CY 2025 Part C Reporting Requirements

60-day PRA Package Comments

Topic	Commenter	Comment	CMS Response
	N/A	N/A	We inadvertently included the following text on page 26 under the "inclusions" section of Element ID C: "For members who disenrolled from and re-enrolled into the same plan, excludes any HRAs (initial or reassessment) performed during their previous enrollment unless the re-enrollment occurred the day after the disenrollment." This text contradicts the correct text that follows in the next paragraph: "For members who dis-enrolled from and re-enrolled into the same plan, includes HRAs (initial or reassessment) performed during their previous enrollment if the HRAs are not more than 365 days old."
Supplemental benefits-Counting all enrollees ever eligible for a benefit	Blue Cross Blue Shield of Michigan	Members who leave a plan and return later in the year would be counted twice.	No change-plans should not double count enrollees who leave and return to a plan within the same coverage year. CMS wishes to understand supplemental benefit utilization, which includes utilization for enrollees who may not be enrolled for the full coverage year. Enrollees in this case may still be eligible for and utilize supplemental benefits.
Supplemental benefits-Visitor/Travel benefit	Kaiser Foundation Health Plan, UnitedHealthcare	The crosswalk states that the Service Area Related Services section/ visitor/travel program and out-of-network categories	Change-this is correct. CMS will update the Reporting Requirements document to remove this section. This section was erroneously

Topic	Commenter	Comment	CMS Response
		were removed to include as reported PBP elements. However, the Service Area Related Services section remains in the Reporting Requirements, but the section was removed from the Technical Specifications. This should be removed from the Reporting Requirements to align with the crosswalk and technical specifications.	included in the Reporting Requirements document, but correctly removed from both the Technical Specifications document and crosswalk.
Supplemental benefits-Crosswalk document	Lumeris	At the end of the spreadsheet there were several notes that were labeled as being clarifications to the supplemental benefits reporting section but were for elements that do not appear on the supplemental benefits report. For example, these notes reference Data Element A as an open text field for listing supplemental items or services, but Data Element A is the plan's contract ID.	No change-CMS will update the crosswalk appropriately, however no changes to the Reporting Requirements are necessary as a result of this comment.
Supplemental benefits-Category renumbering	UnitedHealthcare	UHC noted some typos in numbering of supplemental benefit categories and updates from current PBP layouts which were not transcribed into the Reporting Requirements document	Change-CMS appreciates this feedback and has corrected the noted issues.
Supplemental benefits-Reporting Visitor/Travel benefit	UnitedHealthcare	UHC encourages CMS to clarify the scope of the required reporting, as the majority of POS or V/T benefit are spent on Medicare covered services.	No change-CMS has clarified in the 30 day version of the Reporting Requirements and Technical Specifications that plans should report Visitor/Travel or Point of Service utilization and costs for Medicare covered benefits. These are labeled

Topic	Commenter	Comment	CMS Response
			as "V/T" and "POS" in the PBP Category field.
Supplemental benefits- VBID benefits combined maximum	UnitedHealthcare	Some plans count VBID and non-VBID benefits toward the same combined maximum. Analyzing only the non-VBID benefits may lead users to draw inaccurate conclusions about utilization and costs.	No change-While CMS understands that plans may use different methods to administer benefits, plans should have in place systems to separate out spending and utilization based on the individual benefits as they appear in the Reporting Requirements and in the PBP. Data elements in these Reporting Requirements are structured to minimize any such inaccurate conclusions due to different administration methods of plans.
Supplemental benefits- Element F, Network type	UnitedHealthcare	UHC requests that CMS confirm whether it expects plans to report all three network types for every supplemental benefit category on every plan, even if, for example, a supplemental benefit is only offered in network.	No change. CMS intends that this new element will allow plans which offer different levels of coverage to report on all utilization and costs based on these different coverage levels. CMS anticipates that there may be lower utilization for services offered out of network (OON) and requires this information for more accurate data analysis. It is our intention that plans split out reporting for benefits based on the network type. CMS will release file formats for reporting which accounts for this change.
Supplemental benefits- Element M (How the plan accounts for the cost of the benefit), Element O (Total Out of	UnitedHealthcare	UHC requests CMS confirm whether Data Element M and O be broken out by network type.	No change. Reporting for both Element M and O should be broken out by network type. CMS notes that for each network type a plan may account for the cost of the benefit differently and apply

