

**Part C Reporting Requirements: Supplemental Benefit Utilization and Cost
60-Day PRA Comments**

Topic	Approx. commenter count	Summary of comments	Proposed Action, if any, and responses
Demographic Data	3	<p>All 3 commenters recommended a specific set of demographic variables they recommended including:</p> <ul style="list-style-type: none"> - 1 commenter suggested age, race, ethnicity, and language; - Another commenter suggested age, race, ethnicity, education, and income; and - Yet another commenter suggested race, ethnicity, age, rural/urban status, disability, language, sex, sexual orientation, and gender identity. <p>2 commenters noted that the addition of demographic variables would help advance President Biden’s Executive Order 13985, the CMS Framework for Health Equity 2022-2023, and the HHS Equity Action Plan.</p>	<p>No changes.</p> <p>There are efforts within and outside CMS to collect additional demographic data, and to establish best practices in collecting demographic data. We believe it prudent to wait for experts within CMS and other federal partners to implement new collections and establish best practices before we implement demographic categories into this collection.</p> <p>In addition, we are concerned about the manner in which plans would be able to obtain this data. For example, plans may leverage self-identified or another approach to capturing these data, and variance in the collection of these data create multiple challenges. Moreover, any demographic data collection by the plan from the enrollee would be optional, creating an</p>

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			<p>important challenge in CMS' ability to analyze this data confidently.</p> <p>We could add demographic variables later once there is more of a template set of "best practices" for us to leverage.</p>
<p>Employer Group Waiver Plans (EGWPs)</p>	<p>4</p>	<p>All 4 commenters recommended that EGWPs be excluded from this collection. All expressed concern over the unique burden this collection would place on EGWPs. Reasons given were:</p> <ul style="list-style-type: none"> - EGWP benefits are effectively offered at the contract-level, not the PBP-level, and MAOs do not file EGWP-offered benefits in the PBP; - A single EGWP PBP may support many clients with different benefits, including differences in coverage, cost-sharing, or vendor contracted rates (most commenters expressed this concern); - EGWP PBPs are filed to reflect Traditional Medicare benefit design, and that pricing of any benefits above or beyond Traditional Medicare is addressed through the underwriting process - Given these differences, CMS would face challenges in meaningfully analyzing supplemental benefit utilization and cost data received from EGWPs (most commenters expressed this concern); and - Exempting EGWPs here would be consistent with how CMS waives EGWPs from certain PBP and bid filings, regulatory filings of plan marketing and communications, and other CMS requirements. 	<p>No changes.</p> <p>While commenters correctly note that EGWPs differently report their PBP benefit offerings, making analysis difficult, we believe there is still value in collecting data this data from EGWPs. We currently lack visibility into EGWP supplemental benefit cost and utilization. In addition, EGWPs are covered under MLR reporting, and this data collection could be crosswalked against MLR reporting to ensure complete MLR reporting.</p>

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Cost Reporting	3	<p>One commenter noted that some plans pay for some supplemental benefits on a FFS basis and others on a PMPM basis. The commenter recommended CMS clarify whether, for supplemental benefits paid on a PMPM basis, submissions should include only benefits actually used by enrollees during the reporting period.</p> <p>Other commenters expressed a similar concern that many plans leverage PMPM arrangements to administer supplemental benefits, and that plan and vendor financial systems are not built to capture this data under PMPM arrangements.</p>	<p>Change the data element to “The total amount incurred by the plan to offer the benefit.” In addition, add explicit instructions to clarify what is required.</p> <p>We want plans that pay for benefits PMPM to report on those costs, even if no enrollees utilize the benefit. The above proposed language change would effectuate that.</p> <p>We also propose to add a note to this data element clarifying that the plan must report its net spend rather than the amount allocated. For example, if the plan allocates \$1,000 to a flex card for dental benefits, and the enrollee uses only \$250, the plan would include \$250 (rather than \$1,000) to its computation for this element. The same approach would apply to any PMPM arrangements with a recoupment mechanism. To help clarify this new data element, we also propose to</p>

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			<p>change the phrase ‘total amount spent’ to ‘total net amount incurred’ which we believe better aligns with the data we intend for plans to report.</p> <p>Add a new free-text field to solicit information on payment arrangement used to implement the supplemental benefit. This would improve our ability to compare submissions across plans. We would leverage this information in the future to establish a standardized list of payment arrangement types, which would enhance our ability to analyze submissions.</p> <p>Add a new free-text field to solicit information on benefit cost accounting. This would importantly fill a knowledge gap we have about how plans understand costs incurred to administer benefits. If we finalize this proposed element, please note that we would not be release this data publicly.</p>
Medicare-Medicaid Plans	1	The commenter expressed concern that MMPs are set, under CMS	No changes.

