Technical Specifications

Public Use File (PUF) of Contract Year (CY) 2022

Part C and D Reporting Requirements Data

Last revision: January 2024

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I. Introduction

Datasets

Each contract year's PUF contains individual datasets for each reporting section, including the raw data as reported by contracts, and if applicable, validated by independent contractors. With a few exceptions, CMS will release all data elements collected within a reporting section. Beneficiary information, proprietary, confidential, or otherwise sensitive data are not included. Technical specifications such as reporting frequency and schedule, inclusions/exclusions, and any other information that is important for accurate interpretation of the data elements are provided.

For reporting sections that undergo data validation (DV), CMS only releases data for contracts receiving at least the minimal data validation score to pass. Contracts which did not pass data validation are excluded from the PUF. Also, contracts that passed data validation but were later found to have significant data issues may be excluded from the PUF. More information about the data validation standards can be found at https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/part-c-and-part-d-data-validation.

The PUF is restricted to contracts and plans that meet minimum enrollment size criteria. Further details regarding how the minimum enrollment size criteria are applied for each reporting section are provided in Section IV.

In accordance with the CMS Cell Suppression Policy,[1] cells containing values of 1 to 10 are not reported in the PUF to protect the privacy of individuals. This policy also suppresses cells that allow a value 1 to 10 to be derived from other reported information. Suppressed data will be denoted with an asterisk (*) in the PUF.

Reporting Sections Included in the PUF

The table below outlines the Part C and D reporting sections that are included in the CY 2022 PUF and whether they were included in the 2023 data validation cycle.

Table 1: CY 2022 PUF Reporting Sections

Reporting Section	Calendar Year	2023 DV Cycle
Grievances – Part C	CY 2022	✓
Organization Determinations and Reconsiderations – Part C	CY 2022	✓
Payments to Providers – Part C	CY 2022	
Rewards and Incentives Programs – Part C	CY 2022	

[1] https://www.hhs.gov/guidance/document/cms-cell-suppression-policy

Reporting Section	Calendar Year	2023 DV Cycle
Special Needs Plans (SNPs) Care Management – Part C	CY 2022	✓
Enrollment and Disenrollment – Part C	CY 2022	
Coverage Determinations & Redeterminations – Part D	CY 2022	✓
Grievances – Part D	CY 2022	✓
Improving Drug Utilization Review Controls – Part D	CY 2022	✓
Medication Therapy Management (MTM) Programs – Part D	CY 2022	✓
Enrollment and Disenrollment – Part D	CY 2022	

Data elements included in the PUF are listed in Section IV as they appear in the CY 2022 Part C and D Reporting Requirements documents. The Reporting Requirements documents can be found at the following locations:

Part C reporting sections - https://www.cms.gov/medicare/enrollment-renewal/health-plans/part-c

Part D reporting sections - https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/part-d-reporting-requirements

Reporting Sections Excluded from the PUF

- Data that are non-validated and are used for CMS monitoring only:
  - Employer Group Plan Sponsors (Part C and Part D)

II. CMS Disclaimer – User Agreement for Public Use Data

The Part C and Part D Reporting Requirements Public Use Files are provided by the Centers for Medicare & Medicaid Services (CMS). By downloading and using these Public Use Files, the User agrees to comply with this Agreement.

This Agreement outlines the responsibility of CMS and the user in regard to the processing and understanding of the data files.

- Users acknowledge that the Part C and Part D Reporting Requirements data are submitted to CMS by Part C and Part D sponsors on an annual basis as a condition of their participation in the Medicare Advantage and Part D Prescription Drug Benefit Program.
- Users should carefully review the applicable Reporting Requirements and Technical Specifications documents for each Contract Year. Data reporting requirements and technical specifications may change from year to year. Therefore, users must familiarize themselves with any modifications when considering these data across plan years.
- As applicable, most sponsor-reported data undergo the data validation (DV) process. Sponsor-reported data that undergo DV and do not meet CMS' specifications are excluded from the PUF.
- CMS posts these PUFs on an annual basis, following the DV process and other CMS reviews. CMS cannot guarantee the release of these data files to meet any timeframe.
- Users should review the PUF technical specifications. CMS has a policy of not reporting data on fewer than 11 cases to protect the privacy of individuals. This policy also includes cases where counts of fewer than 11 cases can be derived from presented information. As a result, released data may be limited. The user shall not use the information in a manner that is inaccurate or misleading.
- CMS has no responsibility for the data file after it has been converted, processed, or otherwise altered. CMS has no responsibility for assisting users with converting the data to another format.

III. Technical Assistance

Questions about the PUFs should be sent to the below mailboxes:

Part C reporting sections - partcplanreporting@cms.hhs.gov

Part D reporting sections - partd-planreporting@cms.hhs.gov

IV. PUF Specifications by Reporting Section

The following subsections provide specifications of each individual dataset of the PUF including, for each reporting section:

- Reporting section details, such as the year of data included and level and frequency at which the data are reported by sponsors
- PUF dataset details, such as any minimum size and/or data validation criteria applied to exclude or suppress data from the PUF
- File layout, including variable names and definitions

All datasets are provided in an excel file in .xlsx format.

