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## CENTER FOR MEDICARE

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**DATE:** February 21, 2024

**TO:** All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstration Organizations

**FROM:** Jennifer R. Shapiro, Director, Medicare Plan Payment Group

**SUBJECT:** Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records

In addition to covering all Traditional Medicare items and services, Medicare Advantage (MA) organizations<sup>1</sup> can also offer “supplemental benefits,” such as dental and vision coverage. MA organizations can offer supplemental benefits to their enrollees as part of plan offerings when those plan bids are below the benchmark amounts for the counties where they operate; these supplemental benefits are funded through a portion of the difference between the bid and the benchmark, called MA rebates. Supplemental benefits include additional Part A and B services (beyond the “basic benefits” covered by Traditional Medicare), other health-related benefits, and non-health related benefits. Over the past five years, supplemental benefits have grown considerably, and per-person payments from the Centers for Medicare & Medicaid Services (CMS) to MA organizations for these benefits have more than doubled. Supplemental benefits have the promise of supporting beneficiaries’ health by providing non-Medicare and non-traditional benefits that improve health, allowing beneficiaries to manage their chronic conditions, and supporting access to care.

Given the importance and increased interest in supplemental benefits, CMS has invested in new initiatives that we have previously announced to collect additional information on the use and value of supplemental benefits in MA. These initiatives include the Contract Year 2023 MA and Part D final rule (87 FR 27704),<sup>2</sup> which included a new requirement for MA organizations to report expenditures for various categories of supplemental benefits through the Medical Loss Ratio (MLR) reports, a recently finalized Information Collection Request (ICR) on data elements related to supplemental benefits cost and utilization among Part C plan enrollees,<sup>3</sup> and a

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<sup>1</sup> In this memo, references to the term Medicare Advantage organizations should be read as including other submitting organizations offering Medicare private health plans (cost plans and Programs of All-Inclusive Care for the Elderly (PACE) organizations), unless otherwise indicated.

<sup>2</sup> <https://www.federalregister.gov/d/2022-09375/p-1343>

<sup>3</sup> <https://www.federalregister.gov/documents/2023/03/14/2023-05145/agency-information-collection-activities-proposed-collection-comment-request>

proposed ICR to improve plan benefit package (PBP) categorization of supplemental dental services.<sup>4</sup> In addition, we are now announcing that CMS has made system changes and updated our submission instructions so that MA organizations can more easily submit supplemental benefits into the MA Encounter Data System (EDS). This memorandum provides instructions on submission of supplemental benefits data into the EDS. New technical instructions that provide additional submission details have been published on the CSSC Operations website.<sup>5</sup> The technical instructions document is called, “Medicare Advantage General Supplemental Services Submission Guide.”

CMS has been collecting MA encounter data starting with 2014 dates of service, and MA organizations have been submitting these data reliably for many years now. While collecting encounter data for Medicare-covered items and services (basic benefits) has thus far been the focus of our data quality improvement work with plans, CMS requires that MA organizations submit to CMS all items and services, including supplemental benefits.

Specifically, CMS requires organizations providing services or items to Medicare beneficiaries to submit data that characterize the context and purpose of each item and service provided to a Medicare beneficiary, as described in regulation at 42 CFR 422.310. The regulation at 422.310(b) states, “Each MA organization must submit to CMS (in accordance with CMS instructions) the data necessary to characterize the context and purposes of each item and service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner. CMS may also collect data necessary to characterize the functional limitations of enrollees of each MA organization.”

In 2008, CMS revised 42 CFR 422.310(d) to further clarify that CMS has the authority to require MA organizations to submit encounter data for each item and service provided to an MA plan enrollee in order to fulfill the requirements provided at 422.310(b).<sup>6</sup> Consistent with that authority, CMS began collecting encounter data with 2014 dates of service.

