MEDICARE PART C AND D REPORTING REQUIREMENTS

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1054 and expires on XXXXXXXX. The time required to complete this information collection is estimated to average 117 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4- 26-05, and Baltimore, Maryland 21244-1850.

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PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0992 (expires August 31, 2027). The time required to complete this information collection is estimated to average 15 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Effective as of January 1, 2027 **2025**

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Revision History (from Contract Year 2026 to 2027)

The following list is provided as a courtesy and includes certain changes to this document made between Contract Year (CY) 2026 and CY 2027. Compare the documents from both years for all the changes between the two CYs.

1. The Part C and D Reporting Requirements information for Medicare Advantage Organizations (MAOs) and Part D plan sponsors is combined into one document.
2. Clarified the definition of no enrollment contracts and plans.
3. Clarified whether contracts should report data for their 800 series plans.
4. For certain reporting sections that require reporting at the Plan-level, added a new data element allowing sponsors to indicate that there is no data to report for a particular Plan ID: Employer Group Plan Sponsors, Special Needs Plans (SNPs) Care Management, D-SNP Enrollee Advisory Committee, D-SNP Transmission of Admission Notifications, and Medicare Prescription Payment Plan reporting sections.
5. Aligned the data elements in the Enrollment and Disenrollment reporting section so Part C and D sponsors will submit the same data elements. Part C sponsors will report four new data elements to align with Part D: one new data element for Enrollment and three new data elements for Disenrollment. Health Plan Management System (HPMS) will now have combined reporting for both Part C and D sponsors, similar to the Employer Group Plan Sponsors reporting section.
6. The Grievances reporting section will have combined reporting in HPMS for both Part C and D sponsors, similar to the Employer Group Plan Sponsors reporting section.
7. The Coverage Determinations, Redeterminations (including At–Risk Redeterminations under a Drug Management Program), and Reopenings for Part D reporting section has revised subsection titles and data element descriptions for clarity. Specifically, Subsection 1b, Elements D, E, F, and G; Subsection 1d, Element K; Subsection 2b, Elements D, E, F, and G; Subsection 2d; and Element L, were updated.
8. For the Coverage Determinations, Redeterminations (including At–Risk Redeterminations under a Drug Management Program), and Reopenings reporting section, subsection 3: Reopenings, data elements were removed: Element A (the total number of reopened (revised) decisions, for any reason), and Element B1 (Contract Number). The remaining data elements were re-lettered. Additionally, response options for the Reopening disposition element no longer include “Pending”.
9. For the Organization Determinations & Reconsiderations reporting section, subsection 5: Reopenings, data elements were removed: Element A (the total number of reopened (revised) decisions, for any reason), and Element B (Contract Number). The remaining data elements were re-lettered. Additionally, response options for Reopening disposition element no longer include “Pending”.
10. The data element descriptions were clarified in the Rewards and Incentives Programs reporting section.
11. In the Supplemental Benefit Utilization and Costs reporting section, the following updates were made:
    a. Consistent with other reporting sections, contract ID and PBP ID are no longer data

elements.

b. Sponsors should only report data for PBP category codes (Element A) that the sponsor indicated would be offered in the plan benefit package (PBP) they submitted to CMS for the CY. They should not report PBP category codes that the plan did not offer. Because of this, the option of "not offered" was removed from Element B.

c. The following data element has been removed, which in CY 2026 was Element D: "Supplemental benefit name, if the PBP Category (Element C) has an "Other" designation".

d. The following data element has been added: Element D (Description of Network type, if Element C is "Other"). In CY 2026, this data was instead collected in Element M.

e. Element K was moved to a new position in the list of data elements, and the description has been clarified.

f. Element L is no longer a free text field, and there is now a specific list of options to pick from.

g. Data elements were re-lettered as a result of these changes.

12. In the Medication Therapy Management Programs reporting section, the following updates were made:

    a. Consistent with other reporting sections, contract ID is no longer a data element. Data elements were re-lettered.

    b. Element R was updated as follows:

        i. Removed "Pharmacist – Other."

        ii. Added "Pharmacy Resident, MTM Vendor Long Term Care (LTC) Consultant, and Disease Management Pharmacist."

        iii. Changed "Plan Benefit Manager (PBM)" to "Pharmacy Benefit Manager (PBM)" and "LTC Consultant Pharmacist to Long Term Care (LTC) Consultant Pharmacist."

    c. Element P was updated from "(If more than 1 CMR was performed, report the date the initial CMR written summary was provided or sent.)" to "(If more than 1 CMR written summary was provided or sent, report the date the initial CMR written summary was provided or sent.)"

13. For Improving Drug Utilization Review Controls reporting section, there is a new Element BB. As a result, data elements following BB were re-lettered. The descriptions of Elements EE and GG were updated.

Introduction

Section 1857(e)(1) and 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 Medicare Advantage Organizations (MAOs) and 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 MAOs in regulation at 42 CFR § 422.516 and for Part D sponsors in regulation at 42 CFR §423.514.

42 CFR § 422.516~~423.514~~(a) and requires each MAO~~Part D sponsor~~ to have a 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, statistics indicating the following:

1) The cost of its operations.
2) The procedures related to and utilization of its services and items.
3) The availability, accessibility, and acceptability of its services.
4) To the extent practical, developments in the health status of its enrollees.
5) Information demonstrating that the MAO has a fiscally sound operation.
6) Other matters that CMS may require.

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 ~~The purpose of 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.

MAOs and Part D sponsors must report all data based on the most current Reporting Requirements documentation as of the reporting deadline. MAOs and Part D sponsors should be able ~~is~~ to support

[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.

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the accuracy of their data submissions based on their ~~assure a common~~ understanding of the Reporting Requirements documentation. MAOs and Part D sponsors should retain documentation supporting their Health Plan Management System (HPMS) data submissions and resubmissions. MAOs and Part D sponsors must retain this complete archive for the 10-year retention period required per federal regulations and be prepared ~~Part D reporting requirements and how these data will be used~~ to provide the archive ~~monitor the prescription drug benefit provided~~ to ~~Medicare beneficiaries.~~ CMS upon request.