Grievances – Part C

Reporting Section Details

Year: CY 2022

Level: Contract

Frequency: 1/Year

PUF Details

File Level: Unique at Organization Type level.

Exclusion Criteria: Contracts that were not required to submit Part C Grievances data[2] or that did not have at least one enrollee in all four quarters of the year are excluded. Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2022 - December 2022) according to HPMS are excluded. Contracts that fail to meet the Data Validation criteria described below.

Data Validation: Contracts scoring less than 95% in DV for their reporting of the Grievances section will be excluded. Contracts that scored 95% or higher in DV for this section but that were not compliant with DV standards/sub-standards for at least one data element listed in the file layout described below will be excluded.

File Layout

Variable Name	Definition
Organization Type	Organization Type
Number of Contracts	Number of Contracts that meet the criteria for inclusion in the PUF
Average Monthly Enrollment (HPMS)	Total average monthly HPMS enrollment during the reporting year for Contracts that meet the criteria for inclusion in the PUF
TOTAL_GRIEVE	Number of Total Grievances (Element A)
TIMELY_GRIEVE	Number of Total Grievances in which timely notification was given (Element B)
TOTAL_EXP	Number of Expedited Grievances (Element C)
TIMELY_EXP	Number of Expedited Grievances in which timely notification was given (Element D)
DISMISSED_GRIEVE	Number of Dismissed Grievances (Element E)

[2] Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met.

Organization Determinations and Reconsiderations and Reopenings– Part C

Reporting Section Details

Year: CY 2022

Level: Contract

Frequency: 1/Year

PUF Details

File Level: Unique at Organization Type level.

Exclusion Criteria: Contracts that were not required to submit Organization Determinations and Reconsiderations and Reopenings data[3] or that did not have at least one enrollee in all four quarters of the year are excluded. Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2022 - December 2022) according to the Health Plan Management System (HPMS) are excluded. Contracts that fail to meet the Data Validation criteria described below.

Data Validation: Contracts scoring less than 95% in DV for their reporting of the Organization Determinations and Reconsiderations and Reopenings section will be excluded. Contracts that scored 95% or higher in DV for this section but that were not compliant with DV standards/sub-standards for at least one data element listed in the file layout described below will be excluded.

File Layout

Variable Name	Definition
Organization Type	Organization Type
Number of Contracts	Number of Contracts that meet the criteria for inclusion in the PUF
Average Monthly Enrollment (HPMS)	Total average monthly HPMS enrollment during the reporting year for Contracts that meet the criteria for inclusion in the PUF

[3] Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met.

Variable Name	Definition
DET_ISSUED	Total Number of Organization Determinations Made in the Reporting Period Above (Element 1.A)
DET_WITHDRAWN	Number of Organization Determinations - Withdrawn (Element 1.B)
DET_DISMISSED	Number of Organization Determinations - Dismissals (Element 1.C)
DET_FULLFAV	Number of Organization Determinations – Fully Favorable. The sum of Elements 2.A, 2.B, 2.C, and 2.D.
DET_PARTFAV	Number of Organization Determinations – Partially Favorable. The sum of Elements 2.E, 2.F, 2.G, and 2.H.
DET_ADV	Number of Organization Determinations – Adverse. The sum of Elements 2.I, 2.J, 2.K, and 2.L.
TOTAL_REC_MADE	Total Number of Reconsiderations Made in Reporting Time Period Above (Element 3.A)
REC_WITHDRAWN	Number of Reconsiderations - Withdrawn (Element 3.B)
REC_DISMISSED	Number of Reconsiderations - Dismissals (Element 3.C)
REC_FULLFAV	Number of Reconsiderations – Fully Favorable. The sum of Elements 4.A, 4.B, 4.C, and 4.D.
REC_PARTFAV	Number of Reconsiderations – Partially Favorable. The sum of Elements 4.E, 4.F, 4.G, and 4.H.
REC_ADV	Number of Reconsiderations – Adverse. The sum of Elements 4.I, 4.J, 4.K, and 4.L.
TOTAL_REOPENED	Number of reopened/revised decisions, for any reason, in time period above (Element 5.A)

Payments to Providers – Part C

Reporting Section/Measure Details

Year: CY 2022

Level: Contract

Frequency: 1/Year

PUF Details

File Level: Unique at Organization Type level.

Exclusion Criteria: Contracts that were not required to submit Payments to Providers data[4] are excluded. Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2022 - December 2022) according to HPMS are excluded.

Data Validation: No

File Layout

Variable Name	Definition
Organization Type	Organization Type
Number of Contracts	Number of Contracts that meet the criteria for inclusion in the PUF
Average Monthly Enrollment (HPMS)	Total average monthly HPMS enrollment during the reporting year for Contracts that meet the criteria for inclusion in the PUF
TOTAL_PAY	Total Medicare Advantage payment made to contracted providers (Element A)
TOTAL_PAY_FFS_NO_LINK	Total Medicare Advantage payment made on a fee-for-service basis with no link to quality (Category 1) (Element B)
TOTAL_PAY_FFS_LINK	Total Medicare Advantage payment made on a fee-for-service basis with a link to quality (Category 2) (Element C)
TOTAL_PAY_ALT_MODEL	Total Medicare Advantage payment made using alternative payment models built on fee-for-service architecture (Category 3) (Element D)
TOTAL_PAY_RISK	Total Risk-based payments not linked to quality (e.g. 3N in APM definitional framework) (Element E)

[4] Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met.