The requirements and authorities codified at 42 CFR 422.310 apply not only to Medicare Part A and B covered items and services, but also extend to supplemental benefits offered by MA organizations, i.e., MA organizations are required to submit encounter data for supplemental benefits provided to their enrollees. While MA organizations have always been able to submit some supplemental benefits to the EDS, not all MA organizations have regularly submitted the supplemental benefits that could be submitted. Further, a number of these benefits could not be submitted because certain data elements required for EDS to accept the data did not exist and, in some situations, CMS has not provided specific instructions for the submission of supplemental benefits.

Below, CMS provides general instructions on how to submit encounter data records (EDRs) for supplemental benefits into the EDS. These instructions include information that addresses challenges MA organizations have faced in submitting EDRs for supplemental benefits, such as

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<sup>4</sup> <https://www.federalregister.gov/documents/2023/10/27/2023-23790/agency-information-collection-activities-proposed-collection-comment-request>

<sup>5</sup> <https://www.csscoperations.com/>

<sup>6</sup> Final 2009 inpatient prospective payment system (IPPS) rule, 73 Fed. Reg. 48434 (August 19, 2008). <https://www.federalregister.gov/documents/2008/08/19/E8-17914/medicare-program-changes-to-the-hospital-inpatient-prospective-payment-systems-and-fiscal-year-2009>

when an MA organization lacks certain required data elements for non-medical supplemental services.

MA organizations must submit data for supplemental benefits in accordance with these instructions beginning with contract year (CY) 2024 dates of service. We understand that organizations will need time to implement these new procedures for submitting data for supplemental benefits; however, CMS encourages MA organizations to submit data in accordance with the instructions below as soon as possible for CY 2024 dates of service (01/01/2024 through 12/31/2024). MA organizations that are already successfully submitting EDRs for any supplemental benefits should continue their current practices as they develop the capability to submit data on additional supplemental benefits, as well as the additional fields, as discussed in the technical instructions. MA organizations that are not yet submitting EDRs for supplemental benefits but are now aware of the requirement and already have or can obtain the minimum data elements for EDR submission should begin submitting any supplemental benefits data.<sup>7</sup>

In order to support the full submission of supplemental benefits, CMS plans to monitor submissions and reach out to MA organizations that may not be submitting many supplemental benefits of the types expected based on their bids. Where needed, we will provide technical assistance, gather feedback on challenges, and provide additional guidance.

Please note that the EDS filtering logic for risk score calculations remains unchanged.<sup>8</sup>

### **Instructions for Submission of Supplemental Benefits**

CMS collects MA encounter data (ED) using the X12 837 Version 5010 industry standard format used to transmit health care claims electronically. CMS' guidance for the submission of MA ED comprises the national standards established for the X12 837 Version 5010 format, as set forth in the national Technical Report Type 3 (TR3) implementation guides, with supplemental guidance for requirements unique to MA EDRs. CMS' requirements specific to submission of encounter data to the MA EDS are described in Chapter 3 of the *Encounter Data Submission and Processing Guide* and Appendix 3A, "MA Companion Guide: CMS' Supplemental Instructions for EDR & CRR Data Elements."<sup>9</sup>

Specifically, for all supplemental (and basic) benefits, the MA organization must submit data for these services in the standard EDR format. CMS expects that most supplemental benefits covering extensions of Medicare-covered items and services (such as additional acute inpatient days), as well as supplemental benefits for vision and hearing, can be submitted in this format without issue.

In an effort to learn more about issues MA organizations may face related to the submission of supplemental benefits to the EDS, CMS conducted technical assistance calls with multiple MA organizations over a period of several months. Through these conversations, two overarching

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<sup>7</sup> Available at: <https://www.csscooperations.com/>

<sup>8</sup> Refer to the December 22, 2015, HPMS memo titled, "Final Encounter Data Diagnosis Filtering Logic"

<sup>9</sup> Available at: <https://www.csscooperations.com/>

challenges were identified related to submitting EDRs for supplemental dental benefits and non-medical items and services:

1. MA organizations do not receive information from providers in such a way that an X12 837 Version 5010 record can be populated and successfully accepted by the EDS. In particular, MA organizations lack information necessary to populate required EDR fields, such as National Provider Identifiers (NPIs), procedure codes, diagnosis codes, and/or revenue codes.
2. Benefits are not provided in a manner that allows for standard reporting procedures without additional instructions from CMS, or the information necessary to populate an X12 837 Version 5010 record does not exist. For instance, non-medical benefits may have very different patterns of utilization than medical benefits, or benefits (medical or non-medical) may be paid on a capitated or periodic basis (e.g., annual gym memberships and pre-funded allowance cards).

