Medicare Part C Technical Specifications Document Contract Year 2025

Effective as of January 1, 2025

Updated: February 2025

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

Table of Contents

A. **INTRODUCTION**

The Part C Technical Specifications are a more detailed description than the Part C Plan Reporting Requirements, which is largely a description of the data elements. The Part C Reporting Requirements are subject to OMB review and approval in compliance with the Paper Reduction Act of 1995, and its OMB control number is 0938-1054. This document and the Part C Reporting Requirements are located on the CMS website: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.

The technical specifications supplement the Part C Plan Reporting Requirements, and do not change, alter, or add to the data collection described above. The technical specifications serve to further define data elements and alert plans on how CMS will review and analyze the data. This technical guidance helps assure that organizations have a common understanding of the data reported and assists in preparing and submitting datasets to help ensure a high level of accuracy in the data reported to CMS, thereby reducing the need to correct and resubmit data.

This document also lists reporting timeframes and required levels of reporting. Plans will report data elements at the Plan Benefit Package (PBP) level or the individual Contract level, as identified in the chart below. These requirements are subject to change at the discretion of CMS.

B. GENERAL INFORMATION

Level of data reported

Contract-level reporting indicates data should be entered at the H#. Plan-level reporting indicates data should be entered at the 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.

Section Number	Section Description	Reporting Level	Submission Method
I.	Grievances	Contract	Upload
II.	Organization/Determinations and Reconsiderations (ODR)	Contract	Upload
III.	Employer Group Plans	Contract (each plan within a contract)	Upload
IV.	Special Needs Plans (SNP) Care Management	Plan	Upload
V.	Enrollment/Disenrollment	Contract	Upload
VI.	Rewards and Incentives Programs	Contract	Upload
VII.	Payments to Providers	Contract	Upload
VIII.	Supplemental Benefit Utilization and Costs	Plan	Upload
IX.	D-SNP Enrollee Advisory Committee	Plan	Data Entry
X.	D-SNP Transmission of Admission Notifications	Plan	Data Entry

Timely submission of data

- Compliance with the Part C reporting requirements is a contractual obligation of all Medicare Advantage Organization (referred to as "organization" throughout). Compliance requires data be accurate and submitted in a timely manner. Data submissions are due by 11:59 p.m. Pacific Time on the date of the reporting deadline.

- Please note the quarterly reports are now due annually and will be available in HPMS on or after 12/31/25. Organizations should generate these reports at the end of each quarter of the contract year and hold them for the annual submission.

- Only data that reflect a good faith effort by an organization to provide accurate responses to Part C reporting requirements will count as data submitted in a timely manner.

- Organizations must not submit "placeholder" data (e.g., submitting the value "0" in reporting fields in HPMS).

- CMS tracks resubmissions, including the number of resubmissions after the deadline. Data not submitted by organizations requesting a resubmission is overdue. CMS expects data to be accurate on the date of submission. The deadline for data resubmissions is March 31 following the last quarter or end of year reporting deadline.

- CMS urges organizations to store revised data for CMS auditors and data validation reviewers. Plans should retain documentation supporting their reported data.

- The following steps must be followed by organizations to request resubmission:

- On the HPMS Part C Plan Reporting Start Page, click the Resubmission Request link.

  Select/complete the following: ○ Reporting section (e.g., Reconsiderations); ○ Time period (e.g., 1st quarter 2024); ○ Select contracts or plans, depending on reporting level; and ○ The reason for the resubmission request.

General Data Entry Rules

- HPMS will not allow the entry of greater than sign (>); less than sign (<); or semi-colon (;) in any data entry field or uploaded file.

- Unless otherwise noted: a zero entry is allowed; a negative value entry is not allowed; or a decimal is not allowed except for Payment to Providers reporting elements A-G which allows a decimal up to two places.

- Information relevant to Employer DBA and Legal Name, Employer Address, Employer Tax Identification Numbers (Employer Group Plans), and Beneficiary Name is proprietary information and not subject to public disclosure under provisions of the Freedom of Information Act (FOIA). A plan may need to provide independent justification for protecting this data following a submission of a FOIA request.

Correction of Previously Submitted Data / Resubmission Requests

If previously submitted data are incorrect, the organization should request the opportunity to correct and resubmit data. Submission of inaccurate or incorrect data does not satisfy the obligation to report that data when the organization is aware or becomes aware of the inaccuracy. Corrections of previously submitted data are appropriate if due to an error made at the date of the original submission, or as otherwise indicated by CMS. Once a reporting deadline has passed, organizations that need to correct data must submit a formal request to resubmit data via the

HPMS Plan Reporting Module. Per § 422.516(g), each organization must subject information collected under paragraph (a) of this section to a yearly independent audit to determine their reliability, validity, completeness, and comparability in accordance with specifications developed by CMS. Paragraph (a) specifies a number of categories of data, including information about "other matters that CMS may require." In the 2009 NPRM and 2010 final rule adding the DV requirement at § 422.516(g), CMS made clear that the DV requirement in that regulation is applicable to the data collected and used for quality rating. (74 FR 54682; 75 FR 19760 through 19762.)

A plan can only initiate a resubmission request after the original reporting deadline (e.g., the last Monday in February) has expired. The deadline to submit data corrections is March 31 following the last quarter or end of year reporting deadline. This deadline is essential to accommodate data validation activities.

CMS reserves the right to establish deadlines for data submissions. Plans can access detailed instructions for resubmissions on the starter page of the HPMS Plan Reporting Module User Guide at the following link: https://hpms.cms.gov/app/ng/prm/documentation.

Note: CMS' outlier notifications serve only to give organization the opportunity to correct submitted data if needed, and does not indicate that submitted data are incorrect, or that resubmissions are required.

Due Date Extension Requests

Generally, CMS does not grant extensions of reporting deadlines, as these have been established and published well in advance. It is our expectation that organizations do their best with the information provided in the most current versions of the business requirements and technical specifications to prepare for data submission in a timely fashion. Any assumptions that organizations may make in order to submit data timely should be fully documented and defensible under audit. CMS will consider appropriate "Resubmission Requests" through the Plan Reporting Module (PRM).

Once a reporting deadline has passed, CMS requires the organizations to submit a formal request to resubmit any data. HPMS designates this request as a Request Resubmission. Approval for resubmission requests will be for 7 days only from the date of CMS review and approval of the request. Organizations should not submit resubmission requests until they have data available to submit. Data is late if the submission is after the given reporting period deadline and may not be incorporated within CMS data analyses and reporting. HPMS will not allow the resubmission of data identical to the original data submission.

Periodic Updates to the Technical Specifications

- If CMS clarifies a technical specification for a data element (resulting from an inquiry), CMS will require plans to incorporate this change for the entire reporting period.

- For questions specific to Part C Grievance, Organization/Determination,

Enrollment/Disenrollment, and Special Needs Plan reporting, a plan may direct their inquiry to the individual resource mailboxes identified in each of these reporting sections.

- For other Part C reporting questions, plans may contact the following mailbox: PartCplanreporting@cms.hhs.gov. Please be aware immediate responses to individual questions may not always be possible due to email volume. CMS recommends plans first refer to the current Medicare Part C Reporting or Technical Specifications for answers.

- For technical assistance relevant to file formats and uploads, please contact the HPMS help desk: 1-800-220- 2028 or email: hpms@cms.hhs.gov.

Exclusions from Part C Reporting

- Excluded from Part C Reporting are National PACE Plans and 1833 Cost Plans. Medicare-Medicaid Plans (MMPs) are also excluded from Part C reporting as of the contract year (CY) 2025 reporting period, due to the transition of the Financial Alignment Initiative demonstrations to dual eligible special needs plan (D-SNP) models.

- Organizations should report their data based on their interpretation the Part C Reporting and Technical Specifications and should be able to support their decisions. Plans may contact the following mailbox PartCplanreporting@cms.hhs.gov for additional questions.

- NOTE: If a contract terminates before July 1 in the following year after the reporting period for the contract year, the contract is not required to report any data for the respective two years – the CY reporting period, and the following year.

- Example: Contract terminates June 2024. The contract will not report CY 2023 (contract year reporting period) or CY 2024 data (following year reporting period).

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

C. REPORTING SECTIONS

I. GRIEVANCES

This section requires file upload into HPMS at the Contract level. Please refer to HPMS layouts and templates for more information.

Organization Types Required to Report	Frequency Level	Report Period (s)	Due Date (s)
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 series plans. 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. Validation required.

According to the MMA statute, all MA organizations must have meaningful procedures for hearing and resolving grievances between an enrollee and the Plan, including an entity or individual through which the organization provides benefits. A grievance is any complaint or dispute, other than an organization determination or appeal, about any aspect of the operations, activities, or behavior of a MA organization, regardless of any remedial action 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 requested by the enrollee or if the MA organization needs additional information and provides documentation that the 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 redetermination requires a response from the MA organization within 24 hours.

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

Quality Assurance Checks/Thresholds: Procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- The percentage of beneficiaries filing grievances is examined for outlier data. After accounting for enrollment, plans with values above the 95th percentile for their plan type or below the 5th percentile for their plan type will be flagged as outliers.
- The percent of grievances for which the plan provided timely notification of its decision will be examined for outlier data. All plans with values below the 5^{th} percentile for their plan will be flagged as outliers.
- CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from Part C Plans.

Edits and Validation Checks: Recommended Part C validation checks prior to data submission.

- Contracts should validate Number of Total Grievances is not less than all other data elements combined.

Analysis: How CMS will evaluate reported data, as well as how other data sources may be monitored.

- The total grievance rate per 1,000 enrollees is equal to the sum of the total number of grievances divided by average enrollments, multiplied by 1,000.
- [Total Grievance Rate per 1,000 enrollees] = Total # Grievances / Avg. Enrollment x 1,000
- The grievance rate by category per 1,000 enrollees is equal to the sum of the grievance element divided by average enrollment, multiplied by1,000.
- [Grievance Rate by Category per 1,000 enrollees] = Grievance Element / Avg. Enrollment x 1,000

- CMS will order contracts based on rates of grievances per 1,000 enrollees and determine percentile rankings.

- CMS will correlate grievances with complaints in the CMS complaints tracking module (CTM)

Additional clarifications to the Grievance Reporting Section:

- A grievance is defined at 42 C.F.R. § 422.561 as "Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken." An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration or invoked an extension to an organization determination or reconsideration timeframe. In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

- For Part C reporting, grievances are defined as those grievances completed (i.e., plan has notified enrollee of its decision) during the reporting period, regardless of when the request was received; and include grievances filed by the enrollee or his or her representative.

