EDPS, The Next Frontier: Supplemental Services Submission

Presented By:

Dawn R. Carter, BSBA, CPC, CRC, CPMA, CDEO, CPCO, CSM, CSPO, Director of Product Strategy, Centauri Health Solutions

RISE®

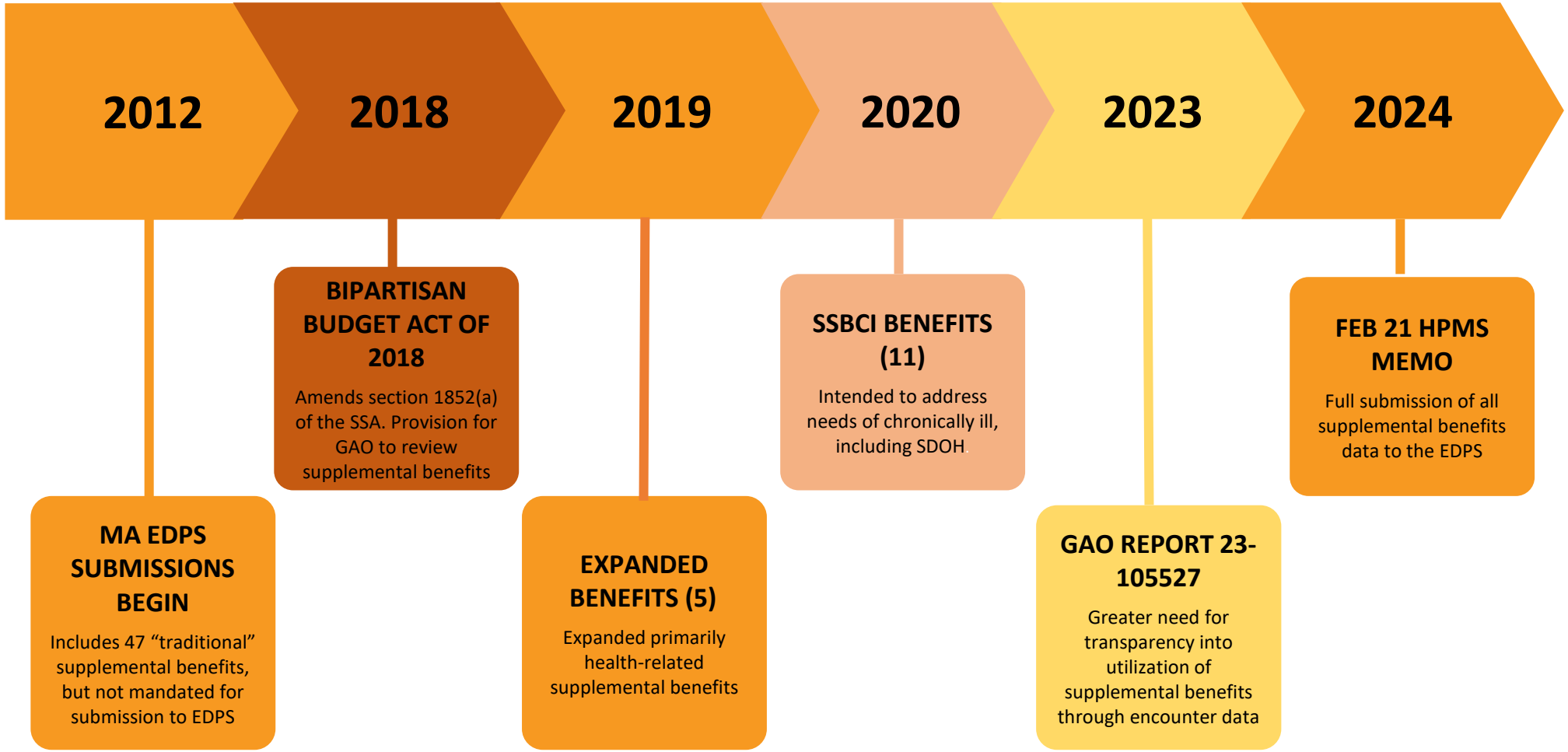
Webinar Participant Tips

- All participant lines are muted. To protect your privacy, you will only see your name and the presenters names in the participant box.
  - To submit a question to the presenters any time during the event;
  - In the Event window, in the Panels drop-down list, select Q & A.
  - Type your question in the Q & A box.
  - Click “Send”.

