MEDICARE PART D
REPORTING REQUIREMENTS

PRA Disclosure Statement

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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 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 ~~added~~included ~~to~~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~~s~~ has been removed if it was duplicative of information found in cited regulations/policy guidance.
12. Minor clarifications have been made~~to lists of data elements~~ ~~in~~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)~~CMS~~, to its enrollees, and to the general public, at the times and in the manner that CMS requires, ~~statistics~~ 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.

~~The purpose of this document is to assure a common understanding of the Part D reporting requirements and how these data will be used to monitor the prescription drug benefit provided to Medicare beneficiaries. CMS will use the following terminology to ensure consistency in these reporting requirements:~~

~~Part D sponsor – an organization which has one or more contract(s) with CMS to provide Part D benefits to Medicare beneficiaries. Each contract is assigned a CMS contract number (e.g., H# or S#).~~

~~Plan – a plan benefit package (PBP) offered within a Part D contract (e.g., Plan ID #).~~

~~This document lists reporting timeframes, deadlines and required levels of reporting. Reporting deadlines may occur in the subsequent calendar year. Data elements may be reported at the Plan (PBP) level, or the individual Contract level.~~

~~The following criteria were used in selecting reporting requirements:~~

~~Minimal administrative burden on Part D sponsors;~~

[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.

Commented [SS1]: This used to be a * but has been changed to an actual footnote.

Commented [SS2]: We agreed to remove this sentence.

Commented [SS3]: These Plan and Contract descriptions have been rewritten for clarity in the Level of Data Reported section of this introduction.

Commented [SS4]: We agreed to remove this selection criteria, as it is duplicative of information in PRA materials.

~~Legislative and regulatory authority;~~

~~Validity, reliability, and utility of data elements requested; and~~

~~Wide acceptance and current utilization within the industry.~~

~~PACE Organizations offering Part D coverage are exempt from these Part D reporting requirements.~~[2]

Commented [SS5]: This was removed as it was duplicative of the new and improved Inclusions and Exclusions sections of this introduction.

[2] ~~Unless otherwise specified, drug utilization data should include all covered* Part D drugs, including compounded drugs~~

~~Medicare/Medicaid Plans (MMPs) should refer to the Medicare-Medicaid Financial Alignment Model Reporting Requirements for additional reporting guidance. Some MMP measures may have specific timelines that may be different.~~

~~*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.~~

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.

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)[3]
2. Demonstration Plans

[3] 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.

Commented [SS6]: Removed as these do not exist in 2026.

Commented [SS7]: The following sections of the introduction are set to match exactly to the Part C RR doc, except in specific minor instances where C and D differ.

Commented [SS8]: From Part D TS.

Commented [SS9]: We discussed this as a team, even with Bene or case level reporting, we are only referencing the top level reporting (contract or plan).

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 ~~will~~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 ~~still~~ 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 months within the reporting period.

Commented [SS10]: Agreed as a team for 2026, all RR sections will adopt the same rule as MTM. No enrollment contracts will NOT show up for any reporting section. No enrollment contracts will not report data. Their contract number would not even show up in the HPMS.

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.[4]

Commented [SS11]: We agreed as a team to use the same language that is in the DV manual.

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.

[4] See 42 CFR § 422.516(g) and § 423.514(j)

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.

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

All enrollment and disenrollment activity involving a Part D benefit (e.g., standalone prescription drug plans (PDPs), MA prescription drug plans (MA-PDs) ~~prescription drug plan~~, 1876 C~~c~~ost plans with Part D optional supplemental benefit) is reported via the Part D Reporting R~~r~~equirements. MA ~~MA~~Organizations and 1876 Cost plans report enrollment and disenrollment activity that does not involve a Part D benefit under the Part C R~~r~~eporting R~~r~~equirements.

~~Section 1 Enrollment, elements 1.A-1.K must include all enrollments. Disenrollments must not be included in Section 1 Enrollment. Section 2 Disenrollment, elements 2.A-2.F, must include all voluntary disenrollment transactions.~~

	~~Period 1~~	~~Period 2~~
~~Reporting Period~~	~~January 1 – June 30~~	~~July 1 – December 31~~
~~Data due to CMS/HPMS~~	~~Last Monday of August~~	~~Last Monday of February~~

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.

