Sherlock Benchmarks

All Universes Edition

Volume II

Medical Management Metrics

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Sherlock Expense Evaluation Report

All Universes Edition - 2019

Volume II: Medical Management Metrics

Sherlock Company

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INTRODUCTION AND BACKGROUND

Background

This is the "Medical Management Metrics" book of Volume II of the *2019 Sherlock Benchmarks – All Universes Edition*. Together, these volumes provide statistics and analysis summarizing the administrative expenses and operational metrics of 40 health plans. These plans consist of Blue Cross Blue Shield Plans, Independent/Provider-Sponsored plans, Medicaid plans and Medicare plans. They are intended to facilitate comparisons for users and to assist in the management of health plan administrative expenses. They should be useful to operational and financial managers of health plans, consultants and third-party vendors. *Sherlock Benchmarks* should also be valuable to Boards and persons charged with corporate finance responsibilities including strategic planners and investment bankers.

Organization of Sherlock Benchmarks

The *2019 Sherlock Benchmarks are* a carefully compiled and scrubbed summary of the surveyed operational characteristics of leading health plans.

Sherlock Benchmarks assists in performance improvements for health plans by facilitating comparisons between plans and their universe as a whole. It quantifies health plans' relative performance and identifies sources of variance at a highly granular level. *Sherlock Benchmarks* information is unusually comprehensive and a highly valid analytical tool.

The *Sherlock Benchmarks* are produced in two volumes:

Volume I: Financial Metrics includes analyses of administrative expenses through financial ratios such as percent of revenues and per member per month. Data is divided into fourteen product lines and approximately 74 functions. Additional descriptions are found below.

Volume II complements Volume I by facilitating in-depth analyses of the financial metrics. It is subdivided into four books: Operational, Staffing and Compensation, Medical Management and Utilization.

Operational metrics translate operating performance into expense performance, so expenses are often analyzed into factors of user demand, employee productivity, unit cost, staffing ratios and cost per employee. For instance, Claim and Encounter Capture and Adjudication is analyzed into claims per member, productivity of claims processors, cost per claim and per-employee costs of claims. In addition, every function is analyzed by factors of staffing ratios, staffing costs per FTE and non-labor costs. Numerous drivers of costs and quality are also provided. In the claims area, for example, these include metrics of electronic submission, auto-adjudication and factors requiring manual intervention.

This document, Volume II - Medical Management, is divided into eight sections:

TAB 1. INTRODUCTION AND BACKGROUND

This section describes the organization, conventions, applicability and processes of the *Sherlock Benchmarks* studies and this volume in particular.

TAB 2. MEDICAL MANAGEMENT ADMINISTRATIVE EXPENSES AND OUTSOURCING

This section provides a summary of costs of Precertification, Case Management, Disease Management and Nurse Information Line. It also includes a summary analysis of cost components of medical management by type of medical management activity. Outsourcing of these activities are also analyzed.

TAB 3. PRECERTIFICATION AND RECERTIFICATION

Pre-Certification includes carrying out pre-certification and medical necessity reviews on designated referrals and targeted outpatient procedures, services and inpatient admissions including to rehabilitation units as well as referrals. This analysis includes analyses of cost components (such as staffing ratios and productivity), In-Plan and Out-of-Plan certification and approval and denial rates.

TAB 4. CASE MANAGEMENT

"Case Management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes." Source: *Case Management Society of America.* This analysis includes analyses of cases and costs by major practice category, productivity and staffing ratios.

TAB 5. DISEASE MANAGEMENT

Disease management is the process in which a population is identified and support services that help educate members are put in place. The outcomes are then processed, measured, evaluated and the results are reported to the relevant parties. This analysis includes analyses of cases and costs by major practice category, productivity, staffing ratios and the propensity to outsource disease management.

TAB 6. NURSE INFORMATION LINE

Nurse Information Line is telephonic one-on-one guidance to information, resources and tools to increase the member's ability to manage their own condition, understand their health care options and become active decision makers with their physician. It is staffed by Registered Nurses or other healthcare

professionals qualified or trained to provide support for health care decision making, education and assessment of health symptoms. This analysis includes cost per member, staffing metrics and inbound and outbound calls.

