Volume 19, Number 14 *July 25, 2013*

MEDICARE ADVANTAGE NEWS

EDS System for MA Takes Hold; Use for Risk Adjustment Is Coming

As of this past April, CMS's new Medicare Advantage encounter-data system (EDS) had processed 132 million provider "encounters," and 98% of MA organizations in 2012 were fully certified by the agency in use of the system, according to the CMS official who heads the program. This in turn appears to mean that CMS is getting closer to shifting its MA risk-adjustment system for determining plan payments over to use of EDS, although it is likely that even if the agency starts using EDS for risk adjustment next year, plans would have until 2016 to fix any problems found.

That at least is the impression industry sources had in the aftermath of agency communications and a presentation this spring by Greg McGuigan, director of encounter data and risk adjustment operations in CMS's Medicare Plan Payment Group. Speaking at the agency's webinar-only spring conference May 6, McGuigan said that before any EDS use for risk-score calculation begins, CMS must analyze the data and conduct "a parallel analysis" that involves all aspects of creating risk-adjustment factors (RAFs) via encounter data.

The data he presented in May, though, suggest that CMS already has come a long way since the agency implemented the EDS for MA Jan. 3, 2012 *(MAN 9/29/11, p. 3)*. The agency, for instance, according to McGuigan, this year completed the processing and storing of EDS "production data" for all 2012 dates of service and began quarterly software releases to maintain and enhance the EDS. And CMS as of April 2013 had "priced" 64 million of the 132 million encounters it processed, he added. The 132 million comprises 116 million professional encounters, 13 million institutional ones and 3 million involving durable medical equipment.

Looking more in detail, McGuigan said 536 of 549 MA organizations were EDS certified by CMS by the Aug. 31, 2012, certification deadline and that the certified MAOs account for 99% of MA enrollees. The figures are somewhat lower for Program of All-inclusive Care for the Elderly plans, with 72 of the 89 PACE organizations, representing 87% of PACE enrollees, certified by the Feb. 28, 2013, deadline for that program, he noted.

And the patterns are continuing with new MA and PACE organizations. McGuigan's data showed 34 of 37 MA contracts that are new for 2013 had been certified for EDS as of the time of his presentation and that three of the five new PACE contracts had been certified.

Timing of EDS Use for RAFs Is Uncertain

It is not the certification but rather the RAF uses of EDS that appear to be of most concern to MA plans, however. CMS has been running the EDS and traditional risk adjustment payment system (RAPS) "in parallel" since EDS was implemented in January 2012 and has continued so far to rely only on RAPS for determining the RAFs. Moreover, while McGuigan clearly stated that CMS will utilize data from EDS to determine the RAFs used to adjust capitated payments, he stressed that the agency first must conduct a "parallel analysis" on this.

McGuigan did not say when the transition might be completed and did not take questions at the end of his presentation. And CMS officials did not respond to *MAN* requests for more information about the timetable.

"I wouldn't be surprised" if CMS started using MA encounter data for risk adjustment in 2014, Dan Rizzo, chief innovation officer at health care data analytics specialist Inovalon, Inc., tells *MAN*. But Rizzo adds that diagnosis codes from the encounter data for 2014 dates of service could be fixed until 2016. Before the agency makes the switchover, he adds, it needs to disseminate a document not yet out to clarify for plans which data are considered usable for encounter-data purposes.

Part of the problem in determining this, he explains, lies in the differentiations CMS makes between approved and not-approved provider specialties for purposes of supplying diagnoses. He cites as an

example that diagnosis data can come, as far as CMS is concerned, from "therapeutic" radiologists but not from "diagnostic" radiologists.

Overall, though, according to Rizzo, the process of submitting MA encounter data now has become smooth. At the beginning, he says, it was not always smooth, and there were substantial problems last year in getting MA organizations certified by CMS on encounter data. He attributes this to numerous factors, including that health plans often get their data from a variety of sources and the encounter-data process "required them to bring those diverse sources together." Another issue for some MA plans was converting paper claims into the required electronic format, Rizzo notes.

With these issues largely behind them, MA plans now must turn their attention to the upcoming use of encounter data for risk-adjusted payments, he suggests. Specifically, he says, plan sponsors this year should be reconciling their EDS files with those for CMS's RAPS since 2013 still is a "grace period" during which the agency won't yet use encounter data for payment.

Rizzo asserts that plans need to determine now any gaps in results coming from the two systems, even if those gaps occur in only 1% or 2% of cases, and he warns that "those discrepancies hide in the shadowy corners." He envisions a "very intense" period for plans to resolve the kinds of issues these gaps present.

CMS is not required to give plans advance notice of when it will switch to EDS for risk adjustment, so Inovalon in its work with clients is operating on the assumption that it could be 2014, he says. His sense, however, is that MA sponsors just are beginning to focus on this since they had to first get certified for encounter data and then had to start submitting the data this year.

The process is not necessarily easier for bigger plans, contends Rizzo, especially since they may have grown via acquisitions that mean they have been dealing with multiple claims systems. The largest problems Inovalon is seeing as it works with clients on reconciling RAPS and encounter data include having to use data "not always managed with the best discipline" and identifying which diagnoses need to be added to and subtracted from basic claims data, he says.

Ultimately, though, according to Rizzo, there will be no major effect of the switchover to EDS on MA plan revenue, especially since plans have "visibility" on what is needed. He adds that the net result will be cleaner and better data for use in such key functions as care management.

Dawn Carter, EDS product manager for Verisk Health, tells *MAN* it is likely CMS will start using EDS submissions for payment year 2015, using 2014 dates of service.

She attributes this belief to the fact that CMS "relaxed the timely filing requirement to ensure submission of complete data, and this has been a challenge due to the rapidly changing edit requirement because CMS is using edits based on fee-for-services."

Adds Carter: "There are submission requirements that are unique to the MA industry that CMS found over the course of Tier II testing as plans have widened the range of encounter scenarios they are sending. Plus, CMS recently allowed the submission of skilled nursing and home health data, which bodes well for plans because CMS will have a more complete data set."

Contact Rizzo via spokesperson Jennifer Cosenza at jennifer.cosenza@fkhealth.com and Carter via Thayer Montague at thayer.montague@veriskhealth.com. Visit www.tarsc.info and www.csscoperations.com for more information about the MA EDS. ✧