Frequently Asked Questions – Contract Year 2025 Part C Reporting Requirements – Supplemental Benefit Utilization and Costs Section

Last Updated May 2025

CMS introduced the Supplemental Benefit Utilization and Costs section in the Part C Reporting Requirements (OMB Control Number 0938-1054) for contract year (CY) 2024 and made additional changes effective for CY 2025. We are providing a summary of frequently asked questions about this reporting section.

This document does not change the data elements to be reported but provides additional clarification based on sponsors' questions. Review the Part C Reporting Requirements and Technical Specifications document from the appropriate contract year for information on the data elements being collected. Available at: https://www.cms.gov/medicare/enrollment-renewal/health-plans/part-c.

General

1) Did any data elements change between CY2024 and CY2025 reporting requirements?

Yes. Beginning with CY 2025, Elements A and B are now Contract ID and Plan Benefit Package (PBP) ID, causing re-lettering of the elements. Element F (Network type) and Element O (Total out-of-pocket costs for enrollees who utilized the benefit) are also new elements.

2) Are decimals allowed?

No. Round all numeric values to whole numbers. For example, if the median amount calculated for Element K ends in a decimal, please round to the nearest whole number. If it ends in .5 - .9, round up to the next whole number. If it ends in .1 - .4, round down to the next whole number.

3) How do I know if I need to report data for this reporting requirements section?

Your contract must report this section if it meets the following requirements:

- Your contract has at least one plan (PBP) that offers at least one supplemental benefit (regardless of whether any beneficiaries utilized the benefit(s)).
- Your contract falls under one of the following contract types:[1]
    i. 01 – Local CCP
    ii. 02 – MSA
    iii. 03 – RFB PFFS
    iv. 04 – PFFS
    v. 06 – 1876 Cost
    vi. 11 – Regional CCP
    vii. 14 – ED-PFFS
    viii. 15 – RFB Local CCP
    ix. 17 – ED-LPPO

[1] This is the correct list of contract types. The list of contract types in the Part C Reporting Requirements Technical Specifications will be corrected in the future.

- Employer/Union Direct contracts should report this reporting section, regardless of contract type. Your contract should include all 800 series plans when reporting this section.
- Your contract had at least one beneficiary enrolled during the reporting period.

Element-Specific

Element C – PBP Category

1) Where do I get a list of the PBP category codes?

Refer to the list of codes in the Part C Reporting Requirements or Technical Specifications documents.

2) Do I need to report any information if I don't offer a PBP category code?

Each plan must report data for all PBP category codes. If your PBP does not offer a PBP category, submit values for Elements A, B, C, and D, and submit NO for Element E, meaning not offered. Then, leave the rest of the fields blank.

3) Do I need to report any information if I offer a PBP category code, but no beneficiaries utilize that benefit?

Each plan must report data for all PBP category codes. If no beneficiaries utilized a benefit that was offered, you may report zero for Elements I, J, and K, but submit information for other elements such as Elements M and N regarding payment arrangements and costs.

Element D – Supplemental Benefit Name

1) Do I need to submit a name for each PBP category? Doesn't Element C already provide CMS with that information?

    - Only report text for Element D if the PBP Category (Element C) has an "Other" designation (13d, 13e, 13f, or 13i11, 13i12, 13i13, 13i14, and 13i15[2] only).
    - Do not report text for Element D (meaning leave Element D blank) if the PBP category is a value not equal to an "Other" designation (13d, 13e, 13f, or 13i11, 13i12, 13i13, 13i14, and 13i15 only). HPMS will auto-populate the names of these PBP Categories in Element D based on what is submitted in Element C.
    - If your plan does not offer one of the PBP categories (Element C) with an "Other" designation (13d, 13e, 13f, or 13i11, 13i12, 13i13, 13i14, and 13i15 only), then report "not offered" in Element D and report NO in Element E. See Table 1 for an example.

[2] The is the correct list of PBP categories with an "Other" designation. The list in the Part C Reporting Requirements Technical Specifications will be corrected in the future.

Element E – How is the Supplemental Benefit offered?

1) Can I report offering a PBP Category more than one way?

Yes. Submit separate rows of data for all unique combinations of Elements A, B, C, D, E, and F. See Table 1 for an example.

Element F – Network Type

1) How do I report this Element F? Can I report "Other" as a network type?

The system will accept one of the following list of values in Element F: INN, OONPPO, OONHMO, VT, O.