- For an explanation of Medicare Part C Grievance Procedures, refer to CMS Regulations and Guidance: 42 CFR Part 422, Subpart M, and the 'Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance via the CMS website: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index.html.

- The total number of expedited grievances is reported in the total number of grievances.

- The total number of dismissed grievances is not to be reported in the total number of grievances.

Report:

- Report only those grievances processed in accordance with the grievance procedures outlined in 42 CFR Part 422, Subpart M (i.e., Part C grievances).

- Report grievances if the member is ineligible on the date of the call to the plan but was eligible previously.

- Dismissals: This element is a means for a plan to report a grievance received but the plan did not process because the plan did not meet the requirements for a valid grievance. A dismissal would generally occur when the plan does not meet the procedure requirements

for a valid grievance and is unable to cure the defect.

Do Not Report:

- Enrollee complaints only made through the CMS Complaints Tracking Module (CTM). A CTM complaint process is separate and distinct from the plan's procedures for handling enrollee grievances. Therefore, plans should not report their CTM records to CMS as their grievance logs.
- Enrollee grievances processed in accordance with the grievance procedures described under 42 C.F.R., Part 423, Subpart M (i.e., Part D grievances).
- Grievances filed by non-enrollees, including prospective enrollees.
- If a grievance is related to a service or item only covered under the plan's Medicaid benefits and never covered by Medicare and not covered by the MA plan as a supplemental Medicare benefit (such as Medicaid home- and community-based longterm services and supports).
- Withdrawn grievances

Additional Guidance:

- If an extension is requested after the required time frame for decision making has elapsed, the decision is considered non-timely. For example, an organization receives a grievance on 1/1/2024 at 04:00pm with an extension request at 1/31/2024 04:05pm. An investigation is completed and the plan provides notification on 2/5/2024 04:00pm (35 calendar days after receipt). The grievance is non-timely for reporting.
- If an enrollee files a grievance and then files a subsequent grievance on the same issue prior to the organization's decision or deadline for decision notification (whichever is earlier), the issue is counted as one grievance.
- If an enrollee files a grievance and then files a subsequent grievance on the same issue after the organization's decision or deadline for decision notification (whichever is earlier), then the issue is counted as a separate grievance.
- If an enrollee files a grievance about multiple issues during a call or in writing, report as separate grievances.
- If the enrollee files a grievance with a previous contract but enrolls in a new contract before the grievance is resolved, the previous contract is still responsible for investigating, resolving, and reporting the grievance.
- For MA-PD contracts: Include only grievances that apply to the Part C benefit. If a clear distinction cannot be made for an MA-PD, cases are reported as Part C grievances.

- For additional details concerning these reporting requirements, please see Appendix 1: FAQs.

For additional questions about the Part C Grievance technical specifications, please contact the following mailbox: https://appeals.lmi.org

II. ORGANIZATION DETERMINATIONS/RECONSIDERATIONS

This section requires a file upload. Please refer to HPMS layouts and templates for more information.

Organization Types Required to Report	**Frequency Level**	**Report Period (s)**	**Due date (s)**
01 – Local CCP 02 – MSA, RFB, 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.	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[1] – ALL ORGANIZATION DETERMINATIONS**
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
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

[1] 1 The date of disposition is the date the required written notice of a revised decision was sent per 42 CFR § 405.982.

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
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 Noncontract 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.	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)
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)
N.	Reopening disposition (Fully Favorable; Partially Favorable, Adverse, or Pending)

Quality Assurance Checks/Thresholds: Procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- The rate of organization determinations per 1,000 enrollees will be examined for outlier data. After accounting for enrollment, plans with values above the 95th percentile for their plan type or below the 5th percentile for their plan type will be flagged as outliers.

- The percent of organization determinations requests approved by the contract will be examined for outlier data. Contracts with values above the 95th percentile or below the 5th percentile will be flagged as outliers.

- CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from MA organizations.

- The rate of reconsiderations per 1,000 enrollees will be examined for outlier data. After accounting for enrollment, contracts with values above the 95th percentile or below the 5th percentile will be flagged as outliers.

- The percent of reconsiderations resulting in a full or partial reversal of the original decision will be examined for outlier data. After accounting for the number of reconsiderations filed, contracts with values above the 95th percentile or below the 5th percentile will be flagged as outliers.

- The percent of reconsiderations resulting in upholding the original decision will be examined for analysis purposes.

- The rate of re-openings per 1,000 enrollees will be examined for outlier data. After accounting for enrollment, contracts with values above the 95th percentile or below the 5th percentile will be flagged as outliers. CMS will also identify outliers in the percent of organization determinations and reconsiderations that are reopened.

Edits and Validation Checks: Validation checks that should be performed by each organization prior to data submission.

- Contracts should validate that the Case_Reopened_Date field is later than or equal to the Original_Disposition_Date field and that Reopening_Disposition_Date field is later than or equal to Case_Reopened_Date field.

- All data elements should be positive values.

Analysis: How CMS will evaluate reported data, as well as how other data sources may be monitored.

- CMS will evaluate organization determination request rates per 1,000 enrollees and will trend rates from quarter to quarter and from previous years. Rates of appeals will be calculated per 1,000 enrollees. This means the total appeal rate per 1,000 enrollees is equal to the sum of the total number of appeals divided by average enrollment, times 1,000.

- Total # of appeals/average enrollment x 1,000 = Total appeals rate per 1,000 enrollees.

Notes:

- For an explanation of organization determinations, reconsiderations, and re-openings procedures, refer to CMS regulations and guidance: 42 CFR Part 422, Subpart M, and the 'Parts C & D Enrollee Grievances Organization/Coverage Determinations, and Appeals Guidance via the CMS website: https://www.cms.gov/Medicare/Appeals-andGrievances/MMCAG. For reporting, the data elements that state "provider on behalf of an enrollee" would be a contract provider. Non-contract providers have their own reporting elements. Completed organization determinations and reconsiderations (i.e., plan has notified enrollee of its pre-service decision or adjudicated a claim) during the reporting period, regardless of when the request was received. Plans are to report an organization determination or reconsideration where a substantive decision has been made, as described in this section and processed in accordance with the organization determination and reconsideration procedures described under 42 C.F.R. Part 422, Subpart M and the 'Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance via the CMS website: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG.

- Organization determinations, reconsiderations, and re-openings should be included, if requested consistent with the applicable regulations. For instances when the organization approves an initial request for an item or service (e.g., physical therapy services) and the organization approves a separate additional request to extend or continue coverage of the same item or service, include the decision to extend or continue coverage of the same item or service as another, separate, fully favorable organization determination.

- If the plan receives an organization determination or reconsideration request and the request is withdrawn or dismissed, the plan would report only the withdrawal or dismissal (or both) as appropriate.

- The total number of withdrawals are not included in the total number of organization determinations or reconsiderations. Instead, withdrawn organization determinations or reconsiderations (which are dismissed as a result of a withdrawal request) are distinct categories.

- If the plan processes a timely withdrawal request, the plan must report the withdrawn organization determination or reconsideration request and the plan's dismissal of that request.

- The total number of dismissals are not included in the total number of organization determinations or reconsiderations.

Definitions for purposes of plan reporting:

- **Organization Determination** is a plan's response to a request for coverage (payment or provision) of an item, service, or Part B drug, including auto-adjudicated claims, service authorizations which include prior-authorization (authorization that is issued prior to the services being rendered), concurrent authorization (authorization that is issued at the time the service is being rendered), post authorization (authorization that is issued after the service has been rendered), and requests to continue previously authorized ongoing courses of treatment. It includes pre-service organization determination requests submitted by the enrollee, enrollee's representative, contract provider on behalf of the enrollee and requests from non-contract providers. It does not include claims payment requests from contract providers that are governed by the contractual arrangement between the MAO and its contract providers. Applicable integrated plans report integrated organization determinations per 42 CFR § 422.631.

- **Reconsideration** is a plan's review of an adverse or partially favorable organization determination as defined in 42 CFR § 422.580. Applicable integrated plans report integrated reconsiderations per 42 CFR § 422.633.

- **Fully Favorable decision** means an item or service was covered in whole.

- **Partially Favorable decision** means an item or service was partially covered. For example, if a claim has multiple line items, some of which were paid and some of which were denied, it would be considered partially favorable. Also, if a pre-service request for 10 therapy services was processed, but only 5 were authorized, this would be considered partially favorable.

- **Adverse decision** for reporting purposes means an item or service was denied in whole.

- **Withdrawn organization determination or reconsideration** is one that is, upon request, removed from the plan's review process. This category excludes appeals that are dismissed.

- **Dismissal** is a decision not to review an organization determination or reconsideration request because it is considered invalid or does not otherwise meet Medicare Advantage requirements.

Report:

- Completed organization determinations and reconsiderations (i.e., plan has notified enrollee of its pre-service decision or adjudicated a claim submitted by the enrollee or non- contract provider) during the reporting period, regardless of when the request was received. Plans are to report organization determinations or reconsiderations where a substantive decision has been made, as described in this section and processed in accordance with the organization determination and reconsideration procedures described under 42 C.F.R. Part 422, Subpart M.

- Pre-service organization determination and reconsideration requests submitted by the enrollee, enrollee's representative, or contract provider on behalf of the enrollee, and requests from non-contract providers.

- Requests for payment of a Part B drug submitted by the enrollee or non-contract provider are reportable as organization determinations or reconsiderations.

- Claims with multiple line items at the "summary level."

- A request for payment, other than contract provider, as a separate and distinct organization determination, even if a pre-service request for that same item or service was also processed.

- A denial of a Medicare request for coverage (payment or provision) of an item or service as either partially favorable or adverse, regardless of whether Medicaid payment or provision ultimately is provided, in whole or in part, for that item or service. However, Dual Eligible Special Needs Plans (D-SNPs) that are applicable integrated plans as defined in 42 CFR § 422.561 should report a request for a Medicare item or service based on the outcome of applying both Medicare and Medicaid coverage criteria.

- Denials based on exhaustion of Medicare benefits.

- Dismissals

- Withdrawals

Do Not Report:

- Independent Review Entity (IRE) decisions.

- Claims payment or appeals from contract providers that are governed under the contractual arrangement between the MAO and its contract providers.

- An appeal by an enrollee (or other party) of the plan's dismissal of a coverage determination.

- A decision by the plan to uphold or reverse its dismissal of an organization determination as a result of an enrollee (or other party) appealing a dismissal.

- Plan decisions regarding a request to vacate a dismissal.

- Re-openings requested or completed by the IRE, Administrative Law Judge (ALJ), or Appeals Council.

- Concurrent reviews during hospitalization that do not result in organization determinations.

- Concurrent reviews of Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) care that do not result in organization determinations.

