~~Medicare Part~~MEDICARE PART C ~~Reporting Requirements~~REPORTING REQUIREMENTS

~~Effective January 1, 202~~6~~5~~

~~Prepared by:~~
~~Centers for Medicare & Medicaid Services~~
~~Center for Medicare Drug Benefit and C&D Data Group~~

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 ~~January 31, 2028~~XXXXXXXX. The time required to complete this information collection is estimated to average 42 hours per response, including the time to review instructions, search existing data resources, ~~and~~ 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.

Effective as of January 1, 2026

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Revision History (from Contract Year 2025 to 2026)

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

1. Formatting changes have been made throughout the document.
2. Additional information on timely submission of data has been included in the introduction. This information used to be found in the Technical Specifications.
3. Clarification of definitions of level of data to be reported has been added to the introduction.
4. Additional information on inclusions and exclusions from Reporting Sections has been included in the introduction.
5. Clarification has been added to the introduction about terminated contracts and contracts/plans with no enrollment.
6. Additional information on Data Validation has been included in the introduction.
7. Information has been added to the introduction on CMS Analysis of Reporting Requirements data and publication of the Limited Data Set.
8. The new mailbox for questions about Part C Reporting Requirements has been added to the introduction.
9. Duplicative information has been removed, including information duplicative of the Technical Specifications.
10. Information on whether each Reporting Requirement section is to be reported as a file upload or as data entry has been removed. This information is now in Technical Specifications. Note that for CY 2026, the two D-SNP Reporting Requirement sections will now be reported via file upload.
11. Summaries describing each Reporting Requirement section have been added.
12. Minor clarifications have made to most Reporting Requirement section's parameters table.
13. Information to clarify technical specifications for data elements and data upload specifications has been moved to the Technical Specifications.
14. Minor clarifications have been made to most Reporting Requirements sections' data elements.

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Background and Introduction

Section 1857(e)(1) of the Social Security Act (the Act) provides broad authority for the Secretary to add terms to the contracts with Medicare Advantage Organizations (MAOs), 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.

42 CFR § 422.516(a) requires each MAO 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 MA organization has a fiscally sound operation.
6) Other matters that CMS may require.

CMS has authority to establish reporting requirements for Medicare Advantage Organizations (MAOs) as described in 42CFR §422.516 (a). Pursuant to that authority, each MAO must have an effective procedure to develop, compile, evaluate, and report information to CMS in the time and manner that CMS requires. Additional regulatory support for the Medicare Part C Reporting Requirements is also found in the Final Rule entitled "Medicare Program; Revisions to the Medicare Advantage and Prescription Drug Program" (CMS 4131-F).

All Part C Reporting Requirements documents will be posted at: Centers for Medicare & Medicaid Services Part C Reporting Requirements website. CMS believes providing these separate instructions will better serve the organizations reporting these data, while satisfying the Paperwork Reduction Act requirements.

Organizations for which these specifications apply are required to collect these data. Reporting will vary depending on the plan type and reporting section. Most reporting sections will be reported annually. Additional Supplemental Benefits Utilization and Cost inquiries are directed to the following mailbox: https://dpapportal.lmi.org/DPAPMailbox.

The following data elements listed directly below are considered proprietary, and CMS considers these as not subject to public disclosure under provisions of the Freedom of Information Act (FOIA): *
Employer DBA and Legal Name, Employer Address, Employer Tax Identification Numbers (Employer Group Sponsors)

*Under FOIA, Plans may need to independently provide justification for protecting these data if a FOIA request is submitted.

Commented [SS1]: As a team, agreed we do not need this paragraph.

Commented [SS2]: We agreed as a group to remove this, and remove the equivalent in Part D RR doc.

Commented [SS3]: We agreed as a group to remove this. The purpose of this document is to explain what data you need to collect. This info should be in the PRA statements.

Commented [SS4]: We agreed as a team to remove this paragraph.

Commented [SS5]: We agreed to move this to the TS.

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

Formatted: Right: 0.11", Space Before: 13.75 pt, Line spacing: Multiple 1.04 li

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.

Commented [SS6]: Sentence moved here from TS

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

Commented [SS7]: Moved here from TS.

Level of Data Reported

Da~~In order to provide guidance to Part C Sponsors on the actual process of entering reporting requirements data into the Health Plan Management System, a separate Health Plan Management System (HPMS) Plan Reporting Module (PRM) User Guide may be found on the PRM start page.~~ta 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.

Commented [SS8]: Remove, include in TS

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

Inclusions and Exclusions from Reporting

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

Commented [SS10]: List updated based on parameters.

~~Exclusions from Reporting:~~

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

[1] Denotes that these the plans are required to report the Employer Group Plan Sponsors reporting section, because this section is reported by both Part C and Part D plans.

Terminations

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

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

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

No Enrollment Contracts and Plans

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

~~zesare~~Data Validation

CMS requires that sponsoring organizations (SOs) contracted to offer Medicare Part C and/or Part D benefits be subject to an independent yearly audit to validate certain data reported to CMS to determine its reliability, validity, completeness, and comparability in accordance with specifications developed by CMS.[2]

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 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 Reporting Requirements should be sent via email to PartsCDPlanReportingAndDV@cms.hhs.gov.

Commented [SS11]: Terminations language moved here from TS,

Commented [SS12]: Run by Michelle: In almost all cases, a contract cannot report data in HPMS if they are terminating/have terminated. The contract number will not pop up in HPMS for submission. Even if they somehow managed to report, we would not use or look at their data.

Commented [SS13R12]: This language may appear in other documents and would need to be updated there.

Commented [AL14R12]: Michelle, I advised that we avoid saying "terminated plans should not report data" aka should.

Do you think we should state explicitly terminated plans will not be allowed to report?

Commented [SS15R12]: Alice, Please see if you are ok with the edits I made at Michelle's request.

Commented [AL16R12]: OK. Operational "must" is ok

Commented [SS17]: Agreed as a team for 2026, all RR sections will adopt the same rule as MTM. No enrollment contracts will NOT show up for any reporting section. No enrollment contracts will not report data. Their contract number would not even show up in the HPMS.

Commented [SS18]: The Part C TS had a different paragraph about DV. However, we agreed as a team to use the same language that is in the DV manual. The TS will no longer mention DV as the info is now in the RR doc.