Learning Objectives

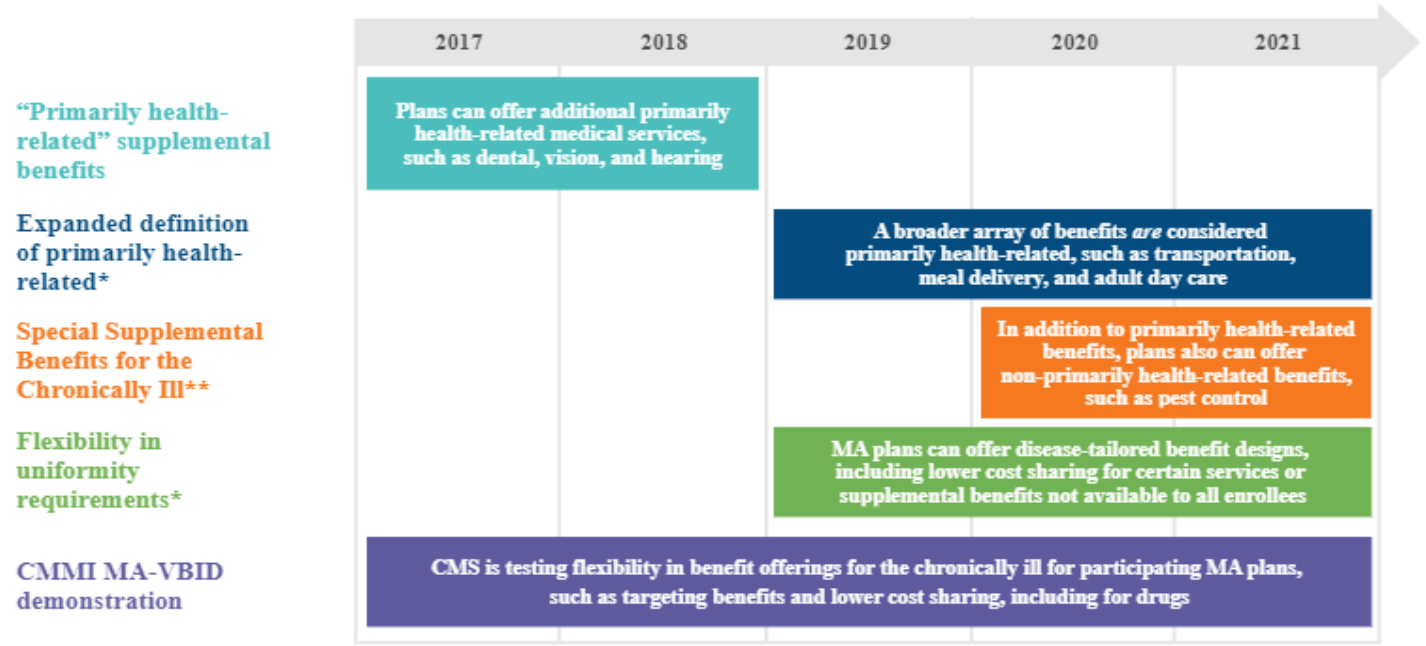
- **In-depth overview** of CMS requirements for the submission of supplemental benefit data
- **A high-level overview** of an operational and technical implementation plan for the changes
- **Overview** of new post-production benchmarking and reporting that will be needed to support successful submissions

