RAPS to EDS Collaboration: A Data-Driven Analysis

National Medicare Advantage Summit

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Background

- CMS uses a risk adjustment process to modify Medicare Advantage (MA) plan payments to better reflect the composition of each plan's enrollees.

- Payments to each MA plan are modified based on risk scores that reflect enrollees' health status and demographic characteristics derived from member claims data.

- MA plans are currently transitioning from the traditional **Risk Adjustment Processing System (RAPS)**—where risk adjustment filter rules are applied by health plans—to the new **Encounter Data System (EDS)**—where MA Organizations (MAOs) submit their members' claims and CMS applies the filtering logic.

- The transition to EDS is intended to be revenue budget neutral because the change in format was expected to result in the same risk scoring.
  - However, the two approaches involve very different levels of information in their respective processes. The RAPS system involves only five necessary data elements (dates of service, provider type, diagnosis code and beneficiary Health Insurance Claim (HIC) number), while the EDS system utilizes all elements from the claims (i.e., HIPAA standard 5010 format 837).

- A January 2017 Government Accountability Office (GAO) report documents numerous problems MA plans have had in submitting data and receiving reliable edits from the agency.[1]

[1] GAO-17-223, page 2, "CMS does not expect the diagnoses in MA Encounter data to differ from those in RAPS."

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RAPS vs. EDS Process Flows

RAPS

EDS

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RAPS to EDS Transition: Need for a Study

RAPS - EDS COLLABORATION

A collaboration of industry partners and eight health plans initiated a study to help quantify the potential risk at an overall industry and individual health plan level to help prepare for an uncertain transition from a 100% RAPS to a 100% EDS-based system.

- Inovalon/Avalere were asked to support the research project leveraging its collective data integration, analytics, technologies and statistical research capabilities.

OBJECTIVE

The goal of this research was to test the neutrality theory using sample data from representative MAOs.

- The study aimed to evaluate the risk score and financial impact of the transition by comparing results reported back to plans from running the same set of claims data through the RAPS process to results from the EDS process.

METHODOLOGY

Participating MA plans submitted their 2014 and 2015 claims to CMS and provided Inovalon/Avalere with the results from the two sources of data used for risk adjustment for payment in the 2015 and 2016 payment years.

RAPS − EDS Collaboration Study Participants

Participation is representative of more than 30 H-Contracts across the nation and over 1 million beneficiaries

	2014	2015
Number of Plans (H-Contracts)	8 (36)	8 (33)
Blue Cross Blue Shield of Michigan	284,000	305,000
Blue Cross Blue Shield of Minnesota	5,500	5,200
Blue Cross Blue Shield of North Carolina	105,000	92,000
Blue Care Network	53,000	62,000
Cigna	408,000	409,000
Gateway Health Plan	45,000	51,000
Geisinger Health System	63,000	71,000
Healthfirst	115,000	121,000
Total Number of Beneficiaries	**1,078,000**	**1,116,000**