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

~~National PACE Plans and 1833 Cost Plans are excluded from reporting all Part C Reporting Requirements reporting sections.~~

Commented [SS19]: Removed as it is duplicative of the new and improved Inclusions and Exclusions section in this intro.

REPORTING SECTIONS

Reporting Sections

Section I. Grievances GRIEVANCES

MAOs must comply with grievance requirements for timely hearing and resolving of grievances as established in regulations at 42 CFR Part 422 Subpart M and further described in the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.564.

Grievances

According to MMA statute, all MAOs must provide meaningful procedures for hearing and resolving grievances between enrollees, and the organization or any other entity or individual through which the organization provides health care services under any MA plan it offers. A grievance is any complaint or dispute, other than one that constitutes an organization determination, which expresses dissatisfaction with any aspect of an MA organization'sMAOs or provider's operations, activities, or behavior, regardless of whether remedial action is requested. MA organizationsMAOs are required to notify enrollees of their decision no later than 30 days after receiving their grievance based on the enrollee's health condition. An extension up to 14 days is allowed if it is requested by the enrollee, or if the organization needs additional information and documents that this extension is in the interest of the enrollee. An expedited grievance that involves refusal by an MA organizationMAO to process an enrollee's request for an expedited organization determination or reconsideration requires a response from the MA organization MAO within 24 hours.

I. GRIEVANCES

This reporting section requires an upload.

Organization Types Required to Report	Report Frequency, Level	Report Period (s)	Data Due Date(s)
- 01 – Local Coordinated Care Plan (CCP) - Medicare Savings Accounts (02 – MSAs) - 03 – Religious Fraternal Benefit (RFB) PFFS Private Fee for Services (PFFS)) - 04 – Private Fee for Services (PFFSS) - 06 – 1876 Cost - 11 – Regional CCP - 14 – Employer/Union Only Direct Contract Employee Union Direct (ED) - PFFS - 15 – RFB Local CCP -	1/Year /Contract LLevel	Q1: 1/1-3/31 Q2: 4/1-6/30 Q3: 7/1-9/30 Q4: 10/1-12/31 (RReporting will include eachat quarterly level)	First Monday of February ofin the following year. Data Validation required.

Commented [SS20]: Updates in citations provided/approved by SMEs.

Commented [SS21]: Streamlined to point to policy, instead of restating specific policies which may change. Same for all sections.

Commented [SS22]: These sentences were removed as this information is now in TS.

Commented [SS23]: These tables in each RR section have all been updated to match the 2025 parameters. The changes were already discussed with SMEs as needed in 2025 parameters process.

Commented [SS24]: As a team, we agreed to remove the numbers associated with contract org type, as they are not meaningful to contracts.

- 17 – Employer/Union Only Direct Contract Employee Union Direct (ED) - LPPOLocal CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.			

Commented [SS25]: This contract types was not included in previous RR docs, however that was an oversight. No contracts actually have this Org type so it is only here for completeness. You may see similar instances in other parameters tables. The explanation is the same in each instance.

Data Element ID	Data Element Description
A.	Number of Total Grievances
B.	Number of Total Grievances in which timely notification was given
C.	Number of Expedited Grievances
D.	Number of Expedited Grievances in which timely notification was given
E.	Number of Dismissed Grievances

Section II. Organization Determinations & Reconsiderations~~ORGANIZATION DETERMINATIONS & RECONSIDERATIONS~~

~~Title~~ 42 CFR~~,~~ Part 422~~,~~ Subpart M outlines organization determination and reconsideration requirements for MA-O~~organizations~~, including timeframes for handling determinations, and further described in the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance~~.~~

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

~~This section requires a file upload.~~

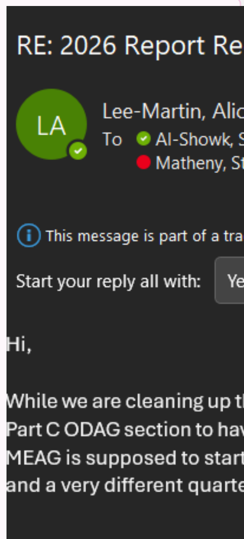
Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due Date(s)
- ~~01 –~~ Local CCP - ~~02 –~~ MSA - ~~03 –~~ RFB PFFS - ~~04 –~~ PFFS - ~~06 –~~ 1876 Cost - ~~11 –~~ Regional CCP - Employer/Union Only Direct Contract PFFS ~~14 – ED-PFFS~~ - ~~15 –~~ RFB Local CCP - Employer/Union Only Direct Contract Local CCP~~17 – ED-LPPO~~ Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.	1/Year Contract Level	Q1: 1/1-3/31 Q2: 4/1- 6/30 Q3: 7/1-9/30 Q4: 10/1-12/31 (R~~r~~eporting at quarterly level)	Last Monday of February of~~in~~ the following year. Data Validation required.

Commented [SS26]: Shafa, I am highlighting that Michelle added this.

Commented [SA27R26]: Perfect thank you.

Commented [SA28R26]: There is a section after this paragraph that is removed. I want to discuss it further as a team.

Commented [SA29R26]:



Commented [AL30R26]: Thanks Shafa! I am good with MBK's addition of the MEAG guidance link. Since the reporting periods are listed in the table here, I am ok with not writing it out in paragraph form.