TAB 7. UTILIZATION REVIEW AND APPEALS

Utilization Review and Appeals includes appeals of Utilization Management / Precertification / Recertification. These appeals are exclusively medical. The section also includes retrospective reviews of use of emergency departments, care received and out of system admissions. The review of eligibility and benefits and the conduction of investigations and / or required reviews are also included in this section. This analysis includes types of appeals (internal, expedited, written and external written), rates of approvals and denials, staffing ratios and an application of utilization review to certain high cost services.

TAB 8. QUALITY ASSURANCE AND WELLNESS

Quality Assurance and Wellness is concerned with the review of the quality of health care provided by providers. This includes NCQA Health Plan Report Card and CMS Star Plan Ratings. Reviews of quality management, the recommendation of solutions to problems and the collecting and synthesizing of quantitative and qualitative data to drive decisions is also incorporated into this section. This analysis includes costs, types of quality cases (total, written and telephone) and staffing ratios.

Conventions Used in this Report

In the *Sherlock Benchmarks,* we analyzed costs and operations for the health plans as a whole, by functional area and also by product. We have employed a number of reporting conventions, which we discuss below.

1. The terms “high” and “low” mean the average of the *two* highest and *two* lowest values, respectively. The standard deviation is the measure of dispersion. To facilitate comparability of standard deviations, we have expressed standard deviation as a percent of the mean, commonly termed the coefficient of variation.

2. Statistical results are un-weighted. That is, each metric reflects equally the experience of each health plan that reports a functional area for a product, without regard to the plan’s size.

3. Statistical measures for each functional area are calculated independently. Accordingly, the statistical analysis of total expenses is not the sum of the statistical analysis of each component cost.

4. Results were carefully validated to identify, and correct if possible, reporting errors.

5. Within each firm, ratios based on the total scope of products (for instance in the Total and Comprehensive

values) are intrinsically weighted by the relative importance of each product to that firm. For instance, a firm with a heavy commitment to Indemnity & PPO ASO will reflect that product's weighting and its company-wide costs will be lower as a result.

We offer a few additional comments regarding Volume II - Medical Management.

1. The information we received is through our contact, typically someone in the finance area, rather than directly from the operational department themselves.

2. The response rate was considerably lower in operational metrics as compared with financial metrics. Operational metrics are largely voluntary to help assure quality of responses.

3. The components may not sum to totals, for example in the case of product line breakouts. That is because response rates varied in each of the component parts and in totals.

4. Additional discussion about *Sherlock Benchmarks* survey procedures, data analysis and presentation is found under Tab 1 of Volume I – Financial Metrics.

5. A complete description of the characteristics of the participating plans is found in Tab 10 of Volume I – Financial Metrics.

Questions and Comments

We invite questions and comments on the *Sherlock Benchmarks.*

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In addition, please know that we support your use of the *Sherlock Benchmarks*. We hope that you will not hesitate to contact us if you have any questions concerning classifications, calculation methodologies and the application of the *Sherlock Benchmarks* to improve the performance of your health plan.

Tab 2

Medical Management Administrative Expenses and Outsourcing

Metric **Page**

Administrative Expenses Per Member Per Month

Precertification.......... 3

Case Management (High-Risk, Complex and Catastrophic)
Maternity Complications.......... 3
Diabetes Mellitus.......... 4
Asthma.......... 4
Chronic Obstructive Pulmonary Disease (COPD).......... 5
Coronary Artery Disease (CAD).......... 5
Congestive and Other Heart Failure (CHF).......... 6
Depression.......... 6
Other.......... 7
Total.......... 7

Disease Management (Chronic)
Diabetes Mellitus.......... 8
Asthma.......... 8
Chronic Obstructive Pulmonary Disease (COPD).......... 9
Coronary Artery Disease (CAD).......... 9
Congestive and Other Heart Failure (CHF).......... 10
Other.......... 10
Total - From Financial Metrics Survey.......... 11

Nurse-Information Line.......... 11

Health Management / Wellness Programs
Diabetes Mellitus.......... 12
Obesity.......... 12
Other.......... 13
Total.......... 13