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(MMPs)	(MAO)	guidance to date, to sunset at the end of 2024. The commenter also expressed concern that MMPs are combined benefit plans, and that the Medicare-specific data cannot be carved out, making reporting for MMPs particularly challenging. The commenter recommends that CMS exclude MMPs from this collection.	Other Part C reporting requirements include MMPs and are not exempting them yet. In addition, the Duals Office has indicated that in some states, MMPs are being extended through 2025. These extensions were discussed in the preamble to the CY2024 final rule, but they have not been implemented yet.
Units of Utilization	3	<p>All commenters recommended CMS provided more guidance as to expected units of utilization. All reasoned that the lack of standardized units would impede CMS' ability to compare the data across PBPs.</p> <p>One commenter reasoned that plans often contract with entities to provide packages or episodes of care with multiple “touch points,” and thus that CMS needed to outline standardized units of service to ensure clarity and uniformity across such contracts. This commenter also highlighted home and community-based services as especially difficult under this reporting for D-SNPs, as Medicaid MCOs often subcontract coordination and management for some or all related services. The commenter provided an example of when a supplemental benefit is a supportive service for a caregiver, clarity would be important to provide regarding to whom the service would be attributed.</p> <p>Another commenter expressed support for the flexibility CMS proposed to provide MAOs here. This commenter recommended that “CMS consider the potential differences in interpretation when finalizing how to contextualize the unit of utilization.”</p>	<p>No changes.</p> <p>We do not feel well positioned to establish standardized units of utilization at this time. We expect that MAOs measure benefits differently, and more analysis is needed to understand which units might best reflect service delivery.</p> <p>The data we receive through this collection will better position CMS to consider appropriate standardized units of utilization.</p>

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		Yet another commenter expressed concern that the lack of standard units would make comparisons related to non-medical benefits particularly tricky.	
Public Reporting	7	<p>2 commenters urged CMS to publicly release the data in a manner useful to researchers.</p> <p>4 commenters expressed concern about the prospect of CMS publicly releasing this data for the following reasons:</p> <ul style="list-style-type: none"> - Any reporting might inadvertently disclose beneficiary-level information (or otherwise violate HIPAA). - Any reporting might disclose proprietary plan or vendor data, or otherwise harm competition. - Any reporting might lead to misinterpretation about the “true costs” or value of supplemental benefits to stakeholders, including beneficiaries considering plans. - If this collection (PBP-level) is crosswalked against MLR reporting (contract-level), the comparisons may be skewed because of the difference in reporting level. <p>Another commenter recommended that CMS collect and communicate data in a way that better reflects the many ways plans are tailoring and packaging supplemental benefits for specific populations and beneficiary choice.</p>	<p>No changes.</p> <p>We are still considering what data we would release publicly, and in what manner we would release any such data.</p>
Timeline	5	<p>2 commenters requested that CMS clarify when exactly MAOs will be required to submit the first report under this collection, and which reporting period it will apply to.</p> <p>5 commenters recommended that CMS delay implementing all or part of this proposed collection. Reasons generally related to:</p> <ul style="list-style-type: none"> - Time for claims run out and to the lack of readiness of supplemental benefit vendors (often community-based organizations, non-profits, and/or small businesses) to collect and transmit data. - A concern that enrollees often wait until end of CY to use 	<p>No changes.</p> <p>MAOs would be required to submit the first set of data under this collection by the last Monday in February in CY 2025, and this submission would cover all supplemental benefits furnished during CY 2024.</p>