Commented [SA31]: Approved by the SME

Subsection 1: Organization Determinations

Data Element ID	Data Element Description
A.	Total Number of Organization Determinations mMade ~~in the Reporting Period Above~~
B.	Number of Organization Determinations - Withdrawn
C.	Number of Organization Determinations - Dismissals
D.	Number of Organization Determinations requested by enrollee/representative or provider on behalf of the enrollee (Services)
E.	Number of Organization Determinations submitted by Enrollee/Representative (Claims)
F.	Number of Organization Determinations requested by Non-Contract Provider (Services)
G.	Number of Organization Determinations submitted by Non-Contract Provider (Claims)

Subsection 2: Disposition – All Organization Determinations

Data Element ID	Data Element Description
A.	Number of Organization Determinations – Fully Favorable (Services) Requested by enrollee/representative or provider on behalf of the enrollee
B.	Number of Organization Determinations – Fully Favorable (Services) Requested by Non-contract Provider
C.	Number of Organization Determinations – Fully Favorable (Claims) Submitted by enrollee/representative
D.	Number of Organization Determinations – Fully Favorable (Claims) Submitted by Non-contract Provider
E.	Number of Organization Determinations – Partially Favorable (Services) Requested by enrollee/representative or provider on behalf of the enrollee
F.	Number of Organization Determinations – Partially Favorable (Services) Requested by Non-contract Provider
G.	Number of Organization Determinations – Partially Favorable (Claims) Submitted by enrollee/representative.
H.	Number of Organization Determinations – Partially Favorable (Claims) Submitted by Non-contract Provider

Commented [SS32]: This used to be one big table, not has been split into different tables by subsection to help with 508. The subsection names used to be in the table, and have now been taken out of the table and made into headings. The subsection names have not changed.

Data Element ID	Data Element Description
I.	Number of Organization Determinations – Adverse (Services) Requested by enrollee/representative or provider on behalf of the enrollee
J.	Number of Organization Determinations – Adverse (Services) Requested by Noncontract Provider
K.	Number of Organization Determinations – Adverse (Claims) Submitted by enrollee/representative
L.	Number of Organization Determinations – Adverse (Claims) Submitted by Noncontract Provider

Commented [SS32]: This used to be one big table, not has been split into different tables by subsection to help with 508. The subsection names used to be in the table, and have now been taken out of the table and made into headings. The subsection names have not changed.

Subsection 3: Reconsiderations

Data Element ID	Data Element Description
A.	Total number of Reconsiderations ~~M~~made ~~in Reporting Time Period Above~~
B.	Number of Reconsiderations - Withdrawn
C.	Number of Reconsiderations - Dismissals
D.	Number of Reconsiderations requested by or on behalf of the enrollee (Services)
E.	Number of Reconsiderations submitted by Enrollee/Representative (Claims)
F.	Number of Reconsiderations requested by Non-Contract Provider (Services)
G.	Number of Reconsiderations submitted by Non-Contract Provider (Claims)

Commented [SS33]: When we say "above" what are we referring to? Should this just say "in the reporting period"?

Commented [SA34R33]: Discussion with Alice and we remove "above".

Commented [SA35R33]: We looked at other reporting section language and we decided to change it to Reporting Period to be consistent.

Commented [AL36R33]: I am wondering do we need to state this at all. We do not say ODs in the reporting period.

Commented [SA37R33]: It would say: Total number of Reconsiderations made.

In Subsection 1: Organization Determination, Element A says: Total Number of Organization Determinations Made in the Reporting Period.

I am going to remove that as well.

I also checked the file layout for Part C ODR, and it says in the description, Enter the Total number of Reconsiderations Made in Reporting Time Period for Reconsiderations. So we should be good.

A	Total number of Reconsiderations Made in Reporting Time Period	NUM Required	1

Commented [SA38R33]: Side note, I would like to change the file layout for next year. It isn't very intuitive.

Commented [SA39R33]: We decided to remove the reference for reporting period since we have it in the table above.

Subsection 4: Disposition – All Reconsiderations

Data Element ID	Data Element Description
A.	Number of Reconsiderations – Fully Favorable (Services) requested by enrollee/representative or provider on behalf of the enrollee
B.	Number of Reconsiderations – Fully Favorable (Services) requested by Non-contract Provider
C.	Number of Reconsiderations – Fully Favorable(Claims) submitted by enrollee/representative
D.	Number of Reconsiderations – Fully Favorable (Claims) submitted by Non-contract Provider

Data Element ID	Data Element Description
E.	Number of Reconsiderations – Partially Favorable (Services) requested by enrollee/representative or provider on behalf of the enrollee
F.	Number of Reconsiderations – Partially Favorable (Services) requested by Noncontract Provider
G.	Number of Reconsiderations – Partially Favorable (Claims) submitted by enrollee/representative
H.	Number of Reconsiderations – Partially Favorable (Claims) submitted by Noncontract Provider
I.	Number of Reconsiderations – Adverse (Services) requested by enrollee/representative or provider on behalf of the enrollee
J.	Number of Reconsiderations – Adverse (Services) requested by Non-contract Provider
K	Number of Reconsiderations – Adverse (Claims) submitted by enrollee/representative
L.	Number of Reconsiderations – Adverse (Claims) submitted by Non-contract Provider

Subsection 5: Re-Openings

Data Element ID	Data Element Description
A.	Total number of reopened (revised) decisions, for any reason~~, in Time Period Above~~
B.	Contract Number
C.	Case ID
D.	Case level (Organization Determination or Reconsideration)
E.	Date of original disposition
F.	Original disposition (Fully Favorable, Partially Favorable, or Adverse)
G.	Was the case processed under the expedited timeframe? (Y/N)
H.	Case type (Service or Claim)

Commented [SS40]: For 2027, we are considering removing Element A (both here and in CDR)

Commented [SS41]: Should this say "in the reporting period"?

Commented [SA42R41]: Discussion with Alice we changed to Reporting period to be consistent with other sections.

Commented [SA43]: Should we remove this as well, following the same pattern as OD and reconsiderations?

Commented [SS44R43]: If this was resolved, please delete this comment.

Commented [SA45R43]: I removed the language referencing the reporting period since it is mentioned in the table above.

Commented [SS46]: Information about file upload that used to be in the second row of this table has been moved to the TS as all info about file upload and data entry is now in the Tech Specs.

Data Element ID	Data Element Description
I.	Status of treating provider (Contract, Non-contract)
J.	Date case was reopened
K.	Reason(s) for reopening (Clerical Error, Other Error, New and Material Evidence, Fraud or Similar Fault, or Other)
L.	Additional Information (Optional)
M.	Date of reopening disposition (revised decision)[3]
N.	Reopening disposition (Fully Favorable; Partially Favorable, Adverse or Pending)

Commented [SA47]: We removed the citation to the TS

[3] The date of disposition is the date the required written notice of a revised decision was sent per § 405.982.

