MILLIMAN WHITE PAPER

Medicare Advantage's transition from RAPS to EDS risk scores: 2017 impact

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What happened in 2017

In 2017, many changes came to Medicare Advantage (MA) risk adjustment, as the transition continued from Risk Adjustment Processing System (RAPS) data to Encounter Data System (EDS) data. Based on the Advance Notice Part I[1] from the Centers for Medicare and Medicaid Services (CMS), released December 27, 2017, the payment year (PY) 2019 will also see complexity and challenges to MA organizations (MAOs). We list some of the highlights from the past 12 months:

- **A 25% EDS weight for PY 2017:** For PY 2017, EDS risk scores received a 25% weight for payment, higher than both PY 2016 (10%) and PY 2018 (15%). It is critical for MAOs to ensure both RAPS-based and EDS-based risk scores are complete and accurate in order to receive timely and accurate revenue.
- **EDS file layout updates and deadline extension:** CMS updated the MAO-002 and MAO-004 file layouts several times throughout the year. CMS announced it will update the MAO-004 layouts again (Phase III, Version 3) in April 2018.[2] With this, CMS extended the deadlines to submit encounter data for PY 2016 and PY 2017 so plans have enough time to review the new reports and resubmit data.
- **PY 2016 EDS deadline extension and change to payment timing:** As noted above, CMS extended the deadline for PY 2016 EDS submissions (with diagnoses from 2015 dates of service). The risk scores and payments in the October 2017 monthly membership reports (MMRs) were the first to incorporate PY 2016 EDS submissions—with runout through May 1, 2017. At the time of this publication, the submission window remains open and CMS has not yet specified a final deadline for PY 2016 EDS submissions. CMS announced a second final reconciliation with a submission deadline for PY 2016 EDS data of April 2, 2018,[3] but because CMS is releasing a new version of the MAO-004 reports in April this will not be the ultimate final reconciliation.
- **PY 2017 RAPS and EDS deadline extensions**: For PY 2017 (with diagnoses from 2016 dates of service), both the RAPS and EDS submission deadlines have been extended;[4] the RAPS deadline is May 4, 2018, and the EDS deadline is currently unspecified but will be after April 2, 2018. CMS has indicated that MAOs will receive a PY 2017 adjustment in July 2018 based on submissions through January 31, 2018, with an additional settlement later.
- **Including inpatient RAPS diagnoses in EDS risk scores for PY 2019:** In the 2019 Advanced Notice Part I,[5] CMS proposed supplementing the EDS diagnosis data with RAPS inpatient diagnoses to improve data completeness. The additional RAPS inpatient diagnoses will help close the gap between RAPS and EDS risk scores.

The submission deadline extensions provide an opportunity for MAOs to implement and review new EDS reports and improve EDS diagnosis submission accuracy.

EDS-based risk scores continue to lag behind RAPS-based risk scores

In December 2016, Milliman completed a study of how the transition from RAPS data to EDS data is affecting PY 2016 risk scores and revenue for fifteen MAOs. Milliman published the results in the paper "Impact of the transition from RAPS to EDS on Medicare Advantage risk scores."

In December 2017, Milliman performed a second study with a new group of participating organizations. The updated results reflect fewer organizations and members (10 MAOs, 313,000 members, 104 plans), but provide outcomes for a cross-section of small and medium plans. However, we caution that these results may not be representative of the overall MA market. The study relied on the Phase III EDS MAO-004 files and RAPS return files available at the end of October 2017. Our second study, like our first, evaluated EDS versus RAPS risk scores

[1] CMS (December 27, 2017). Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for the Medicare Advantage (MA) CMS-HCC Risk Adjustment Model. Retrieved February 2, 2018, from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2019Part1.pdf.

[2] CMS (December 20, 2017). Phase III Version 3 MAO-004 Report Release Date and Announcement Regarding Final Encounter Data Deadlines for Payment Years 2016 and 2017.

[3] CMS (October 20, 2017). Announcement of Deadline for Second Final Reconciliation of Payment Year (PY) 2016.

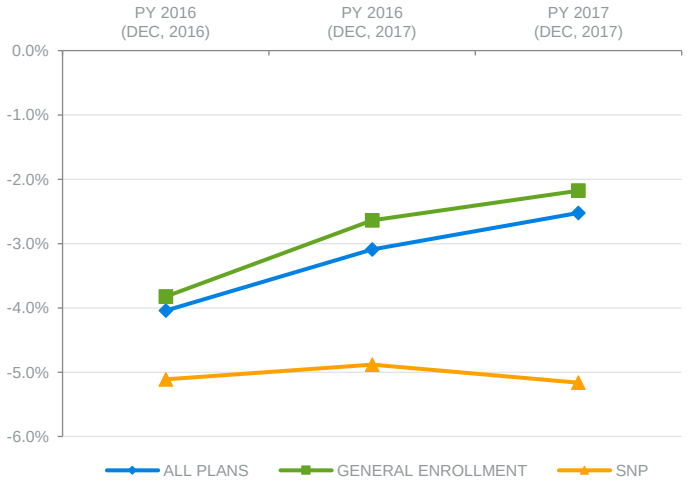
[4] CMS (January 26, 2018). Extension of PY 2017 Risk Adjustment Processing System (RAPS) Final Reconciliation Data Submission Deadline.

[5] CMS, Advance Notice of Methodological Changes for Calendar Year (CY) 2019, ibid.

using each payment year's CMS-Hierarchical Condition Category (HCC) model.

The updated study shows the median percentage difference between PY 2016 Part C risk scores based on RAPS and the EDS data is -3.1% compared to the -4.0% result found in our previous study. The difference in the results is due to additional RAPS and EDS submissions and a different mix of participating MAOs. For PY 2017 the median difference declined to -2.5% as shown in Figure 1.