- Duplicate payment requests concerning the same service or item.

- Payment requests returned to a provider/supplier in which a substantive decision (fully favorable, partially favorable or adverse) has not been made – e.g., payment requests or forms are incomplete, invalid or do not meet the requirements for a Medicare claim (e.g., due to a clerical error).

- Part B drugs that are paid or denied at the pharmacy and point-of-sale Part B drug claim rejections are not reportable as organization determinations. If the plan subsequently processes an organization determination, this should be reported under data element "E" subsection #1.

- A Quality Improvement Organization (QIO) review of an individual's request to continue Medicare-covered services (e.g., a SNF stay) and any related claims/requests to pay for continued coverage based on such QIO decision.

- A service only covered under the plan's Medicaid benefits and never covered by Medicare and not covered by the MA plan as a supplemental Medicare benefit (such as Medicaid home-and community-based long-term services and supports).

NOTE: For purposes of this current reporting effort, plans are not required to distinguish between standard and expedited organization determinations or standard and expedited reconsiderations.

- For additional details concerning these reporting requirements, see Appendix 1: FAQs.

Re-openings (Organization Determinations and Reconsiderations):

- A reopening is a remedial action taken to change a final determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record. Refer to 42 CFR §422.616 and Part 422, Subpart M; see also 'Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance' via the CMS website: https://www.cms.gov/Medicare/Appeals-andGrievances/MMCAG. Reopened organization determinations and reconsiderations should be included, except reopened claims submitted by contract provider.

- For cases that are in a reopening status across multiple reporting periods, contracts should report those cases in each applicable reporting period. For example, if a plan reopened an organization determination in the first quarter of a given calendar year, and sent the notice of the revised decision in the second quarter of the same calendar year that case should be reported as "pending" in the Q1 data file and then as resolved in Q2 (either Fully Favorable, Partially Favorable or Adverse).

- If the IRE fully or partially overturns the plan's determination, the case is not and must not be reported as a reopening.

NOTE: For additional questions on technical specifications for Organization/Determination/Reconsideration reporting, please contact the following mailbox: https://appeals.lmi.org.

III. EMPLOYER GROUP PLAN SPONSORS

This section requires a file upload into HPMS at the Plan (PBP) and Contract level. Please refer to HPMS layouts and templates for more information.

Organization Types Required to Report	Freq. Level	Reporting Period(s)	Data Due date(s)

01 – Local CCP 02 – MSA 04 – PFFS 06 – 1876 Cost Plan 11 – Regional CCP 14 – ED-PFFS 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/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, NonProfit, Church)
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 "N," provide non-calendar year start date.
J.	Current/Anticipated Enrollment

Quality Assurance Checks/Thresholds: Procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous**.** CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from Part C Organizations.

Additional clarifications:

- HPMS displays one module for reporting both MA and Part D Employer/UnionSponsored Group Health Plan Sponsors data.

- All employer groups who have an arrangement in place with the MA organization for any portion of the reporting period should be included in the file upload, regardless of enrollment. In this case, plans should use the date they have an arrangement in place with the employer group to identify the reporting year.

- For employer groups maintaining multiple addresses with your organization, please report the address from which the employer manages the human resources/health benefits.

- Federal Tax ID is a required field in the file upload. Organizations should work with their employer groups to collect this information directly. Alternatively, several commercially lookup services available that may be used to locate this number.

- Data Element G.: Type of contract (insured, ASO, other) refers to the type of contract the organization holds with the employer group that binds you to offer benefits to their retirees.

- For Data Element J.: Current/Anticipated Enrollment the enrollment to be reported should be as of the last day of the reporting period and should include all enrollments from the particular employer group into the specific PBP noted.

- (If an employer group canceled mid-way through the reporting period, they would still appear on the listing but would show zero enrollments.)

- The employer organization type is based on *how* plan sponsors file their taxes. For organizations that provide coverage to private market employer groups and which are subject to Mandatory Insurer Reporting (MIR) of Medicare Secondary Payer data, CMS permits these organizations to use the employer address and tax ID information submitted via the MIR to also satisfy CMS' Part C Reporting and Validation Requirements. This does not imply, however, that if the organization has already submitted this information to CMS for some other purpose, they do not have to resubmit it to us for the purposes of the Part C reporting requirements.

IV. SPECIAL NEEDS PLANS (SNP) CARE MANAGEMENT

This section requires a file upload in HPMS. Please refer to HPMS layouts and templates for more information.

Organization Types Required to Report	Report Frequency Level	Reporting Period	Data Due Date

SNP PBPs under the following types: 01 – Local CCP 11 – Regional CCP 15 – RFB Local CCP Organization 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.

Note: Some of the language below has been revised for clarification purposes, but data elements remain the same. A summary of the data elements and the inclusions and exclusions for the reporting of the data elements are:

Data Element ID A **Data Element Description:** Number of new enrollees due for an Initial Health Risk Assessment	**Inclusions:** The enrollee should be reported under this element when: The enrollee has an effective enrollment date that falls within the measurement year and is continually enrolled for at least 90 days during the measurement year. The enrollee has an effective enrollment date that falls within the measurement year, is continuously enrolled for fewer than 90 days, and completes an initial HRA. The enrollee has an effective enrollment date that falls in the previous measurement year, but a 90-day deadline for initial HRA completion that falls in this measurement year, if no initial HRA was completed in the previous measurement year. The initial HRA is expected to be completed within 90 days (before or after) the effective date of enrollment. Includes individuals who dis-enrolled from and re-enrolled into the same plan if an initial HRA was not performed prior to disenrollment.

	Exclusions Exclude enrollees under this element when: Enrollees who are continuously enrolled in a plan with a documented initial or reassessment HRA in the previous measurement year. New enrollees who disenroll from the plan prior to the effective enrollment date or within the first 90 days after the effective enrollment date if they did not complete an initial HRA prior to disenrolling. Enrollees who receive an initial or reassessment HRA and remain continuously enrolled under a MAO whose contract was part of a consolidation or merger under the same legal entity during the enrollee's continuous enrollment, where the consolidated SNP is still under the same Model of Care (MOC) as the enrollee's previous SNP.
Data Element ID B **Data Element Description:** Number of enrollees eligible for an annual re-assessment HRA	**Inclusions:** The enrollee should be reported under this element when: The enrollee has been continuously enrolled for 365 days or more starting from their initial enrollment date if no initial HRA had been performed, or from the date of their previous HRA. The enrollee is a new enrollee who missed the deadline to complete an initial HRA but completed a reassessment HRA by the 365-day deadline (even if the enrollee was covered for fewer than 365 days). The enrollee is a new enrollee who missed both: • **the deadline to complete an initial HRA;** • **the deadline to complete a reassessment HRA; and** • **is enrolled for all 365 days of the measurement year.** Includes enrollees who dis-enrolled from and re-enrolled into the same plan if an initial HRA was performed within 90 days of reenrollment and the enrollee has continuously enrolled in the same plan for up to 365 days since the initial HRA.

	Exclusions Exclude enrollees under this element when: New enrollees for whom the initial HRA was completed within the current measurement year. New enrollees who miss the deadline to complete an initial HRA and have not yet completed their reassessment HRA, but whose 365-day reassessment deadline is not until the following calendar year. Excludes enrollees who were not continuously enrolled in their same health plan for 365 days after their last HRA and did not receive a reassessment HRA.
Data Element ID C **Data Element Description:** Number of initial HRAs performed on new enrollees	**Inclusions:** The enrollee should be reported under this element when: Initial HRAs performed on new enrollees (as defined above in data element A) within 90 days before or after the effective date of enrollment or re-enrollment. If the initial HRA is performed in the 90 days prior to the effective enrollment date, it is reported as an initial HRA in the reporting year in which the effective enrollment date falls. For enrollees who dis-enrolled from and re-enrolled into the same plan, includes HRAs (initial or reassessment) performed during their previous enrollment if the HRAs are not more than 365 days old.
	Exclusions Exclude enrollees under this element when: An HRA that is performed after the first 90 days of enrollment.

Data Element ID D **Data Element Description:** Number of initial HRA refusals	**Inclusions:** The enrollee should be reported under this element when: Initial HRAs not performed on new enrollees within 90 days (before or after) the effective date of enrollment due to enrollee refusal and for which the SNP has documentation of enrollee refusal.
	Exclusions Exclude enrollees under this element when:
	Initial HRAs not performed for which there is no documentation of enrollee refusal.
Data Element ID E **Data Element Description:** Number of initial HRAs not performed because SNP is unable to reach new enrollees.	**Inclusions:** The enrollee should be reported under this element when: Initial HRAs not performed on new enrollees within 90 days (before or after) the effective date of enrollment due to the SNP being unable to reach new enrollees and for which the SNP has documentation showing that the enrollee did not respond to the SNP's attempts to reach them. Documentation must show that a SNP representative made at least 3 "non-automated" phone calls and sent a follow-up letter in its attempts to reach the enrollee.
	Exclusions Exclude enrollees under this element when: Initial HRAs not performed where the SNP does not have documentation showing that the enrollee did not respond to the SNP's attempt to reach them.

Data Element ID F **Data Element Description:** Number of annual reassessments performed on enrollees eligible for a reassessment	**Inclusions:** The enrollee should be reported under this element when: Reassessments performed within 365 days of last HRA (initial or reassessment HRA) on eligible enrollees. It also includes "first time" assessments occurring within 365 days of initial enrollment on individuals continuously enrolled up to 365 days from enrollment date without having received an initial HRA. Note: When an initial assessment is performed in the 90 days prior to the effective enrollment date, the first annual reassessment must be completed no more than 365 days after the initial HRA.
	Exclusions Exclude enrollees under this element when: A reassessment HRA that is completed past the 365-day deadline.
Data Element ID G **Data Element Description:** Number of annual reassessment refusals	**Inclusions:** The enrollee should be reported under this element when: Annual reassessments not performed due to enrollee refusal and for which the SNP has documentation of enrollee refusal.
	Exclusions Exclude enrollees under this element when: Annual reassessment not performed for which there is no documentation of enrollee refusal.

Data Element ID H **Data Element Description:** Number of annual reassessments where SNP is unable to reach enrollee	**Inclusions:** The enrollee should be reported under this element when: Annual reassessments not performed due to the SNP's inability to reach enrollees and for which the SNP has documentation showing that the enrollee did not respond to the plan's attempts to reach them. Documentation must show that a SNP representative made at least 3 non-automated phone calls and sent a follow-up letter in its attempts to reach the enrollee.
	Exclusions Exclude enrollees under this element when: Annual reassessment not performed for which the SNP does not have documentation showing that the enrollee did not respond to the SNP's attempts to reach them. Required documentation of SNP's attempts to contact the enrollee show that the SNP made at least 3 phone calls and sent a follow-up letter in it is attempts to reach the enrollee.

