CY 2027 Part C and D Reporting Requirements- 60-day Comments and Responses

CMS received comments from 11 entities, including Part C and D sponsors, professional organizations, and various stakeholders. Comments were focused on specific reporting sections - Medicare Prescription Payment Plan, Grievances, Supplemental Benefits Utilizations, Organization, Determinations & Reconsiderations, Coverage Determinations, Redeterminations, and Reopenings, Employer Group Plan Sponsors, and various general topics including burden hours, oversight, and data transparency.

Reporting Section – Part D Medicare Prescription Payment Plan (MPPP)

Comment: One commenter expressed concern regarding the proposed addition of Data Element "P" in the CY 2027 Part C and D Reporting Requirements, which would require plans to indicate whether data are available for each associated Plan ID (PBP). The commenter recommended that, rather than introducing this new field, CMS reevaluate the MPPP reporting parameters more broadly and eliminate the requirement to report at the PBP level. The commenter noted that, during the first year of reporting, PBP-level reporting proved inefficient because many PBPs had no data or only minimal data to report. The commenter asserted that shifting to contract-level reporting would reduce administrative burden for plans while maintaining the utility of the information collected, as CMS would continue to be able to assess MPPP volumes at the contract level to evaluate program performance.

Response: CMS appreciates this comment and will consider it in future years. For CY 2027, the MPPP reporting section will remain at the PBP level.

Comment: One commenter strongly supported the MPPP but raised concerns about its lower-than-anticipated enrollment. The commenter noted that only 0.4 percent of Part D beneficiaries have enrolled, compared to CMS' earlier projection of up to 6 percent. The commenter also noted that 74 percent of seniors remain unaware of the program, underscoring the need for ongoing enrollment monitoring, real-time claims tracking, and continued complaint surveillance through 1-800-Medicare. The commenter supported CMS' collection of "likely to

benefit" information and data on election request processing and recommended that CMS use these data to routinely assess the likely-to-benefit threshold. The commenter urged CMS to publicly report enrollment statistics with breakdowns by beneficiary subgroups and demographics, establish accountability mechanisms for health plans, and explore the feasibility of a real-time, point-of-sale election process.

Response: CMS appreciates this comment. We will consider it as we continue to administer the MPPP program.

Reporting Section – Part C Supplemental Benefits Utilization and Costs

Comment: The commenter stated that Data Element L, which asks plans to describe the "type of payment arrangement(s) used to implement the benefit," should remain a free-text field rather than be changed to a predefined list of options in the CY2027 Medicare Part C and D Reporting Requirements.
The commenter expressed concern that converting this element to a fixed list could increase reporting burden, require additional interpretation by plans, and potentially result in inconsistent or inaccurate reporting. Accordingly, the commenter requested that CMS retain the free-text format for Element L to preserve flexibility and reduce the risk of misclassification.

Response: CMS appreciates this comment. This change is meant to reduce the burden on plans as open text entry requires plans to enter data for each plan type, benefit, offering type, and network type. Limiting responses to a preset list should decrease the complexity of reporting and therefore this element will remain without modifications. We also note that additional information about the list of options to pick from in Element L will be available in the CY 2027 Technical Specifications.

Comment: One commenter recommended that CMS allow Employer Group Waiver Plan (EGWP) PBPs with no sold groups and no enrollment during the reporting period to be excluded from reporting the Supplemental Benefit Utilization and Costs reporting requirements section. The commenter noted that EGWP PBPs are submitted as Standard Bids and are filed using Original Medicare cost-sharing limits. Although these PBPs may ultimately support employer groups with supplemental benefits, not all filed PBPs have associated groups or enrolled

members during the plan year. As a result, requiring reporting for these inactive PBPs creates unnecessary administrative burden and operational complexity without providing CMS with meaningful oversight value. The commenter argued that allowing such exclusions would better focus both plan and CMS resources on PBPs with active enrollment or reportable activity.

Response: CMS thanks the commenter. While we appreciate that there is some burden associated with submitting data for a plan without enrollment, CMS believes this burden is low, and the costs associated with it are accordingly minimal. We may consider a mechanism to allow plans to inform CMS they have no data to report in future reporting years. We note that for CY 2027, EGWPs must submit data for all benefits which are offered by the plan, even if the plan has submitted a PBP which does not list all benefits offered. However, plans should not report PBP category codes that the plan did not offer.

