Plan Management Navigator
Analytics for Health Plan Administration May 2014

Measuring the Efficacy of Medical Management in Medicare and Medicaid

While private sector insurance participation is growing modestly, government programs are growing much more rapidly. Medical management can affect the viability of these programs since medical management is part of the cost structure, as are the health care costs that they are intended to manage.

This article contains an analysis of the effectiveness of medical management on Medicaid and Medicare programs. It comprises the results of 27 health plans with Medicare products and 17 plans with Medicaid products. Collectively, they served 2.6 million Medicare and 2.3 million Medicaid members.

The results were not overwhelming but stronger for the Medicaid products.

Background

One of the most challenging cost optimization tasks is determining the appropriate level of medical management. In principle, too much investment in medical management and money is wasted, but too little of an investment and health care costs climb. As a practical matter, measurement of the payoff can be confounded by other factors such as inconsistent application of approaches by providers and population differences. In an earlier *Plan Management Navigator* we noted that "It is even hard to test efficacy of specific techniques since open panels permit passive realization of reduced benefit costs by low spending plans."

In January 2014, we published a new metric for the payoff of medical management. In summary, it was the distance above or below

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PULSE Refocused

Plan Management Navigator and its sister publication, *PULSE* are complementary publications. While *Navigator* focuses on operational issues, *PULSE* provides insights on how operational performance translates into valuation and capital costs. If you are not yet a subscriber, let us know and we will be delighted sign you up. Also, if it would be helpful to evaluate *PULSE*, we'll be please to provide you a sample copy.

We've recently re-launched *PULSE,* to focus on and improve its highest value aspects. These include:

- Financial tables with summary valuation metrics and operating measures for all public health plans.
- Analysis of public and private M&A activity in the health plan industry.

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Medicare and Medicaid Benchmark Universes Being Formed

In the coming weeks, we will begin our preparations for our annual performance benchmarking surveys for Medicaid-focused and Medicare-focused health plans. The survey forms will be distributed immediately after the Medicare bids are due on June 2 and will survey 2013 results. We encourage your plan's participation in the Sherlock Benchmarks.

Participation is timely because of the substantial growth opportunities in each of these market segments. Medicaid is central to the Affordable Care Act's goal of increasing the

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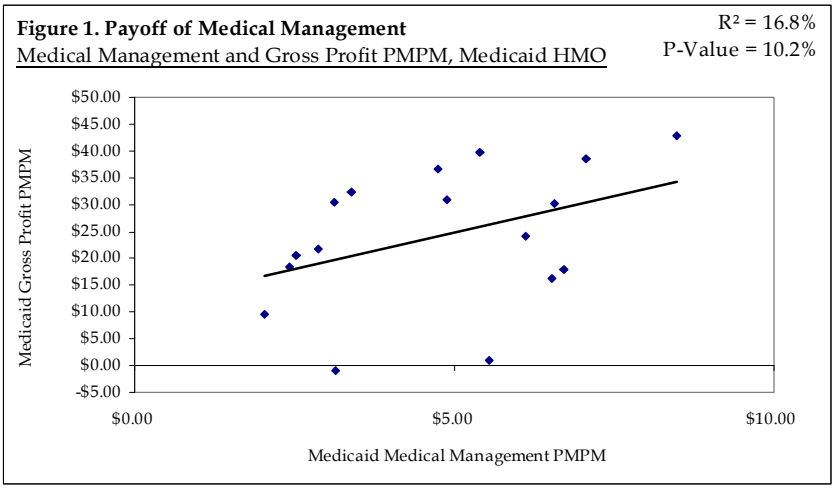
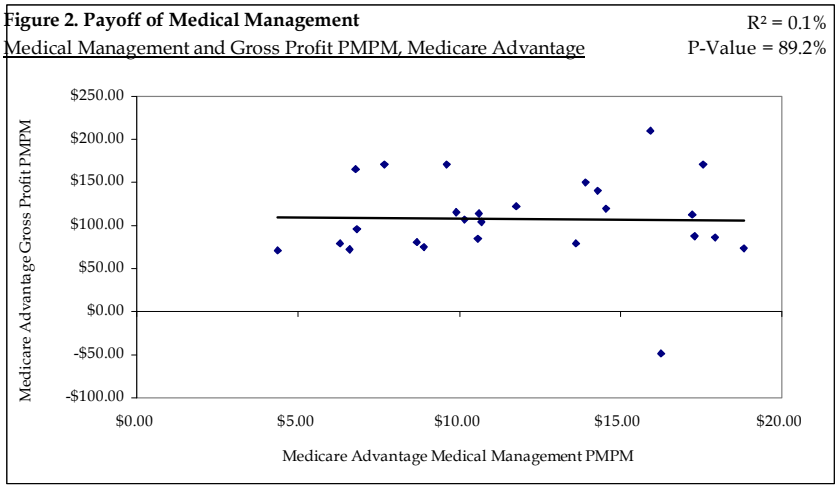
the regression line of the relationship between medical management costs and gross profit as expressed in dollars. To eliminate the effects of product mix differences, both variables are expressed as *differences* from the average for the universe, after weighting the universe to match the product mixes of each plan. The link is here: http://www.sherlockco.com/docs/navigator/January%202014%20Navigator.pdf.