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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 ~~will use the~~ following ~~terminology to ensure consistency in these reporting requirements:~~

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~~Part D sponsor – an~~ organization types are excluded from reporting all **Part C** Reporting Requirements[2]:

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1. Demonstration Plans
2. Healthcare Prepayment Plan (HCPP) – 1833 Cost Plans
3. National PACE Plans
4. Fallback Plans
5. Prescription Drug Plans (PDPs)
6. Employer/Union Only Direct Contract PDPs
7. LI NET Sponsor Plans

The following organization types are excluded from reporting all **Part D** Reporting Requirements[2]:

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

[2] There are three Reporting Requirements sections for which HPMS displays combined reporting data for both Part C and Part D: Enrollment and Disenrollment, Grievances, and Employer Group Plan Sponsors. This list of exclusions does not apply to those Reporting Requirements sections.

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

Contracts with no enrollment must not report data for any reporting section. No enrollment signifies that the contract~~which~~ has no enrollees for all the months within the~~one or more~~ contract year.

Data Validation

- ~~(s) with~~ CMS requires that sponsoring organizations (SOs) contracted to offer Medicare Part C and/or ~~provide~~ Part D benefits be subject to an independent yearly audit to validate certain data reported to ~~to Medicare beneficiaries. Each contract is assigned a~~ CMS to determine its reliability, validity, completeness, and comparability in accordance with specifications developed by CMS.[3] ~~contract number (e.g., H# or S#).~~

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 analyzes data submitted for accuracy and trends. In addition, certain data reported by MAOs and Part D sponsors are 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 C and Part D Reporting Requirements should be sent via email to PartsCDPlanReportingAndDV@cms.hhs.gov.

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

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Reporting Sections

- ~~Section I.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:~~

1) ~~Minimal administrative burden on Part D sponsors;~~
2) ~~Legislative and regulatory authority;~~
3) ~~Validity, reliability, and utility of data elements requested; and~~
4) ~~Wide acceptance and current utilization within the industry.~~

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

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

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~~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.~~

~~Section I.~~ Enrollment and Disenrollment (Part C and Part D)

The annual reporting requirements described below apply to both MAOs and Part D sponsors. HPMS has combined reporting of both Part C and Part D enrollment and disenrollment data.

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

~~CMS will collect data~~ on ~~the elements for~~ these requirements, refer~~which are otherwise not available~~ to the MA ~~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 plan, MA prescription drug plan, cost plan with Part D optional supplemental benefit) is reported via the Part D requirements. MAOs and 1876 Cost plans report enrollment and disenrollment activity that does not involve a Part D benefit under the Part C reporting requirements.~~

~~Section 1 Enrollment, elements 1.A–1.K must include all enrollments. Disenrollments must not be included in Section 1~~ Enrollment and~~, Section 2~~ Disenrollment Guidance, available at: https://www.cms.gov/medicare/enrollment-renewal/part-d-enrollment-eligibility. ~~, elements 2.A–2.F, must include all voluntary disenrollment transactions. Reporting~~

~~timeline:~~

	~~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~~

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

~~**1. Enrollment:**~~

~~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 A, the number of enrollment requests complete at the time of initial receipt.~~

~~C. Of the total reported in 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 representative).~~

~~D. Of the total reported in A, the number of enrollment requests denied due to the sponsor's determination that the applicant was not eligible for an election period.~~

~~E. Of the total reported in C, the number of enrollment requests received that are incomplete upon initial receipt and completed within established timeframes.~~

~~F. Of the total reported in C, the number of enrollment requests denied due to the~~

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~~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 A, the number of paper enrollment requests received.
H. Of the total reported in A, the number of telephonic enrollment requests received (if sponsor offers this mechanism).
I. Of the total reported in A, the number of electronic enrollment requests received via an electronic device or secure internet website (if sponsor offers this mechanism).
J. Of the total reported in A, the number of Medicare Online Enrollment Center (OEC) enrollment requests received.
K. Of the total reported in A, the number of enrollment requests received from an applicant through an agent or broker.

2. Disenrollment:

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 A, the number of disenrollment requests complete at the time of initial receipt.
C. Of the total reported in A, the number of disenrollment requests that were not complete at the time of initial receipt.
D. Of the total reported in A, the number of disenrollment requests denied due to the sponsor's determination that the enrollee was not eligible for an election period.
E. Of the total reported in C, the number of disenrollment requests received that are incomplete upon initial receipt and completed within established timeframes.
F. Of the total reported in 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 G, the number of disenrolled individuals who submitted a timely request for reinstatement for Good Cause.
I. Of the total reported in H, the number of favorable Good Cause determinations.
J. Of the total reported in I, the number of individuals reinstated.

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~~Section II.~~

~~**Medication Therapy Management Programs**~~

~~The requirements stipulating that Part D sponsors provide Medication Therapy Management (MTM) programs are described in Title I, Part 423, Subpart D, § 423.153. For monitoring purposes, Part D sponsors will be responsible for reporting several data elements related to their MTM program. Data will be uploaded in a data file.~~

~~Reporting timeline:~~

		~~YTD~~	
Organization Types Required to Report		**Reporting Frequency, Level~~Period~~**	**Repor Period** ~~Decem~~
- 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 Organizations should exclude 800 series plans. ~~**Data due to CMS/HPMS**~~	2/Year, Contract Level	Period 1: 1/1-6/30 Period 2: 7/1- 12/31 (Reporting at bi-annual level)	Period Period of the Data V

~~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).~~

~~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.~~

~~A. Contract Number.~~
~~B. MBI Number.~~
~~C. Beneficiary first name.~~
~~D. Beneficiary last name.~~

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~~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; 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.~~

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Subsection 1: Enrollment

~~Grievances~~

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

~~Sponsors should:~~

- ~~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.~~

~~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.~~

~~Reporting timeline:~~

Data Element ID	Data Element Description~~Quarter 1~~	~~Quarter 2~~	~~Quarter 3~~	~~Quarter 4~~
A~~Reporting Period~~	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.~~January 1 - March 31~~	~~April 1 - June 30~~	~~July 1 - September 30~~	~~October 1 - December 31~~

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Data Element ID	Data Element Description~~Quarter 1~~	~~Quarter 2~~	~~Quarter 3~~	~~Quarter 4~~
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 incomplete 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~~Data due to CMS/HPMS~~	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).~~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)~~
E	Of the total reported in Element C, the number of enrollment request 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 information 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			

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Data Element ID	Data Element Description~~Quarter 1~~	~~Quarter 2~~	~~Quarter 3~~	~~Quarter 4~~
	an applicant through an agent or broker.			