Quality Components.......... 14

Medical Informatics.......... 14

Utilization Review.......... 15

Other Medical Management.......... 15

Total Medical Management / Quality Assurance / Wellness.......... 16

Medical Management Outsourcing

Estimated Outsourced FTEs as a Percent of Total FTEs.......... 17

Total Outsourced Costs as a Percent of Comprehensive Total Costs.......... 17

Percent of Membership in Managed Care Plans.......... 18

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Tab 3
Precertification and Recertification

Metric — **Page**

Precertifications

Per 100 Members per Year
In-Network
Approved Precerts Per 100 Members per Year........ 23
Denied Precerts Per 100 Members per Year........ 23
Total Precerts Per 100 Members per Year........ 24

Out-of-Network
Approved Precerts Per 100 Members per Year........ 24
Denied Precerts Per 100 Members per Year........ 25
Total Precerts Per 100 Members per Year........ 25

Total Precertifications
Approved Precerts Per 100 Members per Year........ 26
Denied Precerts Per 100 Members per Year........ 26
Total Precerts Per 100 Members per Year........ 27

Composition
Percent of In-Network
Percent of In-Network Approved........ 27
Percent of In-Network Denied........ 28

Percent of Out-of-Network
Percent of Out-of-Network Approved........ 29
Percent of Out-of-Network Denied........ 29

Percent of Total Precertifications
Percent of Total Precertifications Approved........ 30
Percent of Total Precertifications Denied........ 30

Percent of Total Precertifications
Percent of Total Precertifications In-Network........ 31
Percent of Total Precertifications Out-of-Network........ 31

Recertifications

Per 100 Members per Year
In-Network
Approved Recerts Per 100 Members per Year........ 32
Denied Recerts Per 100 Members per Year........ 32
Total Recerts Per 100 Members per Year........ 33

Out-of-Network
Approved Recerts Per 100 Members per Year........ 33
Denied Recerts Per 100 Members per Year........ 34
Total Recerts Per 100 Members per Year........ 34

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Precertification and Recertification (continued)

Metric	Page
Recertifications (continued)	
Per 100 Members per Year (continued)	
Total Precertifications	
Approved Recerts Per 100 Members per Year	35
Denied Recerts Per 100 Members per Year	35
Total Recerts Per 100 Members per Year	36
Composition	
Percent of In-Network	
Percent of In-Network Approved	37
Percent of In-Network Denied	37
Percent of Out-of-Network	
Percent of Out-of-Network Approved	38
Percent of Out-of-Network Denied	38
Percent of Total Recertifications	
Percent of Total Recertifications Approved	39
Percent of Total Recertifications Denied	39
Percent of Total Recertifications	
Percent of Total Recertifications In-Network	40
Percent of Total Recertifications Out-of-Network	40
Precertifications and Recertifications	
Composition by Type of Precertification and Recertification	
Acute Admissions	41
Behavioral Health	41
LTAC	42
Rehabilitation	42
Skilled Nursing Care	43
Outpatient Surgeries	43
Radiology	44
Laboratory Tests	44
PT / OT / ST	45
Home Health Care Services	45
Other	46
Total Precertifications and Recertifications	46

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Precertification (continued)

	Metric	Page
	Percent of Total Recertifications Denied (continued)	
	Non-Clinical Staff per Clinical Staff	48
	Non-Clinical Staff per Precert FTE	48
	Clinical FTE per Total Precert FTE	48
	Percent of Total Recertifications Denied Cost Summary	
	0	
	Precerts/Recerts Per 100 Members per Year	48
x	Members Per Total Precert FTEs	48
=	Precerts/Recerts Per Precert FTEs Per Year	48
x	Cost per Precerts/Recerts	48
=	Costs Per Total Precert FTEs	48
x	Total Percert FTEs Per 10,000 Members	48
=	Costs Per Member Per Month	48
	Cost Summary	
	Non-Labor Costs per FTE	48
+	Staffing Costs per FTE	48
=	Total Costs per FTE	48
x	FTEs per 10,000 Members	48
=	Costs Per Member Per Month	48

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Tab 4
Case Management

Metric | **Page**

Case Management Activities

Identified Case Management Cases as a Percent of Total Members 51
Screened Case Management Cases as a Percent of Identified Cases 51
Opened Case Management Cases as a Percent of Screened Cases 52

