Medicare Part C Reporting Requirements

Effective January 1, 2024

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Background and Introduction

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. Effective January 1, 2024 a new reporting section, Supplemental Benefit Utilization and Costs, has been added to the Part C Reporting Requirements. 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.

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.

Exclusions from Reporting

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

Overview of the parameters for current Part C Reporting Requirements reporting sections.

Reporting Section	Organization Types Required to Report	Report Frequency Level	Report Period (s)	Data Due Date (s)
I. Grievances	Coordinated Care Plans (CCPs); Private Fee-For-Service Plans (PFFS);1876 Cost; Medicare Savings Accounts (MSAs) (includes all 800 series plans); Employer/ Union Direct Contracts; Religious Fraternal Benefit (RFB).	1/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (reporting will include each quarter)	First Monday of February in the following year. Validation required.
II. Organization Determinations/ Reconsiderations	CCP; PFFS; 1876 Cost; MSAs, Religious Fraternal Benefit (RFB) PFFS; (includes all 800 series plans), Employer/Union Direct Contracts should also report this section regardless of organization type.	1/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (reporting will include each quarter)	Last Monday of February in the following year. Validation required.
III. Employer Group Plan Sponsors	CCP; PFFS; 1876 Cost; MSA (includes 800 series plans and any individual plans sold to employer groups), Employer/Union Direct Contracts should also report this section, regardless of organization type.	1/Year PBP	1/1-12/31	First Monday of February in the following year.

Reporting Section	Organization Types Required to Report	Report Frequency Level	Report Period (s)	Data Due Date (s)
IV. Special Needs Plans (SNP) Care Management	Local CCP; Regional CCP, RFB Local CCP with SNPs. Excludes 800 series plans if they are SNPs.	1/Year PBP	1/1-12/31	Last Monday of February in the following year. Validation required.
V. Enrollment/Disenrollment	MAOs offering MA only (no Part D) plans.[1] 1876 Cost Plans with no Part D. 800 series plans are excluded.	2/Year Contract	1/1-6/30, 7/1-12/31	Last Monday of August (1/1-6/30) Last Monday of February in the following year. (7/1-12/31)
VI. Rewards and Incentives Programs.	Local CCPs MSAs PFFS, and Regional Coordinated Care Plans (CCPs) MMP's 800 series plans are included.	1/Year Contract	1/1-12/31	Last Monday of February in the following year.
VII. Payments to Providers	Local CCP Regional CCP RFB Local CCP PFFS MMP (excludes 800 series plans).	1/Year Contract	1/1-12/31	Last Monday of February in the following year.

[1] MA only. MAPD and PDPs report under Part D.

Reporting Section	Organization Types Required to Report	Report Frequency Level	Report Period (s)	Data Due Date (s)
VIII. Supplemental Benefit Utilization and Costs	01 – Local CCP 02 – MSA 03 – RFB PFFS 04 – PFFS 05 – MMP 06 – 1876 Cost 11 – Regional CCP 12-14 – ED-PFFS 13-15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this measure, regardless of organization type.	1/Year PBP	1/1-12/31	Last Monday of February in the following year.

REPORTING SECTIONS

Grievances

According to MMA statute, all Medicare Advantage organizations 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's or provider's operations, activities, or behavior, regardless of whether remedial action is requested. MA organizations 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 a MA organization to process an enrollee's request for an expedited organization determination or reconsideration requires a response from the MA organization within 24 hours.

I. GRIEVANCES

This reporting section requires an upload.

Reporting section	Organization TypesRequired to Report	Report FrequencyLevel	Report Period (s)	Data Due Date(s)
Grievances	01 – Local CCP 02 – MSAs 03 – Religious Fraternal Benefit (RFB PFFS) 04 – Private Fee for Services (PFFS) 06 – 1876 Cost 11 – Regional CCP 14 – Employee Union Direct (ED)-PFFS 15 – RFB Local CCP Organizations should include all 800 seriesplans. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.	1/Year /Contract level	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (reporting will include each quarter)	First Monday of February in the following year. Validation 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

II. ORGANIZATION DETERMINATIONS & RECONSIDERATIONS

This section requires a file upload.

Organization Types Required to Report	Reporting 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 14 – ED-PFFS 15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.	1/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (reporting will include each quarter)	Last Monday of February in the following year. Validation required.

Data Element ID	Data Element Description
Subsection #1	**ORGANIZATION DETERMINATIONS**
A.	Total Number of Organization Determinations Made 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**
A.	Number of Organization Determinations – Fully Favorable (Services) Requested by enrollee/representative or provider on behalf of the enrollee

Data Element ID	Data Element Description
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
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 Non-contract Provider
K.	Number of Organization Determinations – Adverse (Claims) Submitted by enrollee/representative
L.	Number of Organization Determinations – Adverse (Claims) Submitted by Non-contract Provider
Subsection #3:	**RECONSIDERATIONS**
A.	Total number of Reconsiderations 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)
Subsection #4:	**DISPOSITION – ALL RECONSIDERATIONS**
A.	Number of Reconsiderations – Fully Favorable (Services) requested by enrollee/representative or provider on behalf of the enrollee