Variable Name	Definition
TOTAL_PAY_POP_BASED	Total Medicare Advantage payment made using population-based payment (Category 4) (Element F)
TOTAL_PAY_CAP	Total capitation payment not linked to quality (e.g. 4N in the APM definitional framework) (Element G)
TOTAL_PROV	Total number of Medicare Advantage contracted providers (Element H)
TOTAL_PROV_FFS_NO_LINK	Total Medicare Advantage contracted providers paid on a fee-for-service basis with no link to quality (Category 1) (Element I)
TOTAL_PROV_FFS_LINK	Total Medicare Advantage contracted providers paid on a fee-for-service basis with a link to quality (Category 2) (Element J)
TOTAL_PROV_ALT_MODEL	Total Medicare Advantage contracted providers paid based on alternative payment models built on a fee-for-service architecture (Category 3) (Element K)
TOTAL_PROV_RISK	Total Medicare Advantage contracted providers paid based risk-based payments not linked to quality (e.g. 3N in the APM definitional framework) (Element L)
TOTAL_PROV_POP_BASED	Total Medicare Advantage contracted providers paid based on population based payment (Category 4) (Element M)
TOTAL_PROV_CAP	Total Medicare Advantage contracted providers paid based on capitation with no link to quality (e.g. category 4N in the APM definitional framework) (Element N)

Rewards and Incentives Programs – Part C

Reporting Section/Measure Details

Year: CY 2022

Level: Contract

Frequency: 1/Year

PUF Details

File Level: Unique at Organization Type level.

Exclusion Criteria: Contracts that were not required to submit Rewards and Incentives Programs[5] are excluded. Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2022 - December 2022) according to HPMS are excluded.

Data Validation: No

File Layout

Variable Name	Definition
Organization Type	Organization Type
Number of Contracts	Number of Contracts that meet the criteria for inclusion in the PUF
Average Monthly Enrollment (HPMS)	Total average monthly HPMS enrollment during the reporting year for Contracts that meet the criteria for inclusion in the PUF
Number of Contracts with an R&I Program	The number of contracts that responded Yes to Element A (Do you have a Rewards and Incentives Program(s)?)
Number of R&I Programs	Number of R&I Programs submitted under Element B (Rewards and Incentives Program Name)
TOTAL_ENROLLED	How many enrollees are currently enrolled in the program? (Element G)
TOTAL_REWARDS	How many rewards have been awarded so far? (Element H)

[5] Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met.

Special Needs Plans (SNPs) Care Management – Part C

Reporting Section Details

Year: CY 2022

Level: Plan

Frequency: 1/Year

PUF Details

File Level: Unique at SNP Type level.

Exclusion Criteria: Plans that were not required to submit SNP Care Management data[6] or that did not undergo DV are excluded. Additionally, plans whose sum of new enrollees (Element A) and enrollees eligible for an annual reassessment (Element B) is less than 11 are excluded. Plans that fail to meet the Data Validation criteria described below.

Data Validation: Plans scoring less than 95% in DV for their reporting of the SNP Care Management section will be excluded. Plans that scored 95% or higher in DV for this section but that were not compliant with DV standards/sub-standards for at least one data element listed in the file layout described below will be excluded. Note: There may be a number of reasons for less than 100% completion of the HRA, including refusals on the part of beneficiaries despite proactive efforts by plans

File Layout

Variable Name	Definition
SNP Type	Special Needs Plan Type
Number of Plans	Number of Plans that meet the criteria for inclusion in the PUF
Average Monthly Enrollment (HPMS)	Total average monthly HPMS enrollment during the reporting year for Plans that meet the criteria for inclusion in the PUF
NEW_ENROLLEES	Number of new enrollees due for an Initial Health Risk Assessment (HRA) (Element A)
ELIGIBLE_ENROLLEES	Number of enrollees eligible for an annual reassessment HRA (Element B)
INITIAL_ASSESSMENTS	Number of initial HRAs performed on new enrollees (Element C)
INITIAL_REFUSALS	Number of initial HRA refusals (Element D)

[6] Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met.

Variable Name	Definition
INITIAL_UNREACHABLE	Number of initial HRAs not performed because SNP is unable to reach new enrollees (Element E)
ANNUAL_REASSESSMENTS	Number of annual reassessments performed on enrollees eligible for a reassessment (Element F)
ANNUAL_REFUSALS	Number of annual reassessment refusals (Element G)
ANNUAL_UNREACHABLE	Number of annual reassessments where SNP is unable to reach enrollee (Element H)

Enrollment and Disenrollment – Part C

Reporting Section/Measure Details

Year: CY 2022

Level: Contract

Frequency: 2/Year

PUF Details

File Level: Unique at Organization Type level.