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

~~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~~

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~~Section IV.~~

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Subsection 2: Disenrollment

~~**Improving Drug Utilization Review Controls**~~

~~Part D sponsors 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) 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)).~~

~~Reporting timeline:~~

Data Element ID	Data Element Description	~~Quarter 2~~	~~Quarter 3~~	~~Quarter 4~~
A~~Reporting Period~~	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. ~~January 1 – March 31~~	~~January 1 – June 30~~	~~January 1 – September 30~~	~~January 1 – December 31~~
B	Of the total reported in Element A, the number of disenrollment requests completed 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 incomplete 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 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 specified time period.			
H~~Data due to CMS/HPMS~~	Of the total reported in Element G, the number of disenrolled individuals who submitted a timely request for reinstatement for Good Cause. ~~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)~~
I	Of the total reported in Element H, the number of favorable Good Cause determinations.			

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J	Of the total reported in Element I, the number of individuals reinstated.

1. Opioid Care Coordination Safety Edit at 90 MME

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.

Of the total reported in element D:
E. The number of claim rejections overridden by the pharmacy within 24 hours of the initial claim rejection.
F. The number of claim rejections overridden by the pharmacy due to an exemption.
G. Of the total not in element F, the number of claim rejections overridden by the pharmacy as a result of prescriber consultation.
H. The number of unique beneficiaries with at least one claim rejected due to the care coordination edit.

Of the total reported in element H:
I. The number of unique beneficiaries with at least one claim rejection overridden by the pharmacy.

J. The number of unique beneficiaries with at least one claim rejection overridden by the pharmacy within 24 hours of the initial claim rejection.

K. The number of unique beneficiaries with at least one claim rejection overridden by the pharmacy due to an exemption.

L. Of the total 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.

2. Hard MME Safety Edit

M. Did the plan have a hard MME edit in place during the time period above? (Y (yes) or N (no)).

If yes to element M:

N. The cumulative MME threshold used.

O. The prescriber count criterion used, if applicable.

P. The pharmacy count criterion used, if applicable.

Q. The number of claims rejected due to the hard MME edit.

R. The number of unique beneficiaries with at least one claim rejected due to the hard MME edit.

S. Of the total reported in element R, the number of unique beneficiaries with at least one claim rejection overridden by the pharmacy due to an exemption.

T. 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. 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.

3. Opioid Naïve Days Supply Safety Edit

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.

Of the total reported in element W:

X. The number of rejected claims overridden by the pharmacy due to an exemption.

Y. The number of rejected claims overridden by the pharmacy because the beneficiary was not opioid naïve.

Z. Of the total 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. The number of unique beneficiaries with at least one claim rejected due to the opioid naïve days supply edit.

~~Of the total reported in element AA:~~

~~BB. The number of unique beneficiaries with at least one rejected claim overridden by the pharmacy due to an exemption.~~

~~CC. The number of unique beneficiaries with at least one rejected claim overridden by the pharmacy because the beneficiary was not opioid naive.~~

~~DD. The number of unique beneficiaries for whom up to a 7 day supply (covered by the plan) was dispensed by the pharmacy.~~

~~EE. 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 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 II. Grievances (Part C and Part D)

The annual reporting requirements described below apply to both MAOs and Part D sponsors. HPMS has combined reporting of both Part C and Part D grievances data.

MAOs and Part D sponsors must comply with grievance requirements for timely hearing and resolving of grievances as established in regulations at 42 CFR Part 422 Subpart M and 42 CFR Part 423 Subpart M, respectively. Requirements are 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 - Medicare Savings Accounts (MSAs) - RFB PFFS - PFFS - 1876 Cost - PDP - Regional CCP - Employer/Union Only Direct Contract – PFFS - Employer/Union Only Direct Contract PDPs - 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 (Reporting at quarterly level)	First Monday of February of the following year. Data Validation is 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

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Section III. Employer Group Plan Sponsors (Part C and Part D)

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The annual reporting requirements described below apply to both MAOs and Part D sponsors offering employer group plans. HPMS has combined reporting of both Part C and Part D employer group plan sponsors data.

CMS reviews data provided by employer group plan sponsors to verify that MAOs and Part D sponsors are administering employer group plans in accordance with 42 CFR § 422.106 and 42 CFR § 423.458(c), respectively.

Additional information regarding employer group health plans can be found in Chapter 9 of the Medicare Managed Care Manual (https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c09.pdf) and 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.	1/Year, PBP Level	1/1 - 12/31 (Reporting at annual level)	First Monday of February of the following year. Data Validation is 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)
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
K	Does the plan wish to indicate there is no data to report for the respective Plan ID? (Y (yes) or N (no))

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Section IV. Organization Determinations & Reconsiderations (Part C)

For information on organization determinations, reconsiderations, and re-openings procedures, refer to CMS regulations 42 CFR Part 422, Subpart M, and the 'Parts C & D Enrollee Grievances Organization/Coverage Determinations, and Appeals Guidance via the CMS website: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG. For information on the integrated appeals guidance manual, refer to the update to the OMB-Approved Applicable Integrated Plan Coverage Decision Letter: https://www.cms.gov/files/document/dsnpcoveragedecisionlettermemocy2025.pdf.

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due Date(s)
- Local CCP - MSA - RFB PFFS - PFFS - 1876 Cost - Regional CCP - Employer/Union Only Direct Contract PFFS - RFB Local CCP - 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 (Reporting at quarterly level)	Last Monday of February of the following year. Data Validation is required.