Case Management Cases Entailing Offsite Visits as a Percent of Opened Cases 52

Number of Identified Case Management Cases per:
Licensed RN Case Manager 53
All Other Case Managers 53
Total Case Manager 53

Number of Screened Case Management Cases per:
Licensed RN Case Manager 53
All Other Case Managers 53
Total Case Manager 53

Number of Opened Case Management Cases per:
Licensed RN Case Manager 53
All Other Case Managers 53
Total Case Manager 53

Case Management Cases per 1,000 Admissions 54
Admissions per Case Management Case 54

Percent of Case Management FTEs that are Case Managers 55
Percent of Cases Entailing Offsite Visits 55

Case Management Engagement Rate 56

Case Management Cases per 10k Members by Major Practice Category
Maternity Complications 57
Diabetes Mellitus 57
Asthma 58
Chronic Obstructive Pulmonary Disease (COPD) 58
Coronary Artery Disease (CAD) 59
Congestive and Other Heart Failure (CHF) 59
Depression 60
Neoplasms 60
Rare Disease Management 61
Transplants 61
Obesity 62
Acute Injury or Accident 62
Other 63
Total Cases 63

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Case Management (continued)

	Metric	Page
	Percent of Case Management Cases by Major Practice Category	
	Maternity Complications	64
	Diabetes Mellitus	64
	Asthma	65
	Chronic Obstructive Pulmonary Disease (COPD)	65
	Coronary Artery Disease (CAD)	66
	Congestive and Other Heart Failure (CHF)	66
	Depression	67
	Neoplasms	67
	Rare Disease Management	68
	Transplants	68
	Obesity	69
	Acute Injury or Accident	69
	Other	70
	Total Cases	70
	Case Management Cost Summary	
	Cost Summary	
	Case Management Cases Per Member	71
x	Members Per Case Managament FTE	71
=	Cases Per Case Managament FTEs Per Year	71
x	Cost per Case	71
=	Cost Per Case Management FTE	71
x	Case Management FTEs Per 10,000 Members	71
=	Cost Per Member Per Month	71
	Cost Summary	
	Non-Labor Costs per FTE	71
+	Staffing Costs per FTE	71
=	Total Costs per FTE	71
x	FTEs per 10,000 Members	71
=	Costs Per Member Per Month	71

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Tab 5
Disease Management

Metric | **Page**

Disease Management Activities

Identified Disease Management Cases as a Percent of Total Members........ 75
Screened Disease Management Cases as a Percent of Identified Cases........ 75
Opened Disease Management Cases as a Percent of Screened Cases........ 76

Number of Identified Disease Management Cases per Manager........ 76
Number of Screened Disease Management Cases per Manager........ 76
Number of Opened Disease Management Cases per Manager........ 76

Disease Management Cases per 1,000 Admissions........ 77
Admissions per Disease Management Case........ 77

Percent of Members Actively Managed through Disease Management Programs........ 78

Disease Management Cases per 10k Members by Major Practice Category
Diabetes Mellitus........ 79
Asthma........ 79
Chronic Obstructive Pulmonary Disease (COPD)........ 80
Coronary Artery Disease (CAD)........ 80
Congestive and Other Heart Failure (CHF)........ 81
Depression........ 81
Neoplasms........ 82
Rare Disease Management........ 82
Transplants........ 83
Obesity........ 83
Other........ 84
Total Cases........ 84

Percent of Disease Management Cases by Major Practice Category........ 85
Diabetes Mellitus........ 86
Asthma........ 86
Chronic Obstructive Pulmonary Disease (COPD)........ 87
Coronary Artery Disease (CAD)........ 87
Congestive and Other Heart Failure (CHF)........ 88
Depression........ 88
Neoplasms........ 89
Rare Disease Management........ 89
Transplants........ 90
Obesity........ 90
Other........ 91
Total Diseases........ 91

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Disease Management (continued)

	Metric	Page
	Disease Management Cost Summary	
	Cost Summary	
	Disease Management Cases Per Member	92
x	Members Per Disease Management FTEs	92
=	Disease Management Cases Per Disease Management FTEs Per Year	92
x	Cost per Disease Management Case	92
=	Cost Per Disease Management FTEs	92
x	Disease Managament FTEs Per 10,000 Members	92
=	Cost Per Member Per Month	92
	Cost Summary	
	Non-Labor Costs per FTE	92
+	Staffing Costs per FTE	92
=	Total Costs per FTE	92
x	FTEs per 10,000 Members	92
=	Costs Per Member Per Month	92