For reporting purposes, the "measurement year" is the same as the calendar year.

IMPORTANT: **An enrollee cannot be counted more than once in the same data element for the same plan in the same measurement year.**

Quality Assurance Checks/Thresholds: Procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- The percent of HRAs by the contract will be examined for outlier data. Contracts with values above the 95th percentile or below the 5th percentile will be flagged as outliers.

- CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from Part C Organizations.

- The rate of HRAs per 1,000 enrollees will be examined for outlier data. After accounting for enrollment, contracts with values above the 95th percentile or below the 5th percentile will be flagged as outliers.

- The rate of HRAs per 1,000 enrollees will be examined for outlier data. After accounting for enrollment, contracts with values above the 95th percentile or below the 5th percentile will be flagged as outliers. CMS will also identify outliers in the percent of coverage determinations and redeterminations that are reopened.

Edits and Validation Checks: Validation checks that should be performed by each Part C Organization prior to data submission.

- All data elements should be positive values.

Analysis: How CMS will evaluate reported data, as well as how other data sources may be monitored.

- CMS will evaluate HRAs rates per 1,000 enrollees and will trend rates from previous years.

- Rates of HRAs will be calculated per 1,000 enrollees. This means the total HRA rate per 1,000 enrollees is equal to the sum of the total number of HRAs divided by average enrollment, times 1,000.

- Total # of HRAs average enrollment x 1,000 = Total HRAs rate per 1,000 enrollees **HRA**

Reporting Timeline:

- For Part C reporting, there are never to be more than 365 days between Health Risk Assessments (HRAs) for enrollees in Special Needs Plans.

- SNPs are required to conduct an initial HRA within 90 days before or after a beneficiary's effective enrollment date.

- If a new enrollee does not receive an initial HRA within 90 days of enrollment, then 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.

- Initial HRAs conducted prior to the effective enrollment date are counted as initial HRAs in the year in which the effective enrollment date falls. For example, an initial HRA performed on November 23, 2024 for an enrollee with an effective date of enrollment of January 1, 2025 would be counted as an initial HRA in 2025.

- If the initial HRA is not completed within 90 days before or after the effective enrollment date, the SNP will be deemed non-compliant with this requirement.

  If there is no HRA occurring within 90 days (before or after) of the effective enrollment date, the SNP is to complete an HRA as soon as possible. In this case, the HRA would be considered a reassessment.

- The count for the 365-day cycle period for the HRA begins with the day after the date the previous HRA was completed for the enrollee. Likewise, SNPs are required to conduct an initial HRA within 90 days before or after a beneficiary's effective enrollment date. That means that the EED is considered day 0, and the next day would be considered day 1 of the 90-day timeline.

- All annual reassessment HRAs are due to occur within 365 days of the last HRA. Thus, when an initial HRA is performed in the 90 days prior to an effective enrollment date that falls in the beginning of a calendar year, in order to comply with the requirement to perform the annual reassessment within 365 days of the last assessment, the first annual reassessment will be due within the same measurement year as the initial HRA.

- There are situations when a new enrollee who has remained enrolled in the SNP for 365 days after the date of the initial HRA, will be counted in both data elements A and B. because the individual is a new enrollee (A) and an enrollee eligible for an annual reassessment (B).

  Example: The effective enrollment date is January1, 2025 and the initial HRA was completed in November 2024. The annual reassessment will be due in November 2025. The initial HRA and the annual reassessment HRA will both be reported for 2025 and the enrollee will be counted as both a new enrollee and as an enrollee eligible for annual reassessment.

- An HRA may be reported before an individualized care plan (ICP) is completed.

- Any HRA completed after the 365-day completion period is considered non-compliant for reporting purposes. However, the non-compliant HRA does reset the 365-day compliance period to complete the next HRA. Note, the only event that changes a reassessment deadline is a completion of an HRA. This is long standing guidance we have provided to the plans through correspondence.

  Example: A plan fails to complete an HRA for an enrollee by the 5/15/2025 completion deadline. The plan also fails to complete an HRA for the enrollee during measurement years 2023 and 2024. However, the plan is able to complete an HRA on 2/2/2026. This HRA would be considered late since it was completed well after the due date of 5/15/2025. However, the HRA completed on 2/2/2026 would establish a new completion timeline for the enrollee. If the plan completed a second HRA within

- 365 days of 2/2/2026, for example 5/1/2026, then the plan could report the HRA as a completed reassessment for Measurement Year 2025 (using the example completion date of 5/1/2025).

Multiple reporting events during a Measurement Year:

A plan's reporting should be based off of the enrollee's most recent HRA activity.

- If the enrollee completes more than one (1) reassessment HRA during the reporting period, then the plan should base their reporting off of the most recent reassessment HRA completed.

  Example: An enrollee can only be counted once in data element F if the enrollee completes more than one (1) reassessment during the reporting period. If the SNP completed an HRA with the enrollee on 2/1/2025 and 6/1/2025, just report the HRA reported on 6/1/2025. Do not report both under element F.

- If a plan appropriately documents an event under Elements G and/or H as noted in this guide, but later completes an HRA with the enrollee during the same measurement year, the plan should record all applicable events separately.

- A member cannot be counted more than once in the same data element for the same plan in the same measurement year.

- Example: a member completes two reassessment HRAs during the same measurement year, but the plan also recorded an UTR and a refusal. In this case, the plan would report one HRA as being completed (the plan should report the most recent HRA) under Element ID F, a refusal under Element ID G, and the UTR under Element ID H. The SNP avoids violating the double counting rule noted early by only reporting the one reassessment HRA under Element ID F. The refusal and the UTR are reportable under separate ID categories, so the double counting rule doesn't apply. If the SNP encountered two refusal events with the same member during the measurement year, then the plan would only report the latest refusal to avoid double counting.

- If an enrollee has multiple reassessments within the 90 day or the 365-day time periods, just report one HRA for the period in order to meet the reporting requirement.

Eligibility Determination:

- A SNP should not perform, or report on, an HRA if the beneficiary is not yet determined to be eligible to enroll in the SNP.

MMPs Transitioning to D-SNPs:

- Enrollees who were previously in a Medicare-Medicaid Plan and received an initial or annual HRA that were cross walked to a D-SNP within the MAO after the end of a Financial Alignment Initiative demonstration will not need to participate in a second initial HRA. They should be included in element B.

Reporting Enrollees Who Are Unable to be Reached:

NOTE: CMS will treat the lack of an HRA as being due to the enrollee's refusal or because the SNP could not reach the enrollee after reasonable attempts if the following conditions are met.

The enrollee did not respond to at least 3 "non-automated" phone calls and a follow-up letter from the SNP where all the efforts were to solicit participation in the HRA.

- None of the efforts to solicit participation were automated calls ("robo" or "blast" calls). Phone call attempts must be made by a SNP representative so that when an enrollee is reached, it is possible to perform the HRA at that time, by phone.

- Documentation of the enrollee's refusal and/or the SNP's inability to reach enrollee is available at any time to CMS for CMS to determine health plan compliance with Part C reporting requirements.

What Constitutes a Completed HRA:

- Only completed HRAs that comprise direct beneficiary and/or caregiver input will be considered valid for purposes of fulfilling the Part C reporting requirements. For example, HRAs completed only using claims and/or other administrative data would not be acceptable. For data elements C and F, CMS requires only completed assessments. This reporting section excludes cancelled enrollments.

- A cancelled enrollment is one that never becomes effective.

  Example: An individual submits an enrollment request to enroll in Plan A on March 25th for an effective date of April 1st. Then, on March 30th, the individual contacts Plan A and submits a request to cancel the enrollment. Plan A cancels the enrollment request per our instructions in Chapter 2, and the enrollment never becomes effective.

- If eligibility records received after completion of the HRA indicate the individual was never enrolled in the plan, do not count this individual as a new enrollee and do not count the HRA.

- The date the HRA is completed by the sponsoring organization is the completed date of the HRA.

•

D-SNP Enrollees and Medicaid HRAs:

- For dual eligible SNPs (D-SNPs) only, CMS will accept a Medicaid HRA that is performed by the same organization (or an affiliate under the same parent organization) within 90 days before or after the effective date of Medicare enrollment as meeting the Part C obligation to perform an HRA, if the HRA meets the requirements at 42 CFR § 422.101(f).

Re-enrollment and Disenrollment:

- Questions have arisen regarding how to report data elements in this reporting section when enrollees disenroll and then re-enroll, either in the same SNP or a different one (different organization or sponsor) within the measurement year. When an individual disenrolls from one SNP and enrolls into another SNP (a different sponsor or

organization), the individual should be counted as a "new enrollee" for the receiving plan.

- Enrollees who received an initial HRA and remain continuously enrolled under a MAO that was part of a consolidation or merger within the same MAO or parent organization will not need to participate in a second initial HRA. This guidance also applies to enrollees who were cross walked from a non-renewing D-SNP PBP under a broader MA contract to a D-SNP-only contract per 42 CFR 422.107(e).

- When an individual enrolls, disenrolls, and re-enrolls, into any SNP under the same contract number, the previous HRA is still considered valid and can continue to be used as long as it is not more than 365 days old. Even if the individual is re-enrolling into the same plan, the individual would still not be counted more than once in any category.

- As noted in the table for Element ID A, column "inclusions," SNPs should include individuals who disenrolled from and re-enrolled into the same plan if an initial HRA was not performed prior to disenrollment. When this occurs, SNPs should calculate the enrollee's eligibility date starting from the date of re-enrollment.

NOTE: Additional SNP HRA inquiries are directed to the following mailbox: https://dpap.lmi.org/dpapmailbox/mailbox

V. ENROLLMENT AND DISENROLLMENT

This section requires a file upload into HPMS at the Contract level. Please refer to HPMS layouts and templates for more information.

Organization Types Required to Report	Frequency Level	Report Period(s)	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)

For Part C Reporting:

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-PD plans 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 and Part D Enrollment and Disenrollment Guidance, available at: https://www.cms.gov/medicare/enrollment-renewal/part-d-enrollment-eligibility.

QA checks/thresholds – procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- The percent of disenrollment request denied by the contract will be examined for outlier data. After accounting for the number of disenrollment request filed, contracts with values above the 95th percentile for their contract type will be flagged as outliers.

- CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from Part C Organizations.