Topic	Commenter	Comment	CMS Response
Pocket cost per utilization)			differing levels of cost sharing. CMS wishes to capture this information in the data.
Supplemental benefits-PFFS reporting	UnitedHealthcare	UHC offers a non-network Private Fee for Service plan which does not fit into either the "in-network" or "out-of-network" labels. UHC requests that CMS confirm what label it should apply for this type of plan.	Change-CMS has added an option for "other" to be included in Data Element F. Plans may specify what the designation of "Other" in this data element means for the plan in Element M.
Supplemental benefits-Activating V/T benefit	UnitedHealthcare	UHC's V/T benefit requires a member to call and notify us before they travel to activate their benefit. While any member can use V/T, not all members choose to activate this benefit. Please clarify whether it is CMS's expectation that all members who could activate the benefit be included in the count.	No change. Plans should report on the overall number of enrollees eligible, not only on those who "activated" the benefit. Plans should also not include those who "activated" but did not utilize a benefit in its utilization measures.
Supplemental benefits- Notes section clarification	UnitedHealthcare	CMS indicates plans may report "Not applicable" however some fields require only numeric or dollar entries.	Change. CMS will edit this field in the notes section to clarify when plans may use "Not applicable" in reporting. Note also that file formatting is not within scope of this PRA package. CMS will clarify formatting at the appropriate time and in the appropriate manner.
Supplemental benefits-Element ID and notes field discrepancies between Reporting Requirements and Technical Specifications	UnitedHealthcare	CMS has labeled 2 separate Data Elements as "J" and not included the "The total out-of-pocket-cost per utilization for enrollees who utilized the benefit" in Reporting Requirements documents. There are other discrepancies as well due to this initial error.	Change. CMS will update typos and rectify any discrepancies noted in the Reporting Requirements document.

Topic	Commenter	Comment	CMS Response
Payments to Providers- Out of network payments	Alignment	Page 39 states that "CMS will collect data from MA organizations 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". However the description for Data Element ID "A" on page 41 states "Total dollars paid to providers (in and out of network) for Medicare Advantage enrollees in [CY 20XX] or most recent 12 months". Should the Plan only report out of network payments associated with contracted providers?	Change. CMS will further clarify the definition for this element in the FAQ.
Payments to Providers- "or most recent 12 months" is unclear.	BCBS Michigan	Plan is seeking clarification regarding the phrase "or most recent 12 months." Under this proposal, would the plan submit payments to providers made between January 1 and December 31 of the current plan year as it is done today or should the submission include payments made to providers across plan years to meet the "or most recent 12 months" requirement? For example, if a plan contracts with a provider in March 2024 and that provider is paid through January of 2025, should the plan include payments made to the contracted provider in their data submission in February 2025?	Change. CMS will edit the FAQ to clarify that "or most recent 12 months" means the most current 12-month period for which the health plan can report payment information.

Topic	Commenter	Comment	CMS Response
Payments to Providers- Category 1 FFS payments.	BCBS Michigan	Plan is seeking clarification regarding Category 1 Element B expectations as they find the language unclear.	Change. CMS will further clarify the definition for this element.
Payments to Providers- Legacy Payments	BCBS Michigan	Plan is seeking a definition of the term "legacy payment" in order to submit data effectively.	Change. CMS will further clarify the definition for this element in the FAQ.
Payments to Providers- Total provider payment	United Healthcare	The Frequently Asked Question indicates the sum of all elements B through R should equal A. We ask that CMS clarify if this is accurate when only Data Element ID A includes both in and out of network providers and the remaining elements are limited to contracted providers.	Change. CMS appreciates this feedback and has corrected the noted issues.
Payments to Providers- Category 2 subtotal.	United Healthcare	UHC also asks that CMS clarify if data element ID E is a subtotal for data elements IDs C as FAQ indicates the sum of all elements B through R should equal A.	Change. CMS appreciates this feedback and has corrected the noted issues.
Payments to Providers- Category 3 subtotal.	United Healthcare	In addition, we ask CMS for clarification on whether data element ID J is a subtotal for elements F through I as the FAQ indicates the sum of all elements B through R should equal A	Change. CMS appreciates this feedback and has corrected the noted issues.
Payments to Providers- Foundational Spending	United Healthcare	Data Element ID D - Can CMS provide the definition and examples for "foundational spending?"	Change. CMS appreciates this question and has provided additional examples in the FAQ.
Payments to Providers- Traditional shared savings	United Healthcare	Data Element ID F - Can CMS provide the definition and examples for "traditional shared¬ savings?"	Change. CMS appreciates this question and has provided additional examples in the FAQ.