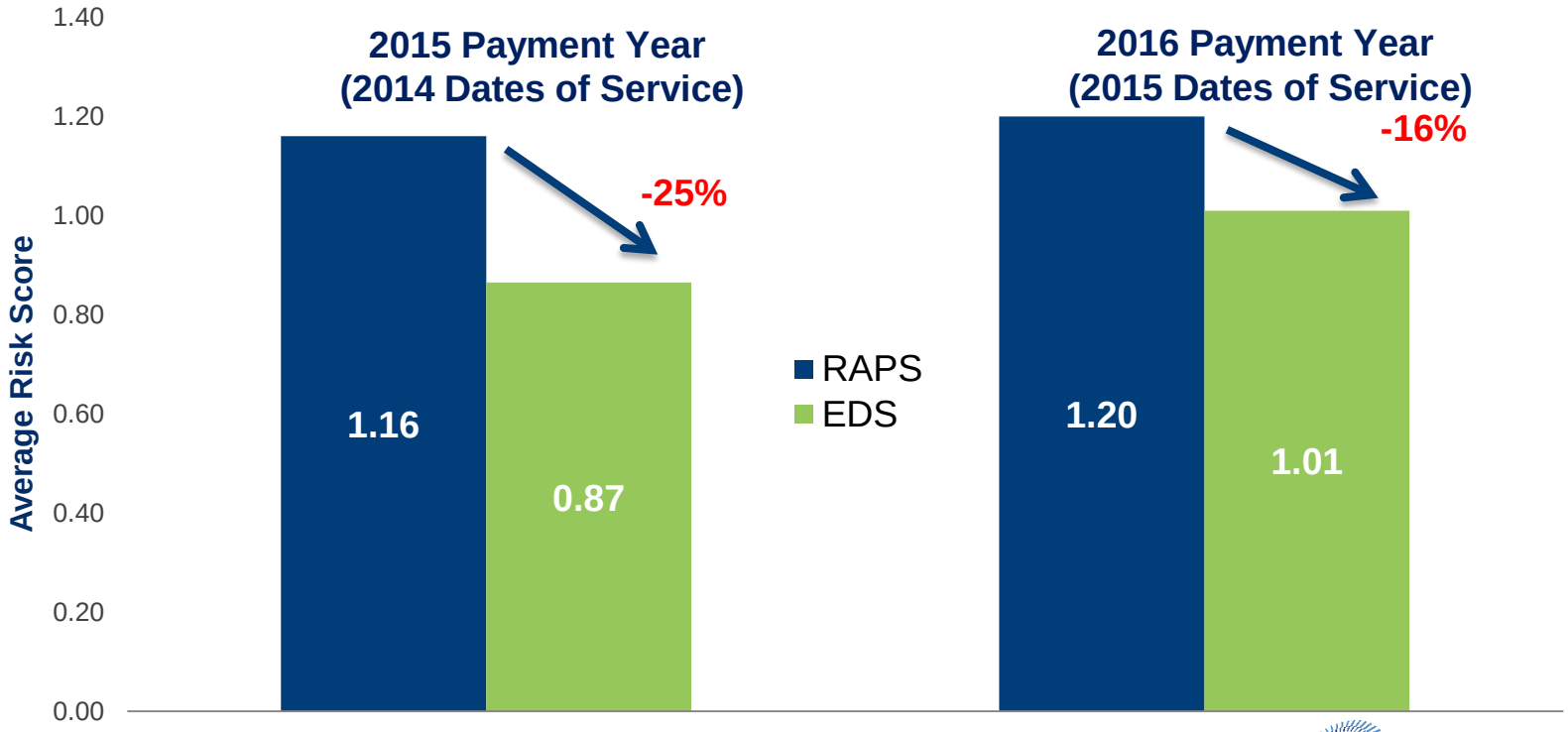
Research Questions

- Differences in Risk Scores: RAPS vs. EDS
- Payment Impact Based on Transition Scenarios
- Difference in HCCs Identified: RAPS vs. EDS