Section III. ~~EMPLOYER~~ Employer ~~GROUP~~ Group ~~PLAN~~ Plan ~~SPONSORS~~Sponsors

CMS regulations (42 CFR § 422.106) stipulate specific parameters for MAOs offering employer group health plans. Additional information regarding waivers can be found in Chapter 9 of the Medicare Managed Care Manual (https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c09.pdf).~~This reporting section requires a file upload.~~

Organization Types Required to Report	Report Frequency~~,~~/ Level	Report Period~~ ~~(s)	Data Due Date~~ ~~(s)
- ~~–~~Local CCP - ~~–~~MSA - RFB PFFS - ~~04 –~~ PFFS ~~0~~ - ~~06 –~~ 1876 Cost - ~~10 –~~ PDP - ~~11 –~~ Regional CCP - Employer/Union Only Direct Contract ~~13 – ED-~~PDPs - Employer/Union Only Direct Contract PFFS - RFB Local CCP - Employer/Union Only Direct Contract Local CCP ~~14 – ED-PFFS~~ ~~15 – RFB Local CCP~~ ~~17 – ED-LPPO~~ Organizations should include all 800 series plans and any individual plans sold to employer groups. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.	1/~~y~~Year PBP Level	1/1 - 12/31 (Reporting at annual level)	First Monday of February of~~in~~ the following year. Data Validation not required.

Commented [SS48]: I updated the title of this section to match 1. the title in HPMS and 2. The title in Part C documentation.

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

Section IV. Special Needs ~~PLANS~~ Plans (SNPs) ~~CARE~~ Care ~~MANAGEMENT~~ Management

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

Commented [SA49]: Approved by SME

~~This reporting section requires a file upload into HPMS.~~

Organization Types Required to Report	Report Frequency, Level	Report Period (s)	Data Due Date (s)
SNP PBPs under the following types: - ~~01 –~~ Local CCP - ~~11 –~~ Regional CCP ~~15 – RFB Local 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 required.

Commented [SS50]: This was here incorrectly. Fixed for 2026.

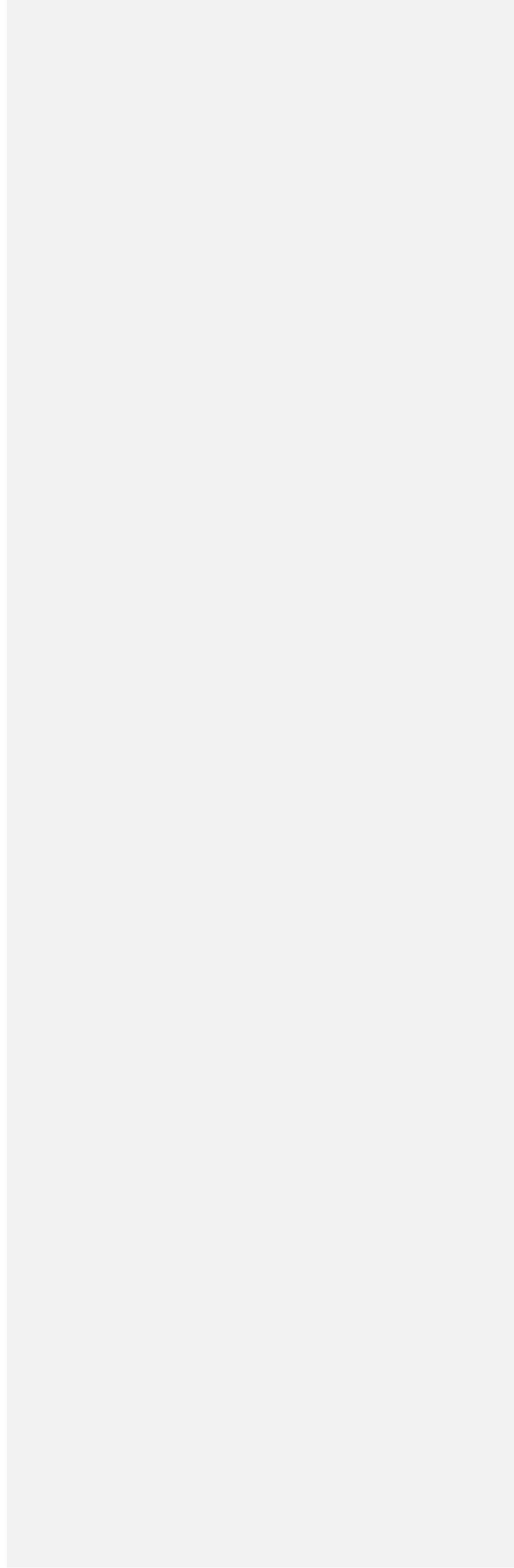
Commented [SS51]: Added for additional clarity from the 2025 Parameters document.

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

~~**Notes:**~~

~~If a new enrollee does not receive an initial HRA within 90 days of enrollment that enrollee's annual HRA is due to be completed within 365 days of enrollment. A new enrollee who receives an HRA within 90 days of enrollment is due to complete a reassessment HRA no more than 365 days after the initial HRA was completed.~~

Commented [SS52]: Removed as these notes are in the TS under HRA Reporting Timeline.



Section V. ~~ENROLLMENT~~ Enrollment and~~AND~~ ~~DISENROLLMENT~~Disenrollment

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

For Part C reporting, MAOs offering MA-only plans (i.e., no Part D benefit) are to report enrollment, disenrollment, and reinstatement activity for these plans in this reporting section. Similarly, 1876 Cost plans are to report enrollment, disenrollment, and reinstatement activity for PBPs that do not include a Part D optional supplemental benefit. Enrollment, disenrollment, and reinstatement activity for MA prescription drug plans (MA-PDs) and 1876 Cost plan PBPs that include a Part D optional supplemental benefit must report under the appropriate section in the Part D Reporting Requirements.

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

~~This reporting section requires a file upload into HPMS.~~

Organization Types Required to Report	Reporting Frequency, Level	Report Period(s)	Data Due date-(s)
- MA~~Os offering MA~~-only (no Part D~~)~~ plans) - ~~01~~ Local CCP - ~~03~~ RFB PFFS - ~~04~~ PFFS - 1876 Cost (PBPs that do not include a Part D optional supplemental benefit) - ~~11~~ Regional CCP - ~~15~~ RFB Local CCP	2/Year Contract Level	Period 1: 1/1-6/30 Period 2: 7/1- 12/31 (Reporting at bi-annual level)	Last Monday of August ~~(1/16/30)~~ Last Monday of February of~~in~~ the following year. ~~(7/1-12/31)~~ Data Validation not required.