Let’s start with some history…



Supplemental Benefits Evolution

Timeline of New Medicare Advantage Plan Benefit Flexibilities



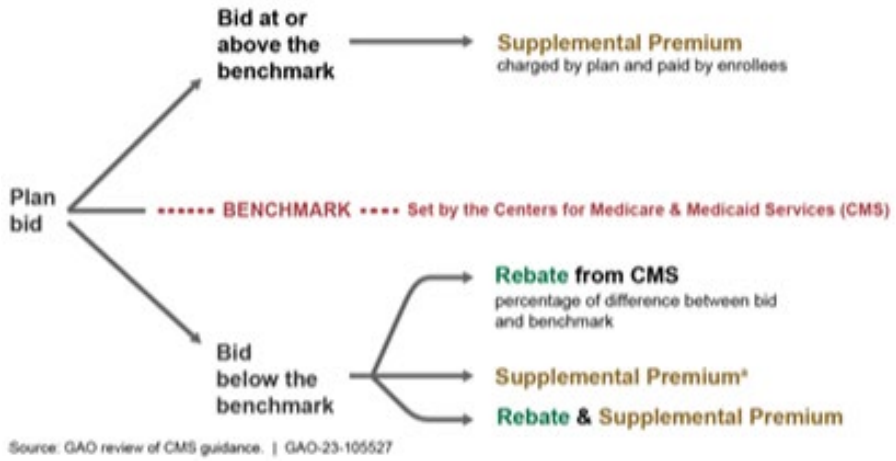
Notes: Years correspond to when policy changes took effect. MA = Medicare Advantage; CMMI = Center for Medicare and Medicaid Innovation; VBID = Value-Based Insurance Design; CMS = Centers for Medicare and Medicaid Services.
* Included in CY 2019 Rate Announcement and Final Call Letter.
** Enacted as part of the CHRONIC Care Act, BBA of 2018.

Source: Thomas Kornfield et al., *Medicare Advantage Plans Offering Expanded Supplemental Benefits: A Look at Availability and Enrollment* (Commonwealth Fund, Feb. 2021). https://doi.org/10.26099/345k-kc32

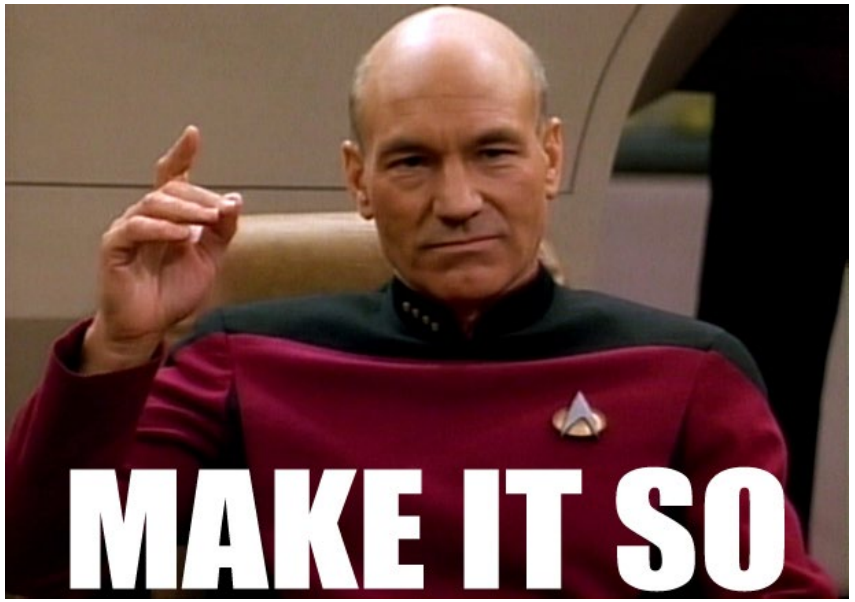
Here is another visualization of supplemental benefits evolution.

