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DATE: August 23, 2024

TO: All Part D Plans

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SUBJECT: Contract Year (CY) 2025 Part D Reporting Requirements and Draft
Technical Specifications for the Medicare Prescription Payment Plan

The Centers for Medicare & Medicaid Services (CMS) has released the final CY 2025 Part D Reporting Requirements (CMS-10185; OMB control number: 0938-0992). The Part D documents are posted on the CMS website at the following link:

<https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/part-d-reporting-requirements>.

We are also releasing draft technical specifications for the new Medicare Prescription Payment Plan reporting section to help ensure accurate and consistent data reporting. Please see the [Appendix](#) to this memo.

CMS is seeking comments on these draft Medicare Prescription Payment Plan Technical Specifications prior to releasing the final Part D Reporting Requirements Technical Specifications across all reporting sections. Specifically, we seek comments or questions to help ensure the technical specifications are clear for sponsors to report these data. Comments should not be submitted regarding the data elements, since those have already been finalized for CY 2025. The comment period will be open for two weeks and end on September 6, 2024. Comments should be emailed to partd-planreporting@cms.hhs.gov with the subject line “Medicare Prescription Payment Plan Technical Specifications.”

CMS expects to post the final Part D Reporting Requirements Technical Specifications across all reporting sections later this fall.

Questions regarding the CY 2025 Part D Reporting Requirements should be sent via email to partd-planreporting@cms.hhs.gov and should include the title of the specific reporting section and data element to which your question applies in the subject line.

Appendix: Draft CY 2025 Medicare Prescription Payment Plan Technical Specifications

Introduction

These technical specifications supplement the Part D Reporting Requirements (OMB 0938-0992) and do not change, alter, or add to the data collection. They serve to further define data elements and alert sponsors to how CMS will review and analyze these data.

The purpose of these technical specifications is to help ensure a common understanding of the data to be reported by sponsors, to assist sponsors in preparing and submitting datasets, to ensure a high level of accuracy in the data reported to CMS, and to reduce the need for sponsors to correct and resubmit data.

Each Part D reporting section is listed in this document with information regarding the following subjects:

- A. Data element definitions: details for each data element reported to CMS, including examples, methods for calculations, and how various data elements are associated.
- B. QA checks/Thresholds: procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- C. Edits and Validation Checks: validation checks that should be performed by each Part D sponsor prior to data submission.
- D. Analysis: how CMS will evaluate reported data, as well as how other data sources may be monitored.
- E. Notes: additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

General Information

Level of Data to be Reported

The level of reporting for each reporting section is specified in the Reporting Requirements document and within each reporting section in HPMS. Sponsor-level reporting indicates data may be submitted from an organization that is associated with more than one CMS- issued Part D contract. Contract-level reporting indicates data should be entered at the H#, S#, R#, or E# level. Plan-level reporting indicates data should be entered at the plan benefit package (PBP) level (e.g., Plan 001 for contract H#, R#, S#, or E). Plan-level reporting is necessary to conduct appropriate oversight and monitoring of some areas.

A summary of the reporting level required for each reporting section is below.

REPORTING REQUIREMENT SECTION	LEVEL OF REPORTING
Enrollment and Disenrollment	Contract
Medication Therapy Management (MTM) Programs	Contract
Grievances	Contract
Improving Drug Utilization Review Controls	Contract
Coverage Determinations and Redeterminations	Contract & Plan
Employer/Union-Sponsored Group Health Plan Sponsors	Contract & Plan
Medicare Prescription Payment Plan	Contract & Plan

Timely Submission of Data

Data submissions are due by 11:59 p.m. Pacific time on the date of the reporting deadline.

Only data that reflect a good faith effort by a sponsor to provide accurate responses to Part D Reporting Requirements will count as data submitted in a timely manner. Sponsors must report all data based on the most current Technical Specifications as of the reporting deadline.

- Sponsors should not submit “placeholder” data.
- HPMS will not allow the resubmission of data that are identical to the original data submission.

