Transitioning to the Encounter Data System: Impact and Implications

Avalere Health | An Inovalon Company

RAPS to EDS Transition: Need for a Study

RAPS - EDS COLLABORATION

A collaboration of 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 initially 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. This session includes an update to the 2015 data based on new MA0 reports.

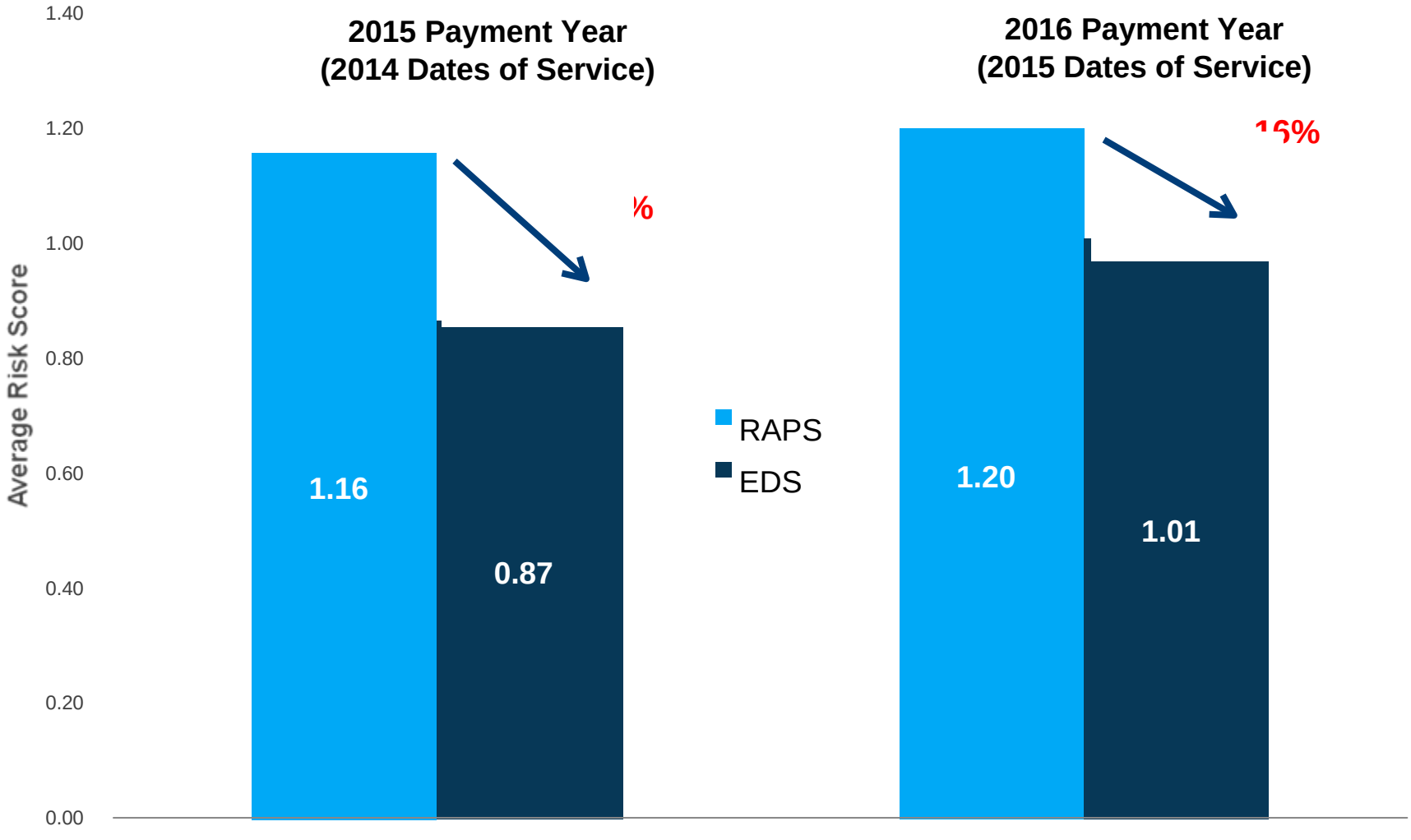
Research Questions

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

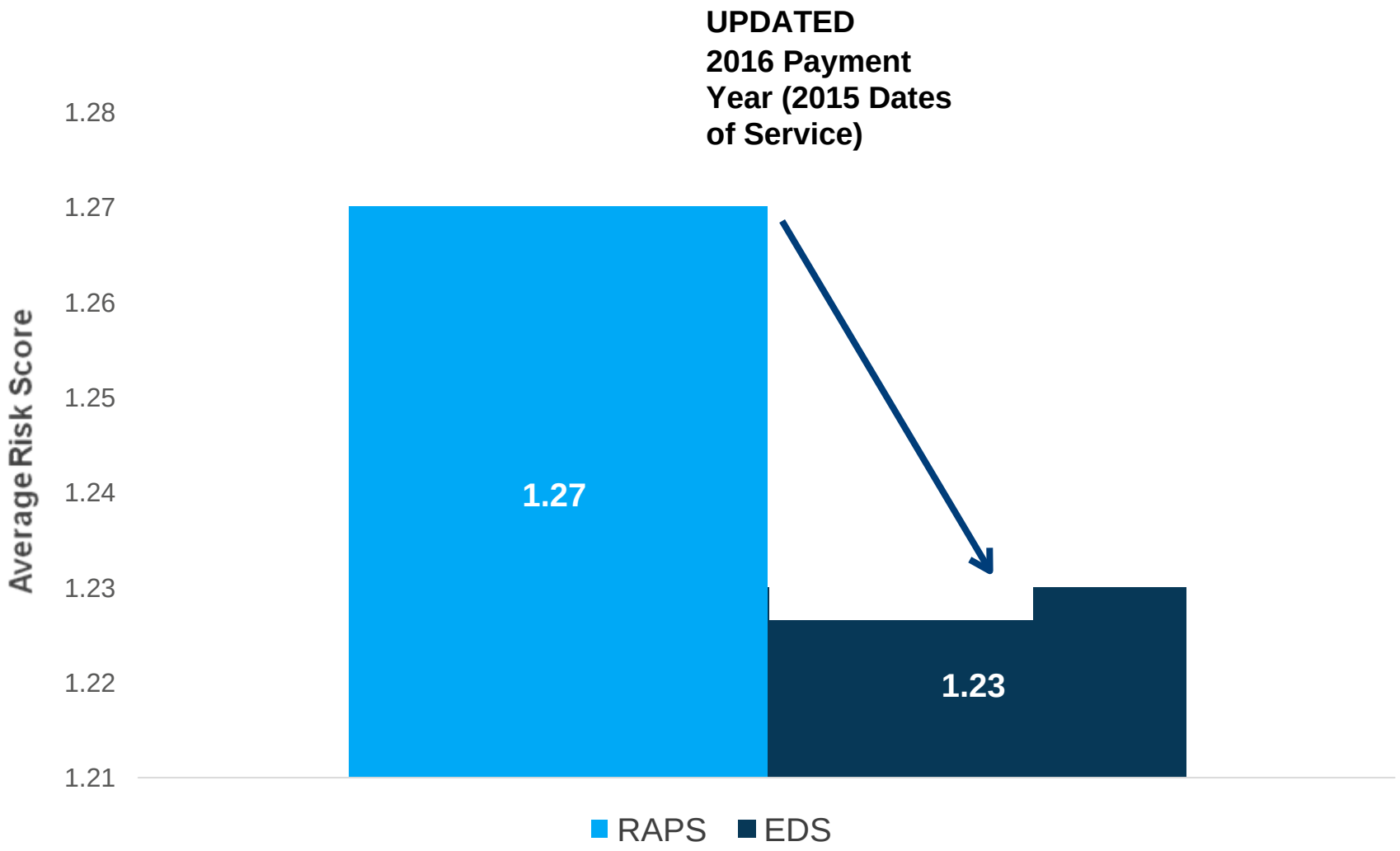
Study Population Plan and Member Characteristics