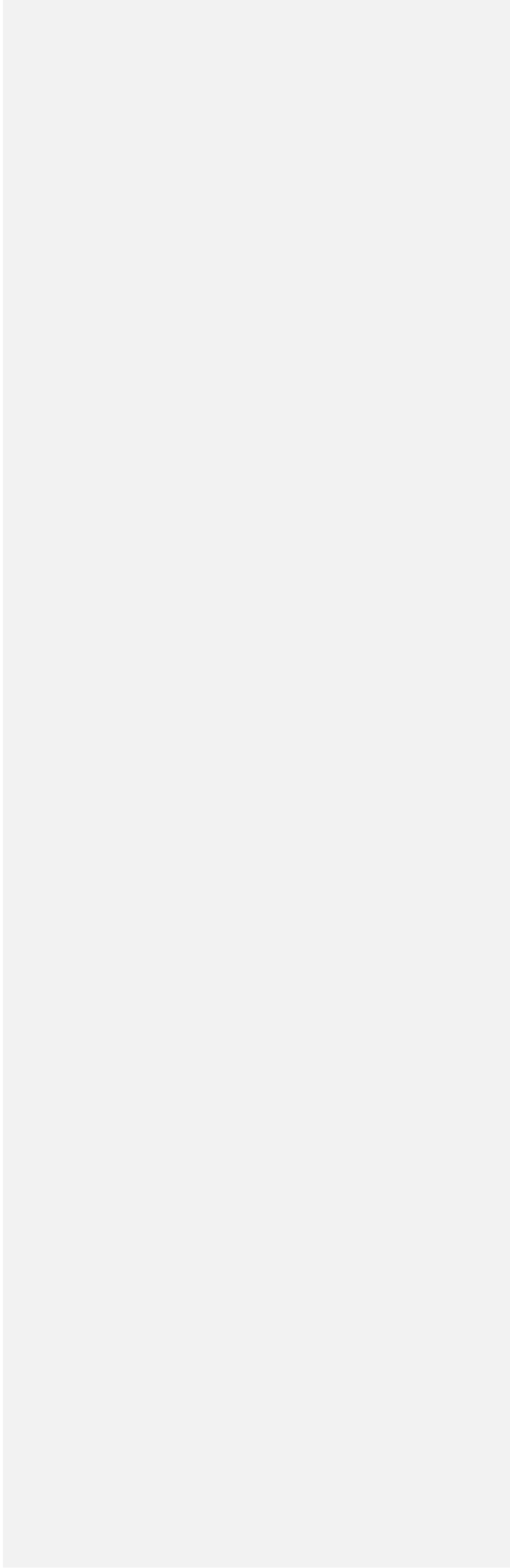
~~CMS provides guidance for MAOs and Part D sponsors' processing of enrollment and disenrollment requests.~~

Commented [SS53]: Agreed as a team to remove this, as it is fluff. The introductions should just be citations of policy/regs, possible links if relevant.

Commented [SS54]: Moved here from TS.

Commented [SS55]: These specific contract types have been added for clarity, and to be consistent with the way the other parameters tables are laid out. It does not indicate any changes in the types of contracts required to report this section.

Commented [SS56]: Removed sentence as it provides no real information.



Subsection 1: Enrollment

~~For questions specific to enrollment/disenrollment requirements please contact the following mailbox: https://enrollment.lmi.org/deepmailbox.~~

Data Element ID	Data Element Description
A.	The total number of enrollment requests (~~i.e., requests~~ initiated by the beneficiary or his/her authorized representative) received in the ~~specified time~~reporting period. Do not include auto/facilitated or passive enrollments, rollover transactions, or other enrollments effectuated by CMS.
B.	Of the total reported in Element A, the number of enrollment requests complete at the time of initial receipt (i.e., required no additional information from applicant or his/her authorized representative).
C.	Of the total reported in Element A, the number of enrollment requests that were not complete at the time of initial receipt and for which the sponsor was required to request additional information from the applicant (or his/her authorized representative).
D.	Of the total reported in Element A, the number of enrollment requests denied due to the sponsor's determination of the applicant's ineligibility to elect the plan (i.e., individual not eligible for an election period).
E.	Of the total reported in Element C, the number of incomplete 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.

Commented [SS57]: Removed as we are no longer sending people to these mailboxes. SMEs have been informed.

Commented [SS58]: Slight edits made throughout to match Part D document.

Commented [SS59]: We ensured we always say "authorized representative" so that we are consistent between C and D rr docs. Note that while the Part C reg says "authorized representative", the Part D reg just says "Representative".

Commented [SS60]: For 2027, The Part D RR doc has an element K: Of the total reported in A, the number of enrollment requests received from an applicant through an agent or broker.

Alice said we should talk to SMEs about adding for 2027.

Subsection 2: Disenrollment

Data Element ID	Data Element Description
A.	The total number of voluntary disenrollment requests received in the ~~specified time period~~ reporting period. Do not include disenrollments resulting from an individual's enrollment in another plan.
B.	Of the total reported in Element A, the number of disenrollment requests complete at the time of initial receipt (i.e., required no additional information from enrollee or his/her authorized representative).
C.	Of the total reported in Element A, the number of disenrollment requests denied by the Sponsor for any reason.
D.	The total number of involuntary disenrollments for failure to pay plan premium in the specified time period.
E.	Of the total reported in Element D, the number of disenrolled individuals who submitted a timely request for reinstatement for Good Cause.
F.	Of the total reported in Element E, the number of favorable Good Cause determinations.
G.	Of the total reported in Element F, the number of individuals reinstated.

Commented [SS61]: For 2027, Part D has three elements in disenrollment that do not exist here. In Part D those are element C, E, and F.

Alice said for 2027 we should talk to the SMEs about adding these elements to Part C.

Commented [SS62]: This used to be one big table, not has been split into different tables by subsection to help with 508. The subsection names used to be in the table, and have now been taken out of the table and made into headings. The subsection names have not changed.