Data Element ID	Data Element Description
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
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 Non-contract Provider
G.	Number of Reconsiderations – Partially Favorable (Claims) submitted by enrollee/representative
H.	Number of Reconsiderations – Partially Favorable (Claims) submitted by Non-contract 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**
A.	Total number of reopened (revised) decisions, for any reason, in Time Period Above
	For each case that was reopened, the following information will be uploaded in a data file:
B.	Contract Number
C.	Plan ID
D.	Case ID
E.	Case level (Organization Determination or Reconsideration)
F.	Date of original disposition
G.	Original disposition (Fully Favorable, Partially Favorable, or Adverse)
H.	Was the case processed under the expedited timeframe? (Y/N)

Data Element ID	Data Element Description
I.	Case type (Service or Claim)
J.	Status of treating provider (Contract, Non-contract)
K.	Date case was reopened
L.	Reason(s) for reopening (Clerical Error, Other Error, New and Material Evidence, Fraud or Similar Fault, or Other)
M.	Additional Information (Optional)
N.	Date of reopening disposition (revised decision)[2]
O.	Reopening disposition (Fully Favorable; Partially Favorable, Adverse or Pending)

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

III. EMPLOYER GROUP PLAN SPONSORS

This reporting 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 04 – PFFS 06 – 1876 Cost 11 – Regional CCP 14 – ED-PFFS Organizations should include all 800 series plans and any individualplans sold to employer groups. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.	1/year PBP	1/1 - 12/31	First Monday of February in the following year.

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 data element #H is a “N", provide non-calendar year start date.
J.	Current/Anticipated Enrollment

IV. SPECIAL NEEDS PLANS (SNP) CARE MANAGEMENT

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 Organizations should exclude 800 series plans if they are SNPs.	1/Year PBP	1/1-12/31	Last Monday of February in the following year. Validation required.

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 areassessment
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.

V. ENROLLMENT AND DISENROLLMENT

This reporting section requires a file upload into HPMS.

Organization Types Required to Report	Reporting Frequency Level	Report Period	Data Due date (s)
MAOs offering MA- only (no Part D) plans 1876 Cost Plans (PBPs that do not include a Part D optional supplemental benefit.)	2/Year Contract	1/1-6/30 7/1-12/31	Last Monday of August (1/1-6/30) Last Monday of February in the following year. (7/1-12/31)

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

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.

Note: Both Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Manual outline the enrollment and disenrollment periods(Section 30) enrollment (Section 40) and disenrollment procedures (Section 50) for all Medicare health and prescription drug plans.

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

Data Element ID	Data Element Description
Subsection #1	**Enrollment**
A.	The total number of enrollment requests (i.e., requests initiated by the beneficiary or his/her authorized representative) received in the specified time 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 (i.e., required no additional information from applicant or his/her authorized representative).
C.	Of the total reported in A, the number of enrollment requests 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 tothe 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 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 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 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.
Subsection #2	**Disenrollment**
A.	The total number of voluntary disenrollment requests received in the specified time 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 (i.e., required no additional information from enrollee or his/her authorized representative).
C.	Of the total reported in A, the number of disenrollment requests denied by the Sponsor for any reason.
D.	The total number of involuntary disenrollments for failure to pay planpremium in the specified time period.
E.	Of the total reported in D, the number of disenrolled individuals whosubmitted a timely request for reinstatement for Good Cause.
F.	Of the total reported in E, the number of favorable Good Cause determinations.
G.	Of the total reported in F, the number of individuals reinstated.

VI. REWARDS AND INCENTIVES PROGRAMS

This is partial data entry and a file upload into HPMS at the Contract level.

Organization Types Required to Report	Report FrequencyLevel	Report Period(s)	Data Due date (s)
01 – Local CCP 02 – MSA 03 – RFB PFFS 04 – PFFS 05 – MMP 11 – Regional CCP 14 – ED-PFFS 15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.	1/Year Contract	1/1-12/31	Last Monday of February in following year.

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.

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]

VII. PAYMENTS TO PROVIDERS

This reporting section requires a file upload.

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.

Organization Types Required to Report	Report Frequency Level	Report Period (s)	Data Due Date (s)
01 – Local CCP 04 – PFFS 05 – MMP[3] 11 – Regional CCP 15 – RFB Local CCP	1/Year Contract	1/1-12/31	Last Monday of February in the following year.

Data Element ID	Data Element Description
A.	Total Medicare Advantage payment made to contracted providers
B.	Total Medicare Advantage payment made on a fee-for-service basis with no link to quality (category 1)
C.	Total Medicare Advantage payment made on a fee-for-service basis with a link to quality (category 2)
D.	Total Medicare Advantage payment made using alternative payment models built on fee-for-service architecture (category 3)
E.	Total Risk-based payments not linked to quality (e.g., 3N in APM definitional framework)
F.	Total Medicare Advantage payment made using population-based payment (category 4)
G.	Total capitation payment not linked to quality (e.g., 4N in the APM definitional framework)
H.	Total number of Medicare Advantage contracted providers
I.	Total Medicare Advantage contracted providers paid on a fee-for-service basis with no link to quality (category 1)
J.	Total Medicare Advantage contracted providers paid on a fee-for-service basis with a link to quality (category 2)
K.	Total Medicare Advantage contracted providers paid based on alternative payment models built on a fee-for-service architecture (category 3)
L.	Total Medicare Advantage contracted providers paid based risk-based payments not linked to quality (e.g., 3N in the APM definitional framework)
M.	Total Medicare Advantage contracted providers paid based on population-based (category 4)
N.	Total Medicare Advantage contracted providers paid based on capitation with no link to quality (e.g., category 4N in the APM definitional framework)

[3] MMPs should report for all APMs not just Medicare APMs.

