Plan Management Navigator
Analytics for Health Plan Administration

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Please see page 4 for our invitation to participate in the 2023 Medicaid Sherlock Benchmarks.

Medicaid Eligibility Reviews: Planning Using Sherlock Benchmarks and Scale Slopes

> "An unprecedented effort by states to review the eligibility of the more than 90 million people on Medicaid carries high financial stakes for industry group, including hospitals that risk paying more to cover uninsured patients and insurers that could lose some of the money they get for managing state Medicaid programs." *Wall Street Journal*, April 3, 2023.

This morning's *Wall Street Journal* reports on a significant industry risk associated with upcoming eligibility determinations. The article recalls that "Eligibility reviews for people who get Medicaid coverage were paused during the Covid-19 pandemic." But, as eligibility determinations resume, existing members could lose coverage either because they are not financially eligible or "for procedural reasons, such as not having updated contact information on file." The latter cause is believed by the *Wall Street Journal* to result in eight million people failing to be eligible, citing regulators. "Most disenrollments are likely to occur nationwide between June and July."

The impact on individual Managed Care Organizations depends on the attrition in their membership and on individual plan circumstances. The article cites Kaiser Family Foundation's tabulation that, "Medicaid enrollment during the pandemic swelled about 30%-by 20 million enrollees-from February 2020 to November 2022."

We have modeled the effect on a Medicaid plan basing the 23%percent decline in membership indicated by the pandemic related increase of 30%. We assume that this plan operates at industry median costs of $28.57 PMPM from the Medicaid product value for the Medicaid universe found in the October 2022 edition of *Plan Management Navigator*.

Figure 1. Medicaid Eligibility Reviews
The Effect of Membership Decline on Cost

Step	Description	Value	Note
1	BCG Slope from *IPS* universe	**90.5%**	Calculated by Sherlock Company
2	Regular, non-BCG slope.	**-0.1448**	Base 2 log of BCG slope in step 3: =LOG(0.905,2)
3	**Suppose a membership decrease of**	**23.0%**	Assumed
4	Intermediate Step	**0.77**	1 minus membership decline: =(1-0.231)
5	Indicated Percent Difference in Costs	**103.9%**	Step 4 raised to power of regular slope: = 0.77 ^ (-0.2027)
6	Medicaid PMPM Costs	$28.57	From October 2022 *Navigator*
7	Indicated Costs at New Scale	**29.68**	Step 5 x 6
8	Difference in Costs	**$1.10**	Step 7 - 6
9	Difference in Costs, as Percent of Original	**3.9%**	Step 8 / 6

The initial effects on PMPM costs are a 30% increase since the same costs would be spread over 23% fewer members. However, Figure 1 shows the 3.9% increase in PMPM costs after a decline in the membership, *assuming that the plan adapts its costs to its smaller enrollment base*. In that case, per member costs still increase since some health plan activities have partially fixed costs. This is a *favorable* scenario in that it assumes a successful adaptation, though its effects depend on the speed with which it does so. The Corporate Services cluster of functions is notable in its susceptibility to economies of scale and, in this instance, its resistance to cost reductions in the event of membership decline.

The effect on staffing ratios is similar. Here we assume the plan operates with a staffing ratio of 20.90 FTEs per 10,000 members, the indicated staffing ratio for the Medicaid product of the Medicaid universe. (This includes all FTEs regardless of whether they are internal or outsourced.) Again, the immediate effect on the staffing ratio is a 30% increase because the same staff now serves 23% fewer members.

Figure 2 shows the effect of adaptation to overcome the diminished scale. The staffing ratio is modeled to increase to 22.04 FTEs per 10,000 members, a 5.4% increase. The increase stems from some of the staff not being scalable with members. For instance, the Finance and Accounting area is still charged with supplying financial statements to insurance departments regardless of plan size.

Note that the staffing ratio slope is steeper than the cost slope. An important reason for this is that compensation often increases with the size of the plan. This compensation effect adds an additional level of complexity to the management of administrative costs in a diminishing membership environment.

The effect on a health plan of the resumption of Medicaid eligibility reviews depends on individual plan circumstances. These factors include how many members are retained after the eligibility review, how leanly the plan currently operates and how rapidly the plan adapts.

Figure 2. Medicaid Eligibility Reviews

The Effect of Membership Decline on Staffing Ratio

Step	Description	Value	Note
1	BCG Slope from *IPS* universe	**86.9%**	Calculated by Sherlock Company
2	Regular, non-BCG slope.	**-0.2027**	Base 2 log of BCG slope in step 3: =LOG(0.869,2)
3	**Suppose a membership decrease of**	**23.0%**	Assumed
4	Intermediate Step	**0.77**	1 minus membership decline: =(1-0.231)
5	Indicated Percent Difference in Costs	**105.4%**	Step 4 raised to power of regular slope: = 0.77 ^ (-0.2027)
6	Medicaid Staffing Ratio	**20.90**	Calculated by Sherlock Company
7	Indicated Staffing Ratio at New Scale	**22.04**	Step 5 x 6
8	Difference in Staffing Ratio	**1.14**	Step 7 - 6
9	Difference in Staffing Ratio, as Percent of Original	**5.4%**	Step 8 / 6

The slopes employed here are derived from the Independent / Provider – Sponsored universe: it is large and often heavily weighted to Medicaid. The slopes are not statistically significant but represent a rough summary. The effect of scale differs by function as does its statistical significance. Since optimal costs relates in part to individual function performance, an assessment of costs should occur at the function as well as the enterprise level.

Invitation to Participate in the 2023 Medicaid Sherlock Benchmarking Study

In adapting to the challenging new environment, one initial step may be to participate in the Medicaid *Sherlock Benchmarks* in the coming months. Regardless of the actual Medicaid membership attrition, a health plan's knowing about its cost performance is useful under any scenario. The well-validated, well-populated *Sherlock Benchmarks* provide an unbiased ranking and help prioritize cost management activities to have the greatest impact on your health plan's overall operating performance.

The *Sherlock Benchmarks* have been called the "Gold Standard" by leading health care consultants. The 2023 Medicaid plan study will be its 21st consecutive year. Over all universes, by the end of this year, the *Sherlock Benchmarks* will have a cumulative experience of approximately 1,000 health plan years. In the 2022 cycle, plans participating in all universes of the *Sherlock Benchmarks* served 62 million people.

In the past, we have launched the Medicaid universe in the first week in June to accommodate the constraints of efforts of many plans to submit Medicare Advantage bids. Reports begin to be published in September. However, for those who are interested, we can begin immediately and supply an interim Report in July. Participation entails effort on the part of the plans since actionable outputs require relatively granular inputs. However, the cost is relatively modest.

The *Sherlock Benchmarks* are also available to license. Please reach out to Douglas Sherlock at sherlock@sherlockco.com or 215-628-2289 if you are interested in either participation or licensing.

You will be among good company.

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