Table 1: Study Population Plan and Member Characteristics

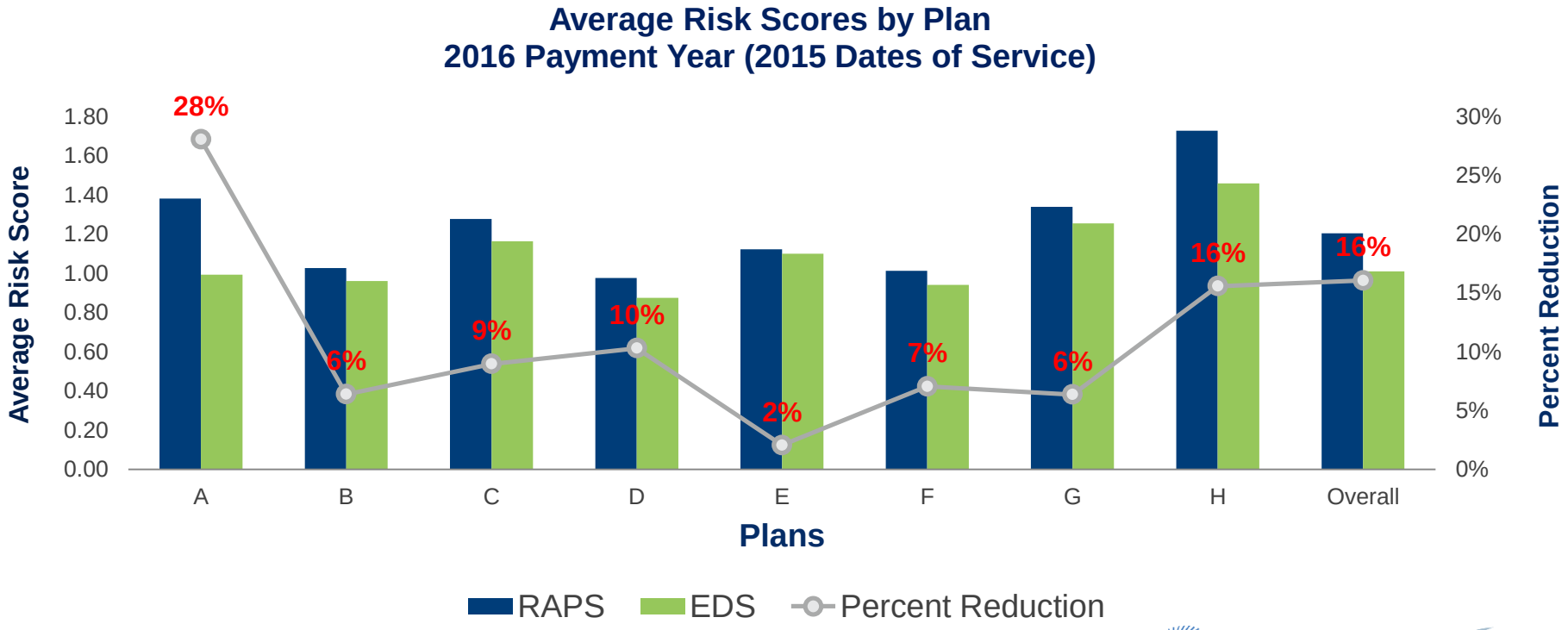
Plan & Member Characteristics	2014	2015
Number of Plans (H-Contracts)	8 (36)	8 (33)
Number of Members: Total	1,078,000	1,116,000
Mean	135,000	140,000
Range	5,500 – 408,000	5,200 – 409,000
Gender: N(%)		
Male	465,000 (43.2%)	482,800 (43.3%)
Female	613,000 (56.8%)	633,3000 (56.7%)
Age: N(%)		
< 65	160,200 (14.9%)	178,200 (16.0%)
65 - 69	208,000 (19.3%)	254,700 (22.8%)
70 - 74	264,400 (24.5%)	268,000 (24.0%)
75 - 79	192,000 (17.8%)	187,800 (16.8%)
80 and over	253,400 (23.5%)	227,300 (20.4%)
Dual Eligible: N(%)	**288,700 (26.8%)**	**299,400 (26.8%)**

