Payment Plan amounts from the reporting period.
M.	The uncollected Medicare Prescription Payment Plan balances from the reporting period.
N.	Number of program participants with uncollected Medicare Prescription Payment Plan balances from the reporting period.
O.	Number of individuals precluded from opting into the Medicare Prescription Payment Plan (in the subsequent year).