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		<p>supplemental benefits.</p> <p>In addition to a phase-in approach, 2 commenters recommended lax enforcement in the first couple years.</p> <p>1 commenter recommended that CMS move the submission due date to be a date after bid submission, and that CMS provide MAOs with additional time to report this data in the first two years after the proposed collection is implemented to ensure that MAOs have ample time to comply.</p>	<p>We believe this first submission date provides sufficient time to report on supplemental benefit utilization and cost accurately. There would be time for plans to ensure that vendors are prepared to submit all necessary data in a timely fashion to plans.</p> <p>CMS is still considering how it would enforce compliance with the requirements of this collection.</p>
Removal of Certain PBP Categories	2	<p>1 commenter recommends excluding:</p> <ul style="list-style-type: none"> - Inpatient Hospital Services – Additional Days - SNF Waive Hospital Stay - Blood Deductible - OON <p>For Inpatient Additional Days and SNF Waiver, the commenter gives several reasons. For Inpatient Additional Days:</p> <ul style="list-style-type: none"> - Claims data for these services are identical to claims data for Medicare-covered days, and there is nothing on a claim to indicate whether the claim is for an additional day. - For bid purposes, MAOs are not required to identify specific alims associated with additional days. CMS developed a 1.2% factor based on FFS data that the certifying actuary may use as a “safe harbor” for the proportion of the inpatient facility days that are non-covered and as a basis for determining the inpatient facility cost-sharing. - Because the additional day is not broken out in claims or bids, 	<p>No changes.</p> <p>We do not find compelling the commenter’s explanation for why we should exclude any of the listed categories. For each discussed category, the commenter effectively says that they cannot identify the claims for which they are making payments. CMS would expect that plans are able to identify claims for which the plan is making payments. We do not agree that this collection would be newly requiring plans, if only as a matter of</p>

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		<p>MAOs would need to develop new processes to try to identify claims that would have exceeded a Medicare Benefit Period if plans are following that period for both IP and SNF stays. Since most MAOs waive the 3-day stay for SNF, it is not clear whether SNF days following a 0-2 day hospital stay would count toward the Benefit Period days. As a result, MAOs will likely develop different ways to account for the days, leading to potential inconsistencies in reported data.</p> <p>For SNF Waiver:</p> <ul style="list-style-type: none"> - Medicare regulations allow MAOs to cover post-hospital SNF care in the absence of the prior qualifying hospital stay that would be required under TM. When this is the case, the coverage is a basic benefit, not a supplemental benefit. - For bid purposes, due to the above situation, plans are not required to identify specific SNF claims that were not preceded by a qualifying stay. - While TM requires specific billing elements to indicate that a SNF stay was preceded by a qualifying IP stay, MAOs typically do not require this coding since they are not used to calculate MA plan benefits. <p>For the Blood Deductible:</p> <ul style="list-style-type: none"> - Because emergency care is covered nationwide, the commenter asserts that most MAOs file a waiver of the blood deductible uniformly on all PBPs and do not track whether the blood was obtained in a donor state or not. - As such, providers may not routinely bill the value codes that TM uses to track blood donations in non-donor states, and - As a result, MAOs would have no way of knowing how many pints of blood were paid for that TM would not have paid for. <p>For OON:</p> <ul style="list-style-type: none"> - These are not always supplemental benefits – e.g., for HMO 	<p>business operations, to have systems in place to ensure that payments are tied to the delivery of specific services.</p> <p>As for the recommendation that CMS include only those benefits for which plans cannot submit encounters, one purpose of this collection is to check for completeness in other collections, including encounter data. We believe it is important to include all supplemental benefit categories to further this goal.</p>