Subsection 1: Organization Determinations

Data Element ID	Data Element Description
A	Total Number of Organization Determinations made
B	Number of Organization Determinations - Withdrawn
C	Number of Organization Determinations - Dismissals
D	Of the total reported in Element A, the number of Organization Determinations requested by enrollee/representative or provider on behalf of the enrollee (Services)
E	Of the total reported in Element A, the number of Organization Determinations submitted by enrollee/representative (Claims)
F	Of the total reported in Element A, the number of Organization Determinations requested by non-contract provider (Services)
G	Of the total reported in Element A, the number of Organization Determinations submitted by non-contract provider (Claims)

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Subsection 2: Disposition – All Organization Determinations

Data Element ID	Data Element Description
A	Of the total reported in subsection 1, Element D, the number of Organization Determinations – Fully Favorable (Services) requested by enrollee/representative or provider on behalf of the enrollee
B	Of the total reported in subsection 1, Element F, the number of Organization Determinations – Fully Favorable (Services) requested by non-contract provider
C	Of the total reported in subsection 1, Element E, the number of Organization Determinations – Fully Favorable (Claims) submitted by enrollee/representative
D	Of the total reported in subsection 1, Element G, the number of Organization Determinations – Fully Favorable (Claims) submitted by non-contract provider
E	Of the total report in subsection 1, Element D, the number of Organization Determinations – Partially Favorable (Services) requested by enrollee/representative or provider on behalf of the enrollee
F	Of the total reported in subsection 1, Element F, the number of Organization Determinations – Partially Favorable (Services) requested by non-contract provider
G	Of the total reported in subsection 1, Element E, the number of Organization Determinations – Partially Favorable (Claims) submitted by enrollee/representative.
H	Of the total reported in subsection 1, Element G, the number of Organization Determinations – Partially Favorable (Claims) submitted by non-contract provider
I	Of the total reported in subsection 1, Element D, the number of Organization Determinations – Adverse (Services) requested by enrollee/representative or provider on behalf of the enrollee
J	Of the total reported in subsection 1, Element F, the number of Organization Determinations – Adverse (Services) requested by non-contract provider
K	Of the total reported in subsection 1, Element E, the number of Organization Determinations – Adverse (Claims) submitted by enrollee/representative
L	Of the total reported in subsection 1, Element G, the number of Organization Determinations – Adverse (Claims) submitted by non-contract provider

Subsection 3: Reconsiderations

Data Element ID	Data Element Description
A	Total number of Reconsiderations made
B	Number of Reconsiderations - Withdrawn
C	Number of Reconsiderations - Dismissals
D	Of the total reported in subsection 3, Element A, the number of Reconsiderations requested by enrollee/representative or provider on behalf of the enrollee (Services)
E	Of the total reported in subsection 3, Element A, the number of Reconsiderations submitted by enrollee/representative (Claims)
F	Of the total reported in subsection 3, Element A, the number of Reconsiderations requested by non-contract provider (Services)
G	Of the total reported in subsection 3, Element A, the number of Reconsiderations submitted by non-contract provider (Claims)

Subsection 4: Disposition – All Reconsiderations

Data Element ID	Data Element Description
A	Of the total reported in subsection 3, Element D, the number of Reconsiderations – Fully Favorable (Services) requested by enrollee/representative or provider on behalf of the enrollee
B	Of the total reported in subsection 3, Element F, the number of Reconsiderations – Fully Favorable (Services) requested by non-contract provider
C	Of the total reported in subsection 3, Element E, the number of Reconsiderations – Fully Favorable (Claims) submitted by enrollee/representative
D	Of the total reported in subsection 3, Element G, the number of Reconsiderations – Fully Favorable (Claims) submitted by non-contract provider
E	Of the total reported in subsection 3, Element D, the number of Reconsiderations – Partially Favorable (Services) requested by enrollee/representative or provider on behalf of the enrollee
F	Of the total reported in subsection 3, Element F, the number of Reconsiderations – Partially Favorable (Services) requested by non-contract provider
G	Of the total reported in subsection 3, Element E, the number of Reconsiderations – Partially Favorable (Claims) submitted by enrollee/representative
H	Of the total reported in subsection 3, Element G, the number of Reconsiderations – Partially Favorable (Claims) submitted by non-contract provider
I	Of the total reported in subsection 3, Element D, the number of Reconsiderations – Adverse (Services) requested by enrollee/representative or provider on behalf of the enrollee
J	Of the total reported in subsection 3, Element F, the number of Reconsiderations – Adverse (Services) requested by non-contract provider

Data Element ID	Data Element Description
K	Of the total reported in subsection 3, Element E, the number of Reconsiderations – Adverse (Claims) submitted by enrollee/representative
L	Of the total reported in subsection 3, Element G, the number of Reconsiderations – Adverse (Claims) submitted by non-contract provider

Subsection 5: Reopenings

Data Element ID	Data Element Description
A	Case ID
B	Case level (Organization Determination or Reconsideration)
C	Date of original disposition
D	Original disposition (Fully Favorable, Partially Favorable, or Adverse)
E	Was the case processed under the expedited timeframe? (Y/N)
F	Case type (Service or Claim)
G	Status of treating provider (Contract, Non-contract)
H	Date case was reopened
I	Reason(s) for reopening (Clerical Error, Other Error, New and Material Evidence, Fraud or Similar Fault, or Other)
J	Additional Information (Optional)
K	Date of reopening disposition (revised decision)
L	Reopening disposition (Fully Favorable; Partially Favorable or Adverse)

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

For information on organization determinations, reconsiderations, and re-openings procedures, refer to CMS regulations 42 CFR Part 422, Subpart M, and the 'Parts C & D Enrollee Grievances Organization/Coverage Determinations, and Appeals Guidance via the CMS website: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG. For information on the integrated appeals guidance manual, refer to the update to the OMB-Approved Applicable Integrated Plan Coverage Decision Letter: https://www.cms.gov/files/document/dsnpcoveragedecisionlettermemocy2025.pdf

~~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.~~

~~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 relating to redeterminations of at-risk determinations made under a plan sponsor's drug management program pursuant to the rules 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.~~

~~Sponsors will report quarterly data on an annual basis at the Contract level. Data files to be~~