Financing of Supplemental Benefits

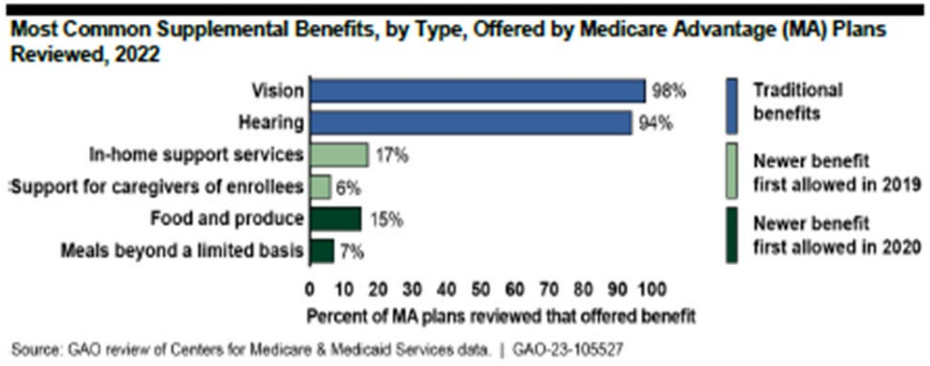
Dawn's dad, 2023



Why? Because I Said So!



- Because the GAO “said so” and says little is known about supplemental benefit utilization.
- CMS needs to distinguish between items and services that are covered under Medicare Part A and Part B, and supplemental benefits.
- CMS wishes to understand the use and value of supplemental benefits in MA for the benefit of future policymaking.
- CMS wants to ensure that what is being provided as supplemental benefits is consistent with the plan bid.
- Health equity and SDOH: ensuring supplemental benefits also support enrollee’s health and social needs.



CMS New Initiatives Related to Supplemental Benefits Data

- New requirement in Contract Year 2023 MA and Part D final rule (87 FR 27704) 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
- A proposed ICR to improve plan benefit package (PBP) categorization of supplemental dental services

General Instructions

- Dates of service beginning with 1/1/2024 to commence “as soon as possible,” with catch-up submissions expected to be concluded by 12/31/2024.

- Technical guidance available at csscoperations.com
- CMS plans to monitor submissions and reach out to MAOs that may not be submitting many supplemental benefits of the types expected based on their bids.
- MA EDPS filtering logic for risk score calculation remains unchanged.

Dental Benefits – Part A and B vs. Supplemental

- 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.
  - Example: Dental procedures that must be done under sedation in a medical facility
- Supplemental dental benefits cover preventive and comprehensive dental services outside of Medicare-covered dental services and will be reported with the X12 837D Version 5010 claims format plus the new requirements for the X12 837 that identify the record as a supplemental benefit.
  - Example: Routine cleanings, x-rays, fillings, etc.

Dental Benefits

- CMS will notify submitters when the EDPS begins accepting dental encounters using the 837D format; ETA is June 2024.
- Organizations with capitated or allowance arrangements must work with vendors to populate a compliant X12 837D. These vendors will not be authorized to submit directly to the EDPS on the plan's behalf.
- A guide will be published “prior to June.”

Default Data

- CMS has specified a set of default data for situations where there does not exist sufficient data to populate an X12 837.
- CMS acknowledges that certain type of benefits do not produce the same type of utilization data that are associated with a medical service and/or have different approaches to payment and have specified how to populate the encounter in these cases.
  - Pre-funded payment cards for over-the-counter items and groceries
  - Payment for membership that allows access to services (i.e., gym memberships)
- All prior CMS requirements for default data still apply in addition to what is specified in Appendix C.

Supplemental Benefits Matrix

- Identify exactly what qualifies as a supplemental benefit according to CMS guidance for each contract/PBP and bid to establish the use cases that will need to be accounted for in testing and production.
- Assign a Supplemental Benefit Services Category Code (SBSC) from the 99 possible values in Appendix B to each identified benefit.
- Construct a matrix of these to facilitate development and testing. Pay special attention to the examples of special cases in section 2.12.3 and 2.12.4 of the Submission Guide to ensure all possible benefits are properly accounted for.

Supplemental Benefits Matrix

- Combined benefits must be broken out into separate encounters by SBSC – this includes the situation where the beneficiary is given a lump sum to spend on a number of benefits.
  - May require working with external vendors to provide appropriate claims information.
  - If members submit reimbursement requests to the plan, ensure that the requests contain the data necessary to fully inform the encounter that is submitted.
- There are three codes in Appendix B for Other that are to be used for benefits not included in the Appendix listing, but CMS will be monitoring the usage of these codes.
- There are 5 SBSCs for SSBCI-related benefits.
- There are 11 SBSCs for dental-related benefits to be used on the X12 837D.