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		<p>and PPO plans, and some OON services for POS plans (like emergency services and out-of-area dialysis) are Medicare-covered.</p> <ul style="list-style-type: none"> - If CMS keeps OON as a reporting category, the commenter recommends that CMS refine it as POS only, since OON services and covered under a POS plan are supplemental. In addition, because POS benefits vary widely and will be difficult to aggregate, the commenter recommends that CMS provide detailed instructions to MAOs on how they should aggregate benefits, as without instruction, CMS will likely receive varying submissions from MAOs. <p>Another commenter recommended including only PBP categories for which there is no ability to submit an encounter data record, citing examples of “fitness benefit, capitated vendor arrangements, reimbursement models, etc.”</p>	
<p>Rollup of Certain PBP Categories</p>	<p>2</p>	<p>1 commenter recommends rolling up:</p> <ul style="list-style-type: none"> - The 3 Worldwide services (Emergency Coverage, Emergency Transport, Urgent Coverage) - Transportation Benefits (any plan-approved location, any health-related location) - Preventive Dental (oral exams, cleaning, x-rays, fluoride) - Comprehensive Dental (non-routine, diagnostic, restorative, endodontics, periodontics, extractions, prosthodontics, other oral/maxillofacial, other) - Vision Eyewear (contact lenses, eyeglasses, eyeglass frames, eyeglass lenses, eyewear upgrades) - Fitness Benefit (physical, memory) - Hearing aids (hearing aids (all types), hearing aids – inner ear, hearing aids – outer ear, hearing aids – over the ear) <p>For Worldwide:</p>	<p>No changes.</p> <p>The granularity of this collection is one of its critical features. If implemented, this collection would newly grant CMS insight into the cost of furnishing supplemental benefits, and into utilization across each plan’s member population. CMS would gain substantially more insight by requiring plans to break out their reporting into these discrete, granular supplemental benefit</p>

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		<ul style="list-style-type: none"> - Most non-US providers are unable to submit claims to MAOs in the same manner as US non-contracted providers. - Receipts are typically in the language of the country where services were obtained, and it can be difficult to translate in enough detail to ensure the services were indeed relevant medical services. - Non-US providers often do not indicate urgent versus emergency coverage. - There is likely large crossover between the 3 categories, and because of the variation in how these services are categorized or reported by non-US providers, recommends that CMS consolidate these subcategories into one Worldwide Coverage PBP category. <p>For Transportation:</p> <ul style="list-style-type: none"> - There is no meaningful difference between Transportation to Plan-approved Location and Transportation to Any Health-related Location – and MAOs may put the same or similar services into these different PBP subcategories depending on how they choose to explain the benefit to enrollees. - Because MAOs may subcategorize the same services differently, consolidating the transportation PBP categories will provider greater consistency in the reporting. <p>For Preventive Dental:</p> <ul style="list-style-type: none"> - Utilization of the services included under the general PBP category of “preventive dental” generally occur during the same member visit, and viewing the data at the overall preventive level will help ensure CMS is receiving meaningful data. <p>For Comprehensive Dental:</p> <ul style="list-style-type: none"> - The services that fall within the included categories are not defined by CMS, and MAOs are not required to split costs 	<p>categories.</p> <p>These benefit categories are borrowed directly from those used in PBP submissions, so we would expect that these categories are not only familiar to plans but also already used in developing their respective PBPs.</p> <p>We believe that for each broader, umbrella supplemental benefit category, the associated granular supplemental benefit categories are sufficiently distinct so as to warrant separate data submission.</p> <p>To the extent that these supplemental benefit categories overlap (or could be understood differently between plans), CMS could still glean valuable information from the data outliers that this purported reality would produce. For example, if CMS were to observe high variation between plans in utilization of a broadly offered benefit,</p>

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		<p>between these categories in their bids.</p> <ul style="list-style-type: none"> - Because MAOs may include different services in each category, recommend combining to ensure consistency in reporting. <p>For Vision Eyewear:</p> <ul style="list-style-type: none"> - There is an overlap between these descriptors, and MAOs may put the same or similar services into different subcategories. - Utilization of many of the services are included within the same claim, so grouping and reporting data at the overall PBP category of Vision Eyewear would likely provide better data and provide greater process efficiencies for MAOs. <p>For Fitness:</p> <ul style="list-style-type: none"> - Generally structured across the industry to include both physical and memory products, and the costs of these two items may not be split out by MAOs when filing bids. Combining would allow for greater process efficiencies and consistency in reporting. <p>For Hearing Aids:</p> <ul style="list-style-type: none"> - There is an overlap between these descriptors, and MAOs may put the same or similar services into different PBP categories. - Consolidation would help ensure consistency in reporting. <p>Another commenter recommended that if CMS does not reduce its PBP categories to those for which plans cannot submit Encounters, CMS should roll up PBP categories as much as possible.</p>	<p>this might represent an opportunity for CMS to add clarity to the specific services contemplated for that supplemental benefit category. In other words, we believe that even if the overlaps or other challenges identified by this commenter were realized, we would still derive value from this collection as proposed.</p>
PBP Categories Clarification	1	<p>1 commenter indicated that CMS did not clarify whether items or services under a specific PBP category should be lumped together into one line item or reported separately. The commenter recommended that CMS provide clarity on how CMS expects MAOs to report.</p>	<p>No changes. To clarify: MAOs would need to report the data elements for each PBP category listed in</p>