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~~uploaded through the HPMS at the Contract level, following templates provided in HPMS.~~

~~Reporting timeline:~~

		~~Quarter 1~~	~~Quarter 2~~	~~Quarter 3~~		~~Quarter 4~~
Organization Types Required to Report	Report Frequency, Level	Report~~Reporting~~ Period(s)	Data Due Date(s)~~January 1~~ ~~March 31~~	~~April 1 June 30~~	~~July 1 September 30~~	~~October 1 December 31.~~
~~Data due to CMS/HPMS~~			- 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.~~Last Monday of February (reporting for~~	1/Year, Contract Level~~Last Monday of February (reporting for all quarters due on this date)~~	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 (reporting for all quarters due on this date)~~	Last Monday of February of the following year.~~(reporting for all quarters due on this~~ Data Validation is required.~~date)~~

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	~~all quarters due on this date)~~			

~~4.~~ *Subsection 1a: Coverage Determinations (including exceptions)*

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

~~Disposition – Coverage Determinations (non-exceptions)~~
~~D. The total number of fully favorable decisions.~~
~~E. The total number of partially favorable decisions.~~
~~F. The total number of adverse decisions.~~
~~Disposition – Utilization Management Exceptions~~
~~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.~~
~~Disposition – Formulary Exceptions~~
~~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.~~
~~Disposition – Tiering Exceptions~~
~~O. The number of tiering exceptions.~~
~~P. The number of fully favorable decisions.~~

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~~Q. The number of partially favorable decisions.~~
~~R. The number of adverse decisions.~~

~~2.~~ *Subsection 1b: Disposition – Coverage Determinations (non-~~**Redeterminations (including**~~ exceptions~~**and at-risk redeterminations**~~)*

Data Element ID~~A. Total Number of Redeterminations Processed (including exceptions and at-risk)~~	Data Element Description
~~B. Total Number of Withdrawn Redeterminations~~	
~~C. Total Number of Dismissed Redeterminations~~	
D	Of the total reported in subsection 1a, Element A, the number of Coverage Determinations~~Disposition – Redeterminations~~ (non-exceptions)
E	Of the total reported in subsection 1b, Element D, the~~. The~~ number of fully favorable decisions~~.~~
F	Of the total reported in subsection 1b, Element D, the~~E. The~~ number of partially favorable decisions~~.~~
G	Of the total reported in subsection 1b, Element D, the number of adverse decisions

Subsection 1c: Disposition – Utilization Management Exceptions

Data Element ID~~F. The number of adverse decisions.~~	Data Element Description
~~Disposition – Utilization Management Exception Redeterminations~~	
H	Of the total reported in subsection 1a, Element A, the~~G. The~~ number of utilization management exceptions~~.~~
I	Of the total reported in subsection 1c, Element H, the~~. The~~ number of fully favorable decisions~~.~~
J	Of the total reported in subsection 1c, Element H, the~~I. The~~ number of partially favorable decisions~~.~~
K	Of the total reported in subsection 1c, Element H, the~~J. The~~ number of adverse decisions~~.~~
~~Disposition – Formulary Exception Redeterminations~~	
~~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.~~	

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Disposition – Tiering Exception Redeterminations
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.
Disposition – At-Risk Redeterminations
S. The number of at-risk redeterminations.
T. The number of fully favorable decisions.
U. The number of partially favorable decisions.
V. The number of adverse decisions.

3. Reopenings

A. The total number of reopened (revised) decisions, for any reason, in the time period above.

B. For each case that was reopened, the following information will be uploaded in a data file:

1. Contract Number;
2. Case ID;
3. Case level (Coverage Determination or Redetermination);
4. Date of original disposition;
5. Original disposition (Fully Favorable; Partially Favorable or Adverse);
6. Was case processed under expedited timeframe (Y/N);
7. Case type (Pre-service; Payment);
8. Date case was reopened;
9. Reason(s) for reopening (Clerical Error, Other Error, New and Material Evidence, Fraud or Similar Fault, or Other);
10. Date of reopening disposition (revised decision);
11. Reopening disposition (Fully Favorable; Partially Favorable, Adverse, or Pending).

~~Section VI.~~ *Subsection 1d: Disposition – Non-Formulary Drug Exceptions*

~~**Employer/Union-Sponsored Group Health Plan Sponsors**~~

~~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.~~

~~Reporting timeline:~~

	~~**YTD**~~
~~**Reporting Period**~~	~~January 1 – December 31~~

Data Element ID~~due to CMS/HPMS~~	Data Element Description ~~First Monday of February~~
L	Of the total reported in subsection 1a, Element A, the number of non-formulary drug exceptions
M	Of the total reported in subsection 1d, Element L, the number of fully favorable decisions
N	Of the total reported in subsection 1d, Element L, the number of partially favorable decisions
O	Of the total reported in subsection 1d, Element L, the number of adverse decisions

Subsection 1e: Disposition – Tiering Exceptions

Data Element ID	Data Element Description
P	Of the total reported in subsection 1a, Element A, the number of tiering exceptions
Q	Of the total reported in subsection 1e, Element P, the number of fully favorable decisions
R	Of the total reported in subsection 1e, Element P, the number of partially favorable decisions
S	Of the total reported in subsection 1e, Element P, 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	Of the total reported in subsection 2a, Element A, the number of Redeterminations (non-exceptions)
E	Of the total reported in subsection 2b, Element D, the number of fully favorable decisions

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Data Element ID	Data Element Description
F	Of the total reported in subsection 2b, Element D, the number of partially favorable decisions
G	Of the total reported in subsection 2b, Element D, the number of adverse decisions

Subsection 2c: Disposition – Utilization Management Exception Redeterminations

Data Element ID	Data Element Description
H	Of the total reported in subsection 2a, Element A, the number of utilization management exceptions
I	Of the total reported in subsection 2c, Element H, the number of fully favorable decisions
J	Of the total reported in subsection 2c, Element H, the number of partially favorable decisions
K	Of the total reported in subsection 2c, Element H, the number of adverse decisions