~~Reporting timeline:~~

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)	2/Year Contract Level	Period 1: 1/1-6/30 Period 2: 7/1-12/31 (Reporting at ~~the~~ biannual level)	Period 1: Last Monday of August Period 2: Last Monday of February of the following year. Data Validation not required.

Commented [SS12]: Agreed as a team to remove this, as it is fluff. The introductions should just be citations of policy/regs, possible links if relevant.

Commented [SS13]: Removed and moved to TS.

Commented [SS14]: Copied from Part C RR doc.

- Regional CCP - RFB Local CCP			

~~*Data files to be uploaded through the HPMS at the Contract level, following templates provided in HPMS.*~~

Commented [SS15]: Sentences like these have been removed as they are duplicative of the TS.

Subsection 1: Enrollment

Data Element ID	Data Element Description
A.	The total number of enrollment requests (initiated by the beneficiary or his/her authorized ~~legal~~ 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 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 ~~that the applicant was 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 ~~legal~~ 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

Commented [SS16]: Data Elements have been moved into table format instead of a list.

Commented [SS17]: We ensured we always say "authorized representative" so that we are consistent between C and D rr docs. Note that while the Part C reg says "authorized representative", the Part D reg just says "Representative".

Commented [SS18]: Slight edits made throughout to match Part C document.

Data Element ID	Data Element Description
	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. ~~due to the sponsor's determination that the enrollee was not eligible for an election period.~~
E.	Of the total reported in Element C, the number of disenrollment requests received that are incomplete upon initial receipt and 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 ~~legal~~ 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.

Commented [SS19]: FYI, Part C description says "the number of disenrollment requests denied by the Sponsor for any reason." SME agreed to say that here.

Section II. Medication Therapy Management Programs

Per 42 CFR § 423.153(d), ~~The requirements stipulating that~~ Part D sponsors must establish ~~provide~~ 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. ~~are described in Title I, Part 423, Subpart D, § 423.153.~~ For monitoring purposes, Part D sponsors must ~~will be responsible for~~ report~~ing several~~ data elements related to all beneficiaries enrolled in their MTM program.

Commented [SS20]: Removed as we agreed with SMEs that this is mentioned in both the first and second paragraph so one mention can be deleted.

~~Reporting timeline:~~

	~~YTD~~
~~**Reporting Period**~~	~~January 1 - December 31~~
~~**Data due to CMS/HPMS**~~	~~Last Monday of February~~

~~Sponsors are required to target beneficiaries for the MTM program who meet specific criteria as specified by CMS in § 423.153(d)(2). Some sponsors also offer enrollment in the MTM program to an expanded population of beneficiaries who do not meet the targeting criteria under § 423.153(d)(2).~~

Commented [SM21]: We struck this to keep it simple so that we do not have to update if requirements change.

~~The following information will be collected for each beneficiary identified as being eligible for the Part D MTM program, whether based on CMS' specifications or other plan-specific expanded targeting criteria within the reporting period. Regardless of this designation, the corresponding MTM services delivered to each beneficiary (such as targeted medication review or comprehensive medication review) must meet CMS definitions. The reported beneficiaries must receive MTM services that meet or exceed CMS' MTM program requirements.~~

Commented [SS22]: This has been moved to TS.

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	~~Period1:~~ 1/1-12/31 (Reporting at ~~the~~ annual level)	Last Monday of February of the following year. Data Validation ~~is~~ required.

Data Element ID	**Data Element Description**

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 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;

Commented [SS23]: Data Elements have been moved into table format instead of a list.

Data Element ID	Data Element Description
	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. ~~Title 42, Part 423, Subpart M describes Part D sponsors requirements for grievances, including timeframes for standard and expedited requests.~~

Commented [SS24]: Updates in citations provided/approved by SMEs.

~~Sponsors should:~~

Commented [SS25]: This has been moved to the TS.

~~Report data based on when the enrollee/enrollee representative is notified (orally or written) of the grievance decision.~~

~~Track multiple grievances by a single complainant and report as separate grievances.~~

~~Sponsors should not:~~

~~Include CTM data when reporting grievances.~~

~~Report general inquiries or questions that do not include a complaint as grievances.~~

~~Include grievances filed by prospective enrollees.~~

~~Report withdrawn grievances.~~

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.	1/Year Contract Level	Q1: 1/1-3/31 Q2: 4/1- 6/30 Q3: 7/1-9/30 Q4: 10/1-12/31 (R~~r~~eporting at quarterly level)	First Monday of February of the following year. Data Validation required.

Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.			

~~Sponsors will report quarterly data on an annual basis. Data files to be uploaded through the HPMS at the Contract level, following templates provided in HPMS.~~

Commented [SS26]: Removed as this is duplicative info.

~~Reporting timeline:~~

	~~**Quarter 1**~~	~~**Quarter 2**~~	~~**Quarter 3**~~	~~**Quarter 4**~~
~~**Reporting Period**~~	~~January 1– March 31~~	~~April 1– June 30~~	~~July 1– September 30~~	~~October 1– December 31~~
~~**Data due to CMS/HPMS**~~	~~First Monday of February (reporting for all quarters due on this date)~~	~~First Monday of February (reporting for all quarters due on this date)~~	~~First Monday of February (reporting for all quarters due on this date)~~	~~First Monday of February (reporting for all quarters due on this date)~~

~~Data elements should be uploaded to HPMS at the Contract level:~~

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

Commented [SS27]: This is duplicative of the table above, removing.

Commented [SS28]: Data Elements have been moved into table format instead of a list. No changes to the elements were made.

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 ~~will report~~ cumulative YTD data by quarter to CMS on the ~~beneficiaries who triggered each of the following opioid safety edits:~~

~~An~~ opioid care coordination ~~safety edit, at 90 morphine milligram equivalent dose (MME)~~hard MME, and the opioid naïve days supply safety edits. ~~per day;~~

~~An optional hard formulary level cumulative opioid daily MME safety edit at 200 MME or more;~~

~~A hard opioid naïve days supply safety edit for initial opioid prescriptions fills that exceed 7 days for the treatment of acute pain.~~

~~All data elements must be uploaded to HPMS at the Contract level. These elements will enable CMS to monitor sponsors' implementation of the opioid point of sale (POS) safety edits as well as the impact and outcome of the edits aggregated at both the claim and unique beneficiary levels (i.e., based on count of unique Medicare Beneficiary Identifiers (MBIs)).~~

Commented [SM29]: Edits were made to point to this page and streamline.

https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/improving-drug-utilization-review-controls-part-d

Commented [SM30]: Worked with Joanne to make edits to decide if this information can be struck since we added the cms.gov website where the actual OMS policies are described.

Commented [SS31]: Removed as this information is now in the Tech Specs.

Commented [MK32]: Moved to TS.

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	1/Year Contract Level	Q1: 1/1-3/31 Q2: 1~~4~~/1- 6/30 Q3: 1~~7~~/1-9/30 Q4: 1~~0~~/1-12/31 (R~~r~~eporting at ~~the~~ quarterly level)	Last Monday of February of the following year. Data Validation required.

- 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.			

Commented [SS33]: We agreed to add the below language to Part D sections requiring employer plans to report for consistency with Part C sections do.

"Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type."

We will ensure this update is made to 2026 parameters.

~~Reporting timeline:~~

	~~Quarter 1~~	~~Quarter 2~~	~~Quarter 3~~	~~Quarter 4~~
~~**Reporting Period**~~	~~January 1 – March 31~~	~~January 1 – June 30~~	~~January 1 – September 30~~	~~January 1 – December 31~~
~~**Data due to CMS/HPMS**~~	~~Last Monday of February (reporting for all quarters due on this date)~~	~~Last Monday of February (reporting for all quarters due on this date)~~	~~Last Monday of February (reporting for all quarters due on this date)~~	~~Last Monday of February (reporting for all quarters due on this date)~~

Subsection 1: Opioid Care Coordination Safety Edit ~~at 90~~ MME

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 E~~e~~lement 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 ~~Of the total~~ not in E~~e~~lement F:~~,~~ T~~t~~he number of claim rejections overridden by the pharmacy as a result of prescriber consultation.
H.	Of the total reported in Element C~~D~~: 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~~Of the total not in~~ E~~e~~lement K:~~,~~ T~~t~~he 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 E~~e~~lement R, the number of unique beneficiaries with at least one claim rejection overridden by the pharmacy due to an exemption.