Plan & Member Characteristics	2014	2015	2015-Updated
Number of Plans (H-Contracts)	8(36)	8(33)	6(30)
Total # of Members	1,078,000	1,116,000	760,000
Average Plan Size	135,000	140,000	127,000
Plan Size Range	5,500-408,000	5,200-409,000	4,300-429,000
Gender: N(%)			
Male	465,000 (43.2%)	482,800 (43.3%)	329,800 (43.4)
Female	613,000 (56.8%)	633,300 (56.7%)	430,000 (56.6)
Age: N(%)			
<65	160,200 (14.9%)	178,000 (16.0%)	163,800 (21.6%)
65-69	208,000 (19.3%)	254,700 (22.8%)	177,400 (23.4%)
70-74	264,400 (24.5%)	268,000 (24.0%)	170,000 (22.4%)
75-79	192,000 (17.8%)	187,800 (16.8%)	118,200 (15.6%)
80 and over	253,400 (23.5%)	227,300 (20.4%)	130,400 (17.2%)
Dual Eligible: N(%)	288,700 (26.8%)	299,400 (26.8%)	291,200 (38.3%)

Average Risk Score Difference: RAPS vs. EDS

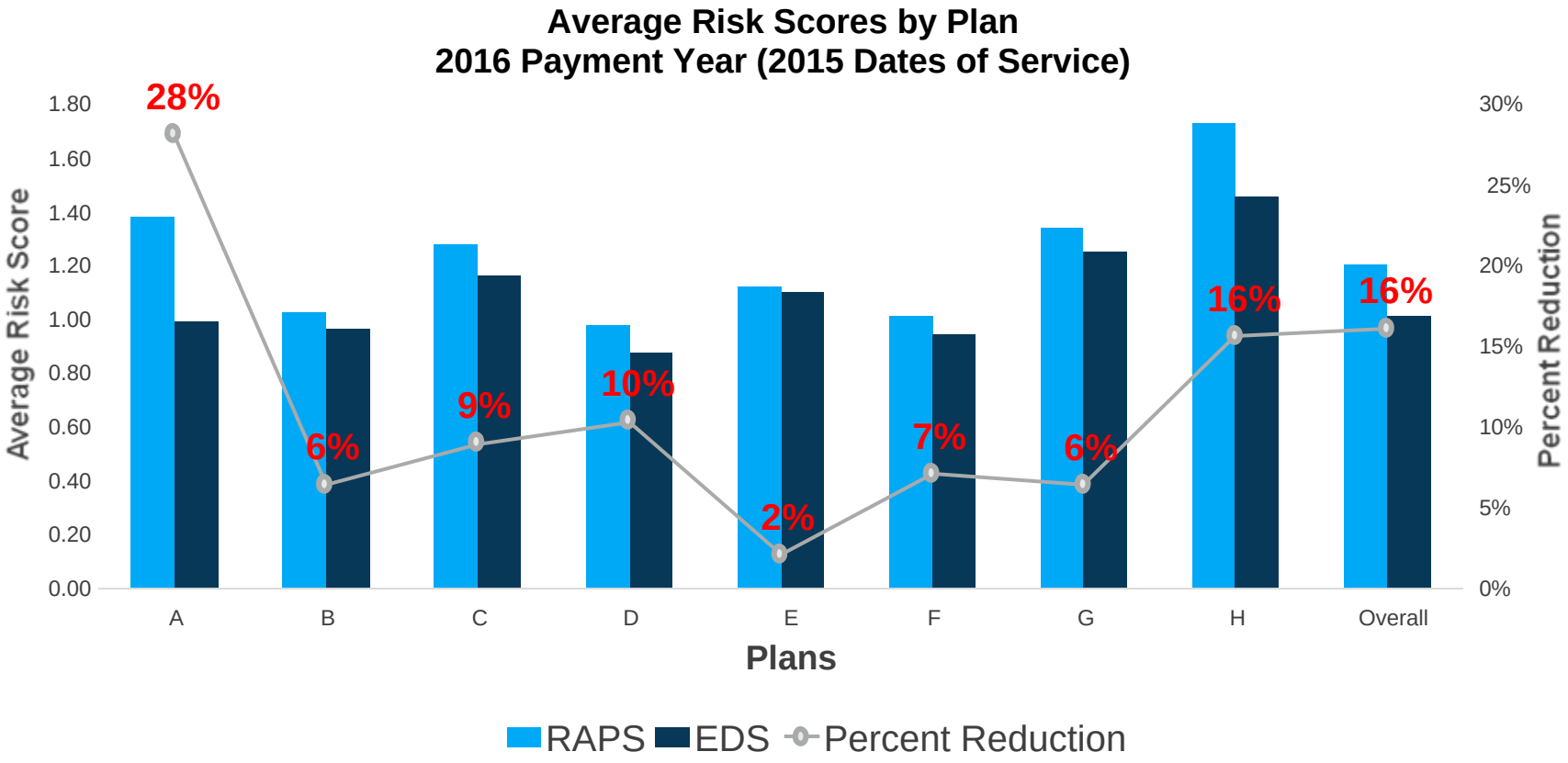


Average Risk Score Difference: RAPS vs. EDS-UPDATED



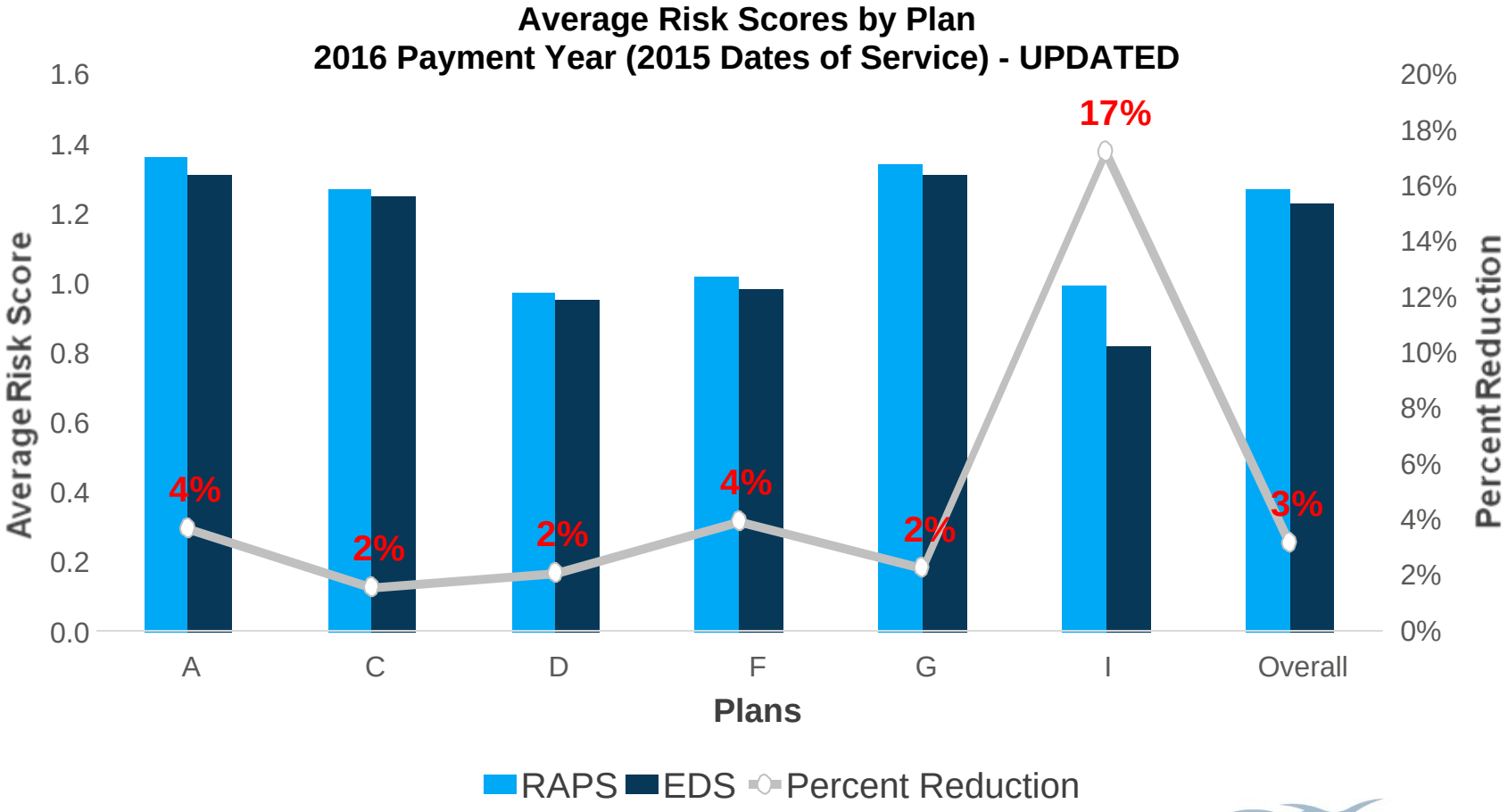
Average Risk Scores: RAPS vs. EDS