To address such circumstances, CMS is providing the following instructions to allow MA organizations to successfully submit data on supplemental benefits to the EDS. As noted above, technical instructions that provide additional supplemental benefits submission details have been published on the CSSC Operations website.<sup>10</sup>

### **Dental Benefits**

Medicare-covered dental services must continue to be submitted using the 837P for dental services that are Part B benefits or the 837I for dental services that are Part A benefits. Supplemental dental benefits cover preventive and comprehensive dental services outside of Medicare-covered dental services; the context and purpose of these benefits are best captured via a dental-specific format. As such, supplemental dental benefits are to be reported using the X12 837D Version 5010 claims format. CMS will notify submitters when the EDS begins accepting dental encounters using the 837D format; we expect that this will be around June 2024. At that time, we expect that MA organizations will begin to submit supplemental dental benefits for dates of services beginning January 1, 2024, and we expect submissions (notwithstanding runoff) to be caught up by the end of 2024.

For more detailed instructions regarding the submission of MA supplemental dental benefits using the X12 837D Version 5010 claims format, see the *Medicare Advantage Supplemental Dental Services Submission Guide*.<sup>11</sup>

### **Other Supplemental Benefits**

We understand that MA organizations may lack a diagnosis code, procedure code, and/or revenue code for many non-medical supplemental benefits (such as transportation, meals, or gym memberships) because such data is not typically collected in the billing for these services and, as a result, MA organizations have been unable to submit EDRs for such benefits. For all

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<sup>10</sup> *Medicare Advantage General Supplemental Services Submission Guide* available at: <https://www.csscoperations.com/>

<sup>11</sup> This guide will be available on the CSSC Operations website (<https://www.csscoperations.com/>) prior to the expected June submission date.

supplemental benefits for which there does not exist sufficient data to populate an X12 837 Version 5010 record, CMS has developed default codes, provided in the technical instructions published concurrently with this memo, which may be used to populate the required data fields. These default codes are only to be used for submitting supplemental benefits data to the EDS when diagnosis, procedure, or revenue code data do not exist for a given item or service (e.g., reporting over-the-counter (OTC) benefit utilization that does not have an associated diagnosis code). In all other circumstances, CMS expects MA organizations to obtain the specific codes necessary for submission from the provider or vendor.

When reporting items and services from atypical providers (defined as an individual or business that bills for services rendered but does not meet the definition of a health provider at 45 CFR 160.103), and therefore is not eligible to obtain an NPI, MA organizations and other submitters are instructed to follow the default NPI and Employer Identification Number (EIN) guidance in Chapter 3 of the *Encounter Data Submission and Processing Guide*.

Additionally, we understand that certain types of supplemental benefits do not produce the same types of utilization data that are associated with a medically related service, medical encounter, or traditional items being furnished; therefore, the utilization of these services cannot be easily enumerated for EDR reporting purposes. For example, gym memberships may be paid for quarterly or annually, and are not paid for on a per-visit basis. Because approaches to payment can vary across types of supplemental benefits and across MA plans, and because supplemental benefits have purchasing arrangements and/or utilization that differ from typical medical services, we have developed the submission instructions below and in the associated technical instructions to identify the most appropriate unit of service to be reported, or instance of utilization to be recorded, for different types of benefits and how to populate the EDR.

When considering how utilization of supplemental benefits should be reported on an EDR, MA organizations should use the guiding principle that a record of utilization should be submitted for every individual instance when an enrollee actually uses the benefit. In certain circumstances in which per-utilization reporting is not practicable (e.g., each time an enrollee uses a physical fitness membership to visit a fitness center or an OTC pre-funded card is used at a participating retailer), MA organizations should instead report when the enrollee first has access to the benefit and is able to use it or at the end of the benefit period to include the portion of an allowance used. MA organizations should apply these general principles when submitting supplemental benefits beyond the examples provided in these instructions.

