DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTER FOR MEDICARE

DATE: November 12, 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 – Reminders, Other Supplemental Service Updates, and Frequently Asked Questions (FAQs)

The purpose of this memorandum is to provide updates and clarifications related to submission of supplemental benefits data on encounter data records (EDRs), including updates to Supplemental Benefit Services Category (SBSC) codes for contract year (CY) 2025 and frequently asked questions (FAQs).

Background

On February 21, 2024, CMS published a memorandum[1] titled "Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records," which outlined system changes and updated submission instructions so that Medicare Advantage (MA) organizations[2] would be able to more easily submit supplemental benefits into the MA Encounter Data System (EDS). Since the publication of that memo and associated technical instructions, CMS has undertaken a series of actions to further support MA organizations in successfully submitting EDRs for supplemental services. These efforts include meetings with health plans to better understand challenges and solutions for reporting, publishing additional instructions specific to reporting of supplemental dental services,[3] and hosting a widely attended user group call to review key instructions and frequently asked questions.

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[1] Previously published Health Plan Management System (HPMS) memoranda can be accessed at https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly

[2] 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.

[3] Refer to the August 22, 2024, HPMS memo titled, "Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records – Dental Services Submission Instructions and Other Supplemental Service Updates"

Given the importance of and increased interest in supplemental benefits, in recent years, CMS has also been investing in other new initiatives to collect additional information on the use and value of supplemental benefits in MA. These initiatives include a new requirement for MA organizations to report expenditures for various categories of supplemental benefits through the Medical Loss Ratio (MLR) reports,[4] a new collection of data elements related to supplemental benefits cost and utilization among Part C plan enrollees,[5] and improved plan benefit package (PBP) categorization of supplemental dental services.[6]

Additionally, the CY 2025 Medicare Advantage and Part D final rule,[7] which was finalized on April 4, 2024, established new guardrails for certain types of supplemental benefits, available only to chronically ill enrollees, to ensure that these supplemental benefits offered by MA plans meet the health needs of people with Medicare by being supported by evidence. That rule also requires MA plans to send a mid-year, personalized communication to their enrollees about accessing unused supplemental benefits.

Supplemental benefits have the promise of supporting enrollees' health by providing non-Medicare and non-traditional benefits that improve health, allowing enrollees to manage their chronic conditions, and supporting access to care. The actions described above will ensure that supplemental benefits meet enrollees' needs while also providing CMS with data needed to answer key policy questions related to supplemental benefits, including what is being offered, what plans are spending, which enrollees use which services, the cost to enrollees, and plan-level utilization.

Please direct any questions regarding the information included in this memo to RiskAdjustmentOperations@cms.hhs.gov and specify "Supplemental Benefits Submission" in the subject line.

Submission of Supplemental Benefits Data

In the February 2024 memo titled "Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records," CMS reminded MA organizations that the requirements and authorities codified at 42 CFR 422.310 for data submission apply not only to Medicare Part A and B covered items and services, but also extend to supplemental benefits offered by MA organizations. In that memo and associated technical instructions (February 2024 *Medicare Advantage General Supplemental Services Submission Guide*), CMS provided MA organizations with both general reporting principles and specific instructions to guide submission of supplemental services in the MA EDS.[8]

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[4] See the CY 2023 MA and Part D final rule (87 FR 27704)

[5] See the Information Collection Request (ICR) at https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing-items/cms-10261

[6] See the ICR at https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing-items/cms-r-262

[7] https://www.federalregister.gov/documents/2024/04/23/2024-07105/medicare-program-changes-to-the-medicare-advantage-and-the-medicare-prescription-drug-benefit

[8] *Medicare Advantage General Supplemental Services Submission Guide*: https://www.csscoperations.com/internet/csscw3_files.nsf/F2/Medicare%20Advantage%20General%20Supplemental%20Services%20Submission%20Guide_508.pdf/$FILE/Medicare%20Advantage%20General%20Supplemental%20Services%20Submission%20Guide_508.pdf

In August 2024, CMS published a memo titled "Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records – Dental Services Submission Instructions and Other Supplemental Service Updates," which announced that the MA EDS began accepting supplemental dental services file submissions in the 837D format as of September 13, 2024.

MA organizations must submit data for supplemental benefits in accordance with the February and August 2024 instructions beginning with CY 2024 dates of service. CMS encourages MA organizations to submit data in accordance with those instructions as soon as possible for CY 2024 dates of service (01/01/2024 through 12/31/2024). Specifically, CMS expects that MA organizations should begin submitting as soon as systems are ready and continue submitting for 2024 dates of service until all data are submitted, and as with all encounter data, submit data on supplemental services on an ongoing basis. Organizations are not expected to resubmit encounters for supplemental services that have already successfully been submitted and accepted by the MA EDS.

Additionally, CMS is clarifying in this memo that there is not a deadline specific to the submission of supplemental benefits data on EDRs. Established deadlines for submission of risk adjustment data to be included in risk score runs do not apply to the submission of supplemental benefits EDRs. Further, as noted in the February 2024 memo, the MA EDS filtering logic for risk score calculations remains unchanged.[9] Generally speaking, diagnoses associated with supplemental benefits are not risk adjustment-eligible. Diagnoses on EDRs that contain supplemental items or services along with a service with an allowable procedure code will be risk adjustment-eligible.

