Sherlock Benchmarks

All Universes Edition

Sherlock Company

Volume II

Medical Management Metrics

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SHERLOCK BENCHMARKS

All Universes Edition - 2023

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 *2023 Sherlock Benchmarks – All Universes Edition*. Together, these volumes provide statistics and analysis summarizing the administrative expenses and operational metrics of 31 health plans. These plans consist of Blue Cross Blue Shield Plans, Independent/Provider-Sponsored plans and Medicaid 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 *2023 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 a total of 14 product lines and almost 80 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. There is a section on Medical Directors as well.

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.

This section also includes metrics related to the management of pharmacy benefits such as the number of formularies.

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.*

Douglas B. Sherlock, CFA
President
Sherlock Company

sherlock@sherlockco.com
215-628-2289

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

Tab 3
Precertification and Recertification

Precertification and Recertification (continued)

Precertification (continued)

Tab 4
Case Management

Case Management (continued)

Tab 5
Disease Management

Disease Management (continued)

Tab 6
Nurse Information Line

Tab 7
Utilization Review and Appeals

Utilization Review and Appeals (continued)

Tab 8
Quality Assurance and Wellness

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Volume II – Medical Management Metrics