Commented [JH34]: Removing specification of CC edit similar to above.

Commented [SS35]: Data Elements have been moved into table format instead of a list.

Commented [SM36]: General note that we can save for 2027 RR document(s) - I don't think we are consistent with the "Of the total" for other sections. One example - part C ODR.

Commented [SM37]: Joanne confirmed this should be Of the total reported in Element C.

Commented [SS38]: "Of the total reported in element H:" was moved directly into the description of each element to avoid unnecessary breaks in the list/table for 508 purposes.

Commented [SS39]: "If yes to Element M:" was moved directly into the description of each element to avoid unnecessary breaks in the list/table for 508 purposes.

Data Element ID	Data Element Description
T.	If yes to Element M: Of the total reported in E~~e~~lement 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 E~~e~~lement 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~~Of the total~~ not in E~~e~~lements X or Y:~~,~~ T~~t~~he 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: ~~Of the total in element EE,~~ T~~t~~he 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.

Commented [SS40]: "Of the total reported in element W:" was moved directly into the description of each element to avoid unnecessary breaks in the list/table for 508 purposes.

Commented [SS41]: "Of the total reported in element AA:" was moved directly into the description of each element to avoid unnecessary breaks in the list/table for 508 purposes.

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. ~~Sponsors will be responsible for reporting several data elements related to coverage determinations and redeterminations, including Part B vs. Part D coverage determinations and redeterminations. Sponsors should report data based on the date the enrollee/enrollee's representative is notified in writing of the coverage determination or redetermination decision. A sponsor's complete decision includes making the determination, appropriately notifying the enrollee of the determination, and authorizing coverage or sending payment, where applicable.~~

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

~~Coverage decisions (both coverage determinations and redeterminations) may result in a partially favorable decision.~~

~~Example of a fully favorable decision: Non-formulary exception request approved for drug and quantity prescribed.~~

~~Example of a partially favorable decision: Non-formulary exception request approved for drug, but full quantity prescribed not approved.~~

~~Sponsors must also report data~~Requirements ~~relating to~~for redeterminations of at-risk determinations made under a plan sponsor's drug management program ~~pursuant to the rules at~~are described at 42 CFR § 423.153(f). ~~, including the number of requests and the disposition. At risk redeterminations may involve decisions about:~~

~~Being identified as an at-risk beneficiary for prescription drug misuse or abuse;~~

~~Having a limitation, or the continuation of a limitation, on access to coverage for frequently abused drugs (i.e., an enrollee specific point-of-sale (POS) edit or the selection of a prescriber and/or pharmacy for purposes of lock-in);~~

~~Sharing information for subsequent Part D plan enrollments.~~

~~Sponsors should report data based on the date the enrollee/enrollee's representative is notified in writing of the at-risk redetermination decision.~~

Title 42, Part 423, Subpart U describes requirements for reopenings of coverage determinations and redeterminations. ~~Sponsors should also include reopened coverage determination and redetermination data, based on the date the enrollee/enrollee's representative is notified in writing of the revised decision. A reopening may or may not change the disposition of the case.~~

Commented [SS42]: Some deletions made if duplicative of policy.

Commented [SS43]: Removed as it is duplicative of TS.

Commented [AL44]: Striking, out of scope for this RR document, encompassed in the reg and guidance citations.

~~Sponsors will report quarterly data on an annual basis at the Contract level. Data files to be uploaded through the HPMS at the Contract level, following templates provided in HPMS.~~

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 (R~~r~~eporting at quarterly level)	Last Monday of February of the following year. Data Validation required.

~~Reporting timeline:~~

	~~Quarter 1~~	~~Quarter 2~~	~~Quarter 3~~	~~Quarter 4~~
~~Reporting Period~~	~~January 1 - March 31~~	~~April 1 - June 30~~	~~July 1 - September 30~~	~~October 1 - December 31~~

Data due to CMS/HPMS	Last Monday of February (reporting for all quarters due on this date)	Last Monday of February (reporting for all quarters due on this date)	Last Monday of February (reporting for all quarters due on this date)	Last Monday of February (reporting for all quarters due on this date)

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 ~~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)

Commented [SS45]: The format of these tables has been fixed to align with 508 standards. There are now 2 columns instead of 1. There are now column headers. Sub headings have been broken out into separate tables.