Average Risk Score Difference: RAPS vs. EDS



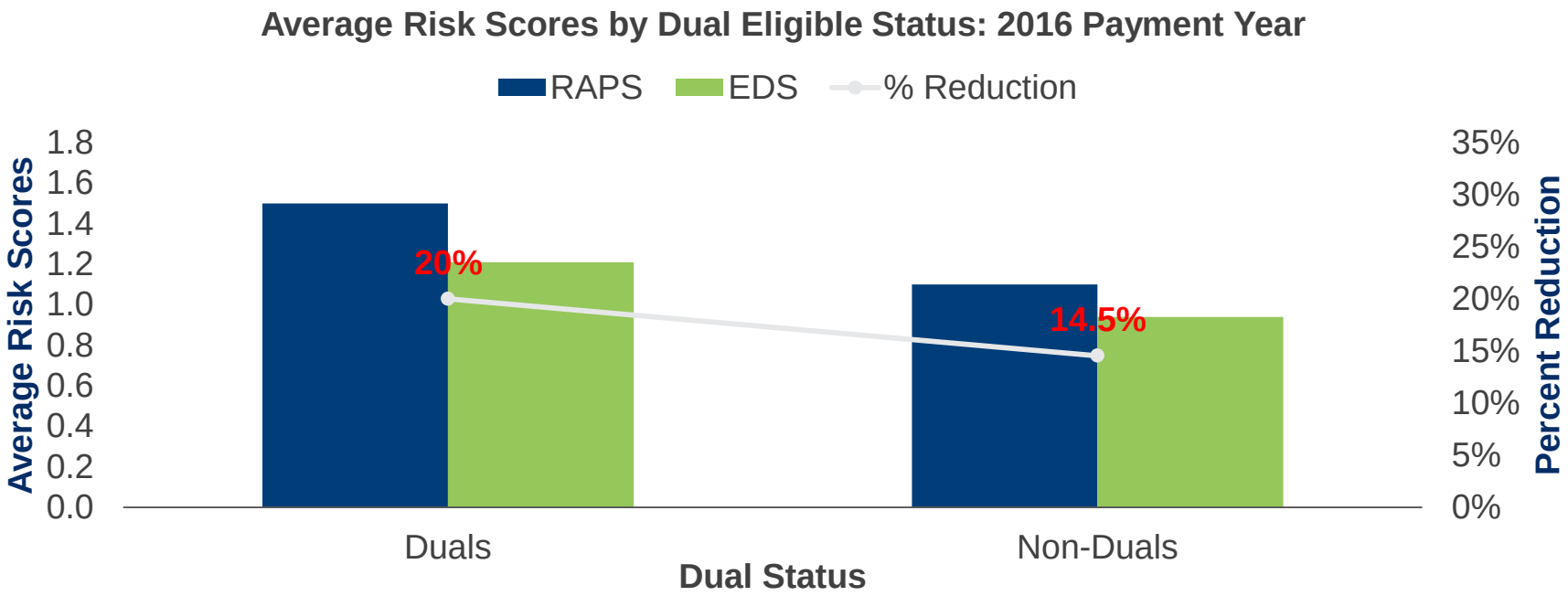
Average Risk Scores: RAPS vs. EDS

A 100% transition to EDS in 2016 would result in risk score decreases of 2% to 28% across plans in study