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 Data elements (Note: Disenrollments must not be included in 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 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 C, the number of incomplete enrollment requests received that are incomplete upon initial receipt and completed within established timeframes.
F.	Of the total reported in C, the number of enrollment requests denied due to the 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 plan premium in the specified time period.
E.	Of the total reported in D, the number of disenrolled individuals who submitted a timely request for reinstatement for Good Cause.
F.	Of the total reported in E, the number of favorable Good Cause determination.
G.	Of the total reported in F, the number of individuals reinstated.

VI. REWARDS AND INCENTIVES PROGRAMS

This section is partial data entry and partial file upload into HPMS at the Contract level. Please refer to HPMS layouts and templates for more information.

Reporting Section	Organization Types Required to Report	Reporting Frequency Level	Reporting Period	Data due date (s)
Rewards and Incentives	01 – Local CCP 02 – MSA 03 – RFB PFFS 04 – PFFS 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 MUST 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 Incentive Program Name
C.	What health related services and/or activities are included in the program? [Text]

Data Element ID	Data Element Description
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]

Quality Assurance Checks/Thresholds: Procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

Edits and Validation Checks: Validation checks that should be performed by each Part C Organization prior to data submission.

Notes:

- Must be positive values.
- Currently Enrolled (Element G) means as of December 31 of the current reporting period, and the number of rewards made "so far" (Element H) means awards made at any time up until December 31 of the current reporting period.

VII. PAYMENTS TO PROVIDERS

This reporting section is a file upload into HPMS at the Contract level. Please refer to HPMS layouts and templates for more information.

Organizations Required To Report	Reporting Frequency	Reporting Period	Data Due date (s)
01 – Local CCP 04 – PFFS 11 – Regional CCP 15 – RFB Local CCP Organizations should exclude 800 series plans.	1/Year Contract	1/1-12/31	Last Monday of February in following year.

Note: Plans are to report based on the year payment was made, regardless of when services were furnished.

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 MA organizations about the proportion of their payments made to contracted providers based on these four categories in order to understand the extent and use of alternate payment models in the MA industry. Descriptions 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).

- Collecting these data will help inform us as we determine how broadly MA organizations are using alternative payment arrangements.

- 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).

- For additional details on the definitions in this section, please see Appendix 2: Measuring Covered Lives in Accountable Care.

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.
CATEGORY 1	
B.	Total dollars paid to providers through legacy payments in CY2025 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. Category 1 also includes diagnosis-related groups that are not linked to quality and value in CY2025 or most recent 12 months.
CATEGORY 2	
C.	Total dollars paid to providers through fee-for-Service 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-forperformance 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.
CATEGORY 3	
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 [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)
CATEGORY 4	
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)
Provider Data	
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 utilizationbased shared-savings (linked to quality)
BB.	Total Medicare Advantage contracted providers paid through fee-forservice-based shared-risk (linked to quality)
CC.	Total Medicare Advantage contracted providers paid through procedurebased bundled/episode payments (linked to quality)
DD.	Total Medicare Advantage contracted providers paid based risk-based payments not linked to quality (e.g., 3N in the APM definitional framework)
EE.	Total Medicare Advantage contracted providers paid based on populationbased (category 4)

FF.	Total Medicare Advantage contracted providers paid through conditionspecific, population-based payments (linked to quality)
GG.	Total Medicare Advantage contracted providers paid through conditionspecific, bundled/episode payments (linked to quality)
HH.	Total Medicare Advantage contracted providers paid through populationbased 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)
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)	
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)].
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)	
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)].

Quality Assurance Checks/Thresholds: Procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

Edits and Validation Checks: Validation checks that should be performed by each. Part C Organization prior to data submission. All data elements should be positive values.

PLAN INQUIRIES Payments to Providers	**CMS RESPONSES for Payment to Providers**

1) What are the four categories of value-based payment? Can you provide examples of each category?	MAOs will report on the proportion of payments made to contracted providers based on the HHS- developed four categories of value based payment: 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); Population-based payment (category 4) For additional guidance regarding the four (4) categories of payment, we ask that you refer to the Learning Action Network Definitional Framework white paper.
2) How are contracted providers defined?	For the purposes of the Payments to Providers Part C reporting requirements, contracted providers include both physicians and clinicians. Payments for administrative services and payments to hospitals, facilities, pharmacies, or labs are not to be reported.
3) For data elements S – FF, how do we report if a provider is paid using multiple payment arrangements that fit under multiple categories?	If a provider is paid under multiple payment arrangements that do not fit in one category, we ask that the MAO report that provider under the category for the dominant payment arrangement.
4) For data elements S. and FF. are we to report by individual providers or by contracts (which include groups with one or more providers)?	Please report by contracts. If a plan is in a contract with a provider group, the provider group counts as one contracted provider. If the plan is in a contract with an individual provider, the individual provider counts as one contracted provider.
5) For data elements A. – R., are we to report payments made to providers in 20XX based on services rendered in the prior year?	Please report based on the year payment was made, regardless of when services were furnished.
6) For data elements A. – R., do payments refer to the total calculated allowed amount or actual payments to providers?	This refers to the total actual payments made to contracted providers based on the aforementioned categories of value-based payment.
7) Should plans report the incentive portion of the alternative payment method or all of the dollars going to the provider under that arrangement?	Plans should report the total dollars (actual payment), which includes the base payment plus any incentive, such as a bonus for performance (P4P), savings that were shared with providers, etc.

8) Should plans report shared savings or capitation without links to quality?	Yes. Risk-based payment with no link to quality (classified as 3N in the Learning Action Network Definitional Framework white paper) should be reported under element number 17.4b. Capitation with no link to quality (classified as 4N in the Learning Action Network Definitional Framework white paper) should be reported under element 17.5b.
9) Are elements B through R subsets of elements A?	Yes. It is possible, however, that there are some forms of payments that would not quality as APM categories (e.g. elements K and R). The sum of all elements B through R should equal A.

VIII. SUPPLEMENTAL BENEFIT UTILIZATION AND COSTS

This reporting section requires a file upload into HPMS.

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 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. VBID plans should also submit reporting for this section, however they should not submit	1/year; PBP	1/1-12/31	Last Monday in February of the following calendar year
reporting for VBID specific benefits.			

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
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)
	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	Three (3) Pint Deductible Waived

Transportation Services	
10b1	Transportation Services - Plan-Approved Health-related Location
10b2	Transportation Services - Any Health-related Location
Other Supplemental Services	
13a	Acupuncture Treatments
13b	Over-the-Counter (OTC) Items
13c	Meal Benefit
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
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

*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 "Other" (13d, 13e, 13f, or 13i-O), or if name otherwise differs from values provided above.
E.	How is the supplemental benefit offered? (Mandatory (all enrollees eligible), Optional, Mandatory-UF (only enrollees eligible for Uniformity Flexibility), Mandatory-SSBCI (only enrollees eligible for SSBCI), not offered)
F	Network type (in-network, out-of-network (for PPO), out-of-network (for HMO-POS), Visitor/travel)
G.	The unit of utilization used by the plan when measuring utilization (e.g., admissions, visits, procedures, trips, purchases)
H.	The number of enrollees eligible for the benefit *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 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.
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.
O.	The total out-of-pocket-cost for enrollees who utilized the benefit (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

Quality Assurance Checks/Thresholds: Procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- The rate of utilization (found using Data Element H and I) will be examined for outlier data. After accounting for eligibility, plans with values above the 95th percentile for their plan type or below the 5th percentile for their plan type will be flagged as outliers.
- CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from Part C Plans.
- Data Element E should be reported as Mandatory, Optional, Mandatory-UF, Mandatory-SSBCI or 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 G-P for each offering type separately.
- Data Elements H through K should be reported as discrete (whole) numbers.
- Data Elements L, O and P should be reported as dollar amounts.

Edits and Validation checks: Recommended Part C validation checks prior to data submission.

- The number of eligible enrollees who utilize the service (I) should be less than or equal to the number who are eligible for the service (H).

Analysis: How CMS will evaluate reported data, as well as how other data sources may be monitored.

- The percent utilization is equal to the number of enrollees who utilized a benefit at least once divided by the number of enrollees who are eligible for the benefit.
- % Utilization = ([The number of enrollees who utilized the benefit at least once] / [The number of enrollees eligible for the benefit]) x 100
- The utilization intensity is equal to the total instances of utilization among eligible enrollees divided by the number of enrollees who utilized the benefit at least once.
- Utilization Intensity = [The total instances of utilizations among eligible enrollees] / [The number of enrollees who utilized the benefit at least once]
- CMS will evaluate utilization rates and will begin to trend rates from previous years when multiple years data becomes available.

- Plan cost per service is equal to the total amount spent by plan on each benefit divided by total instances of utilization among eligible enrollees.

- Plan cost per service = [The total amount spent by plan on offering the benefit for enrollees who utilized the benefit / total instances of utilization among eligible enrollees]

Notes: Additional clarifications to the supplemental benefits reporting section

- CMS notes that debit cards provided to enrollees to pay for plan-covered benefits are tools to administer such benefits and not benefits themselves. Plans MUST be able to determine how benefits administered through such cards are utilized for the purposes of this reporting. If plans administer multiple benefits through a debit card, the plan must be able to break down utilization and costs by service category to ensure compliance with these Reporting Requirements.
- For Part C reporting, supplemental benefits are defined as those benefits delivered (i.e., plan has provided items or services) during the reporting period, regardless of when the benefit was paid in full. However, we note that plans should only report on costs/utilization for services which were approved. In cases where the supplemental benefit coverage was denied, the plan should not report on costs and utilization for that item or service.
- A mandatory supplemental benefit is defined at 42 CFR 422.100I(2)(i)(A) as "Services not covered by Medicare that an MA enrollee must purchase as part of an MA plan that are paid for in full, directly by (or on behalf of) Medicare enrollees, in the form of premiums or cost sharing."
- An optional supplemental benefit is defined at 42 CFR 422.100(c)(2)(i)(B) as "Health services not covered by Medicare that are purchased at the option of the MA enrollee and paid for in full, directly by (or on behalf of) the Medicare enrollee, in the form of premiums or cost sharing. These services may be grouped or offered individually."
- The mathematical median of a set of numbers can be found by ordering all data points and choosing the number which falls exactly at the midway point of the set.
- For waiver categories (i.e. 2-SNF Waive Hospital Stay and 9d-Three (3) Pint Deductible Waived) plans may report $0 spending if no costs are associated. Plans may also write "Not applicable" for the necessary data elements where appropriate (e.g. Element O).
- For additional Supplemental Benefits Utilization and Cost inquiries, please contact the following mailbox: https://dpapportal.lmi.org/DPAPMailbox.

Report:

- Report only those supplemental benefits furnished within the CY for which the reporting period applies.
- Report on all supplemental benefit categories and subcategories. You may include zeros for any categories or subcategories that your plan does not offer.