Exclusion Criteria: Contracts that were not required to submit Part C Enrollment and Disenrollment data[7] or that did not have at least one enrollee in both periods of the year are excluded. Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2022 - December 2022) according to HPMS are excluded.

Data Validation: No

File Layout

Variable Name	Definition
Organization Type	Organization Type
Number of Contracts	Number of Contracts that meet the criteria for inclusion in the PUF
Average Monthly Enrollment (HPMS)	Total average monthly HPMS enrollment during the reporting year for Contracts that meet the criteria for inclusion in the PUF
E_TOTAL_REQUESTS	Total number of enrollment requests received (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. (Element 1.A)
E_INITIAL_COMPLETE	Of the total reported in 1.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). (Element 1.B)

[7] Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met.

Variable Name	Definition
E_INITIAL_INCOMPLETE	Of the total reported in 1.A, the number of enrollment requests for which the sponsor was required to request additional information from the applicant (or his/her representative). (Element 1.C)
E_DENIED_INELIGIBLE	Of the total reported in 1.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) (Element 1.D)
E_INCOMPLETE_TIMELY	Of the total reported in 1.C, the number of incomplete enrollment requests received that are incomplete upon initial receipt and completed within established timeframes (Element 1.E)
E_DENIED_INCOMPLETE	Of the total reported in 1.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 (Element 1.F)
E_REQUESTS_PAPER	Of the total reported in 1.A, the number of paper enrollment requests received (Element 1.G)
E_REQUESTS_PHONE	Of the total reported in 1.A, the number of telephonic enrollment requests received (if sponsor offers this mechanism) (Element 1.H)
E_REQUESTS_PLAN_WEB	Of the total reported in 1.A, the number of electronic enrollment requests received via an electronic device or secure internet website (if sponsor offers this mechanism) (Element 1.I)
E_REQUESTS_OEC	Of the total reported in 1.A, the number of Medicare Online Enrollment Center (OEC) enrollment requests received (Element 1.J)
D_TOTAL_REQUESTS	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 (Element 2.A)
D_INITIAL_COMPLETE	Of the total reported in 2.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). (Element 2.B)
D_DENIED_ANY	Of the total reported in 2.A, the number of disenrollment requests denied by the sponsor for any reason (Element 2.C)
D_INVOLUNTARY_PREMIUM	Total number of involuntary disenrollments for failure to pay plan premium in the specified time period (Element 2.D)

Variable Name	Definition
D_REQUESTS_GOOD_CAUSE	Of the total reported in 2.D, the number of disenrolled individuals who submitted a timely request for reinstatement for Good Cause (Element 2.E)
D_ FAVORABLE_DET	Of the total reported in 2.E, the number of favorable Good Cause determinations (Element 2.F)
D_FAVORABLE_REINSTATE	Of the total reported in 2.F, the number of individuals reinstated (Element 2.G)

Coverage Determinations and Redeterminations and Reopenings – Part D

Reporting Section Details

Year: CY 2022

Level: Contract

Frequency: 1/Year

PUF Details

File Level: Unique at Organization Type level.

Exclusion Criteria: Contracts that were not required to submit Coverage Determinations and Redeterminations and Reopenings data[8] or that did not have at least one enrollee in all four quarters of the year are excluded. Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2022 - December 2022) according to HPMS are excluded. Contracts that fail to meet the Data Validation criteria described below.

Data Validation: Contracts scoring less than 95% in DV for their reporting of the Coverage Determinations and Redeterminations section will be excluded. Contracts that scored 95% or higher in DV for this section but that were not compliant with DV standards/sub-standards for at least one data element listed in the file layout described below will be excluded

File Layout

Variable Name	Definition
Organization Type	Organization Type
Number of Contracts	Number of Contracts that meet the criteria for inclusion in the PUF
Average Monthly Enrollment (HPMS)	Total average monthly HPMS enrollment during the reporting year for Contracts that meet the criteria for inclusion in the PUF
TOTAL_DET	Total Number of Coverage Determinations Processed (Element 1.A)
WITHDRAWN_DET	Total Number of Withdrawn Coverage Determinations (Element 1.B)
DISMISSED_DET	Total Number of Dismissed Coverage Determinations (Element 1.C)

[8] Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met.