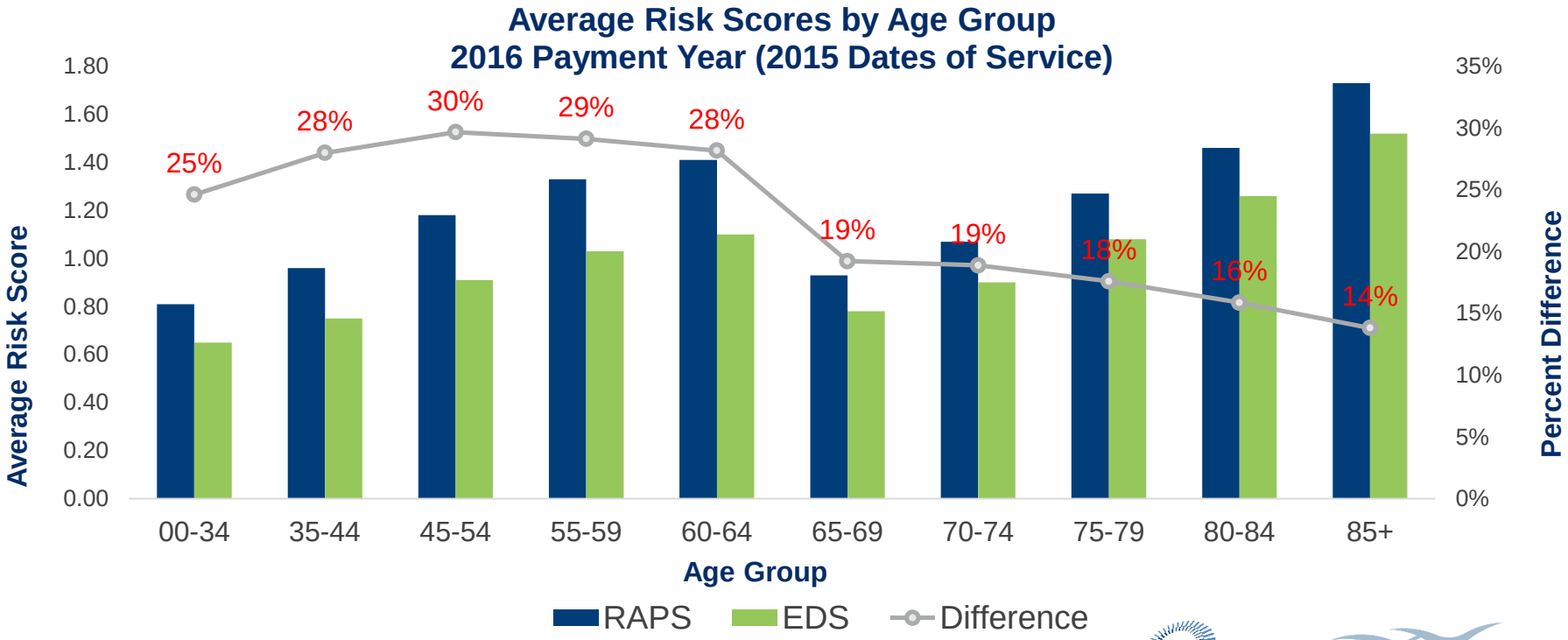
Average Risk Scores by Dual Status

Dual Eligible members' risk scores are impacted more compared to non-duals (5.5 percentage points lower)