Our earlier analysis of 2015 data showed that a 100% transition to EDS in 2016 would have resulted in an average risk score reduction of 16% across the plans in the study ranging from 2% to 28%.



Average Risk Scores: RAPS vs. EDS

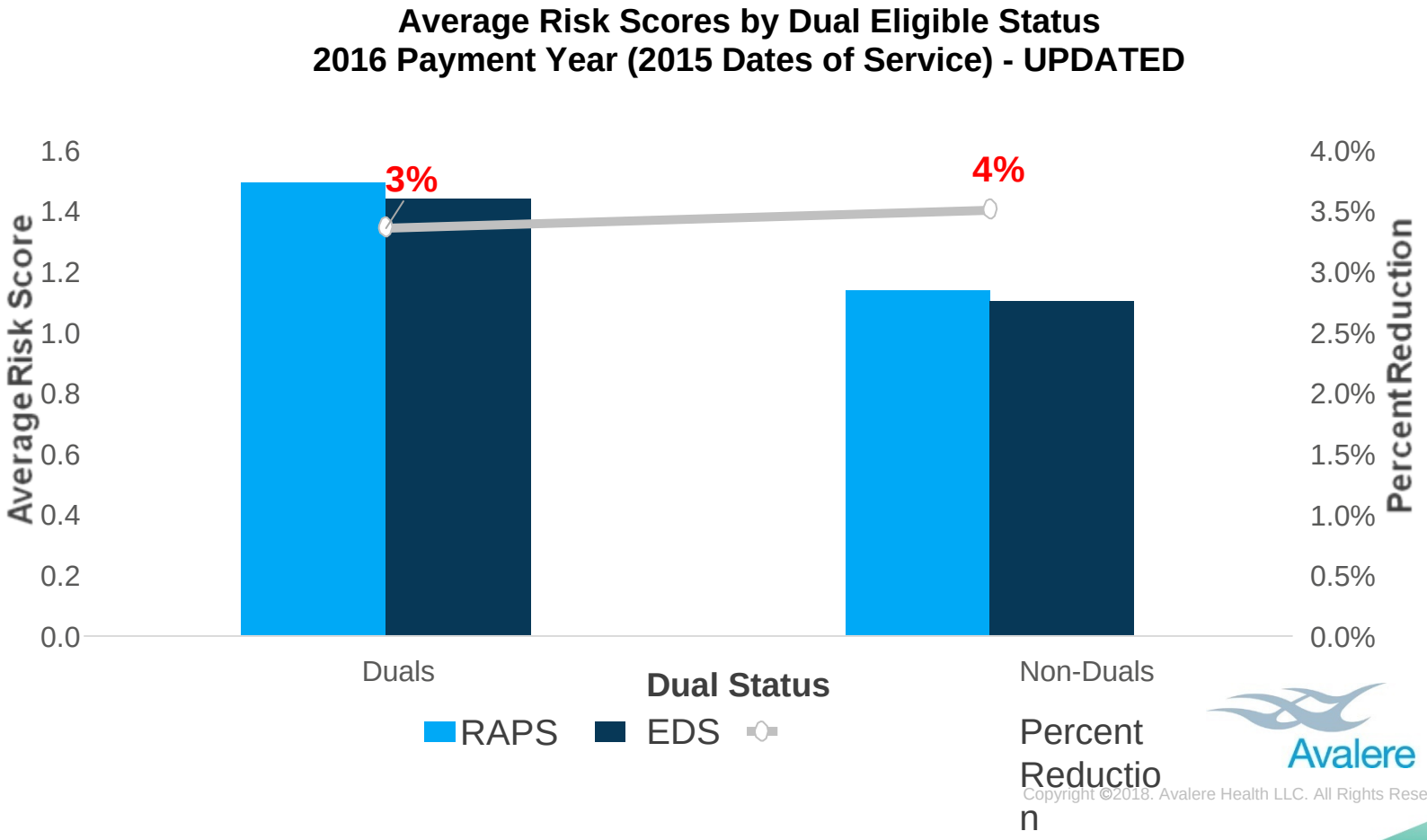
The UPDATED 2015 results show that a 100% transition to EDS would result in an average risk score reduction of only 3% in 2016, with much smaller decreases for most plans in the study, ranging from 2% to 17% for the smallest plan in the analysis.