Do Not Report:

- Benefits, services, or items which are covered under Parts A, B or D of Medicare. For example, do not include reporting on a dental benefit when such benefit is covered as a Part A covered service.

IX. D-SNP ENROLLEE ADVISORY COMMITTEE

This reporting section requires data entry into HPMS.

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	1/1-12/31	Last Monday of February in the following year.

Data Element ID	Data Element Description	Inclusions
A.	Does the D-SNP share an enrollee advisory committee (EAC) with other D-SNP(s)? ("Yes" or "No" only)	"Yes" should be selected in instances where MAOs establish one D-SNP EAC to represent multiple D-SNPs within a state during the measurement year. In other words, the D-SNP EAC includes enrollees or other individuals representing those enrollees from more than one D-SNP. "No" should be selected when only enrollees from the D-SNP or other individuals representing those enrollees participate in the EAC during the measurement year.

Data Element ID	Data Element Description	Inclusions

B.	Provide the total number of D-SNP EAC meetings held during the measurement year.	If the D-SNP entered "No" for Data Element A, enter the count of D-SNP EAC meetings that occurred during the measurement year. If no meetings were held, enter zero (0). If the D-SNP entered "Yes" for Data Element A, the D-SNP should work with its MAO to determine which D-SNP will respond to this element on behalf of all D-SNPs sharing the same EAC. • If the D-SNP is responding on behalf of all D-SNPs sharing the same EAC, enter the count of DSNP EAC meetings that occurred during the measurement year. If no meetings were held, enter zero (0). • If the D-SNP is not responding on behalf of all the D-SNPs sharing the EAC, enter "See response for [four-digit H contract number and three-digit PBP number]." For example, if the D-SNP is not responding on behalf of all the DSNPs sharing the EAC and DSNP H1234-001 is responding on behalf of the other D-SNPs, the D-SNP would enter "See response for H1234-001."

C.	List the dates during the measurement year when the D-SNP EAC met.	If the D-SNP entered "No" for Data Element A, list the two-digit month, twodigit day, and four-digit year for each D- SNP EAC meeting where D-SNP enrollees or other individuals representing those enrollees participated during the measurement year. Separate the meeting dates with commas and list in chronological order. For example, if the D-SNP had enrollees or other individuals representing those enrollees participating in four D-SNP EAC meetings during the measurement year, list the four dates of those EAC meetings (e.g., 01/24/2025, 04/22/2025, 07/15/2025, 10/30/2025). If the D-SNP entered "Yes" for Data Element A, the D-SNP should work with its MAO to determine which D-SNP will respond to this element on behalf of all D-SNPs sharing the same EAC. • If the D-SNP is responding on behalf of all D-SNPs sharing the same EAC, list the two-digit month, two-digit day, and fourdigit year for each D-SNP EAC meeting where D-SNP enrollees or other individuals representing those enrollees participated during the measurement year. Separate the meeting dates with commas and list in chronological order. For example, if the D-SNP had enrollees or other individuals representing those enrollees participating in four D-SNP EAC meetings during the measurement year, list the four dates of those EAC meetings (e.g., 01/24/2025, 04/22/2025, 07/15/2025, 10/30/2025). • If the D-SNP is not responding on behalf of all the D-SNPs sharing

		the EAC, enter “See response for [four-digit H contract number and

Data Element ID	Data Element Description	Inclusions
		three-digit PBP number].” For example, if the D-SNP is not responding on behalf of all the DSNPs sharing the EAC and DSNP H1234-001 is responding on behalf of the other D-SNPs, the D-SNP would enter “See response for H1234-001.”

D.	Were interpreter services offered for each D-SNP EAC meeting? (“Yes” or “No” only)	If the D-SNP entered “No” for Data Element A, “Yes” should be selected when interpreter services were offered for all D-SNP EAC meetings held during the measurement year. This includes when interpreter services were offered but not utilized by meeting participants. “No” should be selected when interpreter services were not offered for one or more D-SNP EAC meetings held during the measurement year. If the D-SNP entered “Yes” for Data Element A, the D-SNP should work with its MAO to determine which D-SNP will respond to this element on behalf of all D-SNPs sharing the same EAC. • If the D-SNP is responding on behalf of all D-SNPs sharing the same EAC, “Yes” should be selected when interpreter services were offered for all D-SNP EAC meetings held during the measurement year. This includes when interpreter services were offered but not utilized by meeting participants. ”No” should be selected when interpreter services were not offered for one or more D-SNP EAC meetings held during the measurement year. • If the D-SNP is not responding on behalf of all the D-SNPs sharing the EAC, enter “See response for [four-digit H contract number and three-digit PBP number].” For example, if the D-SNP is not responding on behalf of all the DSNPs sharing the EAC and DSNP H1234-001 is responding on behalf of the other D-SNPs, the D-SNP would enter “See response for H1234-001.” Interpreter services provide translation

Data Element ID	Data Element Description	Inclusions
		into alternate languages spoken by meeting participants.

E.	Were auxiliary aids and services offered for each DSNP EAC meeting? (“Yes” or “No” only)	If the D-SNP entered “No” for Data Element A, “Yes” should be selected when auxiliary aids and services were offered for all D-SNP EAC meetings held during the measurement year. This includes when auxiliary aids and services were offered but not utilized by meeting participants. “No” should be selected when auxiliary aids and services were not offered for one or more D-SNP EAC meetings held during the measurement year. If the D-SNP entered “Yes” for Data Element A, the D-SNP should work with its MAO to determine which D-SNP will respond to this element on behalf of all D-SNPs sharing the same EAC. • If the D-SNP is responding on behalf of all D-SNPs sharing the same EAC, “Yes” should be selected when auxiliary aids and services were offered for all DSNP EAC meetings held during the measurement year. This includes when auxiliary aids and services were offered but not utilized by meeting participants. ”No” should be selected when auxiliary aids and services were not offered for one or more DSNP EAC meetings held during the measurement year. • If the D-SNP is not responding on behalf of all the D-SNPs sharing the EAC, enter “See response for [four-digit H contract number and three-digit PBP number].” For example, if the D-SNP is not responding on behalf of all the DSNPs sharing the EAC and DSNP H1234-001 is responding on behalf of the other D-SNPs, the D-SNP would enter “See response for H1234-001.”

Data Element ID	Data Element Description	Inclusions
		Auxiliary aides and services are methods by which audible, written, and visually represented information are made accessible to meeting participants with communication disabilities.

Quality Assurance Checks/Thresholds: Procedures used by CMS to establish benchmarks to identify outliers or data that are potentially erroneous.

- The number of D-SNP EAC meetings held will be examined for outlier data. D-SNPs that did not hold a D-SNP EAC meeting during the measurement year will be flagged as outliers.
- CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from D-SNPs.

Edits and Validation Checks: Validation checks that should be performed by each D-SNP prior to data submission.

- The entry for Data Element A should be "Yes" or "No" only.

If the D-SNP is responding for itself or on behalf of other MAOs sharing the D-SNP EAC:

- The entry for Data Element B should be a whole number.
- The entry for Data Element C should be a list of dates in MM/DD/YYYY format in chronological order, separated by commas.
- The entry for Data Elements D and E should be "Yes" or "No" only.

If the D-SNP shares an EAC with other D-SNP(s), and another D-SNP is responding on behalf of the D-SNP:

- The entry for Data Elements B, C, D, and E should be "See response for [four-digit H contract number and three-digit PBP number]."

Analysis: How CMS will evaluate reported data, as well as how other data sources may be monitored.

- CMS will evaluate the total number of D-SNP EAC meetings held during the measurement year. These values will be compared across D-SNPs.
- CMS will analyze the percent of D-SNPs that offered interpreter services.
- CMS will analyze the percent of D-SNPs that offered auxiliary aids and services.
- As data are reported for future years, CMS will conduct trending analyses across various data elements.

X. D-SNP TRANSMISSION OF ADMISSION NOTIFICATIONS

This reporting section requires data entry into HPMS.

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	1/1-12/31	Last Monday of April in the following year.

Data Element ID	Data Element Description	Inclusions
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 fullbenefit dually eligible individuals designated in the D-SNP's state Medicaid agency contract.	Enter the count of hospital admissions and SNF admissions during the measurement year for enrollees that belong to the group(s) of high risk full-benefit dually eligible individuals designated in the DSNP's state Medicaid agency contract. See 42 CFR 422.107(d)(1) for more information about this notification requirement. If an enrollee has more than one hospital and/or SNF admission during the measurement year, all admissions should be counted.
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.	Enter the count of notifications to the state or state designated entity of all hospital admissions and SNF admissions for enrollees that belong to the group(s) of high risk full-benefit dually eligible individuals designated in the D-SNP's state Medicaid agency contract for the measurement year.

Quality Assurance Checks/Thresholds: Procedures used by CMS to establish benchmarks to identify outliers or data that are potentially erroneous.

- The total number of hospital admissions and SNF admissions per 10,000 enrollee months will be examined for outlier data. D-SNPs with values above the 95th percentile or below the 5th percentile will be flagged as outliers.
- The percent of admissions that resulted in notification will be examined for outlier data. D-SNPs with values above the 95th percentile or below the 5th percentile will be flagged as outliers.
- CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from D-SNPs.

Edits and Validation Checks: Validation checks that should be performed by each D-SNP prior to data submission.

- The entry for Data Elements A and B should be a whole number.
- The entry for Data Element B should be equal to or less than Data Element A.

Analysis: How CMS will evaluate reported data, as well as how other data sources may be monitored.

- CMS will analyze the percent of hospital admissions and SNF admissions that resulted in notification to the state or state designated entity during the measurement year (i.e., Data Element B / Data Element A).
- As data are reported for future years, CMS will conduct trending analyses across various data elements.

XI. APPENDIX 1. FAQs: REPORTING SECTIONS

(I) Grievances, (II) Organization Determinations, & Reconsiderations, and (VII) Payments to Providers

PLAN INQUIRIES for Grievances, and Organization Determinations & Reconsiderations	CMS RESPONSES for Grievances, and Organization Determinations & Reconsiderations.
1) Should plans report informal complaints as Grievances under the Part C reporting requirements? For example, during the course of a home visit, a member expresses dissatisfaction regarding a particular issue. The member does not contact the plan directly to file a complaint, but the plan representative determines the member is not happy and logs the issue for Quality Improvement tracking.	Plans are to report any grievances filed directly with the plan and processed in accordance with the plan grievance procedures outlined under 42 CFR Part 422, Subpart M. Plans are not to report complaints made to providers, such as the complaint in the example provided, that are not filed with the plan.