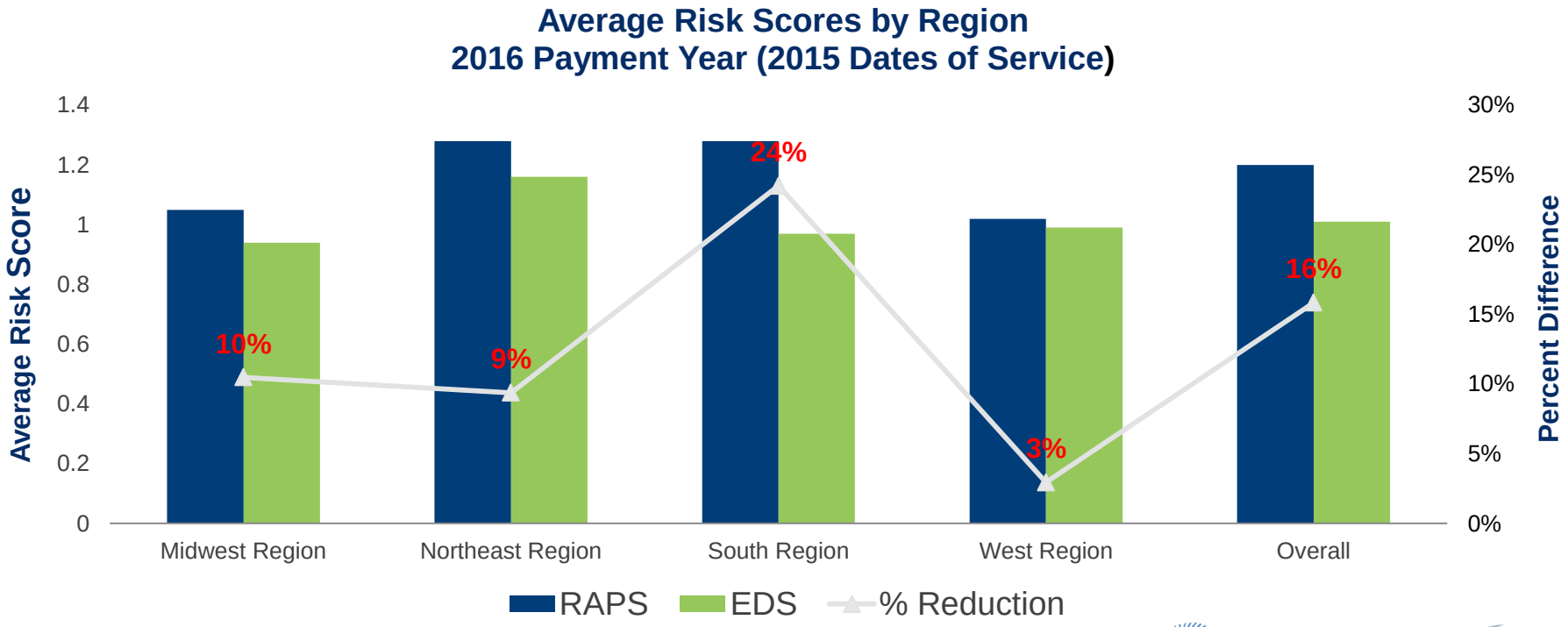
Average Risk Scores by Age Group

Risk score differences between RAPS and EDS range from 14% to 30% across age groups but are *greater for younger beneficiaries* compared to those age 65+



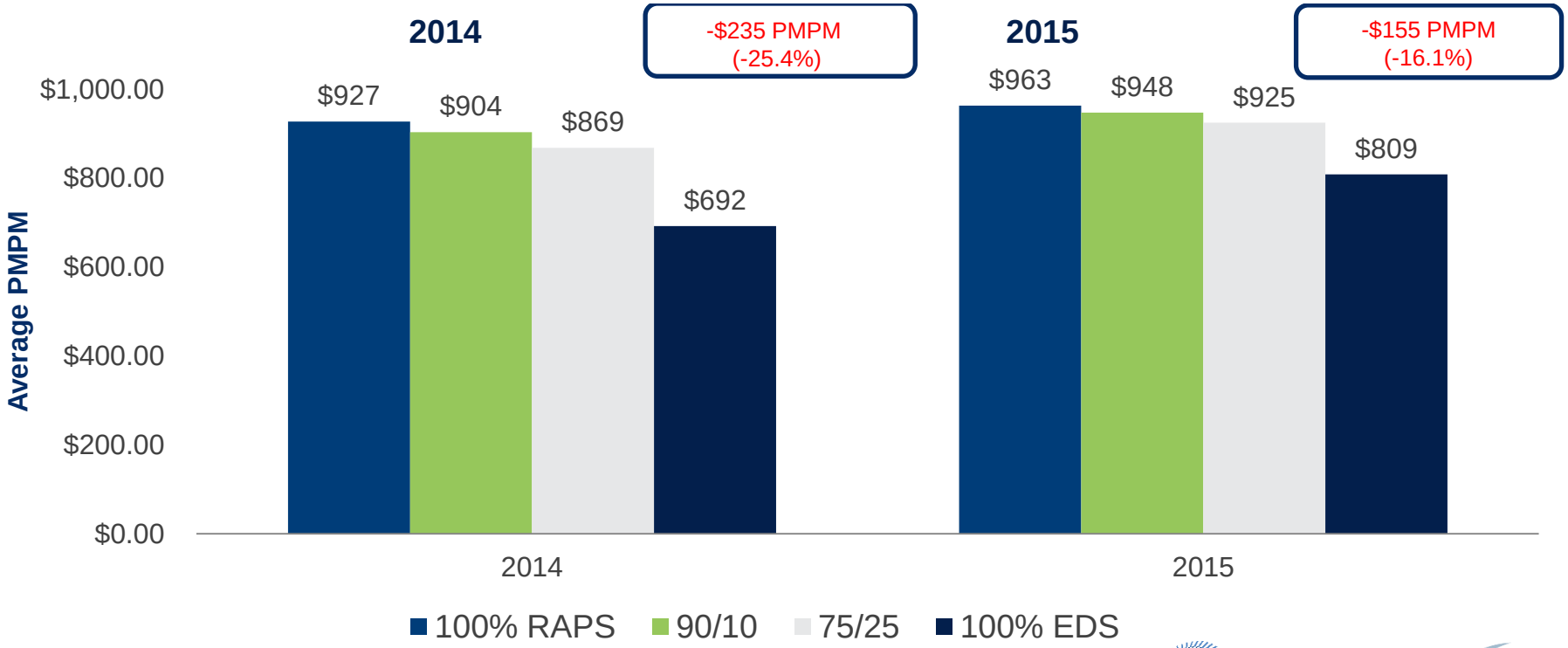
Average Risk Scores by Census Region

Risk score differences between RAPS and EDS range from 3% in the West* to 24% in the South