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			Section VIII of the Part C Reporting Requirements separately. MAOs should not report the data elements as an aggregated or lumped together single line item.
Data Element Phase-in	1	<p>1 commenter recommended that, at least for initial reporting, CMS permit MAOs to report Data Elements C-J in a way that aggregates the authorities under which that the MAO offers the benefit. For example, the commenter would have CMS permit an MAO to report the total out-of-pocket-cost per utilization for enrollees (Element J) for Over-the-Counter (OTC) Items offered in as any benefit type, rather than reporting for OTC Items broken out by mandatory, optional, under uniformity flexibility (UF), and as a Special Supplemental Benefit for the Chronically Ill (SSBCI).</p> <p>The commenter also recommended that, for the initial reporting year, CMS require reporting of Element G (the total instances of utilizations among eligible enrollees) only.</p>	<p>No changes.</p> <p>We believe all proposed data elements are important to collect, and that plans would have sufficient time to collect and submit this data as would be required. We additionally believe that requiring reporting by offering authority is an important feature of this collection so that CMS can compare cost and utilization data within supplemental benefits across benefit offering authorities.</p>
Adding New Data Elements	2	<p>1 commenter recommended adding the following data elements, all specific to dental services:</p> <ul style="list-style-type: none"> - “Total number of beneficiaries (age, race and ethnicity, income, education, ...) - Number of beneficiaries with a dental claim in a plan year (age, race and ethnicity, income, education, ...) as a measure of access - Cost sharing (average benefit paid per user [among enrollees who had a dental visit], average benefit paid per beneficiary [among all enrollees], coinsurance, annual maximums, total average out of pocket spending, ...) 	<p>No changes.</p> <p>The commenter’s proposed dental service data elements are consistent with those we proposed, except for the quality measure data element. Quality measures are outside the scope of the current goals of this collection.</p>

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		<ul style="list-style-type: none"> - Applicable measures for the older adult population from the Dental Quality Alliance.” <p>1 commenter recommended the following new data elements:</p> <ul style="list-style-type: none"> - An element that captures benefits administered through a card. - Plan criteria for determining who is eligible for an SSBCI across all three parts of SSBCI eligibility criteria. - Maximum number of utilizations among enrollees who utilized the benefit at least once. 	<p>As for the other commenter’s recommended new elements, we are not proposing to add these elements at this time. We may consider adding these elements or elements similar to them in a future iteration of this collection.</p>
Duplicative Collection	3	<p>1 commenter claimed that much of the data CMS proposes to include is already in the BPT submitted to CMS and would be duplicative. The commenter also indicated that requiring the submission of data would require MAOs to hire additional staff to collect and submit the data, in addition to expending additional resources for new or updated systems to produce the required reporting and meet data retention requirements. The commenter further expressed concern that much of the supplemental benefit data comes from contracted vendors, and that this data is not always at the level of granularity that CMS is proposing to require. Contracts with vendors may need to be updated – and CMS did not account for this in its burden estimates.</p> <p>Another commenter expressed concern that this proposed collection would be duplicative with encounter data.</p> <p>Yet another commenter expressed concern that this proposed collection would be duplicative with data submitted each year as part of the PBP filing.</p>	<p>No changes.</p> <p>This collection is not duplicative with any existing collection, and it is being implemented in part to respond to stakeholder feedback, including recommendations made by GAO to improve supplemental benefit data collection.</p> <p>As we said in response to other commenters, the granularity of this collection is one of its critical features. If implemented, this collection would newly grant CMS insight into the cost of furnishing supplemental benefits, and into utilization across each plan’s member population. This collection</p>