Variable Name	Definition
FULLY_FAVORABLE_DET	Number of Coverage Determination decisions that were fully favorable. The sum of Elements 1.D, 1.H, 1.L, and 1.P.
PARTIALLY_FAVORABLE_DET	Number of Coverage Determination decisions that were partially favorable. The sum of Elements 1.E, 1.I, 1.M, and 1.Q.
ADVERSE_DET	Number of Coverage Determination decisions that were adverse. The sum of Elements 1.F, 1.J, 1.N, and 1.R.
TOTAL_UM	Number of Utilization Management Exception Coverage Determinations (Element 1.G)
TOTAL_FORM	Number of Formulary Exception Coverage Determinations (Element 1.K)
TOTAL_TIER	Number of Tiering Exception Coverage Determinations (Element 1.O)
TOTAL_REDET	Total Number of Redeterminations Processed (Element 2.A)
WITHDRAWN_REDET	Total Number of Withdrawn Redeterminations (Element 2.B)
DISMISSED_REDET	Total Number of Dismissed Redeterminations (Element 2.C)
FULLY_FAVORABLE_RD	Number of fully favorable Redetermination decisions. The sum of Elements 2.D, 2.H, 2.L, 2.P, and 2.T.
PARTIALLY_FAVORABLE_RD	Number of partially favorable Redetermination decisions. The sum of Elements 2.E, 2.I, 2.M, 2.Q, and 2.U.
ADVERSE_RD	Number of adverse Redetermination decisions. The sum of Elements 2.F, 2.J, 2.N, 2.R, and 2.V.
TOTAL_UM_REDET	Number of Utilization Management Exception Redeterminations (Element 2.G)
TOTAL_FORM_REDET	Number of Formulary Exception Redeterminations (Element 2.K)
TOTAL_TIER_REDET	Number of Tiering Exception Redeterminations (Element 2.O)
TOTAL_ATRISK_REDET	Number of At-Risk Redeterminations (Element 2.S)
TOTAL_REOPENINGS	Number of reopened/revised decisions (Element 3.A)

Grievances – Part D

Reporting Section Details

Year: CY 2022

Level: Contract

Frequency: 1/Year

PUF Details

File Level: Unique at Organization Type level.

Exclusion Criteria: Contracts that were not required to submit Part D Grievances data[9] or that did not have at least one enrollee in all four quarters of the year are excluded. Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2022 - December 2022) according to HPMS are excluded. Contracts that fail to meet the Data Validation criteria described below.

Data Validation: Contracts scoring less than 95% in DV for their reporting of the Grievances section will be excluded. Contracts that scored 95% or higher in DV for this section but that were not compliant with DV standards/sub-standards for at least one data element listed in the file layout described below will be excluded.

File Layout

Variable Name	Definition
Organization Type	Organization Type
Number of Contracts	Number of Contracts that meet the criteria for inclusion in the PUF
Average Monthly Enrollment (HPMS)	Total average monthly HPMS enrollment during the reporting year for Contracts that meet the criteria for inclusion in the PUF
GRIEVE_TOTAL	Total number of grievances (Element A)
GRIEVE_TIMELY	Number of grievances in which timely notification was given (Element B)
EXP_TOTAL	Total number of expedited grievances (Element C)
EXP_TIMELY	Number of expedited grievances in which timely notification was given (Element D)
GRIEVE_DISMISSED	Total number of dismissed grievances (Element E)

[9] Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met.

Improving Drug Utilization Review Controls – Part D

Reporting Section/Measure Details

Year: CY 2022

Level: Contract

Frequency: 1/Year

PUF Details

File Level: Unique at Organization Type level.

Exclusion Criteria: Contracts that were not required to submit Improving Drug Utilization Review Controls data[10] or that did not have at least one enrollee in all four quarters of the year are excluded. Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2022 - December 2022) according to HPMS are excluded. Contracts that fail to meet the Data Validation criteria described below.

Data Validation: Contracts scoring less than 95% in DV for their reporting of the Improving Drug Utilization Review Controls section will be excluded. Contracts that scored 95% or higher in DV for this section but that were not compliant with DV standards/sub-standards for at least one data element listed in the file layout described below will be excluded.

File Layout

Variable Name	Definition
Organization Type	Organization Type
Number of Contracts	Number of Contracts that meet the criteria for inclusion in the PUF
Average Monthly Enrollment (HPMS)	Total average monthly HPMS enrollment during the reporting year for Contracts that meet the criteria for inclusion in the PUF
CARE_REJ_CLAIMS	The number of claims rejected due to the care coordination edit (Element C)
CARE_REJ_OVERRIDE_CLAIMS	Of the total reported in element C, the number of claims rejections overridden by the pharmacy (Element D)

[10] Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met.

Variable Name	Definition
CARE_REJ_24HR_OVERRIDE_CLAIMS	Of the total reported in element D, the number of claim rejections overridden by the pharmacy within 24 hours of the initial claim rejection (Element E)
CARE_REJ_EXMPT_OVERRIDE_CLAIMS	Of the total reported in element D, the number of claim rejections overridden by the pharmacy due to an exemption (Element F)
CARE_REJ_PRSC_OVERRIDE_CLAIMS	Of the total reported in element D and not in element F, the number of claim rejections overridden by the pharmacy as a result of prescriber consultation (Element G)
CARE_REJ_UNIQUE_BENES	The number of unique beneficiaries with at least one claim rejected due to the care coordination edit (Element H)
CARE_REJ_OVERRIDE_BENES	Of the total reported in element H, the number of unique beneficiaries with at least one claim rejection overridden by the pharmacy (Element I)
CARE_REJ_24HR_OVERRIDE_BENES	Of the total reported in element H, the number of unique beneficiaries with at least one claim rejection overridden by the pharmacy within 24 hours of the initial claim rejection (Element J)
CARE_REJ_EXMPT_OVERRIDE_BENES	Of the total reported in element H, the number of unique beneficiaries with at least one claim rejection overridden by the pharmacy due to an exemption (Element K)
CARE_REJ_PRSC_OVERRIDE_BENES	Of the total reported in element H and not in element K, the number of unique beneficiaries with at least one claim rejection overridden by the pharmacy as a result of prescriber consultation (Element L)
Number of Contracts with Hard Edits	Number of Contracts that responded Yes to Element M (Did the plan have a hard MME edit in place during the time period above?)
HARD_REJ_CLAIMS	If yes to element M, the number of claims rejected due to the hard MME edit (Element Q)
HARD_REJ_UNIQUE_BENES	If yes to element M, the number of unique beneficiaries with at least one claim rejected due to the hard MME edit (Element R)
HARD_REJ_EXMPT_OVERRIDE_BENES	Of the total reported in element R, the number of unique beneficiaries with at least one claim rejection overridden by the pharmacy due to an exemption (Element S)