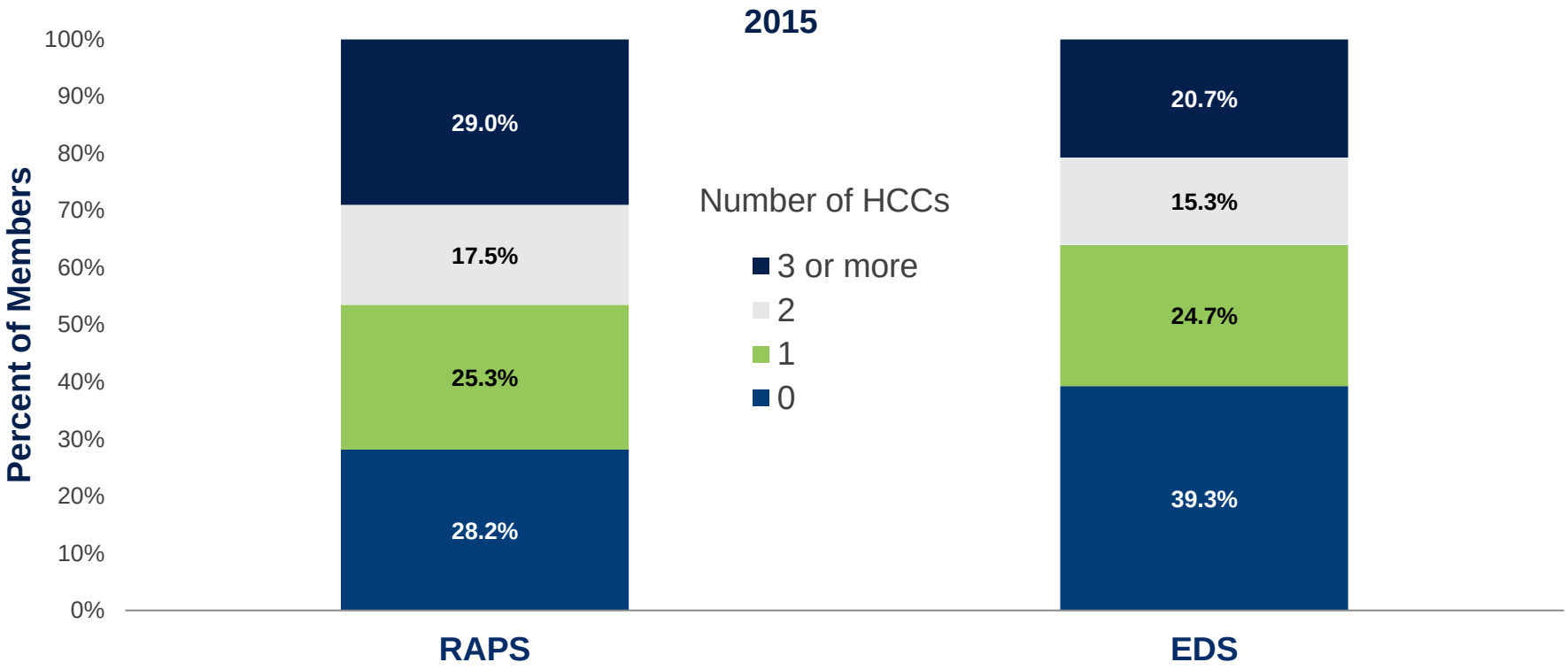


*Note that the sample was underrepresented in the West so this finding is not conclusive.