Topic	Commenter	Comment	CMS Response
Payments to Providers- Utilization based shared savings	United Healthcare	Data Element ID G - Can CMS provide the definition and examples for "utilization-based shared¬ savings?"	Change. CMS appreciates this question and has provided additional examples in the FAQ.
Payments to Providers- fee-for-service based shared-risk savings	United Healthcare	Data Element ID H - Can CMS provide the definition and examples for "fee-for-service based shared-risk savings?"	Change. CMS appreciates this question and has provided additional examples in the FAQ.
Payments to Providers- Category 4 Total	United Healthcare	We request that CMS clarify if data element ID Q is a subtotal for elements L through P as the FAQ indicates the sum of all elements B through R should equal A.	Change. CMS appreciates this feedback and has corrected the noted issues.
Payments to Providers- condition-specific, population-based payments	United Healthcare	Data Element ID L - Can CMS provide the definition and examples for "condition-specific, population-based" payments?	Change. CMS appreciates this question and has provided additional examples in the FAQ.
Payments to Providers- Condition-specific, bundled/episode	United Healthcare	Data Element ID M - Can CMS provide the definition and examples for "condition-specific, bundled/episode" payments?	Change. CMS appreciates this question and has provided additional examples in the FAQ.
Payments to Providers- population-based payments NOT condition specific?	United Healthcare	Data Element ID N - Can CMS provide the definition and examples for "population-based payments NOT condition specific?"	Change. CMS appreciates this question and has provided additional examples in the FAQ.
Payments to Providers- full or percent of premium population-based payments	United Healthcare	Data Element ID O - Can CMS provide the definition and examples for "full or percent of premium population-based payments?"	Change. CMS appreciates this question and has provided additional examples in the FAQ.
Payments to Providers- integrated finance and delivery system programs	United Healthcare	Data Element ID P - Can CMS provide the definition and examples for "integrated finance and delivery system programs?"	Change. CMS appreciates this question and has provided additional examples in the FAQ.

Topic	Commenter	Comment	CMS Response
Payments to Providers-covered lives	United Healthcare	Data element ID GG. Is the covered lives based on payments made to providers or regardless of payments made to providers?	Change. CMS appreciates this question and has provided additional examples in the FAQ.
D-SNP Enrollee Advisory Committee (EAC) Reporting Requirement	Predict Health	Predict Health recommends that CMS adds the following data element: "Provide the number of attendees at each EAC meeting held during the measurement year." Predict Health stated that this information could shed light on whether EAC meetings are in fact substantive or occurring "on paper only" – that is, announced and held, but with no or few enrollees in attendance. It may also help inform future efforts by CMS or others to provide guidance and best practices around a minimum number of attendees needed for meaningful participation.	CMS appreciates this suggestion and agrees that understanding the level of EAC meeting participation may provide useful insight. However, since this is a new reporting requirement, CMS intends to begin implementation with collecting key elements primarily to ensure regulatory compliance, but will consider adding additional elements in the future as we gain more experience with the collected data.
D-SNP EAC Reporting Requirement	Predict Health	Predict Health recommends that CMS adds the following data element: "Does the EAC have a reasonably representative sample of enrollees of the population enrolled in the dual eligible special needs plan or plans, or other individuals representing those enrollees ("Yes" or "No" only)." Predict Health notes that adding an attestation of compliance with this requirement would be both a reasonable and valuable addition.	CMS appreciates this suggestion and agrees that it is important to ensure that EACs include a reasonably representative sample of individuals enrolled in D-SNPs. However, the suggested "yes/no" question is not likely to help distinguish D-SNP performance in this area, particularly since what respondents consider "reasonably representative" may vary across D-SNPs. Although CMS will not add this element to the reporting requirements at this time, we will consider other