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Tab 6
Nurse Information Line

	Metric	Page
	Inbound Calls per Member per Year	
	Inbound Calls per Information Line Nurse per Year	95
	Inbound Calls per Hour	96
	Inbound Calls per Week	96
	Costs per Inbound Call	97
	Costs per Information Line Nurse	97
	Number of of Hours Nurse Line is Available	
	Daily	97
	Weekly	97
	Nurse Information Line Cost Summary	
	Cost Summary	
	Inbound Calls per Member	98
x	Members Per Nurse Information-Line FTE	98
=	Inbound Calls per Nurse Information-Line FTE	98
x	Cost per Inbound Call	98
=	Costs Per Nurse Information-Line FTE	98
x	Nurse Information-Line FTEs Per 10,000 Members	98
=	Costs Per Member Per Month	98
	Cost Summary	
	Non-Labor Costs per FTE	98
+	Staffing Costs per FTE	98
=	Total Costs per FTE	98
x	FTEs per 10,000 Members	98
=	Costs Per Member Per Month	98

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Tab 7
Utilization Review and Appeals

Metric | Page

Medical Necessity Appeals

Percent of Appeals Approved vs. Denied
Internal Appeals
Informal Reconsideration
Percent Approved.......... 101
Percent Denied.......... 101

Formal Internal Appeals - Standard
Percent Approved.......... 102
Percent Denied.......... 102

Formal Internal Appeals - Expedited
Percent Approved.......... 103
Percent Denied.......... 103

Total Internal Appeals
Percent Approved.......... 104
Percent Denied.......... 104

External Appeals
Independent Review Appeals
Percent Approved.......... 105
Percent Denied.......... 105

Total Appeals - Internal and External
Percent Approved.......... 106
Percent Denied.......... 106

Percent of Total Appeals
Internal Appeals
Informal Reconsideration.......... 107
Formal Internal Appeals - Standard.......... 107
Formal Internal Appeals - Expedited.......... 108
Total Internal Appeals.......... 108

External Appeals
Independent Review Appeals.......... 109

Total Appeals - Internal and External.......... 109

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Utilization Review and Appeals (continued)

Metric	Page
Appeals per 10,000 Members	
Internal Appeals	
Informal Reconsideration	110
Formal Internal Appeals - Standard	110
Formal Internal Appeals - Expedited	111
Total Internal Appeals	111
External Appeals	
Independent Review Appeals	112
Total Appeals - Internal and External	112
Total Internal Appeals per Clinical Employee Working on Medical Review	113
Medical Review	
Number of Episodes Medically Reviewed per 1,000 Members	114
Number of Claims Medically Reviewed per 1000 Members	114
Number of Claims Medically Reviewed Per Admission	115
Claims Approved as a Percent of Claims Reviewed	115
Claims Denied as a Percent of Claims Reviewed	116
Claims Denied Per Member	116
Percent of Episodes Medically Reviewed by Medical Director	117
Clinical Employees Working on Medical Review per 10,000 Members	117

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Tab 8
Quality Assurance and Wellness

Metric	Page
Wellness	
Outreach Calls per 10k Members	121
Outreach Calls per 1,000 Admissions (Total Acute, Including Behavioral Health)	121
Cost Summary	
Non-Labor Costs per FTE	122
+ Staffing Costs per FTE	122
= Total Costs per FTE	122
x FTEs per 10,000 Members	122
= Costs Per Member Per Month	122
Quality of Care	
Complaints about Providers per 10k Members	123
Total Quality Cases Per 1k Members Per Month	123
Percent of Quality Review FTEs that are RN's	124
Percent of Quality Review FTEs that are Non-Clinical	124
Total Cases / FTE per Month	124
Does your plan use the following accreditation agency?	
URAC	124
NCQA	124
Cost Summary	
Non-Labor Costs per FTE	124
+ Staffing Costs per FTE	124
= Total Costs per FTE	124
x FTEs per 10,000 Members	124
= Costs Per Member Per Month	124

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