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			<p>would include submission of data not submitted to the BPT or as part of the PBP filing. It also captures cost data not captured by encounter data. Finally, as GAO reported, plans do not fully report supplement benefit utilization as encounters, and we understand that plans struggle to submit encounters for supplemental benefits that lack corresponding codes.</p> <p>We also believe that we have taken into account all relevant costs associated with this proposed collection.</p>
Value-Based Insurance Design (VBID) Model and Medicaid	2	<p>1 commenter expressed support for CMS’s proposal to omit supplemental benefits offered through the VBID Model administered by the Center for Medicare and Medicaid Innovation (CMMI).</p> <p>Another commenter recommended that, to reduce burden, CMS should align these proposed reporting requirements and data elements to those reported for the VBID Model and state Medicaid supplemental benefit reporting where possible.</p>	<p>No changes.</p> <p>We appreciate the support expressed.</p> <p>While we are not making any changes at this time to specifically align to VBID or Medicaid reporting requirements, we will consider changes in the future to align to other CMS</p>

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			program reporting requirements relevant to MAOs.
Segments	1	1 commenter requested clarification regarding how CMS expects MAOs to report utilization on PBPs with segments that offer differing benefits, as segmented plans may have drastically different benefits within a single benefit category.	No changes. CMS would require the MAO to report on utilization of any supplemental benefits offered in any segment. If a supplemental benefit is offered in multiple segments, the MAO is required to aggregate the data across those segments when reporting on the supplemental benefit. If a supplement benefit is offered only in one segment, then the MAO must report the utilization and cost data for the supplemental benefit in that segment
Technical Specifications	3	3 commenters recommended that CMS publish the technical specifications associated with these proposed reporting requirements.	No changes , but we will publish the proposed technical specifications in as part of our 30-day comment period package.
Reporting Systems	2	1 commenter recommended that CMS work with MAOs to develop an automated reporting option for this type of data collection for future reporting years. Another commenter recommended that CMS explore updates to the existing PBP module and reporting mechanisms to identify ways to support more efficient data collection and submission through the Part	No changes. We appreciate these suggestions. We are still considering how we will implement the reporting mechanism for this

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		<p>C bid and reporting processes. Further, this commenter recommended that if CMS determines opportunities to use a new software or interface to support data collection, CMS should invite MAOs to review and test any new data fields prior to implementation to mitigate potential technical issues.</p>	<p>collection. We may consider these recommendations as we develop our implementation approach.</p>
<p>Clarification of Data Elements Eligible Enrollees: Clarification</p>	<p>2</p>	<p>1 commenter recommended that CMS provide clarification on multiple proposed data elements, as follows:</p> <ul style="list-style-type: none"> - Whether the number of enrollees eligible for a benefit should reflect the number eligible at the beginning of the coverage year or at the end of the coverage year for the applicable reporting period. The commenter recommended that, because an individual’s eligibility for a benefit can change month to month, that it is important for CMS to provide clarity in how plans count which enrollees are eligible to reduce confuse and potential differences in reporting. - Whether the total instances of utilization among eligible enrollees should include both paid and denied services. - Which out-of-pocket costs should be included in the reporting. <p>Another commenter recommended that CMS provide definitions or clarification for the terms CMS used in Data Element C: “How is the supplemental benefit offered? (Mandatory, Optional, Uniformity Flexibility, SSBCI, not offered)”</p>	<p>No changes. To clarify:</p> <p>Under our proposed reporting requirements, (1) the number of enrollees eligible for a benefit should be measured as whether a given enrollee was eligible at any point in the contract year; (2) the total instances of utilization among eligible enrollees should include only services actually rendered; and (3) out-of-pocket costs include copays, coinsurance, and premiums, as applicable.</p> <p>For Data Element C, we define “mandatory supplemental benefits” and “optional supplement benefits” in the Medicare Managed Care Manual, Chapter 4. We also codified these concepts in regulation at 42 CFR 422.102.</p> <p>We provide for the</p>

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			<p>definition and requirements related to SSBCI in 42 CFR 422.102(f).</p> <p>We provide for the Uniformity Flexibility benefit offering under 42 CFR 422.100(d)(2)(ii).</p> <p>For all terms, we require MAOs to indicate the benefit type for supplemental benefits offered. As such, we would expect these terms to be familiar to MAOs.</p> <p>Finally, “not offered” means that the MAO’s PBP for which it is reporting does not offer the given benefit.</p>