Section VI. Rewards and Incentives ProgramsREWARDS AND INCENTIVES PROGRAMS

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

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due date(s)
- 01 – Local CCP 02 – MSA - 03 – RFB PFFS - 04 – PFFS - 11 – Regional CCP - Employer/Union Only Direct Contract PFFS - RFB Local CCP - Employer/Union Only Direct Contract Local CCP 14 – ED-PFFS 15 – RFB Local CCP 17 – ED – LPPO Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.	1/Year, Contract Level, Partial Data Entry and File Upload	1/1-12/31 (Reporting at annual level)	Last Monday of February in of the following year. Data Validation not required.

A plan user needs to select *"Yes" or "No"* for data element A. on the edit page. If the plan user selected "No," no upload is necessary. If the plan user selects "Yes," then the user will be required to upload additional information in accordance with the file record layout.

Commented [SS63]: This information has been moved to the TS.

Data Element ID	Data Element Description
A.	Do you have a Rewards and Incentives Program(s)? ("Yes" or "No" only;)
B.	Rewards and Incentives Program Name
C.	What health related services and/or activities are included in the program? [Text]
D.	What reward(s) may enrollees earn for participation? [Text]
E.	How do you calculate the value of the reward? [Text]
F.	How do you track enrollee participation in the program? [Text]
G.	How many enrollees are currently enrolled in the program? [NUM]
H.	How many rewards have been awarded so far? [NUM]

Commented [SS64]: Removed as this information is in the file layouts.

Commented [SS65]: For 2027: Alice noted that these data elements are so different than the others. For ex, element G - other sections would say, "the number of enrollees enrolled in the program". (Currently does not seem correct since data reported for the full CY).

Possible 2027 substantive changes to this section.

Section VII. Payments to ProvidersPAYMENTS TO PROVIDERS

The Department of Health and Human Services (Collecting these data will help to inform us as we determine how broadly MA organizations are using alternative payment arrangements. See Technical Specs for additional information.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. of the four categories are as follows:

- Category one includes a fee-for-service with no link to quality arrangement to include all arrangements where payments are based on volume of services and not linked to quality of efficiency.

- Category two includes fee-for-service with a link to quality to include all arrangements where at least a portion of payments vary based on the quality or efficiency of health care delivery including hospital value-based purchasing and physician value-based modifiers.

- Category three includes alternative payment models built on fee-for-service architecture to include all arrangements where some payment is linked to the effective management of a population or an episode of care. Payments are still triggered by delivery of services, but there are opportunities for shared savings or 2-sided risk.

- Category four includes population-based payment arrangements to include some payment is not directly triggered by service delivery so volume is not linked to payment. Under these arrangements, clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., greater than a year).

CMS will also collect data on the number of lives MA organizations have attributed, aligned, assigned, empaneled, or otherwise associated with accountable care arrangements. Under such arrangements providers have accountability for quality and total cost of care for a period of at least six months (i.e. a longitudinal, aligned care relationship between the beneficiary and clinician/provider). For additional detail on the definition of these concepts, please see LAN Guidance on Measuring Covered Lives in Accountable Care APM Arrangements and APM Data Collection Tool found here (https://hcp-lan.org/data-collection-process/#1601909304600-3b650088-e3e1).

Formatted: Right: 0"

Commented [SS66]: Bindu, Michelle requested to strike these first two sentences. I have done so because I agree (see in all markup). We agreed we are not saying why we collected specific data, and we are not referencing TS in these RR sections.

Commented [BA67R66]: Agree. Thank you.

Commented [SS68]: This paragraph was moved here from the TS.

Commented [SS69]: Removed as SME said second paragraph suffices along with link to policy guidance.

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data Due Date(s)
~~01 –~~Local CCP ~~04 –~~PFFS ~~11 –~~Regional CCP ~~15 –~~RFB Local CCP	1/Year, Contract Level~~,~~ ~~File Upload~~	1/1-12/31 (Reporting at annual level)	Last Monday of February of~~in~~ the following year. Data Validation not required.

Data Element ID	Data Element Description
A.	Total dollars paid to providers (in and out of network) for Medicare Advantage enrollees ~~in [CY 20XX] or most recent 12 months~~.

Commented [SS70]: Removed as this should be inferred.

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) ~~in [CY 20XX] or most recent 12 months~~ 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 ~~in [CY 20XX] or most recent 12 months.~~.

Commented [SS71]: This used to be one big table, not has been split into different tables by subsection to help with 508. The subsection names used to be in the table, and have now been taken out of the table and made into headings. The subsection names have not changed.

Subsection 2: Category 2

Data Element ID	Data Element Description
C.	Total dollars paid to providers through fee-for-s~~S~~ervice plus pay-for-reporting payments (linked to quality) ~~in [CY 20XX] or most recent 12 months~~.
D.	Total dollars paid to providers through fee-for-service plus pay-for-performance payments (linked to quality) ~~in [CY 20XX] or most recent 12 months.~~
E.	Dollars paid for foundational spending to improve care (linked to quality) ~~in [CY 20XX] or most recent 12 months~~.
F.	Total dollars paid in Category 2 ~~in [CY 20XX] or most recent 12 months~~.

Subsection 3: Category 3

Data Element ID	Data Element Description
G.	Total dollars paid to providers through traditional shared-savings (linked to quality) payments ~~in [CY 20XX] or most recent 12 months~~.
H.	Total dollars paid to providers through utilization-based shared-savings (linked to quality) payments ~~in [CY 20XX] or most recent 12 months~~.
I.	Total dollars paid to providers through fee-for-service-based shared-risk (linked to quality) payments ~~in [CY 20XX] or most recent 12 months~~.
J.	Total dollars paid to providers through procedure-based bundled/episode payments (linked to quality) programs ~~in [CY 20XX] or most recent 12 months~~.
K.	Total dollars paid in Category 3 ~~in [CY 20XX] or most recent 12 months~~.
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) ~~in [CY 20XX] or most recent 12 months~~.
N.	Total dollars paid to providers through condition-specific, bundled/episode payments (linked to quality) ~~in [CY 20XX] or most recent 12 months~~.
O.	Total dollars paid to providers through population-based payments that are NOT condition-specific (linked to quality) ~~in [CY 20XX] or most recent 12 months~~.
P.	Total dollars paid to providers through full or percent of premium population-based payments (linked to quality) ~~in [CY 20XX] or most recent 12 months~~.
Q.	Total dollars paid to providers through integrated finance and delivery system programs (linked to quality). ~~in [CY 20XX] or most recent 12 months.~~
R.	Total dollars paid in Category 4 ~~in [CY 20XX] or most recent 12 months~~.
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)
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)