As noted in the February memo, 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.

Clarifications

Below are two clarifications of existing submission guidance.

- Section 2.12.3.4 of the February 2024 *Medicare Advantage General Supplemental Services Submission Guide* describes how submitting organizations should populate the total allowance and dollar amount of the supplemental benefit used, when the supplemental benefit is provided as an allowance. We clarify here that the instructions in section 2.12.3.4 apply to only the dollar allowances for supplemental benefits (e.g., an enrollee uses $90 of a $100 monthly over-the-counter (OTC) benefit). When a supplemental benefit has a maximum benefit amount based on other units (e.g., hours, sessions, etc., as submitted in the PBP), the submitting organization should indicate the number of units used in the quantity field on the EDR (Professional Loop 2400 – SV104, Institutional Loop 2400 – SV205).

[9] Refer to the December 22, 2015, HPMS memo titled, "Final Encounter Data Diagnosis Filtering Logic"

- In the August 2024 memo, CMS noted that the provision of response reports for supplemental dental services submissions in the 837D format will be phased in. In Phase One, which started on September 13, 2024, MA organizations began submitting supplemental dental services in the 837D format and receive only front-end edit reports. In that memo, we specifically noted that MA organizations would receive TA1 and 999 reports; in this memo, we are clarifying that Phase One response reports include the TA1, 999, and the Dental Validation Report.

SBSC Codes for CY 2025

CMS is notifying MA organizations of updates to Appendix 2.12 B: Supplemental Benefit Services Category (SBSC) Codes for 2025 dates of service. Specifically, the SBSC codes have been updated to align with the changes made to the CY 2025 PBP system. Appendix 2.12 B for 2025 dates of services is now available on the CSSC Operations website.[10] For 2024 dates of service, MA organizations should continue to use the SBSC codes as published in the revised Appendix 2.12 B in August 2024. It is the responsibility of the MA organization to ensure the SBSCs assigned to each EDR are for the appropriate service year. On September 26, 2024, CMS hosted a user group call to provide an overview of supplemental benefits data submission and answer questions. The slides from that call, which include FAQs, are posted on the CSSC Operations website. CMS is also publishing the below set of FAQs, developed from questions received on the user group call, to provide additional details and clarifications for MA organizations.

1. **What is the deadline for submission of CY 2024 supplemental benefits encounter data?**

   As noted in the February 21, 2024, HPMS memo titled "Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records," CMS encourages MA organizations to submit data in accordance with the instructions as soon as possible for CY 2024 dates of service (01/01/2024 through 12/31/2024). While there is not a set deadline for submission of supplemental services on EDRs, CMS will be monitoring submissions and will reach out to MA organizations that may not be submitting many supplemental benefits of the types expected based on their bids. CMS expects that MA organizations should begin submitting as soon as systems are ready and continue submitting for 2024 dates of service until all data are submitted and as with all encounter data, submit data on supplemental services on an ongoing basis.

   Established deadlines for submission of risk adjustment data to be included in risk score runs do not apply to the submission of supplemental benefits EDRs. Further, as noted in the February 2024 HPMS memo, the MA EDS filtering logic for risk score calculations remains unchanged. Generally speaking, diagnoses associated with supplemental benefits are not risk adjustment eligible. Diagnoses on EDRs that contain supplemental items or

[10] https://www.csscoperations.com/

services along with a service with an allowable procedure code will be risk adjustment-eligible.

2. **Do MA organizations that have successfully submitted supplemental benefit EDRs need to resubmit those records with the new Supplemental Benefits Indicator?**

   No, MA organizations that are already successfully submitting EDRs for any supplemental benefit 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. These MA organizations are not expected to resubmit encounters that have already successfully been submitted and accepted by the MA EDS.

3. **Does CMS have further guidance that they can provide specific to the Part C reporting of supplemental benefits?**

   The requirements for submission of EDRs for supplemental services, as described in the February 21, 2024, HPMS memo, are separate from the reporting requirements for data elements related to Part C supplemental benefits cost and utilization. As noted in Section VIII of the *Medicare Part C Reporting Requirements*, MA organizations must separately report data on supplemental benefit utilization and cost by the last Monday in February of the following calendar year (e.g., February 24, 2025, for the 2024 calendar year).[11] Please direct inquiries related to the *Medicare Part C Reporting Requirements,* including Section VIII, Supplemental Benefit Utilization and Costs, to the following mailbox: https://dpapportal.lmi.org/DPAPMailbox.