Average Risk Scores by Dual Status

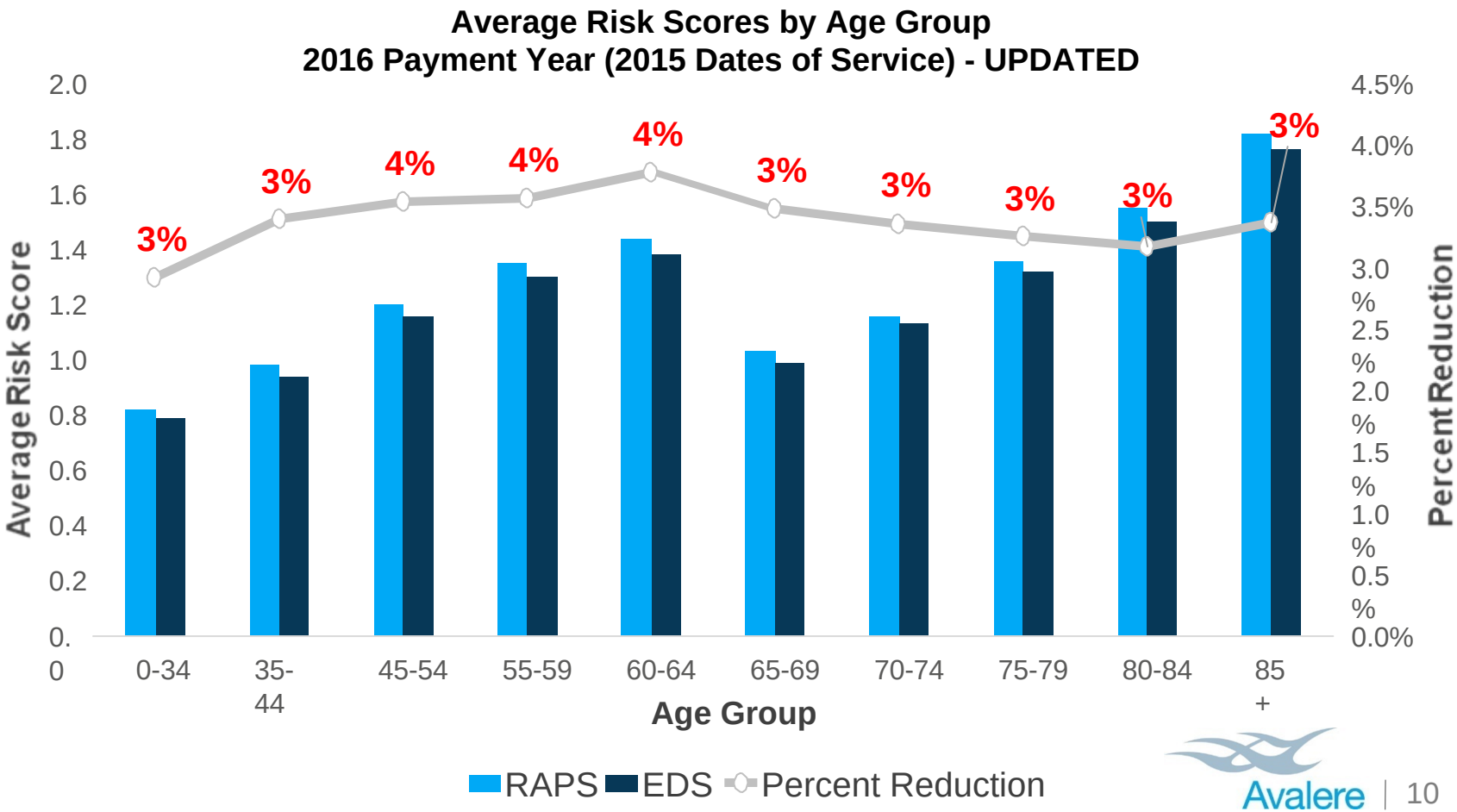
The UPDATED results show an average risk score reduction of only 3% for dual eligible members, and a slightly larger decrease in average risk scores of non-dual members of 4%.