Commented [SS72]: Corrected this throughout, SME said should say "paid through"

Subsection 6: PCP/PCG-Focused Accountable Care Metrics

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

Data Element ID	Data Element Description
LL.	Total Medicare Advantage covered lives ~~in [CY 20XX] or most recent 12 months~~.
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 ~~in [CY 20XX] or most recent 12 months~~. [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 arrangements. 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 ~~in [CY 20XX] or most recent 12 months~~. [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 VIII. Supplemental Benefit Utilization and Costs~~SUPPLEMENTAL BENEFIT UTILIZATION AND COSTS~~

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. Any MAO that offers any of these supplemental benefits (as they noted in the PBO they submitted to CMS for the CY) is required to report this section, whether or not any beneficiaries utilized the benefit.

Organization Types Required to Report	Report Frequency, Level	Report Period(s)	Data due date(s)
- ~~01 –~~ Local CCP - ~~02 –~~ MSA - ~~03 –~~ RFB PFFS - ~~04 –~~ PFFS - - ~~06 –~~ 1876 Cost - ~~11 –~~ Regional CCP - Employer/Union Only Direct Contract PFFS - RFB Local CCP - Employer/Union Only Direct Contract Local CCP ~~12-14 – ED-PFFS~~ ~~13-15 – RFB Local CCP~~ ~~17- ED LPPO~~ Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.	1/year ~~;~~ PBP Level	1/1-12/31 (Reporting at annual level)	Last Monday in February of the following ~~calendar~~ year Data Validation not required.

~~The data elements listed below must be reported for each of the following supplemental benefits:~~

PBP Category	Supplemental Benefit
Inpatient Hospital Services	
1a1	Additional Days for Inpatient Hospital Acute
1a2	Non-Medicare-covered Stay for Inpatient Hospital Acute
1a3	Upgrades for Inpatient Hospital Acute
1a-B	Inpatient Hospital – Acute Services (For B-Only Plans)
1b1	Additional Days for Inpatient Hospital Psychiatric
1b2	Non-Medicare-covered Stay for Inpatient Hospital Psychiatric
1b-B	Inpatient Psychiatric Hospital Services (For B-Only Plans)
Skilled Nursing Facility Services	
2-1	Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)
2-3	SNF – Waiver of 3-Day Hospital Stay*
2-B	SNF Care (For B-Only Plans)

Commented [SS73]: Removed, as it is duplicative of TS.

	Cardiac and Pulmonary Rehabilitation Services
3-1	Additional Cardiac Rehabilitation Services
3-2	Additional Intensive Cardiac Rehabilitation Services
3-3	Additional Pulmonary Rehabilitation Services
3-4	Additional Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD) Services
	Worldwide Emergency/Urgent Coverage
4c1	Worldwide Emergency Coverage
4c2	Worldwide Urgent Coverage
4c3	Worldwide Emergency Transportation
	Health Care Professional Services
7b1	Routine Chiropractic Care
7b2	Chiropractic – Other Service
7f	Routine Foot Care
	Outpatient Blood Services
9d-1	Three (3) Pint Deductible Waived*
	Transportation Services
10b1	Transportation Services to Plan-Approved Health-related Location
10b2	Transportation Services to Any Health-related Location
	Other Supplemental Services
13a	Acupuncture Treatments
13b	Over-the-Counter (OTC) Items
13c	Meal Benefits
13d	Other 1
13e	Other 2
13f	Other 3

13g	Dual Eligible SNPs with Highly Integrated Services

Preventive and Other Defined Supplemental Services	
14b	Annual Physical Exam
14c1	Health Education
14c2	Nutritional/Dietary Benefit
14c3	Additional Smoking and Tobacco Cessation Counseling
14c4a	Fitness Benefit – Physical Fitness*
14c4b	Fitness Benefit – Memory Fitness*
14c4c	Fitness Benefit – Activity Tracker*
14c5	Enhanced Disease Management
14c6	Telemonitoring Services
14c7a	Remote Access Technologies – Nursing Hotline*
14c7b	Remote Access Technologies – Web/Phone-based Technologies*
14c8	Home and Bathroom Safety Devices and Modifications
14c9	Counseling Services
14c10	In-Home Safety Assessment
14c11	Personal Emergency Response System (PERS)
14c12	Medical Nutrition Therapy (MNT)
14c13	Post Discharge In-home Medication Reconciliation
14c14	Re-admission Prevention
14c15	Wigs for Hair Loss Related to Chemotherapy
14c16	Weight Management Programs
14c17	Alternative Therapies
14c18	Therapeutic Massage
14c19	Adult Day Health Services
14c20	Home-Based Palliative Care
14c21	In-Home Support Services
14c22a	Support for Caregivers of Enrollees – Respite Care*
14c22b	Support for Caregivers of Enrollees – Caregiver Training*
14c22c	Support for Caregivers of Enrollees – Other*
Dental	
16b1	Oral Exams
16b2	Dental X-Rays
16b3	Other Diagnostic Dental Services

16b4	Prophylaxis (cleaning)
16b5	Fluoride Treatment
16b6	Other Preventive Dental Services
16c1	Restorative Services
16c2	Endodontics
16c3	Periodontics
16c4	Prosthodontics, removable
16c5	Maxillofacial Prosthetics
16c6	Implant Services
16c7	Prosthodontics, fixed
16c8	Oral and Maxillofacial Surgery
16c9	Orthodontics
16c10	Adjunctive General Services
Eye Exams/Eyewear	
17a1	Routine Eye Exams
17a2	Other Eye Exam Services
17b1	Contact Lenses
17b2	Eyeglasses (Lenses and Frames)
17b3	Eyeglass Lenses
17b4	Eyeglass Frames
17b5	Eyewear Upgrades
Hearing Exams/Hearing Aids	
18a1	Routine Hearing Exams
18a2	Fitting/Evaluation for Hearing Aid
18b1	Prescription Hearing Aids (All Types)
18b2	Prescription Hearing Aids – Inner Ear
18b3	Prescription Hearing Aids – Outer Ear
18b4	Prescription Hearing Aids – Over the Ear
18c	OTC Hearing Aids
Medicare-covered services offered as POS or V/T	
VT	Visitor/Travel Program (Medicare Covered benefits)*