4. **Should supplemental benefits that are an extension of Medicare-covered benefits be submitted separately from the Medicare-covered benefit encounter data?**

   As noted in the *Medicare Advantage General Supplemental Services Submission Guide*, the Supplemental Benefits Indicator is a line level indicator that identifies an item or service as a supplemental benefit. Supplemental services do not need to be submitted as a separate EDR if they were provided as part of a single encounter with other standard services; however, each supplemental service should be reported as a separate line and use the appropriate Supplemental Benefits Indicator fields within the 2400 Loop (line level). For example, for an acute inpatient stay that utilizes Medicare-covered days and additional days, the additional days should be reported as a separate line on the EDR and use the appropriate Supplemental Benefits Indicator fields within the 2400 Loop (line level). We encourage you to review the example in section 2.12.4.1 of the *Medicare Advantage General Supplemental Services Submission Guide*.

5. **What should an MA organization do if a vendor is unable to generate the supplemental benefits encounter data in the 837 format?**

[11] *Medicare Part C Reporting Requirements*: https://www.cms.gov/files/document/cy2024-part-c-reporting-requirements.pdf

For supplemental benefits for which there does not exist sufficient data to populate an X12 837 Version 5010 (837) record, CMS has developed default codes which may be used to populate the respective required data fields. The default codes provided in the *Medicare Advantage General Supplemental Services Submission Guide* are only to be used for submitting supplemental benefits data to the MA 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, including populating the Supplemental Benefit Services Category (SBSC) code, CMS expects MA organizations to obtain from the provider or vendor the specific codes necessary for submission in order to meet the requirements under 42 CR 422.310. This may require modifications to tracking or reporting arrangements with either vendors or providers.

6. **How should MA organizations report returned or reversed purchases that were purchased on a pre-funded card for supplemental benefits?**

   Situations in which the reported utilization needs to be revised after an EDR is submitted should be handled in the same general fashion that an organization would handle the reprocessing and resubmission of an EDR for a medical service or item. The submitting organization can either void the original encounter and submit a revised EDR with the updated values or the organization can submit a replacement EDR. Please see the instructions for replacing or voiding previously submitted EDRs in Sections 2.3.3 and 2.3.4 of the *Encounter Data Submission and Processing Guide*.[12]

7. **Our MA organization provides supplemental dental benefits via a pre-funded card. Do we have to submit supplemental dental utilization in the 837D format, or can we continue to use the 837P format?**

   When MA organizations do not receive claims with sufficient information to submit encounters for supplemental dental services in the 837D format, they may continue to use the 837P format for submission. As stated in Section 2.12.3.4 of the February 2024 *Medicare Advantage General Supplemental Services Submission Guide*, for items that are provided through an allowance or with a maximum plan benefit coverage per period (including a pre-funded card for supplemental dental benefits), MA organizations should populate the total allowance on the Line Item Charge Amount (Professional Loop 2400 – SV102, Institutional Loop 2400 – SV203), and then populate the amount used by the beneficiary in the Service Line Paid Amount (Professional/Institutional Loop 2430 – SVD02). Additionally, supplemental dental services reported on the 837P format must include the appropriate SBSC Code. When sufficient data do not exist to populate the SBSC Code, CMS expects MA organizations to obtain from the provider or vendor the information necessary for submission. This may require modifications to tracking or

[12] *Encounter Data Submission and Processing Guide*: https://www.csscoperations.com/internet/csscw3_files.nsf/F2/2022ED_Submission_Processing_Guide_20221130.pdf/$FILE/2022ED_Submission_Processing_Guide_20221130.pdf

reporting arrangements with either vendors or providers. In cases in which an MA organization is not able to amend vendor or provider reporting arrangements for CY 2024, the submitting organization should use the default procedure and diagnosis codes, where necessary. In addition, submitting organizations should use their best judgement in assigning the appropriate SBSC code.

8. **How should MA organizations submit billing provider information for supplemental benefits provided via an OTC pre-funded card?**

   In general for OTC pre-funded cards, the health plan would be considered the billing provider, the vendor administering the benefit would be considered the ordering provider, and the merchant would be the rendering provider. If there are multiple rendering providers within the timeframe for this EDR, then either the billing provider can be used in that location, or the rendering provider can be left blank.

   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) who are not eligible to obtain an National Provider Identifier (NPI), MA organizations and other submitters are instructed to follow the default NPI and Employer Identification Number (EIN) guidance in Chapter 3, section 3.6 of the *Encounter Data Submission and Processing Guide*.

9. **When should MA organizations add the "zz" suffix to the SBSC code in the PWK06 field?**

   The "zz" suffix should be used in the PWK06 field when a supplemental service is offered as part of a combined supplemental benefits package (a group of benefits with a single Maximum Plan Benefit Amount, as submitted as part of a plan benefit package (PBP)). For example, if an MA organization had submitted a PBP with routine chiropractic and supplemental acupuncture as a combined supplemental benefits group with a combined number of visits, the PWK06 field for the reported category should include the "zz" suffix.

   For more details about entering Combined Supplemental Benefits in the PBP, please see the corresponding section of the Plan Benefit Package (PBP) CY2024 and CY2025 User Guides, available in the documentation section of HPMS.

10. **How should MA organizations report supplemental benefits in cases which per-utilization reporting is not practicable (i.e., fitness benefits)?**

    As noted in section 2.12.2.2 of the February *Medicare Advantage General Supplemental Services Submission Guide*, 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 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 a pre-funded card for OTC items 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.