Variable Name	Definition
HARD_REJ_BENES_COVER_DET	Of the total reported in element R and not in element S, the number of unique beneficiaries who requested a coverage determination for the prescription(s) subject to the edit (Element T)
HARD_REJ_BENES_FAVCOVER_DET	Of the total reported in element T, the number of unique beneficiaries that had a favorable (either full or partial) coverage determination for the prescription(s) subject to the edit (Element U)
NVE_REJ_CLAIMS	The number of claims rejected due to the opioid naïve days supply edit (Element W)
NVE_REJ_EXMPT_OVERRIDE_CLAIMS	Of the total reported in element W, the number of rejected claims overridden by the pharmacy due to an exemption (Element X)
NVE_REJ_HIST_OVERRIDE_CLAIMS	Of the total reported in element W, the number of rejected claims overridden by the pharmacy because the beneficiary was not opioid naïve (Element Y)
NVE_REJ_7DS_OVERRIDE_CLAIMS	Of the total reported in element W and not in elements X or Y, the number of rejected claims for which up to a 7 day supply (covered by the plan) was dispensed by the pharmacy (Element Z)
NVE_REJ_UNIQUE_BENES	The number of unique beneficiaries with at least one claim rejected due to the opioid naïve days supply edit (Element AA)
NVE_REJ_EXMPT_OVERRIDE_BENES	Of the total reported in element AA, the number of unique beneficiaries with at least one rejected claim overridden by the pharmacy due to an exemption (Element BB)

Variable Name	Definition
NVE_REJ_HIST_OVERRIDE_BENES	Of the total reported in element AA, the number of unique beneficiaries with at least one rejected claim overridden by the pharmacy because the beneficiary was not opioid naïve (Element CC)
NVE_REJ_7DS_ BENES	Of the total reported in element AA, the number of unique beneficiaries for whom up to a 7 day supply (covered by the plan) was dispensed by the pharmacy (Element DD)
NVE_REJ_BENES_COVER_DET	Of the total reported in element AA, the number of unique beneficiaries with an opioid naïve days' supply edits claim rejection who requested a coverage determination for the prescription(s) subject to the edit (Element EE)
NVE_REJ_BENES_FAVCOVER_DET	Of the total reported in element EE, the number of unique beneficiaries with an opioid naïve days supply edit claim rejection who had a favorable (either full or partial) coverage determination for the prescription(s) subject to the edit (Element FF)

Medication Therapy Management (MTM) Programs – Part D

Reporting Section Details

Year: CY 2022

Level: Contract

Frequency: 1/Year

PUF Details

File Level: Unique at Organization Type level.

Exclusion Criteria: Contracts that were not required to submit Medication Therapy Management data[11] or that did not undergo data validation (DV) are excluded. Contracts that fail to meet the Data Validation criteria and Minimum Size criteria described below.

Data Validation: Contracts scoring less than 95% in DV for their reporting of the Medication Therapy Management section will be excluded. Contracts that scored 95% or higher in DV for this section but that were not compliant with DV standards/sub-standards for at least one data element listed in the file layout described below will be excluded.

Minimum Size: Contracts reporting fewer than 11 total records in their MTM data are excluded.

Contracts reporting more than 11 total records in their MTM data but between 1 and 10 records in any age bracket (under 65; 65-74; 75-84; 85) will be excluded.

Other: Records that cannot be mapped to a valid beneficiary or that contain dates of MTM program enrollment (Element H) outside of the reporting year are excluded. Additionally, if multiple conflicting records are reported for the same beneficiary by the same contract, those records are excluded.

File Layout

Variable Name	Definition
Organization Type	Organization Type
Number of Contracts	Number of Contracts that meet the criteria for inclusion in the PUF

[11] Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met.