VIII. SUPPLEMENTAL BENEFIT UTILIZATION AND COSTS

This reporting 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 05 – MMP 06 – 1876 Cost 11 – Regional CCP 12-14 – ED-PFFS 13-15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this measure, regardless of organization type.	1/year; PBP	1/1-12/31	Last Monday in February of the following calendar year

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

Plans should note that some PBP Category identifiers have changed so that each benefit has a unique identifier.

*Note - Benefits appearing with the asterisk in red text denotes a benefit category code that has been defined for purposes of collecting these data for the Part C Reporting Requirements. These codes are not part of the CY 2024 Plan Benefit Package (PBP).

PBP Category	Supplemental Benefit
Inpatient Hospital Services	
1a1	Inpatient Acute Additional days
1a2	Inpatient Acute Non-Medicare-Covered Stay
1a3	Inpatient Acute Upgrades
1a-B	Inpatient Hospital – Acute Services (For B-Only Plans)
1b1	Inpatient Psychiatric Additional Days
1b2	Inpatient Psychiatric Non-Medicare-Covered Stay
1b-B	Inpatient Psychiatric Hospital Services (For B-Only Plans)
Skilled Nursing Facility Services	

2-1	SNF Additional Days Beyond Medicare-Covered
2-2	SNF Non-Medicare-Covered Stay
2-3	SNF – Waive Hospital Stay *
2-3a	SNF – Waive Hospital Stay, 3 days *
2-B	SNF Care (For B-Only Plans)
	Cardiac 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 for Peripheral Artery Disease Services
	Worldwide Coverage/Visitor Travel
4c1	Worldwide Emergency Coverage
4c2	Worldwide Urgent Coverage
4c3	Worldwide Emergency Transportation
	Professional Services
7b1	Routine Chiropractic Care
7b2	Chiropractic – Other Service
7f	Routine Foot Care
	Outpatient Hospital Services
9d	Three (3) Pint Deductible Waived
	Transportation
10b1	Transportation to Plan-Approved Health-related Location
10b2	Transportation to Any Health-related Location
	Other Services
13a	Acupuncture Treatments
13b	Over-the-Counter (OTC) Items
13c	Meals
13d	Other 1
13e	Other 2
13f	Other 3
13g	Dual Eligible SNPs with Highly Integrated Services

Preventive 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 Services	
16a1	Oral Exams
16a2	Prophylaxis (Cleaning)
16a3	Fluoride Treatment
16a4	Dental X-Rays
16b1	Non-routine Services
16b2	Diagnostic Services
16b3	Restorative Services
16b4	Endodontics
16b5	Periodontics
16b6	Extractions
16b7	Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Vision Services	
17a1	Routine Eye Exams
17a2	Eye Exams – Other Service
17b1	Contact Lenses
17b2	Eyeglasses (Lenses and Frames)
17b3	Eyeglass Lenses
17b4	Eyeglass Frames
17b5	Eyewear Upgrades
Hearing Services	
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
Service Area-Related Services	
VT1	Visitor/Travel Program – US and its territories *
VT2	Visitor/Travel Program – Other *
OON	Out-of-network Services
Supplemental Benefits for the Chronically Ill (SSBCIs)	
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
13i11	Non-Primarily Health Related Benefits for the Chronically Ill Other 1
13i12	Non-Primarily Health Related Benefits for the Chronically Ill Other 2
13i13	Non-Primarily Health Related Benefits for the Chronically Ill Other 3
13i14	Non-Primarily Health Related Benefits for the Chronically Ill Other 4
13i15	Non-Primarily Health Related Benefits for the Chronically Ill Other 5

The following data elements must be reported:

Data Element ID	Data Element Description
A.	PBP Category
B.	Supplemental benefit name, if "Other" (13d, 13e, 13f, or 13i-O), or if name otherwise differs from values provided above.
C.	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), please report Data Elements C-J for each offering type separately.
D.	The unit of utilization used by the plan when measuring utilization (e.g., admissions, visits, procedures, trips, purchases).
E.	The number of enrollees eligible for the benefit.
F.	The number of enrollees who utilized the benefit at least once.
G.	The total instances of utilizations among eligible enrollees.
H.	The median number of utilizations among enrollees who utilized the benefit at least once.

Data Element ID	Data Element Description
I.	The total net amount incurred by plan for 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 a 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.
J.	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.
K.	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.
L.	The total out-of-pocket-cost per utilization for enrollees.