FIGURE 1: CHANGES IN THE GAP BETWEEN EDS AND RAPS PART C RISK SCORES



Note: Our analysis included non-end-stage renal disease (non-ESRD)/non-hospice members who were enrolled with the plan during the entire diagnosis year.

The percentage differences between RAPS and EDS scores continues to be larger for special needs plans (SNPs) than for general enrollment plans. This is partly because SNPs serve members with more complex health needs compared to general enrollment plans, and therefore the diagnosis component of SNPs' risk scores is larger. Additionally, participating SNPs did not make improvements in their EDS risk scores relative to RAPS from PY 2016 to PY 2017. We caution this may not be reflective of all SNPs; these results were consistent across the plans surveyed and reflect eight organizations offering 29 SNPs.

We see a wide range of differences, but the top performing plans have nearly closed the gap

In PY 2017, EDS risk scores received a weight of 25% in the final risk scores, and therefore closing the gap between RAPS-based and EDS-based scores is critical for avoiding revenue reductions that are due to data source differences. Figure 2 shows the percentile results we found for PY 2017. Similar to our previous study, there continues to be a wide range of results across participating plans. However, we now observe the general enrollment plans at the 80th percentile have reduced their gaps between RAPS-based and EDS-based risk scores to less than 1%.

FIGURE 2: PY 2017 PART C RISK SCORE DIFFERENCE PERCENTILES (EDS VS. RAPS)

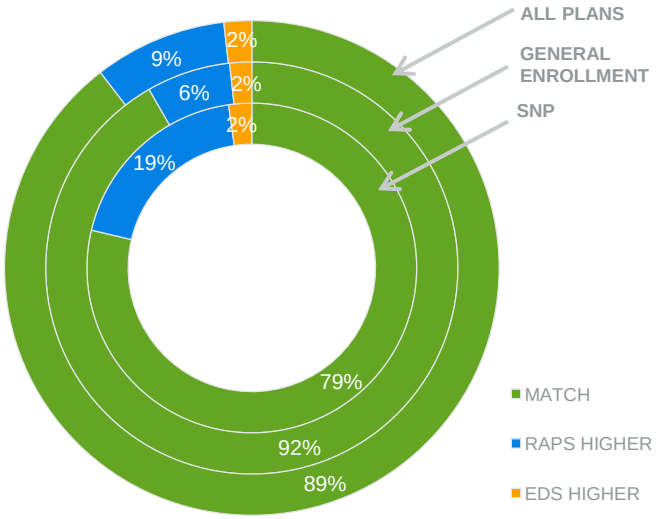
PLAN TYPE	20TH	40TH	50TH	60TH	80TH
ALL PLANS	-6.2%	-3.3%	-2.5%	-2.0%	-0.8%
GENERAL ENROLLMENT	-5.6%	-2.5%	-2.2%	-1.8%	-0.6%
SNP	-6.6%	-5.6%	-5.2%	-3.2%	-1.7%

Note: Our analysis included non-ESRD/non-hospice members who were enrolled with the plan during the entire calendar year 2016.

Most members have identical RAPS and EDS risk scores, though SNP members have the lowest match rates

Figure 3 presents the distribution of differences between the Part C RAPS and EDS risk scores, separately by plan type. The outer ring shows the PY 2017 results for all plans: 89% of members have the same risk score under RAPS and EDS. Ninety-two percent of general enrollment plan members have the same risk score, but only 79% of SNP members do. For all plan types, the members whose RAPS and EDS risk scores do not match tend to have lower EDS-based risk scores. The distribution only reflects members enrolled with the plan during the diagnoses basis year (2016).

FIGURE 3: MEMBER-LEVEL COMPARISON OF EDS AND RAPS PART C RISK SCORES



Best practices for the RAPS to EDS transition

Having two parallel diagnosis submission programs creates an additional systems burden for MAOs. It also provides MAOs with an opportunity to compare the two processes and learn from the differences. (We expect this to change in PY 2019, because CMS has proposed supplementing the EDS diagnoses with inpatient RAPS diagnoses.) As shown above in Figure 3, RAPS-based and EDS-based risk score differences are generally limited to a more manageable subset of members. Below are best practices that have been implemented by MAOs to improve their diagnosis submission processes:

- Analyzing and understanding the drivers of risk scores: Reviewing differences not only between RAPS and EDS, but also between what is accepted by CMS and what MAOs independently calculate based on their own data source systems.
- Developing targets and goals: This may include RAPS and EDS differences, submission timelines, acceptance rates, and submission completeness.
- Measuring results: Monitoring (calculating and reporting) risk scores with each submission using return files and providing timely and complete reports to revenue cycle business owners. Quantify and understand risk score results well before the submission deadline.
- Prioritizing issues and efforts that impact revenue: Spend time and effort on over-submissions and under-submissions that map to hierarchical condition categories (HCCs).

Conclusion

CMS continues to make significant program and operational changes to MA risk adjustment. Milliman's second study on the impact of the transition from RAPS to EDS on MA risk scores shows an improvement in the median difference between RAPS-based and EDS-based risk scores. Our median PY 2017 result is that EDS-based risk scores are 2.5% lower than RAPS. Compared to PY 2016 and PY 2018, PY 2017 EDS risk scores have the greatest weight and, therefore, the greatest effect on revenue. The transition to EDS-based risk scores has been complicated and will continue to affect MAOs' revenue. There are efforts that MAOs can make to improve the accuracy of their submissions and the gaps in payment. CMS provides regular reporting to plans that can be used to monitor and improve processes for both RAPS and EDS. It is important to set goals and regularly measure results in order to take action before submission deadlines.

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