PLAN INQUIRIES for Grievances, and Organization Determinations & Reconsiderations	CMS RESPONSES for Grievances, and Organization Determinations & Reconsiderations.
2) Is a plan to report a grievance, organization determination or reconsideration to CMS when the plan makes the final decision or when the request is received?	Plans are to report grievances, organization determinations and reconsiderations that were completed (i.e., plan has notified enrollee of its decision or provided or paid for a service, if applicable) during the reporting period, regardless of when the request was received.
3) Are plans to report the total number of organization determinations or reconsiderations that were processed timely?	No, plans are no longer required to report timeliness data.
4) Should plans report initial payment or reconsideration requests from contract providers?	No, plans should not report initial payment or reconsideration requests from contract providers.
5) Does service requests from a provider on behalf of an enrollee include contract and non-contract providers?	No, service requests from a provider on behalf of an enrollee only includes contract providers. Service requests from non- contract providers have their own data element.
6) Are plans to report only those organization determinations defined under 42 CFR § 422.566?	Yes, plans report organization determinations as defined at 42 CFR § 422.566(b) and as described in the Part C Technical Specifications reporting section II.
7) We are seeking information on how we should report pre-service requests and payment requests for this category. Do you want fully favorable, partially favorable, and adverse for both pre-service requests and payment requests?	Yes. Plans are to report fully favorable, partially favorable, and adverse pre-service and payment requests (organization determinations and reconsiderations), as described in this guidance.
8) If we have a prior authorization request and a payment request for the same service – is that considered a duplicate or should we report both?	Plans are to report both a prior authorization request and a post-service payment request for the same service if the payment request is submitted by the enrollee or a non-contract provider; this is not considered duplicative. Payment requests from contract providers should not be reported.

PLAN INQUIRIES for Grievances, and Organization Determinations & Reconsiderations	CMS RESPONSES for Grievances, and Organization Determinations & Reconsiderations.
9) Is a request for a predetermination to be counted as an organization determination? Does it matter who requests the predetermination – contracted provider, non-contracted provider, or member? If so, should they also be counted as partially and fully unfavorable?	Plans are to report organization determinations which includes a pre-service request ("predetermination") submitted by an enrollee/representative, a contracted provider on behalf of the enrollee, or a non- contracted provider Plans are to report partially favorable, adverse, and fully favorable pre-service organization determinations, as described in this guidance.
10) Should plans report determinations made by delegated entities or only decisions that are made directly by the plan – e.g., should plans report decisions made by contracted radiology or dental groups?	Yes. Plans are to report decisions made by delegated entities – such as an external, contracted entity responsible for organization determinations (e.g., claims processing and preservice decisions) or reconsiderations.
11) The technical specifications advise plans to exclude certain duplicate/edits when reporting on the claim denial requirement. Is the intent to exclude duplicates or is it to exclude "billing" errors or both? For example, if a claim is denied because the provider didn't submit the claim with the required modifier, should that be excluded from the count?	Plans should exclude duplicate claim submissions (e.g., a request for payment concerning the same service) and claims returned to a provider/supplier due to error (e.g., claim submissions or forms that are incomplete, invalid or do not meet the requirements for a Medicare claim).
12) Do we have to include lab claims for this reporting section? Do we need to report the ones which involve no pre-service as well as the ones that involve pre-service?	A request for payment received from an enrollee or non-contract provider is a reportable organization determination.

PLAN INQUIRIES for Grievances, and Organization Determinations & Reconsiderations	CMS RESPONSES for Grievances, and Organization Determinations & Reconsiderations.

13) Enrollee obtains a rhinoplasty for purely cosmetic reasons, which is a clear exclusion on the policy. Enrollee and provider both know this is likely not covered but they submit the claim. Claim is denied as an exclusion/ non-covered service. Neither the enrollee nor the provider pursues it any further. Is this an organization determination?	The plan is to report this denial as an organization determination. A request for payment (claim) is a reportable organization determination.
14) Enrollee is out of area and in need of urgent care. Provider is out of area / network. The enrollee calls plan and requests an organization determination for this service. Health Plan approves use of out of area services. Claim is submitted and paid in full. Is this counted as one event (i.e., pre-auth. and claim not counted as two events)?	In this example, both the pre-service decision and claim are counted as two, separate fully favorable organization determinations. A claim submitted for payment is an organization determination request. Claims paid in full are reportable (fully favorable) organization determinations.
15) When an organization determination is extended into the future does that extension count in the reporting of org determinations (e.g. on-going approval for services approved in the initial decision)?	Yes. Plans generally are to count an initial request for an organization determination (request for an ongoing course of treatment) as separate from any additional requests to extend the coverage. For example, plans are to count an initial approved request for physical therapy services as one organization determination. If the plan, later, approves a subsequent request to continue the ongoing services, the plan should count the decision to extend physical therapy services as another, separate organization determination.
16) Our interpretation is that the term "contracted provider" means "contracted with the health plan" not "contracted with Medicare."	Yes. For purposes of Part C Reporting Section 6 reporting requirements, "contracted provider" means "contracted with the health plan" not "contracted" (or participating) with Medicare."

PLAN INQUIRIES for Grievances, and Organization Determinations & Reconsiderations	**CMS RESPONSES for Grievances, and Organization Determinations & Reconsiderations.**

17) When we make an adverse determination that is sent to the QIO for review and later our adverse determination is overturned, should we count and report the initial adverse determination that goes to the QIO? We understand that QIO determinations are excluded from our reporting.	Yes. Regardless of whether a QIO overturns an adverse organization determination, plans are to report the initial adverse or partially favorable organization determination.
18) Should cases forwarded to the Part C IRE be counted once in the reporting section, i.e., as the Partially Favorable or adverse decision prior to sending to the IRE?	When a plan upholds its adverse or partially favorable organization determination at the reconsideration level, the plan generally must report both the adverse or partially favorable organization determination and reconsideration. Exceptions: Plans are not to report QIO determinations concerning an inpatient hospital, skilled nursing facility, home health and comprehensive outpatient rehabilitation facility services terminations.
19) Should supplemental benefit data be excluded from the Part C Reporting?	As described in this guidance, a plan's response to a request for coverage (payment or provision) of an item or service is a reportable organization determination. Thus, requests for coverage of a supplemental benefit (e.g., a non-Medicare covered item/service) are reportable under this effort.
20) Can you please clarify in the below how these counts should be included for organization determinations? Example scenario: A pharmacy claim is processed at point-of-sale for test strips; the claim rejects. The pharm tech. resubmits the claim and it rejects again. The pharmacy tech then adjusts the quantity and day's supply and the claim eventually pays. Would this be counted as one paid claim (fully favorable) or should it be counted as two adverse claims and one paid claim?	Do not report point-of-sale (POS) claim rejections. In this scenario, only report an organization determination that is processed following POS claim rejection(s).

PLAN INQUIRIES Payments to Providers	**CMS RESPONSES for Payment to Providers**

1) How are contracted providers defined?	For the purposes of the Payments to Providers Part C reporting requirements, contracted providers include both physicians and clinicians. Payments for administrative services and payments to hospitals, facilities, pharmacies, or labs are not to be reported.
2) Data element A states that it should include payments that are both in and out of network. Should all payments to providers reported in categories 1-4 (data elements B-S) include both in network and out of network payments?	Data element A should include both in and out of network payments, but payments reported in categories 1-4 (data elements B-S) should only include in network payments. Because of this, it is possible that Data element A can equal more than the sum of data elements (B-S).
3) For data elements B – S, how do we report if a provider is paid using multiple payment arrangements that fit under multiple categories?	If a provider is paid under multiple payment arrangements that do not fit in one category, we ask that the MAO report that provider under the category for the dominant payment arrangement.
4) For data elements T - KK are we to report by individual providers or by contracts (which include groups with one or more providers)?	Please report by contracts. If a plan is in a contract with a provider group, the provider group counts as one contracted provider. If the plan is in a contract with an individual provider, the individual provider counts as one contracted provider.
5) For data elements A – S, are we to report payments made to providers in 2025 based on services rendered in 2024?	Please report based on the year payment was made, regardless of when services were furnished.
6) What does the phrase "or most recent 12 months" refer to?	"Most recent 12 months" refers to the most current 12month period for which a plan can report payment information.
7) For data elements A – S, do payments refer to the total calculated allowed amount or actual payments to providers?	This refers to the total actual payments made to contracted providers based on the aforementioned categories of value-based payment.

PLAN INQUIRIES Payments to Providers	**CMS RESPONSES for Payment to Providers**

8) Should plans report the incentive portion of the alternative payment method or all of the dollars going to the provider under that arrangement?	Plans should report the total dollars (actual payment), which includes the base payment plus any incentive, such as a bonus for performance (P4P), savings that were shared with providers, etc.
9) Are elements B-S subsets of elements A?	Yes. It is possible, however, that there are some forms of payments that would not fit into elements B-S and therefore the sum of B-S can be less than A.
10) Is element L a subset of element K?	No. They are both different categories of payment as noted in the referenced alternate payment model (APM) definitional framework.
11) Is element S and subset of element R?	No. They are both different categories of payment as noted in the referenced alternate payment model (APM) definitional framework.
12) Are elements U through JJ (excluding element DD) subsets of element T?	Yes. However, it is possible that there are some forms of payments that would not fit into elements U through JJ (excluding element DD). Hence, the sum of elements U through JJ (excluding element DD) can be less than T.
13) Is element DD a subset of element Y?	No. They are both different categories of payment as noted in the referenced APM definitional network. For detailed information regarding these categories, please refer to the Alternative Payment Model (APM) Framework at: https://hcp-lan.org/workproducts/apmrefresh-whitepaper-final.pdf.
14) Is element KK a subset of element EE?	No. They are both different categories of payment as noted in the referenced APM definitional network. For detailed information regarding these categories, please refer to the Alternative Payment Model (APM) Framework at: https://hcp-lan.org/workproducts/apmrefresh-whitepaper-final.pdf.

PLAN INQUIRIES Payments to Providers	**CMS RESPONSES for Payment to Providers**

15) We understand that the total payment cannot be less than the sum of payments by category. But can the sum of the payments by category be less than or equal to the total payment?	Correct, the sum of the payments by category can be less than or equal to the total payment.
16) What is a "Foundational Payment"?	Includes, but is not limited to, payments to improve care delivery such as outreach and care coordination/management; after-hour availability; patient communication enhancements; health IT infrastructure use. May come in the form of care/case management fees, medical home payments, infrastructure payments, meaningful use payments, and/or per-episode fees for specialists. For more detailed information regarding these terms, please refer to the Alternative Payment Model (APM) 2023 Methodology and Results Report at: apmmethodology-2023.pdf (hcp-lan.org).