Variable Name	Definition
Average Monthly Enrollment (HPMS)	Total average monthly HPMS enrollment during the reporting year for Contracts that meet the criteria for inclusion in the PUF
Number of MTM-Eligible Enrollees	Incremental count of number of MTM records across all Contract IDs in PUF for Contracts that meet the criteria for inclusion in the PUF
Cognitively Impaired	Number of MTM records where the beneficiary was identified as being cognitively impaired at time of CMR offer or delivery of CMR. (Element F)
In LTC Facility	Number of MTM records where the beneficiary was in a long-term care facility at the time of the first CMR offer or delivery of CMR. (Element G)
TARG_CRITERIA_01	Number of MTM records where Element I (Targeting criteria met. Required if met the specified targeting criteria per CMS – Part D requirements) has a value of Multiple chronic diseases/multiple Part D drugs/cost threshold
TARG_CRITERIA_02	Number of MTM records where Element I (Targeting criteria met. Required if met the specified targeting criteria per CMS – Part D requirements) has a value of Drug management program at-risk beneficiary
TARG_CRITERIA_03	Number of MTM records where Element I (Targeting criteria met. Required if met the specified targeting criteria per CMS – Part D requirements) has a value of Both
TARG_CRITERIA_NA	Number of MTM records where Element I (Targeting criteria met. Required if met the specified targeting criteria per CMS – Part D requirements) has a value of Beneficiary did not meet the specified targeting criteria per CMS – Part D requirements
Opt Out	Number of MTM Records where Element L (Reason participant opted out of MTM program, if applicable) identifies the beneficiary as opting out of MTM
CMR Offered	Number of MTM records where the beneficiary was offered a comprehensive medication review (CMR) (Element M)
CMR Received with Written Summary in CMS Standardized Format	Number of MTM records where the beneficiary received an annual CMR with written summary in CMS standardized format (Element O)

Variable Name	Definition
CMR_METHOD_01	Number of MTM records where Element R (Method of delivery for the annual CMR) has a value of Face-to-face
CMR_METHOD_02	Number of MTM records where Element R (Method of delivery for the annual CMR) has a value of Telephone
CMR_METHOD_03	Number of MTM records where Element R (Method of delivery for the annual CMR) has a value of Telehealth consultation
CMR_METHOD_04	Number of MTM records where Element R (Method of delivery for the annual CMR) has a value of Other
CMR_PROVIDER_01	Number of MTM records where Element S (The qualified provider who performed the initial CMR) has a value of Physician
CMR_PROVIDER_02	Number of MTM records where Element S (The qualified provider who performed the initial CMR) has a value of Registered Nurse
CMR_PROVIDER_03	Number of MTM records where Element S (The qualified provider who performed the initial CMR) has a value of Licensed Practical Nurse
CMR_PROVIDER_04	Number of MTM records where Element S (The qualified provider who performed the initial CMR) has a value of Nurse Practitioner
CMR_PROVIDER_05	Number of MTM records where Element S (The qualified provider who performed the initial CMR) has a value of Physician's Assistant
CMR_PROVIDER_06	Number of MTM records where Element S (The qualified provider who performed the initial CMR) has a value of Local Pharmacist
CMR_PROVIDER_07	Number of MTM records where Element S (The qualified provider who performed the initial CMR) has a value LTC Consultant Pharmacist
CMR_PROVIDER_08	Number of MTM records where Element S (The qualified provider who performed the initial CMR) has a value of Plan Sponsor Pharmacist
CMR_PROVIDER_09	Number of MTM records where Element S (The qualified provider who performed the initial CMR) has a value of PBM Pharmacist

Variable Name	Definition
CMR_PROVIDER_10	Number of MTM records where Element S (The qualified provider who performed the initial CMR) has a value of MTM Vendor Local Pharmacist
CMR_PROVIDER_11	Number of MTM records where Element S (The qualified provider who performed the initial CMR) has a value of MTM Vendor In-House Pharmacist
CMR_PROVIDER_12	Number of MTM records where Element S (The qualified provider who performed the initial CMR) has a value of Hospital Pharmacist
CMR_PROVIDER_13	Number of MTM records where Element S (The qualified provider who performed the initial CMR) has a value of Pharmacist – Other
CMR_PROVIDER_14	Number of MTM records where Element S (The qualified provider who performed the initial CMR) has a value of Supervised Pharmacy Intern
CMR_PROVIDER_15	Number of MTM records where Element S (The qualified provider who performed the initial CMR) has a value of Other
CMR_RECIPIENT_01	Number of MTM records where Element T (The recipient of the initial CMR) has a value of Beneficiary
CMR_RECIPIENT_02	Number of MTM records where Element T (The recipient of the initial CMR) has a value of Beneficiary's prescriber
CMR_RECIPIENT_03	Number of MTM records where Element T (The recipient of the initial CMR) has a value of Caregiver
CMR_RECIPIENT_04	Number of MTM records where Element T (The recipient of the initial CMR) has a value of Other authorized individual
TMR	Number of targeted medication reviews (Element U)
THERAPY_RECOMMENDATIONS	The number of medication therapy problem recommendations made to beneficiary's prescriber(s) as a result of MTM services (Element W).
THERAPY_RESOLUTIONS	Number of medication therapy problem resolutions resulting from recommendations made to beneficiary's prescriber(s) as a result of MTM recommendations (Element X)