Our earlier analysis showed that a 100% transition to EDS in 2016 would have resulted in a 20% reduction in average risk scores for dual eligible members compared to 14.5% lower risk scores for non-dual members.



Average Risk Scores by Age Group

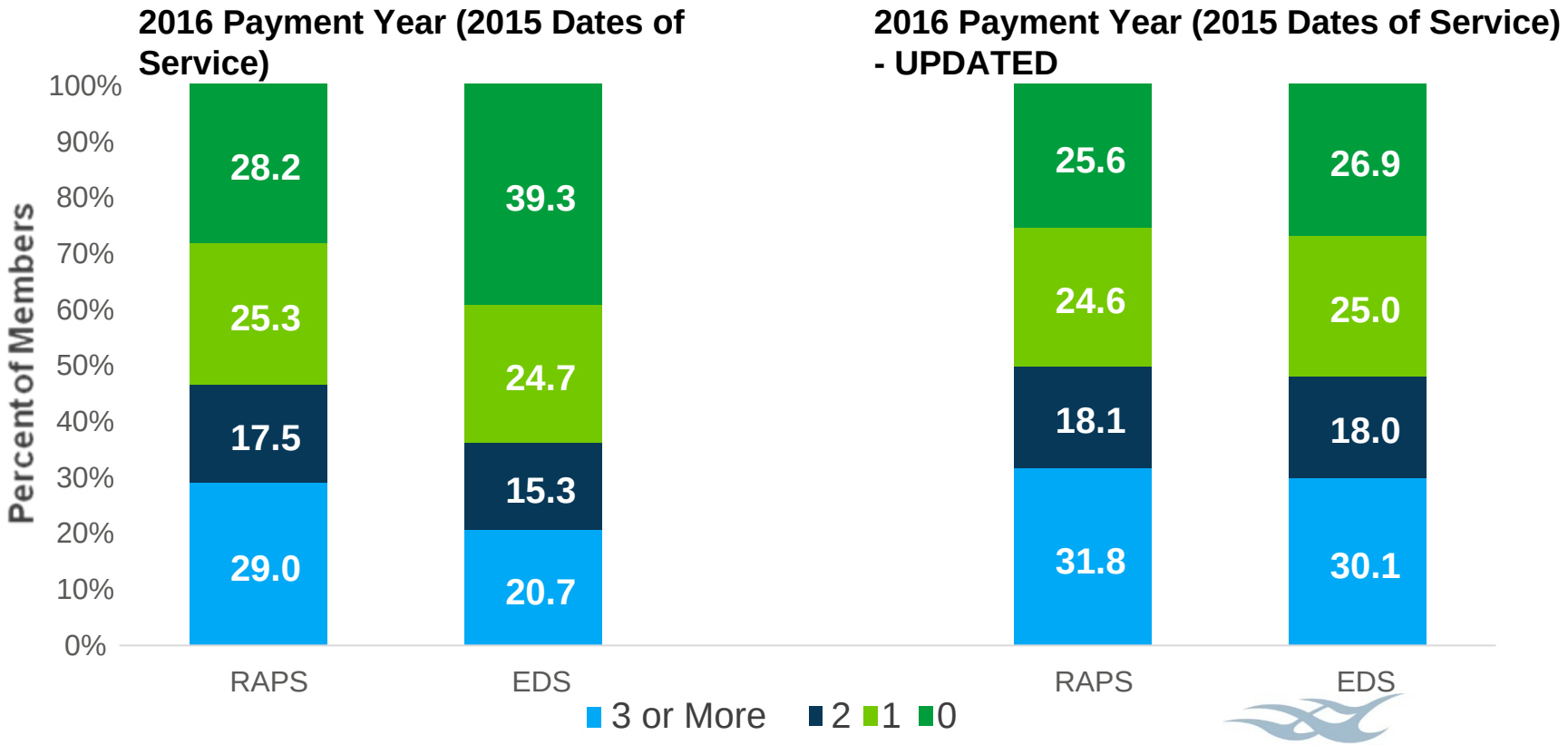
The UPDATED results show a much smaller and more consistent reduction in average risk scores across age groups, ranging from 3-4%.