Subsection 2d: Disposition – Non-Formulary Drug Exception Redeterminations

Data Element ID	Data Element Description
L	Of the total reported in subsection 2a, Element A, the number of non-formulary drug exceptions
M	Of the total reported in subsection 2d, Element L, the number of fully favorable decisions
N	Of the total reported in subsection 2d, Element L, the number of partially favorable decisions
O	Of the total reported in subsection 2d, Element L, the number of adverse decisions

Subsection 2e: Disposition – Tiering Exception Redeterminations

Data Element ID	Data Element Description
P	Of the total reported in subsection 2a, Element A, the number of tiering exceptions
Q	Of the total reported in subsection 2e, Element P, the number of fully favorable decisions
R	Of the total reported in subsection 2e, Element P, the number of partially favorable decisions
S	Of the total reported in subsection 2e, Element P, the number of adverse decisions

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Subsection 2f: Disposition – At-Risk Redeterminations

Data Element ID	Data Element Description
T	Of the total reported in subsection 2a, Element A, the number of at-risk exceptions
U	Of the total reported in subsection 2f, Element T, the number of fully favorable decisions
V	Of the total reported in subsection 2f, Element T, the number of partially favorable decisions
W	Of the total reported in subsection 2f, Element T, the number of adverse decisions

Subsection 3: Reopenings

Data Element ID	Data Element Description
A	Case ID
B	Case level (Coverage Determination or Redetermination)
C	Date of original disposition
D	Original disposition (Fully Favorable, Partially Favorable, or Adverse)
E	Was case processed under expedited timeframe (Y/N)
F	Case type (Pre-service or Payment)
G	Date case was reopened
H	Reason(s) for reopening (Clerical Error, Other Error, New and Material Evidence, Fraud or Similar Fault, or Other)
I	Date of reopening disposition (revised decision)
J	Reopening disposition (Fully Favorable, Partially Favorable or Adverse

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

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

Section VI. Special Needs Plans (SNPs) Care Management (Part C)

Title 42, Part 422, Subpart C outlines the requirements for MAOs offering Special Needs Plans, including specific timeframes, health risk assessments, and models of care.

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due Date(s)
SNP PBPs under the following types: - Local CCP - Regional CCP Only SNP Plans are required to report. Organizations should exclude 800 series plans if they are SNPs.	1/Year, PBP Level	1/1-12/31 (Reporting at annual level)	Last Monday of February in the following year. Data Validation is required.

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Data Element ID	Data Element Description
A	Number of new enrollees due for an Initial Health Risk Assessment (HRA)
B	Number of enrollees eligible for an annual reassessment HRA
C	Number of initial HRAs performed on new enrollees
D	Number of initial HRA refusals
E	Number of initial HRAs not performed because SNP is unable to reach new enrollees
F	Number of annual reassessments performed on enrollees eligible for a reassessment
G	Number of annual reassessment refusals
H	Number of annual reassessments where SNP is unable to reach an enrollee
I	Does the plan wish to indicate there is no data to report for the respective Plan ID? (Y (yes) or N (no))

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Section VII. Rewards and Incentives Programs (Part C)

42 CFR § 422.134 establishes requirements for MAOs offering rewards and incentives programs.

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due date(s)
- Local CCP - MSA - RFB PFFS - PFFS - Regional CCP - Employer/Union Only Direct Contract PFFS - RFB Local CCP - Employer/Union Only Direct Contract Local CCP Organizations should include all 800 series plans.	1/Year, Contract Level	1/1-12/31 (Reporting at annual level)	Last Monday of February of the following year. Data Validation is not required.

Data Element ID	Data Element Description
A	Rewards and Incentives Program offered: "Yes" or "No"
B	Name of Rewards and Incentives Program
C	Description of health-related services and/or activities included in the program
D	Description of reward(s) enrollees may earn for participation
E	Description of how the value of each reward is determined
F	Method used to track enrollee participation in the program
G	Number of enrollees who participated in the program during the reporting period
H	Number of rewards awarded to enrollees during the reporting period

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Section VIII. Payments to Providers (Part C)

The Department of Health and Human Services (HHS) developed the four categories of value-based payments: fee-for-service with no link to quality (Category 1); fee-for-service with a link to quality (Category 2); alternative payment models built on fee-for-service architecture (Category 3); and population-based payment (Category 4). These groupings conform to the Health Care Payment Learning & Action Network (HCPLAN) Alternative Payment Models (APM) Framework categories. For more detailed information, please refer to the LAN APM Framework (https://hcp-lan.org/apmframework/).

CMS will collect data from MAOs about the proportion of their payments made to contracted providers based on these four categories in order to understand the extent and use of alternate payment models in the MA industry.

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due Date(s)
- Local CCP - PFFS - Regional CCP - RFB Local CCP Organizations should exclude 800 series plans.	1/Year, Contract Level	1/1-12/31 (Reporting at annual level)	Last Monday of February of the following year. Data Validation is not required.

Data Element ID	Data Element Description
A	Total dollars paid to providers (in and out of network) for Medicare Advantage enrollees.

Subsection 1: Category 1

Data Element ID	Data Element Description
B	Total dollars paid to providers through legacy payments (including fee-for-service (i.e., payments made for units of service) that are adjusted to account for neither infrastructure investments, nor provider reporting of quality data, nor provider performance on cost and quality metrics). Also includes diagnosis-related groups that are not linked to quality and value.