This approach has two notable virtues. Because it eliminates the effect of product mix differences, it is adaptable in situations in which product mixes vary between the comparison plans. Also, since the dependent variable is gross profit (that is, premiums less health benefits) as opposed to health costs, results are less subject to the distortion of local health care cost differences. However, the regression line had limited explanatory value and we will use the analysis to chiefly compare how plans perform relative to their peers at any given level of medical management expenses.



Focusing on Government Programs

We thought it might be helpful to explore this further with two government programs Medicare and Medicaid. As with the approach used in January, we measured return by gross profit margin to diminish the effect of local cost of living differences. This analysis differs from the January analysis because, by including only one product, no product mix adjustment is required for either variable.

The result for the Medicaid plans is shown in Figure 1. The slope is positive, indicating that the more spent on medical management the greater the gross profit. The R^2 is 16.8% so spending on medical management is not a complete explanation for the gross profit. Also, at a P-Value of 10.2% (corresponding to the chance of there being no relationship

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between the variables) there remains uncertainty about the relationship.

By contrast, as shown in Figure 2, there seems to be no discernible relationship between Medicare medical management costs and gross profits. Even the slope is slightly negative. The R^2 is 0.1% and the P-Value is 89.2%.

We thought that perhaps the values for medical management could be distorted by Medicare Advantage's unique risk adjustment methodology. Medicare Advantage uses demographic and diagnostic information on members to predict and compensate for the cost of care required by the populations that plans serve. Rating and Underwriting is where our participants classify Hierarchical Condition Categories (HCC) activities. However, the chart reviews that are necessary to populate the required demographic and diagnostic information could also be employed as part of the initial assessments for case and disease management, making plausible the potential for misclassification. So, to overcome any potential blurring between the functions, we performed the same analysis using the independent variable as the sum of the Rating and Underwriting and Medical Management functions. The results were substantially the same as without the Rating and Underwriting function.

Why do Medicare and Medicaid Results Differ?

While we don't know why Medicaid medical management appears more effective than similar activities for Medicare, we have had similar results in the past.

One possible reason is that there are relatively few providers serving the Medicaid population as compared with the Medicare population. According to a December 2013 Kaiser Family Foundation analysis of the National Ambulatory Medical Care Survey, while 91% of physicians accept new Medicare patients, only 71% accept new Medicaid patients. Accordingly, Medicaid plans may have smaller, easier to manage panels than Medicare. Moreover, since patient choice is more limited for Medicaid, the chance of one plan free-riding on another's training of conservative styles of practice to shared panels of physicians is limited.

In the future, the MLR rules could also contribute to this difference since they apply to Medicare but not Medicaid products. The minimum MLR rules effectively limit the return on investment in medical management. However, since the data was from 2012, this MLR minimum of 85% likely had little effect. As an aside, we have found that Medicare Star Ratings for Medical Management are positively associated with higher medical management costs.

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- In-depth studies on topics that include: cost management of administrative expenses, economies of scale in health plans, analysis on health plan type, size, and product concentration, and premium rate increases.

Moreover, to enhance usability we are increasing its frequency from monthly to weekly. Financial tables will be sent every week, while in-depth studies will be sent every quarter. Financial analysis and commentary of M&A transactions will be published as they occur. Finally, we are transmitting the documents electronically to enhance its timeliness. The refocused publication will be provided in PDF

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health coverage. According to a recent CMS Report reflecting changes as of February, Medicaid enrollment increased by 3 million including an 8.3% increase in states with expansions under ACA. In the case of Medicare, more than 15 million people are members of Medicare Advantage, nearly 30% of total Medicare beneficiaries. According to Kaiser Family Foundation, Medicare Advantage membership increased by 26% from 2010 to 2013 compared with 6% for regular Medicare.

However, both Medicare and Medicaid payment growth has been limited. Moreover, the Affordable Care Act features minimum MLR rules for Medicare plans. The minimum ratio of 85% is "intended to create incentives for MA organizations and Part D sponsors to reduce administrative costs such as marketing costs, profits, and other uses of the funds…."

Since states limit your plan's membership growth to what can be supported by your accumulated "profits," reducing "marketing costs…and other uses of the funds" is the *only* way to internally finance your growth. Participation in the Sherlock Benchmarks is a timely, adaptive response for Medicare plans and Medicaid MCOs. Sherlock Benchmarks help you optimize your costs. In other words, they:

- Identify whether you are operating at best-of-class cost levels
- Prioritize functional areas for optimization
- Identify key drivers of function variances such as staffing ratios or compensation levels

Sherlock Benchmarks also support Lean Six Sigma techniques to improve performance. And Sherlock Benchmarks have additional uses, such as:

- Evaluating outsourcing of selected operations, and the value-added of management consultants
- Developing a realistic and cost-conscious budget
- Executing business combinations including due diligence, estimation of the effect of synergies and development of a plan for successful integration

Participation is ***deeply*** discounted from licensing, and we support Sherlock Benchmarks' application to your organization. More information is available upon request.

Can we look forward to your participation? While we'll begin right after your Medicare bid is submitted, we'll need to get the paperwork completed well in advance.

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format, with the financial tables in easy to use Excel®.

Streamlining *PULSE* is intended to not only be responsive to your needs, but also be more economical. Accordingly, we are sharing these savings with you. The new price is $375; if you have a subscription any amounts in excess of this price will be credited to future periods. Please contact us if you are interested in a subscription. If you would like a sample copy, please let us know and we'll send one immediately.