Variable Name	Definition
SAFE_DISPOSAL_COMMS	Number of communications sent to beneficiary regarding safe disposal of medications (Element Y).
SAFE_DISPOSAL_COMMS_METHOD_01	Number of MTM records where Element Z (Method of delivery for information regarding safe disposal of medications. If more than one communication is sent, report the method of the initial communications) has a value of CMR
SAFE_DISPOSAL_COMMS_METHOD_02	Number of MTM records where Element Z (Method of delivery for information regarding safe disposal of medications. If more than one communication is sent, report the method of the initial communications) has a value of TMR
SAFE_DISPOSAL_COMMS_METHOD_03	Number of MTM records where Element Z (Method of delivery for information regarding safe disposal of medications. If more than one communication is sent, report the method of the initial communications) has a value of Welcome Letter
SAFE_DISPOSAL_COMMS_METHOD_04	Number of MTM records where Element Z (Method of delivery for information regarding safe disposal of medications. If more than one communication is sent, report the method of the initial communications) has a value of Other

Enrollment and Disenrollment – Part D

Reporting Section/Measure Details

Year: CY 2022

Level: Contract

Frequency: 2/Year

PUF Details

File Level: Unique at Organization Type level.

Exclusion Criteria: Contracts that were not required to submit Part D Enrollment and Disenrollment data[12] or that did not have at least one enrollee in both periods of the year are excluded. Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2022 - December 2022) according to HPMS are excluded.

Data Validation: No

File Layout

Variable Name	Definition
Organization Type	Organization Type
Number of Contracts	Number of Contracts that meet the criteria for inclusion in the PUF
Average Monthly Enrollment (HPMS)	Total average monthly HPMS enrollment during the reporting year for Contracts that meet the criteria for inclusion in the PUF
E_TOTAL_REQUESTS	The total number of enrollment requests (initiated by the beneficiary or his/her authorized legal representative) received in the specified time period. Do not include auto/facilitated or passive enrollments, rollover transactions, or other enrollments effectuated by CMS (Element 1.A)
E_INITIAL_COMPLETE	Of the total reported in 1.A, the number of enrollment requests complete at the time of initial receipt (Element 1.B)

[12] Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met.

Variable Name	Definition
E_INITIAL_INCOMPLETE	Of the total reported in 1.A, the number of enrollment requests that were not complete at the time of initial receipt, and for which the sponsor was required to request additional information from the applicant (or his/her representative) (Element 1.C)
E_DENIED_INELIGIBLE	Of the total reported in 1.A, the number of enrollment requests denied due to the sponsor's determination that the applicant was not eligible for an election period (Element 1.D)
E_INCOMPLETE_TIMELY	Of the total reported in 1.C, the number of enrollment requests received that are incomplete upon initial receipt and completed within established timeframes (Element 1.E)
E_DENIED_INCOMPLETE	Of the total reported in 1.C, the number of enrollment requests denied due to the applicant or his/her authorized legal representative not providing the information required to complete the enrollment request within established timeframes (Element 1.F)
E_REQUESTS_PAPER	Of the total reported in 1.A, the number of paper enrollment requests received (Element 1.G)
E_REQUESTS_PHONE	Of the total reported in 1.A, the number of telephonic enrollment requests received (if sponsor offers this mechanism) (Element 1.H)
E_REQUESTS_PLAN_WEB	Of the total reported in 1.A, the number of electronic enrollment requests received via an electronic device or secure internet website (if Sponsor offers this mechanism) (Element 1.I)
E_REQUESTS_OEC	Of the total reported in 1.A, the number of Medicare Online Enrollment Center (OEC) enrollment requests received (Element 1.J)
E_REQUESTS_AGENT	Of the total reported in 1.A, the number of enrollment requests received from an applicant through an agent or broker. (Element 1.K)
D_TOTAL_REQUESTS	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 (Element 2.A)
D_INITIAL_COMPLETE	Of the total reported in 2.A, the number of disenrollment requests complete at the time of initial receipt (Element 2.B)
D_INITIAL_INCOMPLETE	Of the total reported in 2.A, the number of disenrollment requests that were not complete at the time of initial receipt (Element 2.C)

Variable Name	Definition
D_DENIED_INELIGIBLE	Of the total reported in 2.A, the number of disenrollment requests denied due to the sponsor's determination that the enrollee was not eligible for an election period (Element 2.D)
D_INCOMPLETE_TIMELY	Of the total reported in 2.C, the number of disenrollment requests received that are incomplete upon initial receipt and completed within established timeframes (Element 2.E)
D_DENIED_INCOMPLETE	Of the total reported in 2.C, the number of disenrollment requests denied due to the enrollee or his/her authorized legal representative not providing information to complete the disenrollment request within established timeframes (Element 2.F)
D_INVOLUNTARY_PREMIUM	The total number of involuntary disenrollments for failure to pay plan premium in the specified time period (Element 2.G)
D_REQUESTS_GOOD_CAUSE	Of the total reported in 2.G, the number of disenrolled individuals who submitted a timely request for reinstatement for Good Cause (Element 2.H)
D_ FAVORABLE_DET	Of the total reported in 2.H, the number of favorable Good Cause determinations (Element 2.I)
D_FAVORABLE_REINSTATE	Of the total reported in 2.I, the number of individuals reinstated (Element 2.J)