PWK Segment

- CMS has specified requirements for the 2400.PWK01, 2400.PWK02, and 2400.PWK05 static data element values that are to be used at the **LINE LEVEL** with the SBSC that is provided in the 2400.PWK06 for each SBSC assigned to a use case.
- Each line should contain only one occurrence of the SBSC and should be reported in the first iteration of the PWK segment (since it can repeat).
- Chart review records cannot contain an SBSC.
- Static values:

  PWK01 = IR

  PWK02 = EM

  PWK05 = AC
- Dynamic value: PWK06: populated with the appropriate SBSC from Appendix B appended with “zz”
  - ***Example: Routine Foot Care: PWK01 = IR, PWK02 = EM, PWK05 = AC, PWK06 = 7fzz***
  - ***Example: Fluoride Treatment: PWK01 = IR, PWK02 = EM, PWK05 = AC, PWK06 = 16a3zz***

Sample Requirements Matrix and Examples

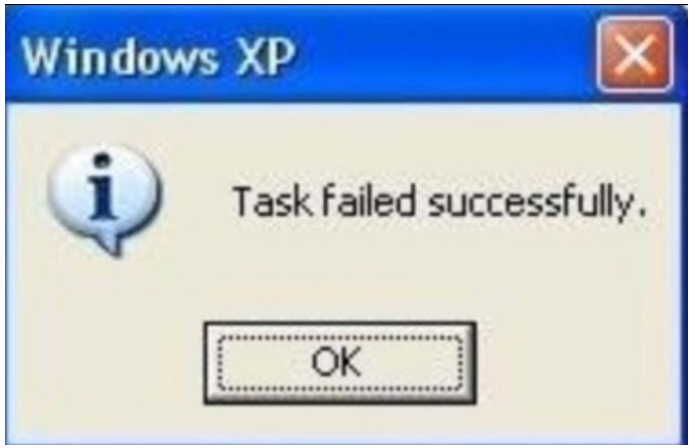
New/Updated MAO-002 Edits

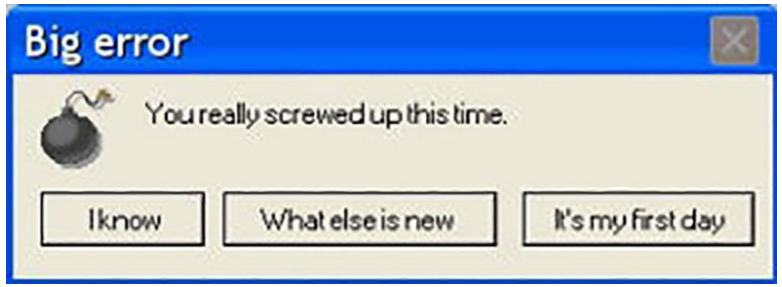
New Edits:

- 19000: Invalid Supplemental Benefit Submission
- 19005: Missing Supplemental Benefit Details
- 19010: Supplemental Service on CRR Not Allowed
- 19015: Not a Valid Code for Date of Service
- 19020: CRR Linked to Supplemental Services

Updated Edits (bypass conditions):

- 98325 - Service Line(s) Duplicated
- 32070 - Non-DME HCPCS Code
- 22340 - ESRD Diagnosis Code Missing
- 22320 - Missing ASC Procedure Code
- 98300 - Exact Inpatient Duplicate Encounter
- 21953 - SNF Claim Missing Revenue Code 0022
- 22100 - Rev Code 0023 Missing/Invalid for DOS
- 22470 - HH Claim Missing Skilled Services
- Preliminary RA Flag reported on the MAO-002