Subsection 2: Category 2

Data Element ID	Data Element Description
C	Total dollars paid to providers through fee-for-service plus pay-for-reporting payments (linked to quality)
D	Total dollars paid to providers through fee-for-service plus pay-for-performance payments (linked to quality)

Data Element ID	Data Element Description
E	Dollars paid for foundational spending to improve care (linked to quality)
F	Total dollars paid in Category 2

Subsection 3: Category 3

Data Element ID	Data Element Description
G	Total dollars paid to providers through traditional shared-savings (linked to quality) payments
H	Total dollars paid to providers through utilization-based shared-savings (linked to quality) payments
I	Total dollars paid to providers through fee-for-service-based shared-risk (linked to quality) payments
J	Total dollars paid to providers through procedure-based bundled/episode payments (linked to quality) programs
K	Total dollars paid in Category 3
L	Total Risk-based payments not linked to quality (e.g., 3N in APM definitional framework)

Subsection 4: Category 4

Data Element ID	Data Element Description
M	Total dollars paid to providers through condition-specific, population-based payments (linked to quality)
N	Total dollars paid to providers through condition-specific, bundled/episode payments (linked to quality)
O	Total dollars paid to providers through population-based payments that are NOT condition-specific (linked to quality)
P	Total dollars paid to providers through full or percent of premium population-based payments (linked to quality)
Q	Total dollars paid to providers through integrated finance and delivery system programs (linked to quality).
R	Total dollars paid in Category 4
S	Total capitation payment not linked to quality (e.g., 4N in the APM definitional framework)

Subsection 5: Provider Data

Data Element ID	Data Element Description
T	Total number of Medicare Advantage contracted providers
U	Total Medicare Advantage contracted providers paid on a fee-for-service basis with no link to quality (Category 1)
V	Total Medicare Advantage contracted providers paid on a fee-for-service plus pay-for-reporting payments (linked to quality)
W	Total Medicare Advantage contracted providers paid on a fee-for-service plus pay-for-performance payments (linked to quality)
X	Total Medicare Advantage contracted providers paid on a fee-for-service basis with a link to quality (Category 2)

Data Element ID	Data Element Description
Y	Total Medicare Advantage contracted providers paid based on alternative payment models built on a fee-for-service architecture (Category 3)
Z	Total Medicare Advantage contracted providers paid through traditional shared savings (linked to quality)
AA	Total Medicare Advantage contracted providers paid through utilization-based shared-savings (linked to quality)
BB	Total Medicare Advantage contracted providers paid through fee-for-service-based shared-risk (linked to quality)
CC	Total Medicare Advantage contracted providers paid through procedure-based bundled/episode payments (linked to quality)
DD	Total Medicare Advantage contracted providers paid through risk-based payments not linked to quality (e.g., 3N in the APM definitional framework)
EE	Total Medicare Advantage contracted providers paid through population-based payments (Category 4)
FF	Total Medicare Advantage contracted providers paid through condition-specific, population-based payments (linked to quality)
GG	Total Medicare Advantage contracted providers paid through condition-specific, bundled/episode payments (linked to quality)
HH	Total Medicare Advantage contracted providers paid through population-based payments that are NOT condition-specific (linked to quality)
II	Total Medicare Advantage contracted providers paid through full or percent of premium population-based payments (linked to quality)
JJ	Total Medicare Advantage contracted providers paid through integrated finance and delivery system programs (linked to quality)
KK	Total Medicare Advantage contracted providers paid based on capitation with no link to quality (e.g., Category 4N in the APM definitional framework)

Subsection 6: PCP/PCG-Focused Accountable Care Metrics

(Metrics below apply to the number of MA plan enrollees in an accountable care arrangement. Metrics are linked to quality.)

Data Element ID	Data Element Description
LL	Total Medicare Advantage covered lives.
MM	Total number of Medicare Advantage health plan enrollees attributed / aligned / assigned / empaneled to a Primary Care Provider (PCP) or Primary Care Group (PCG) participating in a TCOC Category 3 or 4 accountable care APM of six months or longer. [This does NOT include health plan enrollees attributed / aligned / assigned / empaneled to a PCP or PCG, who are paid based on capitation with no link to quality (4N)].

Subsection 7: Non-PCP/PCG-Focused Accountable Care Metric

(Metrics below apply to the number of MA plan enrollees in an accountable care arrangement. Metrics are linked to quality.)

Data Element ID	Data Element Description
NN	Total number of Medicare Advantage health plan enrollees attributed / aligned / assigned / empaneled to non-PCPs (i.e., specialists) participating in a TCOC Category 3 or 4 accountable care APM (e.g., shared savings with upside risk only) of six months or longer. [This does NOT include health plan enrollees attributed / aligned / assigned / empaneled to a non-PCP/PCG provider, who are paid based on capitation with no link to quality (4N)].

Section IX. Supplemental Benefit Utilization and Costs (Part C)

42 CFR § 422.102 provides MAO requirements for mandatory and optional supplemental benefits, and special supplemental benefits for the chronically ill (SSBCI). Refer to the Technical Specifications for a list of the Supplemental Benefit PBP Category Codes. The Data Elements listed below must be reported for all PBP Category Codes that the plan indicated would be offered in the plan benefit package (PBP) they submitted to CMS for the CY[4]. Any MAO that offers any of these supplemental benefits is required to report this section, whether or not beneficiaries utilized the benefit.

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data due date(s)
- Local CCP - MSA - RFB PFFS - PFFS - 1876 Cost - Regional CCP - Employer/Union Only Direct Contract PFFS - RFB Local CCP - Employer/Union Only Direct Contract Local CCP Organizations should include all 800 series plans.	1/Year, PBP Level	1/1-12/31 (Reporting at annual level)	Last Monday in February of the following year. Data Validation is not required.

[4] Note that Employer Group Waiver plans (EGWPs) should 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. Refer to the Medicare Managed Care Manual, Chapter 9, Section 10.6 – Submission of Part C EGWP Bids.

Data Element ID	Data Element Description
A	PBP Category
B	How is the supplemental benefit offered? (Mandatory, Optional, Uniformity Flexibility, and SSBCI) If the same supplemental benefit (as identified by a specific PBP Category) is offered in multiple ways (e.g., as an optional benefit, and also as SSBCI), report Elements C-N for each offering type separately.
C	Network type (in-network, out-of-network (for PPO), out-of-network (for HMO-POS), Visitor/travel, Other). If "Other", specify further in Element D, e.g., full network for PFFS plan. Similar to Element B, if the same supplemental benefit (as identified by a specific PBP Category in Element A) is offered in more than one network type (e.g., as both in-network and out-of-network (for PPO)), report Elements D-N for each network type separately.
D	Description of Network type, if Element C is "Other"
E	The unit of utilization used by the plan when measuring utilization. For example, admissions, visits, procedures, trips, or purchases. This list of examples is not exhaustive. Only one unit of utilization is allowed per PBP Category.
F	The number of enrollees ever eligible for the benefit during the reporting period
G	The number of enrollees who utilized the benefit at least once
H	The total instances of utilizations among eligible enrollees
I	The median number of utilizations among enrollees who utilized the benefit at least once
J	The total net amount incurred by the plan to offer the benefit
K	For the total net amount incurred by plan to offer the benefit (reported in Element J), describe how the plan accounts for the cost of the benefit, including how the plan determines and measures administrative costs, costs to deliver, and any other costs the plan captures.
L	The type of payment arrangement(s) the plan used to implement the benefit (Fee for service (quality linked), Fee for service (no quality linked), Capitated or Per member per month (PMPM), Hybrid payment (multiple payment types used for this service), or Other).
M	The total out-of-pocket-cost for enrollees who utilized the benefit
N	The median out-of-pocket cost for enrollees