In order to accommodate data validation activities, with the exception of the Medicare Prescription Payment Plan section, data corrections must be submitted prior to 11:59 p.m. Pacific time on March 31st, or if March 31st falls on a weekend or federal holiday, prior to 11:59 p.m. Pacific time on the preceding business day.

Data corrections for Medicare Prescription Payment Plan reporting requirements must be submitted prior to 11:59 p.m. Pacific time on May 31st, or if May 31st falls on a weekend or federal holiday, prior to 11:59 p.m. Pacific time on the preceding business day.

Exclusions from Reporting

The Part D Reporting Requirements apply to Part D sponsors offering the Part D benefit, including stand-alone Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs). They do not apply to MA-only Plans. Data relating to Part B claims are excluded from these Part D reports unless otherwise specified (e.g., Coverage Determinations and Redeterminations reporting). PACE Organizations are excluded from these Part D Reporting Requirements.

Per the “Medicare Prescription Payment Plan: Final Part Two Guidance on Select Topics, Implementation of Section 1860D-2 of the Social Security Act for 2025, and Response to Relevant Comments”, CMS does not expect Part D plans that exclusively charge \$0 cost sharing for covered Part D drugs to all plan enrollees to offer enrollees the option to pay their out-of-pocket (OOP) costs through monthly payments over the course of the plan year or otherwise comply with the requirements laid out in the final part one or final part two guidance, including the Medicare Prescription Payment Plan reporting requirements. Plans that exclusively charge \$0 cost sharing for covered Part D drugs to all plan enrollees are excluded from the Medicare Prescription Payment Plan reporting section.

Contracts with no enrollment should select the “no data to report” button (no enrollment signifies that the contract has no enrollees for all months within the reporting period). If a contract has any enrollment during the reporting period, it is required to report all sections. General questions about Part D reporting requirements should be sent via email to partd-planreporting@cms.hhs.gov.

Medicare Prescription Payment Plan

A. Data element definitions:

Data elements to be uploaded into HPMS at the Contract level. HPMS layouts and templates will be provided in advance of the reporting deadline.

B. QA checks/Thresholds:

- CMS' outlier notifications serve only to give Part D sponsors the opportunity to correct submitted data if needed, and do not indicate that submitted data are incorrect, or that resubmissions are required.
- CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from Part D sponsors.

C. Edits and Validation Checks:

- Elements B, C, and D should each be \leq element A.
- The sum of elements B, C, and D should be \geq element A.
- Element E should be \leq F.
- Elements G, H and K should each be \leq element F.
- The sum of elements G and K should be \geq element F.
- The sum of elements I+J should = H.
- Element K should be \geq Element J.
- Element O should be \leq element N.

D. Analysis:

CMS will monitor and evaluate data with Medicare Prescription Payment Plan data received via the Medicare Advantage Prescription Drug (MARx) system and prescription drug event (PDE) reporting.

E. Notes:

- Refer to [Medicare Prescription Payment Plan Guidance](#) for more information and definitions of terms such as "likely to benefit."
- All beneficiaries reported in element A should additionally be reported in either element B, C, or D. Some beneficiaries may be determined to be likely to benefit by multiple means. For example, a beneficiary could be determined to be likely to benefit based on prior to plan year criteria and at point of sale (POS), and so would be reported in both element B and element D. However, that beneficiary would only be reported once in element A.
- If a beneficiary switches between PBPs during the reporting period, they would be reported as a unique beneficiary for both PBPs.
- Part D sponsors are required to put in place reasonable guidelines for ongoing identification of Part D enrollees likely to benefit during the plan year. Element C should only include individuals identified as likely to benefit based on the Part D sponsor's criteria for identification of enrollees likely to benefit from the program and should not

include individuals who are only identified as likely to benefit during the plan year through the POS notification process.