Reimbursement Impact: Average Per-Member Per-Month (PMPM) Payment



Distribution of HCCs Per Member: RAPS vs. EDS



Top 10 HCCs Found 26-40% Less Often On Average Under EDS

HCC	Description	Prevalence (% of HCCs)			
		2014		2015	
		RAPS	EDS	RAPS	EDS
18	Diabetes with Chronic Complications	16.5%	10.4%	19.2%	15.1%
108	Vascular Disease	16.4%	8.0%	17.4%	12.5%
11	Chronic Obstructive Pulmonary Disease	16.2%	9.4%	16.4%	12.1%
19	Diabetes without Complication	13.5%	9.8%	13.2%	10.9%
85	Congestive Heart Failure	12.7%	7.5%	13.0%	9.9%
96	Specified Heart Arrhythmias	12.1%	8.4%	12.3%	10.2%
58	Major Depressive, Bipolar, and Paranoid Disorders	8.9%	4.5%	10.1%	6.5%
22	Morbid Obesity	7.4%	3.5%	8.1%	5.4%
40	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	6.0%	3.8%	6.3%	4.8%
12	Breast, Prostate, and Other Cancers and Tumors	5.8%	4.4%	6.0%	5.1%
Average Prevalence of Top 10 HCCs		**11.5%**	**6.9%**	**12.2%**	**9.2%**

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Key Findings

The transition from RAPS to an EDS- based system will result in **up to 28% lower risk scores for the same enrollees**.

The top 10 most common chronic conditions were identified 26-40% less often with the EDS-based system compared to RAPS.

For the 2016 payment year (based on 2015 claims data) this represents:

- An average **reduction of $260.4 million per year in risk adjusted funds** for the average 140,000 member plan in our study based on 100% transition to EDS.
- **$63.8 million lower reimbursement** based on the 75/25 blended payment approach proposed for 2017 using the same plan.
- **$25.2 million lower reimbursement** based on the 90/10 blended payment approach proposed for 2016.

Next Steps - Recommendations

As MAOs work with CMS to submit encounter data, outlined below are the following best practices to ensure a smooth transition from RAPS to EDS.

Health Plans

- Understanding that EDS submission involves a good workflow and not necessarily a tool for submission.
- Designing workflows with a combination of tools which help with submission, error correction and reporting.
- Building a strong team internally that understands claims data and the flow of data through EDS.
- Keeping informed of CMS system changes and edits.

CMS Partnership

- Working with MAOs to understand their claims data and data flow.
- Providing benchmarks to help better understand operational, performance and data quality needs.
- Continuous evaluation of the data elements collected as part of EDS submission and the filtering logic applied for EDS.

Summary

- The continued transition to an encounter data system is likely to have significant impacts on the MA program and the beneficiaries they serve until the differences in resulting risk scores are resolved.

- Lower reimbursements could influence plans benefit design decisions and ultimately adversely impact the most high need, high cost beneficiaries who are younger, disabled, low income, dual eligible and with multiple comorbidities.

Latest CMS Guidelines - EDS Transition

- For **2016** payment year (2015 DOS), final deadline for submitting EDS data is extended to May 1, 2017. The RAPS deadline was January 31, 2017. Risk scores for the final payment will be calculated using 90% of RAPS and 10% of EDS risk score.
- For **2017** payment year (2016 DOS), 75% of RAPS and 25% of EDS will be used for risk score calculation in the final payment reconciliation.
- From the CMS 2018 Announcement, released on April 3, 2017:
  - In recognition of operational and other challenges associated with the RAPS-to-EDS transition, CMS is proposing to scale back the blend to 85% RAPS, 15% EDS for **2018**.
  - CMS did not include an updated transition schedule for future years.
  - CMS is currently not considering applying a uniform adjustment to the portion of the risk score calculated using EDS data across the industry.
- CMS Monitoring and Compliance Activities Regarding Encounter Data. CMS will focus its oversight on the following areas:
  - Operational Performance: Measures of performance on submission of encounter data and compliance with requirements (e.g., certification to submit and frequency of submission)
  - Completeness Performance: Measures of volume and completeness of encounter data submitted
  - Accuracy Performance: Measures of the “reasonableness” of data submitted (e.g., reasonable patterns of HCPCS and diagnosis codes)

Contact

Arati Swadi
Inovalon
Senior Director
aswadi@inovalon.com


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