POS	Point of Service (Medicare Covered benefits)*
*Non Primarily Health Related Benefits***	
13i1	Food and Produce
13i2	Meals (Beyond limited basis)
13i3	Pest Control
13i4	Transportation for Non Medical Needs
13i5	Indoor Air Quality Equipment and Services
13i6	Social Needs Benefit
13i7	Complementary Therapies
13i8	Services Supporting Self Direction
13i9	Structural Home Modifications
13i10	General Supports for Living
13i-11	Non Primarily Health Related Benefits for the Chronically Ill Other 1
13i-12	Non Primarily Health Related Benefits for the Chronically Ill Other 2
13i-13	Non Primarily Health Related Benefits for the Chronically Ill Other 3
13i-14	Non Primarily Health Related Benefits for the Chronically Ill Other 4
13i-15	Non Primarily Health Related Benefits for the Chronically Ill Other 5

*Benefit category code has been defined for purposes of collecting these data for the Part C Reporting Requirements. These codes are not part of the CY 2025 Plan Benefit Package (PBP).

**Non-Primarily Health Related Benefits are only available as Special Supplemental Benefits for the Chronically Ill (SSBCI)

The following data elements must be reported:

Data Element ID	Data Element Description
A.	Contract ID
B.	PBP ID
C.	PBP Category
D.	Supplemental benefit name, if the PBP Category (Element C) has an "Other" designation "Other" (Only enter information for the following PBP categories: 7b2, 13d, 13e, 13f, or 13i-11 throughthrough 13i-15, and 17a2). The text entered for Element D should be the supplemental benefit name that the plan submitted in the PBP for the CY of the reporting period. O), or if name otherwise differs from values provided above.
E.	How is the supplemental benefit offered? (Mandatory, Optional, Uniformity Flexibility, SSBCI, not offered) 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 an SSBCI), report Data Elements FG-P for each offering type separately.
F.	Network type (in-network, out-of-network (for PPO), out-of-network (for HMO-POS), Visitor/travel, Oother). If "Oother", specify further in Data Element M, e.g., full network for PFFS plan. Similar to Element E, if the same supplemental benefit (as identified by a specific PBP Category in Element C) is offered in more than one network type (e.g., as both in-network and out-of-network (for PPO)), report Elements G-P for each network type separately.
G.	The unit of utilization used by the plan when measuring utilization. For example, (e.g., admissions, visits, procedures, trips, or purchases.. This list of examples is not exhaustive. Only one unit of utilization is allowed per PBP Category.
H.	The number of enrollees ever eligible for the benefit during the reporting period.

Commented [SS74]: For 2027, consider removing Contract and Plan ID from Data Element letters and re-letter.

Data Element ID	Data Element Description
	~~*Plans should include all enrollees ever eligible for this benefit during the calendar year. This number should not be a 'point-in time' number but rather a unique count of all enrollees who were eligible for the benefit.~~
I.	The number of enrollees who utilized the benefit at least once.
J.	The total instances of utilizations among eligible enrollees.
K.	The median number of utilizations among enrollees who utilized the benefit at least once.
L.	The total net amount incurred by plan to offer the benefit. ~~NOTE: When computing this amount, report the net amount spent rather than the gross amount allocated. For example, if the MA plan allocated $1000 for the enrollee to use for certain dental services, but the enrollee used only $250, then the MA plan must include only that $250 in computing the total amount to report under this data element.~~ ~~Similarly, if the MA plan implements the benefit through PMPM arrangement, and the MA plan recoups some of that amount for any reason, the MA plan must include only the amount spent rather than the allocated PMPM amount.~~
M.	The type of payment arrangement(s) the plan used to implement the benefit. The plan may use the categories CMS provides in the Payments to Providers section of the Part C Reporting Requirements. Alternatively, the plan may use other phrases or provide a brief description if its payment arrangement does not neatly fall into one of those categories.
N.	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. ~~NOTE: CMS will not voluntarily release data collected under this element to the public, either individually or in the aggregate. This information will inform future development of cost reporting data elements in these reporting requirements and may inform how CMS requires cost reporting in other contexts.~~
O.	The total out-of-pocket-cost for enrollees who utilized the benefit. ~~T(Note this should be a sum of all enrollee out- of-pocket costs for a service category, broken down by the Data Element E).~~
P.	The median out-of-pocket cost for enrollees.

Commented [SS75]: This was moved to the TS.

Commented [SS76]: This was moved to the TS.

Commented [SS77]: This was moved to TS.

Commented [SS78]: This was moved to TS.

Section IX. D-SNP Enrollee Advisory Committee

42 CFR § 422.107(f) establishes requirements for Enrollee Advisory Committees for any MAO ~~organization~~ 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: - ~~01 –~~ Local CCP - ~~11 –~~ Regional CCP ~~15 – RFB Local CCP~~	1/Year PBP Level	1/1-12/31 (Reporting at annual level)	Last Monday of February of~~in~~ the following year. Data Validation not required.

Commented [SS79]: This was incorrect and has been removed.

Data Element ID	Data Element Description
A.	Does the D-SNP share an enrollee advisory committee (EAC) with other D-SNP(s)? ("Yes" or "No" only)
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? ("Yes" or "No" only)
E.	Were auxiliary aids and services offered for each D-SNP EAC meeting? ("Yes" or "No" only)

Section X. D-SNP Transmission oOf Admission Notifications

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), 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.

Commented [BA80]: This citation is from SME.

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), under the following types: - 01 – Local CCP - 11 – Regional CCP 15 – RFB Local CCP	1/Year PBP Level1/YearPBP	1/1-12/31 (Reporting at annual level)	Last Monday of April ofin the following year. Data Validation not required.

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Commented [SS81]: This was incorrect and has been removed.

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 Data 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.