Topic	Commenter	Comment	CMS Response
			vehicles for assessing D-SNP compliance in this area.
D-SNP EAC Reporting Requirement	Predict Health	Predict Health recommends that CMS adds the following data element: "Describe how the extent to which the EAC includes a reasonably representative sample was assessed."	CMS appreciates this suggestion but at this time prefers to focus this reporting requirement on data collection that we can readily compare across D-SNP submissions. CMS is not making a change in response to this comment.
D-SNP EAC Reporting Requirement	Kaiser Foundation Health Plan (Kaiser)	Kaiser states that there is a lack of substantive data to report. Kaiser notes that it is atypical for a reporting requirement to include "yes/no" responses. Kaiser also notes that a standardized approach to collecting information might not represent the most effective approach given that state Medicaid agencies have flexibility to establish more specific reporting requirements. Kaiser provides the example of California's state Medicaid agency requiring that D-SNP EACs meet quarterly and submit meeting minutes and attendance reports. Kaiser encourages CMS to establish another mechanism to collect such information and consider working with state Medicaid agencies to avoid any duplicative requirements.	CMS appreciates the comment but is not making a change to this reporting requirement. CMS notes that other existing reporting requirements, such as Rewards and Incentives Programs and Employer Group Plan Sponsors, require "yes/no" responses. CMS believes the "yes/no" responses will yield helpful information to better understand how MA organizations are implementing D-SNP EACs while minimizing burden required of MA organizations to respond. Also, not all state Medicaid agency contracts (SMACs) include requirements for D-SNP EAC reporting. We will monitor SMACs for these requirements over time and work with states to minimize any duplicative requirements to the extent possible.
D-SNP Transmission of Admission Notifications Reporting Requirement	Kaiser Foundation Health Plan	Kaiser notes that this reporting requirement will not likely capture the unique aspects of state-specific reporting required for all D-SNPs. It indicates that California's state Medicaid agency requires that - for	CMS appreciates the comment but is not making a change to this reporting requirement. CMS notes that this reporting requirement is structured to account for state-specific differences regarding notification of

Topic	Commenter	Comment	CMS Response
		applicable integrated plans (AIPs) - facilities report admissions directly to the D-SNP. Under the proposed reporting element, this would mean that such plans have no activity to report under Data Element B. Kaiser encourages CMS to work directly with the state Medicaid agencies to acquire the visibility to reporting practices, data, and outcomes.	hospital admissions and skilled nursing facility (SNF) admissions. Specifically, Data Element A is limited to the count of hospital admissions and SNF admissions among the group(s) of high risk full-benefit dually eligible individuals designated in the D-SNP's SMAC with the state. As noted in the technical specifications, this element will serve as the denominator in determining the percent of hospital admissions and SNF admissions that resulted in notification to the state or state designated entity during the measurement year. In response to the comment that California requires facilities to report admissions directly to the D-SNP, we note that this does not satisfy the regulatory requirement at 42 CFR 422.107(d)(1), which requires that the SNP notifies, or arranges for another entity or entities to notify, the state Medicaid agency, individuals or entities designated by the state Medicaid agency, or both, of hospital and SNF admissions for at least one group of high-risk full-benefit dual eligible individuals.
D-SNP Transmission of Admission Notifications Reporting Requirement	UnitedHealthcare	UHC notes that the admissions data submitted by MA organizations differs across states due to differences in how states 1) identify which dually eligible individuals are	CMS appreciates the comment but is not making a change to this reporting requirement. CMS notes that this reporting requirement is structured to account for state-specific differences