Comment: A few commenters urge CMS to reconsider the proposed removal of the Contract ID and Plan Benefit Package (PBP) ID as data elements in the Supplemental Benefit Utilization and Costs reporting section of the CY2027 Medicare Part C and D Reporting Requirements. One of the commenters also seeks clarification on how submitted data will be linked back to PBP-specific information within the file record layout, and how CMS intends to validate that the reported data remains accurately aligned at the PBP level in the absence of these key identifiers.

Response: CMS appreciates this comment. Plan sponsors will still be required to provide both Contract ID and Plan ID in each row of data for the Part C Supplemental Benefits Reporting section. The only change is that Contract ID and Plan ID no longer have element letters. This was done for consistency with all other reporting requirement sections, which do not assign element letters to Contract ID or Plan ID.

Reporting Section- Organization Determinations & Reconsiderations

Comment: One commenter raises concerns about duplicate reporting requirements for data elements related to Organization Determinations & Reconsiderations and the new Service Level Data Collection for Initial

Determinations and Appeals. It notes that although the latter remains in the pilot phase, CMS plans to expand it to all plans in 2027. The commenter recommends that CMS reconcile and consolidate the overlapping data requirements.

Response: CMS appreciates this comment. While the Service Level Data Collection collects similar data to the Part C Reporting Requirements, the collected data is not the same. More specifically, the data collected through the Service Level Data Collection is much more extensive and provides key elements of service delivery, which the Part C Reporting Requirements do not, such as whether a service is subject to prior authorization or the reasoning for an adverse organization determination. As CMS has previously stated during the Service Level Data Collection PRA process, once we have complete service-level data related to plan coverage and appeals decisions, CMS expects to reduce plan burden in other areas, such as reporting at the aggregate level for the Part C Reporting Requirements and the volume of data requested upon audit. While the Service Level Data Collection data is intended to replace and/or supplement some existing reporting, it does not duplicate the data currently reported under the Part C Reporting Requirements. In addition, as noted, the Service Level Data Collection is currently operating as a voluntary pilot with a limited number of plan participants. We will reevaluate the burden the various data collections could cumulatively place upon plans and will also ensure plans had ample opportunity to calibrate their internal systems to support reporting the more detailed data.

Comment: A few commenters highlight the need for stronger reporting on prior authorization, appeals, and grievances. One commenter specifically recommends that CMS require detailed reporting on prior authorization requests, approvals, denials, and overturns, broken down by service type, diagnosis, and care setting, as well as the time it takes for plans to respond to authorization requests and whether required timeframes are met. This granularity would enhance oversight, transparency, and alignment with Star Ratings and performance measurements, ensuring these ratings accurately reflect plan performance and patient experience. They also stress the importance of making relevant information publicly accessible to support informed decision-making. While acknowledging concerns about increased reporting burden, they assert that the benefits of improved data collection outweigh the costs. Overall, they strongly support CMS's proposed

revisions to strengthen the quality and transparency of collected data for better oversight and patient care.

Response: Thank you for the comment. On September 28, 2025, the Office of Management and Budget (OMB) approved a proposed data collection submitted by CMS through the Paperwork Reduction Act (PRA) process. The collection (CMS-10905, OMB:0938-1489), titled Service Level Data Collection for Initial Determinations and Appeals, collects data on Medicare Advantage (MA), plan initial coverage decisions and plan-processed appeals. Please review the memo titled Service Level Data Collection for Initial Determinations and Appeals - Pilot Participation, released on December 16, 2025, for additional information.

OMB approval: **https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=202505-0938-016**

Federal register**:** **https://www.federalregister.gov/d/2024-17773/p-12**

Reporting Section- Coverage Determinations, Redeterminations, and Reopenings

Comment: One commenter urges CMS to expand reporting on Medicare Part D point-of-sale (POS) denials, which are currently not captured in existing oversight. Increased utilization management under the Inflation Reduction Act has led to rising initial denials, but their full impact is unclear because only appealed claims are reported today. The commenter recommends collecting more detailed metrics, including volume, reasons for POS denials, outcomes, timing of access, and movement through appeals, stratified by beneficiary type and drug category. They also recommend plan-level (not contract-level) reporting to reveal variation and improve transparency for beneficiaries and oversight bodies.

Response: Thank you for your comment. CMS will review your suggestions for future years.

Reporting Section- Grievances

Comment: The commenter emphasizes that grievance reporting offers an important complementary perspective on how beneficiaries experience plan operations. CMS already collects several types of contract-level grievance data, including total grievances, timely notifications, expedited cases, and dismissals.