Operational Reporting

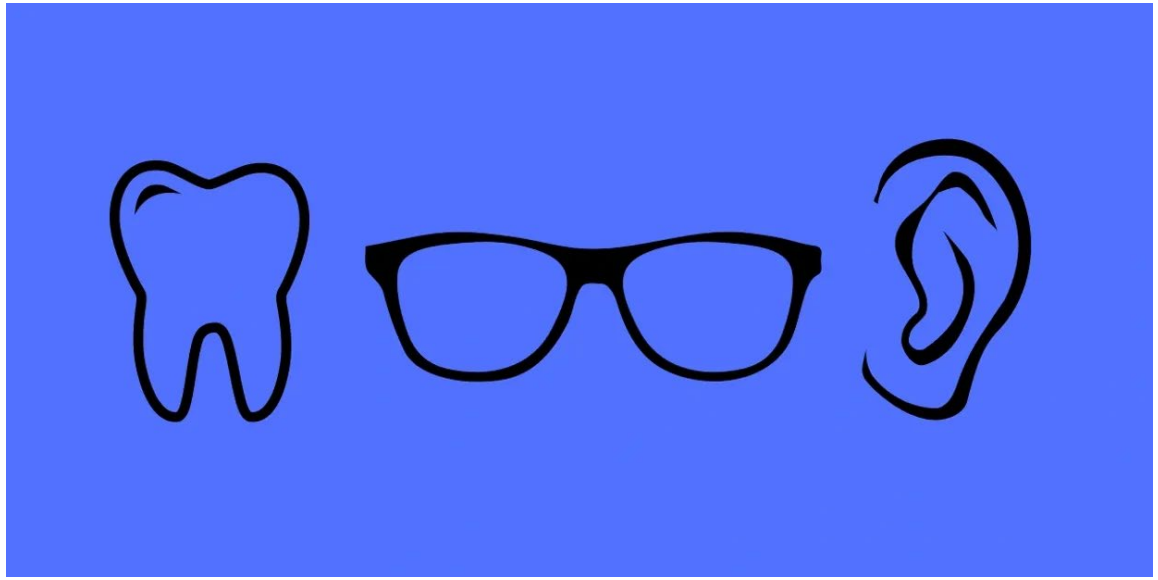
- Run a query at least quarterly to pull in all encounters sent with the PWK01, PWK02 and PWK03 static values. Cross reference these to the SBSC matrix to group by benefit.
  - Compare the SBSCs to what is specified in the bid. Outliers, meaning those that are not listed in the bid, should be investigated.
  - Be sure to include the following data elements in the query:
    - Billing provider NPI
    - Billing Provider Name
    - PWK06 = SBSC type
    - Total Billed Charge
    - Line Charge Amount
    - Line Paid Amount
    - Date of Service

Operational Reporting

- How are these needs being anticipated before the member ever steps foot in an office?
- Has there been appropriate screening for needs that can be served by these benefits?
- Is the need for the service clearly documented in the medical record and represented by a corresponding diagnosis code?
- For referrals, was the loop closed, meaning did the member receive the product/service? How and how often is this measured, and by whom?
- How are these encounters being tied to outcomes?

Outcomes Reporting

- Vision: Does the utilization of these benefits result in fewer falls and car accidents, or accidents in general?
- Dental: Does the utilization of these benefits result in fewer diagnoses with ICD10 codes between K00 – K088?
- Hearing: Does the utilization of these benefits result in reduced prevalence of mental health diagnoses or reports of isolation and loneliness?
- Food/Nutrition: Does the utilization of these benefits result in better diabetes and/or hypertension control? Are there reported reductions in BMI or fewer diagnoses of morbid obesity? Fewer diagnoses of malnutrition or specific nutritional deficiencies?



Summary: Implementation Punch List

- Create benefits matrix for use cases and requirements for technical team
- Create X12 837 mappings for each use case with defaults and PWK segment as appropriate
- Create/adjust MAO-002 level validations
- Tier 2 testing with test X12 837s for each use case
- Get ready for X12 837D submission for dental
- Run reporting for bid comparison and utilization
- Start thinking about tying this data to outcomes, especially those related to health equity and quality measures

THANK YOU

Questions related to CMS technical guidance: RiskAdjustmentOperations@cms/hhs.gov; subject line “Supplemental Benefits Submission”

Dawn Carter
(804) 437-1394
dawn.carter@centaurihs.com
LinkedIn