These values have the following list of meanings:

- In-network = INN
- Out-of-network (for PPO) = OONPPO
- Out-of-network (for HMO-POS) = OONHMO
- Visitor/travel = VT
- Other = O

HPMS will allow the value of O, meaning "Other". If you report O, then provide more information in Element M. This may be updated in future reporting years.

2) Can I report multiple network types for a PBP Category?

Yes. Submit separate rows of data for all unique combinations of Elements A, B, C, D, E, and F. See Table 1 for an example.

Element G – Unit of Utilization

1) Can we submit multiple units of utilization for a single PBP category?

No, plans should only submit one unit of utilization for each PBP category.

Element L – Total Net Amount Incurred by the Plan

1) What types of costs should I include for Element L (the total net amount incurred by the plan to offer the benefit)?

This element should include direct costs only. For example, if a plan pays a per member per month (PMPM) cost to a vendor for a benefit, which includes an administrative cost, the plan may report the full PMPM for the year. If a plan pays a flat rate or PMPM to a vendor to provide several benefits, the plan should divide the rate between the services provided.

Element N – How the Plan Accounts for the Cost of the Benefit

1) How do I answer Element 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)?

Please be as specific as possible in completing this narrative field. CMS has not been prescriptive in guidance to allow plans latitude in describing how they measure costs in the most accurate way possible. If you believe your calculation of Element L (the total net amount incurred by the plan to offer the benefit) could benefit from explanation, please include that here. CMS will take this information into account when analyzing submissions. This element should be reported for all benefits offered by the plan.

Element O – Total Out-of-Pocket Cost

1) What is the definition of "out-of-pocket cost" in Data Element O (the total out-of-pocket-cost for enrollees who utilized the benefit)?

The objective of this element is to understand the level of cost-sharing (e.g., co-pay, co-insurance) borne by enrollees within the plan. This should include the enrollees' direct financial contribution towards the benefit after the plan has covered its portion.

Elements G-P

1) How should I report these data elements to accurately reflect the specific benefit category?

Since a plan may offer a PBP category more than one way (Element E) and in more than one network type (Element F), report each element specific for the unique combination of contract/plan/PBP category/offer type/network type. See Table 1 for an example. If you cannot provide a specific breakout of any element(s), provide information in Element M to describe the methodology used to report your data.

Other FAQ

1) How should a plan report on benefits which may be paid for using a debit card? If the debit card is used for multiple benefits, without the ability to determine which specific service category is being paid for, how should the plan report?

Plans must report information utilizing the categories and subcategories as they appear in the Part C Reporting Requirements. Plans may need to work with vendors to ensure they are able to submit information completely and in compliance with our requirements.

2) How should plans report VBID benefits?

Plans should not report on VBID specific benefits.

Table 1: Example of Supplemental Benefits Data

This table offers an abbreviated example of dummy Supplemental Benefit Utilization and Costs data and is formatted for presentation purposes.

A	B	C	D*	E**	F***	G	H	I	J	K	L	M	N	O	P
H0000	001	1a1		M	INN	Days	20	19	21	1	$100	Text	Text	$5	$1
H0000	001	1a1		M	OONPPO	Days	15	10	13	1	$150	Text	Text	$7	$2
H0000	001	1a1		O	VT	Days	25	21	25	0	$50	Text	Text	$10	$3
H0000	001	13d	Other Primarily Health Related Item or Service[3]	M	INN	Per Item	30	15	18	5	$100	Text	Text	$0	$0
H0000	001	13e	not offered	NO											
H0000	001	13f	not offered	NO											

*Element D is left blank except when Element C has an "Other" designation for PBP categories 13d, 13e, and 13f. Because 13e and 13f are not offered by the plan (Element E = NO), the plan populated Element D with "not offered".

**The PBP Category 1a1 is offered in two ways (Element E = M and Element E = O), so a separate row of data is provided for each unique combination of Elements A – E. When E = NO, the remaining elements (F-P) are left blank.

*** The PBP Category 1a1 is offered in more than one network type where Element E = M (Element F = INN and Element F = OONPPO), so a separate row of data is provided for each unique combination of Elements A – F.

[3] The 13d, 13e, and 13f: "Other" service category is intended for data entry of those *primarily health related* supplemental benefits that are offered by the Medicare Advantage (MA) plan but do not fit into any of the defined PBP service categories. Plans should input the approved benefit name that they entered into the PBP for this benefit.