Distribution of HCCs Per Member: RAPS vs. EDS

The UPDATED 2015 results show a much smaller proportion of members with 0 HCCs and a similar proportion of members with 3+ HCCs in EDS and RAPS.

The previous 2015 results showed a significantly higher proportion of members with 0 HCCs in EDS versus RAPS, and a smaller proportion with 3+ HCCs.



Latest CMS Guidelines- EDS Transition

CMS began collecting encounter data from MA organizations in 2015, with the goal of ultimately using this data in the development of the risk adjustment model. To provide payment stability while also providing an incentive for plans to submit complete data, CMS will use a risk score blend for a certain time period.

Payment Year	Date of Services	RAPS	EDS	Earliest Reflection in Payment	Blended Payment Deadlines
2016	2015	90%	10%	Final Reconciliation-Oct 2017	Open for EDS RAPS: 31-Jan-17
2017	2016	75%	25%	Final Reconciliation-Oct 2018	31-Jan-18
2018	2017	85%	15%	Mid Year Reconciliation-July 2018	1-Mar-18

- For 2016 Payment year (2015 Dates of Service), the RAPS-EDS blended risk score will be applied only for the **Final Reconciliation**. CMS has extended the EDS deadline for submissions and the first final payment will be done in October and a second payment at a later date which is not yet determined.
- For 2017 Payment Year (2016 Dates of Service), the RAPS-EDS blended risk score will be applied for the **Final Reconciliation payment**. Data submitted by **January 31st, 2018** will be used for the final payment.
- For 2018 payment year (2017 Dates of Service), the blended risk score will be applied starting from the mid-year reconciliation i.e. for the 2017 dates of service data submitted by **March 1st, 2018** sweep date.

CMS' Estimate: Bottom Line Impact for 2019 - Final Rate Notice (National)

Year to Year Percent Change in Impact	2019 Advance Notice	2019 Final Notice
Effective Growth Rate	4.35%	5.28%
Rebasing/Re-pricing	TBD*	0.49%*
Changes to Star Ratings	-0.20%	-0.26%***
MA (Medicare Advantage) Coding Intensity Adjustment	0.01%	0.01%
Risk Model Revision	0.28%	0.28%**
Encounter Data Transition	-0.04%	-0.04%
Employer Group Waver Plan Payment Policy	-0.30%	-0.10%
Normalization	-2.26%	-2.26%
Impact of Changes before MA coding Trend (SUBTOTAL)	1.84%	3.40%
MA Coding Trend (CMS estimate)	3.10%	3.10%
Expected Average Change in Revenue (TOTAL)	**4.94%**	**6.50%**

* Based on Change in Applicable Percentage for Healthfirst Service Area. Rebasing/re-pricing impact is dependent on finalization of average geographic adjustment index and will be available with the publication of the 2019 Rate Announcement.
*** Based on information provided by Healthfirst.*
*** Calculation is 25% (CMS suggested blend mix for 2019 PCC model) of the estimated, CMS did not adjust this in the Final Notice to account for changes to Final 2019 Model
INV has updated our estimate.

State of the EDS Union

- Recent Developments: The 2019 President's budget estimated a $10B savings for EDS transition
  - The President's budget proposes transition completed by 2022
  - These estimates can influence policy on phasing in EDS
- There are still problems with quantity and quality under EDS
  - (CMS has acknowledged that EDS inpatient volume is not equivalent to inpatient data submitted for DSH payments through the FFS data system). This situation is most likely even worse for DME, and post-acute-care setting
- Implications of Encounter Data Collection
  - CMS will use encounter data to recalibrate the MA risk adjustment models
  - CMS may use encounter data validate trends and underlying data in plan bids
  - CMS may use encounter data in calculating DSH payments