According to the commenter, these data can serve as an early signal of beneficiary experience and plan performance, especially when notable patterns appear across contracts or over time. The commenter recommends strengthening this section by requiring CMS to establish a limited set of standardized grievance categories. Doing so would allow grievances to be organized into meaningful issue types such as access delays, coverage and authorization problems, provider network issues, customer service concerns, or payment-related problems. They also suggest exploring ways to structure grievance data to better support trend analysis and identify recurring issues within or across contracts, noting that even small refinements could significantly improve the usefulness of these data for monitoring and enforcement.

Response: CMS appreciates this comment. CMS will review your suggestions for future years.

MA Reporting Requirements

Comment: Two commenters urge CMS to keep and strengthen strong Medicare Advantage (MA) reporting requirements. They explain that clear, accurate reporting is important for CMS to effectively oversee plans, monitor their performance, and enforce rules. They also recommend that CMS continue to use MAO reporting as a key tool for identifying and addressing compliance issues, especially as the MA program grows and becomes more complex. Two commenters add that CMS's decision to remove the appeals and complaints measures from the Star Ratings in CY 2027 makes strong reporting even more important, because the change reduces MA plans' financial incentive to fix coverage decision issues on their own.

Response: Thank you for your continued support of CMS' efforts to support oversight and enforcement of MA standards.

PRA Burden Estimates

Comment: The commenter appreciates CMS's effort to recalculate burden hours using a unified methodology; however, they do not believe the proposed changes for CY 2027 will result in a reduction in burden for health plans. The revised estimates do not reflect an actual decrease in operational burden for health plans noting that consolidating Part C and Part D reporting documents simplifies guidance but does not reduce the time needed to pull, validate, and submit data,

and that in some areas, such as Part C Enrollment and Disenrollment reporting, burden may in fact increase due to additional data elements required of MA-only contracts for CY 2027.

Response: CMS appreciates the comment. In response, CMS has increased the burden hours for Enrollment and Disenrollment reporting to account for the additional data elements that MA-only contracts will report for CY 2027, consistent with MA-PDs and PDPs. CMS will continue to evaluate its burden estimation methodology to ensure estimates reflect the operational realities faced by health plans.

Removal of “No Data to Report” Element

Comment: The commenter comments on CMS's proposal to add a new "no data to report" data element for certain plan-level reporting sections. The commenter recommends that CMS instead exclude PBPs with no reportable data from reporting requirements altogether, arguing that requiring placeholder submissions would add unnecessary administrative burden and operational complexity for MAOs without providing any meaningful value, since the data would reflect no actual plan activity.

Response: CMS appreciates the comment. Before this new data element, plan sponsors were instructed to enter zeros in all data elements for PBPs with no data to report. This new data element allows plan sponsors to leave all other data elements blank and indicate that the PBP has no data to report. CMS believes this change will not increase the burden for plan sponsors.

Releases of Technical Specifications for public comments

Comment: The commenter notes CMS's practice of releasing the Technical Specifications alongside the Medicare Part C and D Reporting Requirements and recommends that CMS release the proposed 2027 Technical Specifications for advance review and comment before finalizing the 2027 Reporting Requirements. The commenter argues that this is critical to ensure a shared understanding, identify potential reporting challenges, and clarify ambiguities prior to implementation.

Response: CMS appreciates the comment. CMS will take this suggestion into consideration in future years.

Data Transparency and Accountability

Comment: One commenter emphasized that CMS does not clearly explain how MA reporting data is used. The commentator urged CMS to increase transparency so the organization can better target compliance efforts, reduce duplicate reporting, and support a simpler, more effective oversight framework. Another commenter also encouraged CMS to publish more MA reporting data to strengthen accountability for beneficiaries, providers, and policymakers.

Response: CMS appreciates the comment. CMS notes that it previously released Public Use Files (PUF) to support a broad range of stakeholders, including beneficiaries, providers, researchers, and policymakers. However, consistent with HHS/ CMS's cell suppression policy to protect beneficiary privacy, CMS transitioned to releasing Limited Data Sets (LDS). CMS will consider comments on transparency and accountability in MA reporting as it continues to refine the Medicare Part C and Part D reporting framework.

Out of Scope Comments

Comment: Several comments were received on a range of topics, including interoperability, Fast Healthcare Interoperability Resources (FHIR), modernization of the Medicare Part C and D reporting infrastructure, application programming interfaces (APIs), auditing, and formulary outliers.

Response: CMS appreciates these comments; however, they are outside the scope of the Medicare Part C and D reporting requirements and the current information collection. Therefore, CMS will not incorporate changes related to these topics into this PRA package.