Please see the following examples:

- If reimbursements are paid on a fee-for-service basis, such as for worldwide travel coverage or different levels of hearing aids, and the unit of service being provided is enumerable, then report each individual instance of utilization for each item or service and provide the actual date of service for each individual use.
- CMS strongly encourages MA organizations to report each use of an allowance or payment card and the items or services being paid for with that allowance or payment card. However, submitters are permitted to report the amount of an allowance used, based

on card periodicity, when per-utilization reporting is not practicable.<sup>12</sup> For example, if an OTC pre-funded card is distributed and paid quarterly, then an EDR should be submitted at the end of each quarter and report the amount of the available allowance that was actually used per period. We provide additional instruction on reporting the allowance amount and the amounts used by the enrollee in the technical instructions.

- When allowance amounts on pre-funded cards span multiple categories of supplemental benefits (e.g., a single allowance for OTC items and healthy groceries), MA organizations must separate out spending by category and submit an EDR for each category in which there was utilization.
- When there is a payment for a membership that allows an enrollee to access services, such as a gym membership, submit EDRs for each time period when the membership was active, depending on how payment is made for a membership. For instance, if membership is paid monthly and an enrollee activates the gym membership in January and ends it in March, an EDR should be submitted for each month (January, February, and March). If membership is activated and paid for annually, quarterly, or on another periodic basis, an EDR should correspondingly be submitted annually, quarterly, or on another periodic basis. The “from” date of service would be the first of the month, or the first of the first month in the time period, being paid for. The “through” date of service would be the last day in the time period.

### **Identification of Supplemental Benefits in the EDS**

CMS has developed a Supplemental Benefits Indicator to identify supplemental benefits on encounter data submissions using existing fields on the 837 format, specifically the Paperwork (PWK) fields. The general purpose of the PWK fields is to allow submitters to provide additional documentation and have a variety of uses depending on the payer; CMS has repurposed these fields to provide indicators about a service or record. The PWK fields that should be populated for submission of supplemental benefits and the associated values are provided in the technical instructions published concurrently with this memo. The use of the Supplemental Benefits Indicator will enable CMS to distinguish between items and services covered under Medicare Part A or Part B and those that are supplemental benefits. In addition, to standardize reporting across various supplemental benefits data collection efforts, the Supplemental Benefits Indicator will include values that align with supplemental benefit categories from the PBP software. Submitters are encouraged to begin using the Supplemental Benefits Indicator as soon as possible, but should start submitting complete supplemental benefits even if they are not ready to populate these fields provided that they can fully populate other required EDR fields with non-default values. CMS plans to provide assistance to submitters if challenges arise and will monitor 2024 submissions for this indicator.

CMS is aware that two of the PWK fields are also used to identify chart review records (CRRs). These instructions apply only to supplemental benefits reporting via EDRs; the PWK data fields

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<sup>12</sup> CMS expects that utilization of most supplemental benefits, including dental, vision, and hearing services, is enumerable and will be reported on a per-utilization basis. This applies regardless of the purchasing arrangements or payment mechanisms in place (e.g., individual claims processing or an allowance on a pre-funded card).

for supplemental benefits records must be completed as outlined in the technical instructions. Supplemental benefits are services that should be submitted on EDRs and cannot be submitted via CRRs.

Additional details related to the Supplemental Benefits Indicator can be found in the technical instructions. For more information on EDR submission processes and minimum data elements required for EDR submission, please refer to the CSSC Operations website.<sup>13</sup>

For unusual scenarios, challenges faced, or any other questions related to the requirements discussed in this memo, contact [RiskAdjustmentOperations@cms.hhs.gov](mailto:RiskAdjustmentOperations@cms.hhs.gov). Please specify “Supplemental Benefits Submission” in the subject line. Thank you.

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<sup>13</sup> <https://www.csscooperations.com/>