Commented [CE46]: To be consistent with the rest of the document, recommend adding "The total number of Coverage Determinations (non-exceptions). Unless that addition needs to go through PRA first. The same for Subsection 2b.

Commented [SA47R46]: We are considering for 2027

Data Element ID	Data Element Description
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.

Commented [SA48]: Added per SME feedback

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~~, in the time period above.~~
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)
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).

Commented [SS49]: Data elements have been moved into a table instead of a list.

Commented [SS50]: For 2027, we are considering removing Element A altogether.

Commented [SS51]: For 2027, these are our only alpha numeric elements. We may change to A, B, C, D…. For consistency with Part C reopenings.

Commented [SS52]: Information about file upload that used to be in the second bullet of this list has been moved to the TS as all info about file upload and data entry is now in the Tech Specs.

Section VI. Employer~~/Union-Sponsored~~ Group ~~Health~~ Plan Sponsors

Commented [SS53]: The title of this section has been edited to reflect the title shown in HPMS an in Part C documentation.

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). ~~** (CMS regulations?) stipulate specific parameters for MAOs offering employer group health and prescription drug plans. The information requested is necessary for CMS to fulfill its affirmative oversight obligation to ensure that plans with employer/union group health plan enrollment that provide Part D benefits are properly utilizing these waivers and modifications and that CMS' statutory waiver authority is being implemented in accordance with the requirements of section 1860D-22(b) of the Act.~~

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 (R~~r~~eporting at annual level)	First Monday of February of the following year. Data Validation not required.

~~Reporting timeline:~~

~~Reporting Period~~	~~January 1 – December 31~~
~~Data due to CMS/HPMS~~	~~First Monday of February~~

~~**1.** Data file to be uploaded through the HPMS at the Plan (PBP) level: Employer Legal Name.~~

Commented [SS54]: Duplicative of table above, removing.

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 Edata element H is ~~no~~"N", provide non-calendar year start date.
J.	Current/Anticipated enrollment

Commented [SS55]: These data elements have been moved into a table rather that a list.

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. ~~CMS collects the data described below to assess the performance of Part D Sponsors with respect to the Medicare Prescription Payment Plan. CMS' oversight will help ensure financial stability, quality healthcare services, including pharmacy benefits and regulatory compliance in the Medicare Part D program, ultimately enhancing beneficiary satisfaction and program effectiveness.~~

~~Part D sponsors are responsible for reporting data elements related to their Medicare Prescription Payment Plan offerings at the contract-Plan Benefit Package (PBP) levels. CMS collects beneficiary-level data on the Medicare Prescription Payment Plan through the Medicare Prescription Drug (MARx) System.~~

Commented [SS56]: Moved here from Part D TS.

Commented [SS57R56]: Updated with SME edits.

Commented [SS58]: Struck, as it is duplicative of PRA materials and information in the introductory section of this document.

Commented [SS59]: Struck as it is duplicative of the table below.

Commented [SS60]: Struck as it is not really within scope of a RR document. It is still TBD how we use the RR and MARx data.

~~Reporting timeline:~~

	~~YTD~~
~~**Reporting Period:**~~	~~January 1 – December 31~~
~~**Data due to CMS/HPMS**~~	~~Last Monday of April~~

~~Data file to be uploaded through the HPMS at the Plan (PBP) level:~~

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 (R~~r~~eporting at annual level)	Last Monday of April Data Validation not required.

~~*Likely to benefit identification:*~~

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 E~~e~~lement A, the total number of those individuals who submitted an election request to participate in the Medicare Prescription Payment Plan during the reporting period.

Commented [SS61]: These data elements have been moved into a table rather that a list. No other changes were made to the elements.

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 E~~e~~lement F, the number of election requests that were accepted during the reporting period.
H.	Of the total reported in E~~e~~lement 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 E~~e~~lement H, the number of election requests received that were able to be completed within established timeframes.
J.	Of the total reported in E~~e~~lement H, the number of election requests denied due to the applicant or his/her authorized legal representative

Data Element ID	Data Element Description
	not providing the information required to complete the election request within established timeframes.
K.	Of the total reported in Eelement F, the number of election requests that were denied during the reporting period.

~~**Election request processing:**~~

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).

~~**Unsettled balances:**~~