Section X. D-SNP Enrollee Advisory Committee (Part C)

42 CFR § 422.107(f) establishes requirements for Enrollee Advisory Committees for any MAO offering one or more D-SNPs in a state.

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due Date(s)
D-SNP PBPs under the following types: - Local CCP - Regional CCP Organizations should exclude 800 series plans.	1/Year, PBP Level	1/1-12/31 (Reporting at annual level)	Last Monday of February of the following year. Data Validation is not required.

Data Element ID	Data Element Description
A	Does the D-SNP share an enrollee advisory committee (EAC) with other D-SNP(s)? (Y (yes) or N (no))
B	Provide the total number of D-SNP EAC meetings held during the measurement year.
C	List the dates during the measurement year when the D-SNP EAC met.
D	Were interpreter services offered for each D-SNP EAC meeting? (Y (yes) or N (no))
E	Were auxiliary aids and services offered for each D-SNP EAC meeting? (Y (yes) or N (no))
F	Does the plan wish to indicate there is no data to report for the respective Plan ID? (Y (yes) or N (no))

Section XI. D-SNP Transmission of Admission Notifications (Part C)

42 CFR § 422.107(d) establishes requirements for any D-SNP that is not a fully integrated or highly integrated D-SNP (i.e., FIDE SNP or HIDE SNP), except as specified at 42 CFR § 422.107(d)(2) or as required by a State Medicaid Agency Contract, to notify the State Medicaid agency or designate of hospital and skilled nursing facility admissions for at least one group of high-risk full benefit dually eligible individuals.

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due Date(s)
D-SNP PBPs that are not fully integrated D-SNPs or highly integrated D-SNPs, except as specified under 42 CFR 422.107(d)(2) or as required by a State Medicaid Agency Contract, under the following types: - Local CCP - Regional CCP Organizations should exclude 800 series plans.	1/Year, PBP Level	1/1-12/31 (Reporting at annual level)	Last Monday of April of the following year. Data Validation is not required.

Data Element ID	Data Element Description
A	Provide the total number of hospital admissions and skilled nursing facility (SNF) admissions during the measurement year among the group(s) of high risk full-benefit dually eligible individuals designated in the D-SNP's state Medicaid agency contract.
B	Of the total reported in Element A, provide the total number of admission notifications that the D-SNP transmitted to the state or state designated entity during the measurement year.
C	Does the plan wish to indicate there is no data to report for the respective Plan ID? (Y (yes) or N (no))

Section XII. Medication Therapy Management Programs (Part D)

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)
Part D sponsors with an approved Medication Therapy Management (MTM) Program.	1/Year, Contract Level	1/1-12/31 (Reporting at annual level)	Last Monday of February of the following year. Data Validation is required.

Data Element ID	Data Element Description
A	MBI Number
B	Beneficiary first name
C	Beneficiary last name
D	Beneficiary date of birth
E	Beneficiary identified as cognitively impaired at time of comprehensive medication review (CMR) offer or delivery of CMR. (Y (yes), N (no), or U (unknown))
F	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))
G	Date of MTM program enrollment
H	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).
I	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).
J	Date of MTM program opt-out, if applicable
K	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.
L	Offered annual CMR. (Y (yes) or N (no)). Required if met the specified targeting criteria per CMS – Part D requirements.
M	If offered a CMR, date of (initial) offer

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

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, Part D 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.	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 is 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.

Data Element ID	Data Element Description
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 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 or for whom up to a 7 day supply (covered by the plan) was dispensed by the pharmacy.
CC	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.
DD	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.
EE	Of the total reported in Element AA: The number of unique beneficiaries for whom up to a 7 day supply (covered by the plan) was dispensed by the pharmacy.
FF,	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.
GG	Of the total reported in Element FF: 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 XIV. Medicare Prescription Payment Plan (Part D)

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 enrolleescollects the option to pay their out-of-pocket (OOP) costs through monthly payments overdata described below to assess the course of the plan year or otherwise complyperformance of Part D Sponsors with the requirements at 42 C.F.R § 423.137 and all applicable guidance, including respect to the Medicare Prescription Payment Plan reporting requirements. Plans that exclusively charge $0 cost sharing for covered . 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 drugs to all plan enrolleessponsors, are excluded fromresponsible 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 reporting sectionthrough the Medicare Prescription Drug (MARx) System.

Reporting timeline:

		YTD	
Organization Types Required to Report	**Report Frequency, Level**	**ReportReporting Period(s):**	**Data Due Date(s)**January 1 – December 31
- 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.**Data due to CMS/HPMS**	1/Year, PBP level	1/1-12/31 (Reporting at annual level)	Last Monday of April of the following year. Data Validation is not required.

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Subsection 1: ~~Data file to be uploaded through the HPMS at the Plan (PBP) level:~~

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.

~~A. *Subsection 2:* 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~~

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~~the reporting period.~~

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

~~F. *Subsection 3:* 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.~~

~~K. Of the total reported in element F, the number of election requests that were denied during the reporting period.~~

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

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Data Element ID	Data Element Description
	year).

Subsection 4: Other Information

Data Element ID	Data Element Description
P	Does the plan wish to indicate there is no data to report for the respective Plan ID? (Y (yes) or N (no))

~~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).~~

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