PLAN INQUIRIES Payments to Providers	**CMS RESPONSES for Payment to Providers**

17) What is a "Legacy payment"?	Payments that utilize traditional payments and are not adjusted to account for infrastructure investments, provider reporting of quality data, or for provider performance on cost and quality metrics. This can include fee-for-service, diagnosis-related groups (DRGs), and per diems. For more detailed information regarding these terms, please refer to the Alternative Payment Model (APM) 2023 Methodology and Results Report at: apm-methodology-2023.pdf (hcplan.org).
18) What is a "Traditional shared savings payment"?	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a preestablished set target for spending, as long as they meet quality targets. Traditional shared-savings provides an upside-only financial incentive for providers or provider entities to reduce unnecessary spending for a defined population of patients or an episode of care, and to meet quality targets. For more detailed information regarding these terms, please refer to the Alternative Payment Model (APM) 2023 Methodology and Results Report at: apmmethodology-2023.pdf (hcp-lan.org).

PLAN INQUIRIES Payments to Providers	**CMS RESPONSES for Payment to Providers**

19) What is a "utilization-based shared saving payment"?	A payment arrangement that allows providers to share in a portion of any savings they generate due to meeting quality and utilization targets that produce savings (e.g., Medicare CPC+ Track 1 program). There are no financial targets in these arrangements; instead, there are utilization targets that impact a significant portion of the total cost of care. Examples of utilization measures include, but are not limited to, emergency department utilization, inpatient admissions, and readmissions. Utilization-based shared savings provides an upside-only financial incentive for providers or provider entities to reduce unnecessary care or utilization for a defined population of patients or an episode of care, and to meet quality targets. For more detailed information regarding these terms, please refer to the Alternative Payment Model (APM) 2023 Methodology and Results Report at: apm-methodology-2023.pdf (hcplan.org).
20) What is a "fee-for-service based shared-risk savings payment"?	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending, but also puts them at financial risk for any overspending. Shared risk provides both an upside and downside financial incentive for providers or provider entities to reduce unnecessary spending for a defined population of patients or an episode of care, and to meet quality targets. For more detailed information regarding these terms, please refer to the Alternative Payment Model (APM) 2023 Methodology and Results Report at: apm-methodology-2023.pdf (hcp-lan.org).

PLAN INQUIRIES Payments to Providers	**CMS RESPONSES for Payment to Providers**

21) What is a "conditionspecific, population-based payment"?	A per member per month (PMPM) payment to providers for inpatient and outpatient care that a patient population may receive for a particular condition in a given time period, such as a month or year, including inpatient care and facility fees. For more detailed information regarding these terms, please refer to the Alternative Payment Model (APM) 2023 Methodology and Results Report at: apmmethodology-2023.pdf (hcp-lan.org).
22) What is a "conditionspecific, bundled/episode payment"?	A single payment to providers and/or health care facilities for all services related to a specific condition (e.g., diabetes). The payment considers the quality, costs, and outcomes for a patient-centered course of care over a longer time period and across care settings. Providers assume financial risk for the cost of services for a particular condition, as well as costs associated with preventable complications. For more detailed information regarding these terms, please refer to the Alternative Payment Model (APM) 2023 Methodology and Results Report at: apmmethodology-2023.pdf (hcp-lan.org).
23) What is a "populationbased payment NOT condition specific"?	A per member per month (PMPM) payment to providers for outpatient or professional services that a patient population may receive in a given time period, such as a month or year, not including inpatient care or facility fees. The services for which the payment provides coverage is predefined and could cover primary, acute, and post-acute care that is not specific to any particular condition. For more detailed information regarding these terms, please refer to the Alternative Payment Model (APM) 2023 Methodology and Results Report at: apmmethodology-2023.pdf (hcp-lan.org).

PLAN INQUIRIES Payments to Providers	**CMS RESPONSES for Payment to Providers**

24) What is a "full or percent of premium population-based payment"?	A fixed dollar payment to providers for all the care that a patient population may receive in a given time period, such as a month or year, (e.g., inpatient, outpatient, specialists, out-of-network, etc.) with payment adjustments based on measured performance and patient risk. For more detailed information regarding these terms, please refer to the Alternative Payment Model (APM) 2023 Methodology and Results Report at: apm-methodology-2023.pdf (hcplan.org).
25) What are "integrated finance and delivery system programs"?	Payments in which the delivery system is integrated with the finance system and delivers comprehensive care. These integrated arrangements consist of either insurance companies that own provider networks, or delivery systems that offer their own insurance products, or payer and provider organizations that share a common governance structure, or payer and provider organizations that are engaged in mutually exclusive relationships. For more detailed information regarding these terms, please refer to the Alternative Payment Model (APM) 2023 Methodology and Results Report at: apm-methodology-2023.pdf (hcplan.org).
26) How are "covered lives" defined?	Covered Lives are defined as lives in care relationships with accountability for quality, total cost of care, and longitudinal care (6+ months).
PLAN INQUIRIES Payments to Providers	**CMS RESPONSES for Payment to Providers**

27) What is the required criteria for MA plan members to participate in a PCP-PCG Focused Accountable Care Arrangement?	There is no requirement for MA plan members to participate in a PCP-PCG Focused Accountable Care Arrangement. For more information, please refer to additional guidance for measuring covered lives in accountable care APM arrangements at: https://hcplan.org/workproducts/APM-Measurement/Guidancefor-measuring-covered-lives.pdf.

XII. APPENDIX 2. MEASURING COVERED LIVES IN ACCOUNTABLE CARE

Accountable Care	Accountable Care centers on the patient and aligns their care team to support shared decision-making and help realize the best achievable health outcomes for all through comprehensive, high quality, affordable, equitable, longitudinal care. For the purposes of the LAN's annual survey, accountable care must include two elements or dimensions: 1) the care is longitudinal with a duration of six months or longer; and 2) the payment model incorporates accountability for total cost of care (TCOC) for aligned patients. See TCOC definition and further clarification along with examples below. If an enrollee is in an accountable care arrangement with a provider that is expected to be at least 6 months or longer, but the enrollee	

	does not remain in that arrangement for the full 6 months (regardless of the reason), the intent is for that life to be counted because the accountable care arrangement was structured to be 6 months or longer.	
Assign/assigned/assignment or Align/aligned/alignment	The method by which health plans associate enrollees to a contracted, in-network primary care physician (PCP) or a primary care group (PCG) for the purposes of an accountable care. This term includes a health plan enrollee who chooses (voluntarily, selfdesignates) a contracted, innetwork PCP or PCG. The PCP or PCG is charged with caring for the patients for whom they have been delegated by the contracted health plan. <u>*NOTE*</u>*: Some health plans may have specialty models that assign patients to a specialist based on the model instead of a PCP or PCG. In such cases, the health plan should count these enrollees under Metric #2 –* ***NonPCP/PCG-Focused Accountable Care Metric****. However, if the enrollee is assigned to a specialist and a PCP, the health plan should only count that enrollee one time under either Metrics 1 OR Metric 2, but not both. See General Guidance section above.* See examples of assign/assigned/assignment from the perspective of a health plan or health plan enrollee below. <u>Health Plan Example</u>: Health plans may take this action when the product in which the enrollee enrolls requires the enrollee to select a PCP or PCG. If the	

	enrollee does not select a PCP or PCG at the time of enrollment, the	

	health plan allocates – or assigns – the enrollee to a PCP or PCG within the health plans' preferred provider network. The health plan may consider the PCP or PCG's current panel size, geographic location, enrollee claims' history, and other factors when identifying an appropriate PCP or PCG for the enrollee. Health Plan Enrollee Example: A health plan enrollee may voluntarily select a PCP or PCG at the time of enrollment or at other times while enrolled in the health plan.	
Attributed/attribution	Refers to a statistical or administrative methodology that attributes a patient population to a provider for a particular APM (which must include cost AND quality). "Attributed" patients can include those who choose to enroll in, or do not opt out of, an accountable care organization (ACO), patient centered medical home (PCMH), or other delivery models in which patients are attributed to a provider who is accountable for a patient's total cost of care for six months or longer.	

Empanel/empaneled/empanelment	This term is typically used in a provider-facing manner; however, some health plans may use this term internally to describe the act the health plan takes to assign individual enrollees to individual primary care providers (PCP) or primary care groups (PCG) and care teams with sensitivity to enrollee and family preference. (AHRQ) This act or process results in a	

	provider having a "patient panel." The patient panel is a group of patients assigned to one PCP or primary care group (PCG). The physician and/or group is accountable for the care of the patients within the panel. (Adapted from AHRQ, AMA definitions) Also known as paneled or paneling. See also assign/assigned/assignment.	

Longitudinal Relationship	This is defined as a care relationship where the provider has aligned patients in which they serve as a coordinator for their overall care. At minimum, this longitudinal relationship needs to be six (6) months and often can be determined on a yearly basis in alternative payment models. A provider-patient relationship for an episode of care for a chronic condition or cancer treatment regimen that is six months or longer also qualifies as a longitudinal relationship. <u>Exclusions:</u> A three-month episode for a hip/knee replacement or other such service does not qualify as a longitudinal relationship. Plans are asked to exclude these patients from the accountable care count UNLESS the patient is in an accountable care relationship with another provider that is six months or longer.	
Total Cost of Care	Total cost of care (TCOC) is intended to indicate there is significant financial accountability for the patient's care; however, it does NOT mean that every claim	

	related to a patient must fall under the TCOC arrangement. In other words, TCOC does not need to include ALL of the patient's costs; it can be a significant subset of a patient's costs. Additionally, TCOC covers inpatient and outpatient services (e.g., Medicare Part A and B) and can potentially include drug costs (e.g., Medicare Part B and D) or other long-term services and supports as desired. Providers do not need to be in a capitated payment arrangement or at financial risk for TCOC spending but have some measure(s) that they are assessed on for TCOC as part of their overall performance (e.g., Primary Care First has a measure on Total Per Capita Cost for aligned beneficiaries), however, capitation arrangements or financial risk for TCOC would also count as accountability for TCOC. See TCOC examples below. Example 1: A TCOC arrangement that excludes drug-benefit-related costs can still be considered a TCOC arrangement. Example 2: A TCOC arrangement that is for a patient's primary care services, but not the patient's specialty or facility-related costs can still be considered a TCOC arrangement. Example 3: An episode-based model of 6-month or longer that excludes un-related services, outliers, and other select exclusionary criteria (e.g., major traumas) can still be considered a TCOC arrangement.	

	Example 4: An arrangement that only covers wellness or preventive care is not considered a TCOC arrangement.	