Topic	Commenter	Comment	CMS Response
		included in the submitted admissions data; and 2) what constitutes an "admission." Also, UHC suggests that because D-SNPs report all qualifying admissions to state Medicaid agencies, the admissions data reflect the total number of admissions but don't indicate how many of those admissions are from the same individual. UHC suggests that the admissions data submitted by MA organizations will not allow CMS to perform meaningful comparisons across states and recommends that CMS modify or eliminate the D-SNP Transmission of Admission Notifications Reporting Requirements.	regarding notification of hospital admissions and SNF admissions. Specifically, Data Element A is limited to the count of hospital admissions and SNF admissions among the group(s) of high risk full-benefit dually eligible individuals designated in the D-SNP's SMAC with the state. As noted in the technical specifications, this element will serve as the denominator in determining the percent of hospital admissions and SNF admissions that resulted in notification to the state or state designated entity during the measurement year. This percentage is what CMS will assess and compare across D-SNPs. Regarding the comment that the data will not reflect how many admissions are from the same individual, CMS does not believe such a designation is relevant for the information we are seeking to assess. CMS is interested in the proportion of hospital admissions and SNF admissions that result in notification as required by the state. As such, the unit of measurement for this reporting requirement is admissions, not individuals. D-SNPs should provide notification for all hospital admissions and SNF admissions as required by the state, irrespective of the number of times the

Topic	Commenter	Comment	CMS Response
			admitted individual may or may not have been admitted previously.
D-SNP Transmission of Admission Notifications Reporting Requirement	UnitedHealthcare	UHC recommends that CMS allow MA organizations to submit the D-SNP Transmission of Admission Notifications Reporting Requirements through a file upload rather than a data entry. UHC indicates that the amount of time required for a manual data entry may cause HPMS to "time out" before it can enter all information accurately since UHC offers numerous D-SNPs.	CMS appreciates the comment but does not agree that utilizing data entry for this reporting requirement is burdensome. This reporting requirement includes only two elements, each of which captures a single integer. We do not anticipate that HPMS will "time out" before organizations are able to enter the requisite data.
Table of Contents	Anonymous	Org Determinations & Reconsiderations are missing from the table of contents of CY2025 Part C TechnicalSpecifications	Change-this is correct. CMS will update the Technical specifications document.
Table of Contents	Kaiser	Reporting Requirements and Technical Specifications should align for the Table of Contents sections.	Change-this is correct. CMS will update the Technical specifications document.
Payments to Providers- Total Medicare Advantage contracted providers paid through traditional shared-savings (linked to quality)	Alignment	There is not a separate Data Element under Provider Data for "Total Medicare Advantage contracted providers paid through traditional shared-savings (linked to quality)", which is the contracted provider count that ties to the payment to providers under Data Element ID "F" on page 41 "Total dollars paid to providers through traditional shared-savings (linked to quality)".	Change. CMS appreciates this flag and will add the mentioned data element.
Payments to Providers-	Alignment	There is not a separate Data Element under Provider Data for "Total Medicare	Change. CMS appreciates this flag and will add the mentioned data element.

Topic	Commenter	Comment	CMS Response
Total Medicare Advantage contracted providers paid based on condition-specific, population-based payments (linked to quality)		Advantage contracted providers paid based on condition-specific, population-based payments (linked to quality)", which is the contracted provider count that ties to the payment to providers under Data Element ID "L" on page 41 "Total dollars paid to providers through condition-specific, population-based payments (linked to quality)".	
Payments to Providers- Total Medicare Advantage contracted providers paid through traditional shared-savings (linked to quality)	Alignment	There is not a separate Data Element under Provider Data for "Total Medicare Advantage contracted providers paid through traditional shared-savings (linked to quality)", which is the contracted provider count that ties to the payment to providers under Data Element ID "F" on page 41 "Total dollars paid to providers through traditional shared-savings (linked to quality)".	Change. CMS appreciates this flag and will add the mentioned data element.
Payments to Providers-	Kaiser	Can you please provide more information on what the required criteria for MA plan members is to participate in an accountable care arrangement for the PCP-PCG Focused Accountable Metrics (elements GG – II)	Change. CMS appreciates this question and has provided additional examples in the FAQ.