- CMS intends for each contract year of reporting to capture enrollees' participation in the Medicare Prescription Payment Plan program during that individual contract year. The CY 2025 Reporting Requirements should capture activities associated with program participation in CY 2025.
 - Part D sponsors are required to identify Part D enrollees likely to benefit from the program both prior to and during the plan year. Therefore, some beneficiaries may be identified as "likely to benefit" prior to the start of the plan year and reporting period on January 1st. All likely to benefit determinations or election requests for the CY 2025 plan year that take place before the reporting period begins on January 1, 2025 should still be reported. For example, for element B, a beneficiary may be identified as likely to benefit based on data from the immediately preceding plan year prior to January 1st of the current plan year. These beneficiaries should be reported in element B. As another example, a beneficiary may submit an election request to participate in the Medicare Prescription Payment Plan program for CY 2025 after October 15, 2024 and prior to January 1, 2025. This enrollee's election request should be reported in element E and element F.
 - Any election requests submitted after October 15, 2025 for participation in CY 2026, or prior to plan year likely to benefit identification in advance of the CY 2026 plan year, should not be reported with the CY 2025 data. These election requests should be reported with CY 2026 data.
- The phrase "within established timeframes" refers to the requirement that beneficiaries must provide additional documentation to make the program election request complete within 21 days of receiving a request for additional information. The election request may be denied if the sponsors do not receive the requisite information within this timeframe.
- Beneficiaries reported in element I should also be reported in either element G or in element K.
- Beneficiaries reported in element J should be reported in element K.
- Elements L and M should include all out-of-pocket cost sharing incurred by Medicare Prescription Payment Plan participants through 12/31/2025, even if the billing and collection period extends beyond 12/31/2025. For example, if an enrollee fills a prescription on December 12, 2025, is billed in mid-January 2026, and pays their bill in early February 2026, this amount should be included in element L.
- Element O should include beneficiaries who are precluded in participating in the Medicare Prescription Payment Plan for 2026, as of the reporting deadline. A Part D sponsor may only preclude an individual from opting into the Medicare Prescription Payment Plan in a subsequent year if the individual owes an overdue balance to that Part D sponsor.
- If an enrollee enrolls in a Part D plan and submits a Medicare Prescription Payment Plan election request but cancels their enrollment in the Part D plan prior to the effective date of plan participation, Part D plans should exclude that election request from reporting. For example, if a beneficiary enrolls in a Part D plan effective April 1, 2025 and opts into the Medicare Prescription Payment plan in March 2025 but subsequently cancels the plan taking effect April 1, 2025, the Medicare Prescription Payment Plan election request that

was received in March should be excluded from Element F (as enrollment into the Part D plan ultimately was canceled).

Summary of CY 2025 Part D Reporting Requirements

Reporting Section	Report Level	Reporting Frequency	Report Period(s)	Data Validation Required (Yes/No)	Data Due date(s)
Enrollment and Disenrollment	Contract	Bi-annually	1/1/2025 - 6/30/2025; 7/1/2025 - 12/31/2025	No	Last Monday of August Last Monday of February
Medication Therapy Management Programs	Contract	Annually	1/1/2025-12/31/2025	Yes	Last Monday of February
Grievances	Contract	Annually	1/1/2025-3/31/2025; 4/1/2025-6/30/2025; 7/1/2025-9/30/2025; 10/1/2025-12/31/2025	Yes	First Monday of February

Improving Drug Utilization Review Controls	Contract	Annually	1/1/2025-3/31/2025; 1/1/2025-6/30/2025; 1/1/2025-9/30/2025; 1/1/2025-12/31/2025	Yes	Last Monday of February
Coverage Determinations, Redeterminations and Reopenings	Contract and PBP	Annually	1/1/2025-3/31/2025; 4/1/2025-6/30/2025; 7/1/2025-9/30/2025; 10/1/2025-12/31/2025	Yes	Last Monday of February
Employer/Union-Sponsored Group Health Plan Sponsors	Contract and PBP	Annually	1/1/2025-12/31/2025	No	First Monday of February

Medicare Prescription Payment Plan	Contract and PBP	Annually	1/1/2025- 12/31/2025	No	Last Monday of April
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