Plan Management Navigator

Analytics for Health Plan Administration

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Please see page 7 for our invitation to participate in the 2022 or license the 2021 Sherlock Benchmarks.

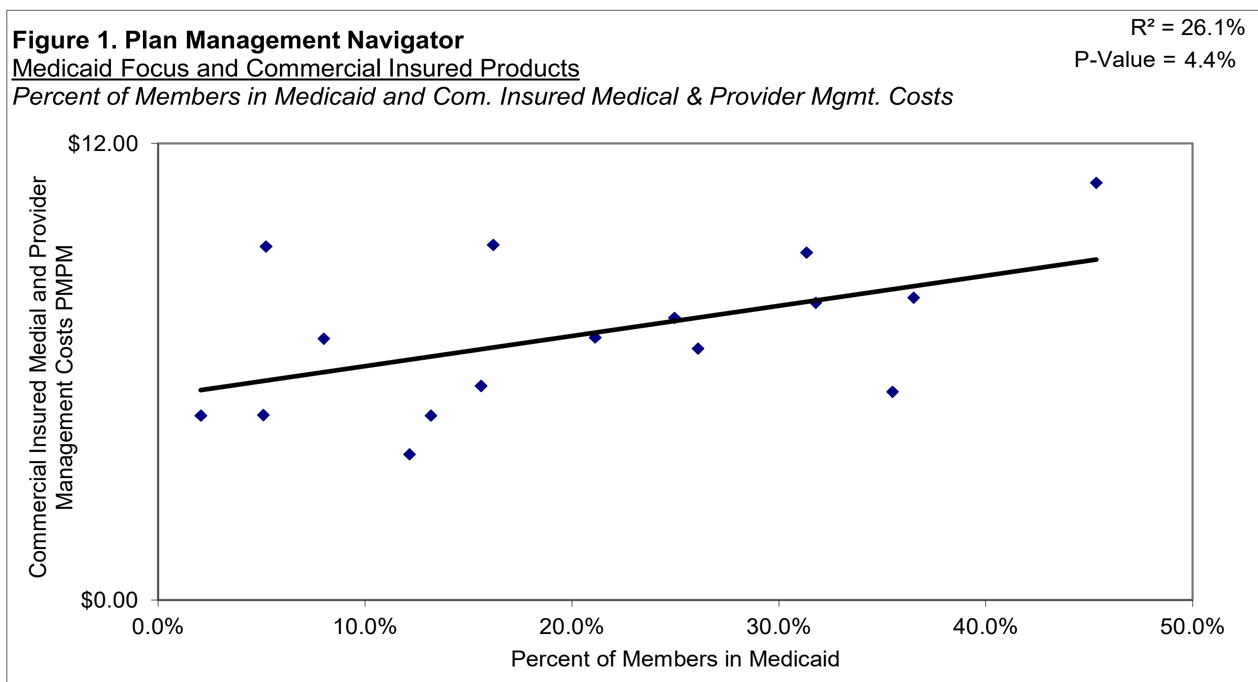
Spill-over between Medicaid and Medical and Provider Management in Commercial Products

While health plans usually offer multiple products, they rarely organize themselves along product lines. In other words, for most plans, it is impractical to operate separate claims, customer services and enrollment functions between their Medicaid and Commercial products. So, for many health plans, their activities in one product may affect activities in other ones. We believe that this is true for Medical and Provider Management.

In this *Plan Management Navigator*, we explore the cost and staffing ratio relationships of 16 health plans in the Blue Cross Blue Shield and Independent / Provider – Sponsored universes that serve both Commercial Insured and Medicaid members during the 2021 cycle of the *Sherlock Benchmarks*.

Medicaid Focus and Commercial Medical and Provider Management Expenses

Figure 1 shows the relationship between the percent of members in Medicaid and Medical and Provider Management cluster of expenses for Commercial Insured. The R^2 was 26.1% and the P-Value was 4.4%. The positive slope, however, implies that the greater the focus on Medicaid, the higher the expenses in Medical and Provider Management cluster of expenses for Commercial Insured.



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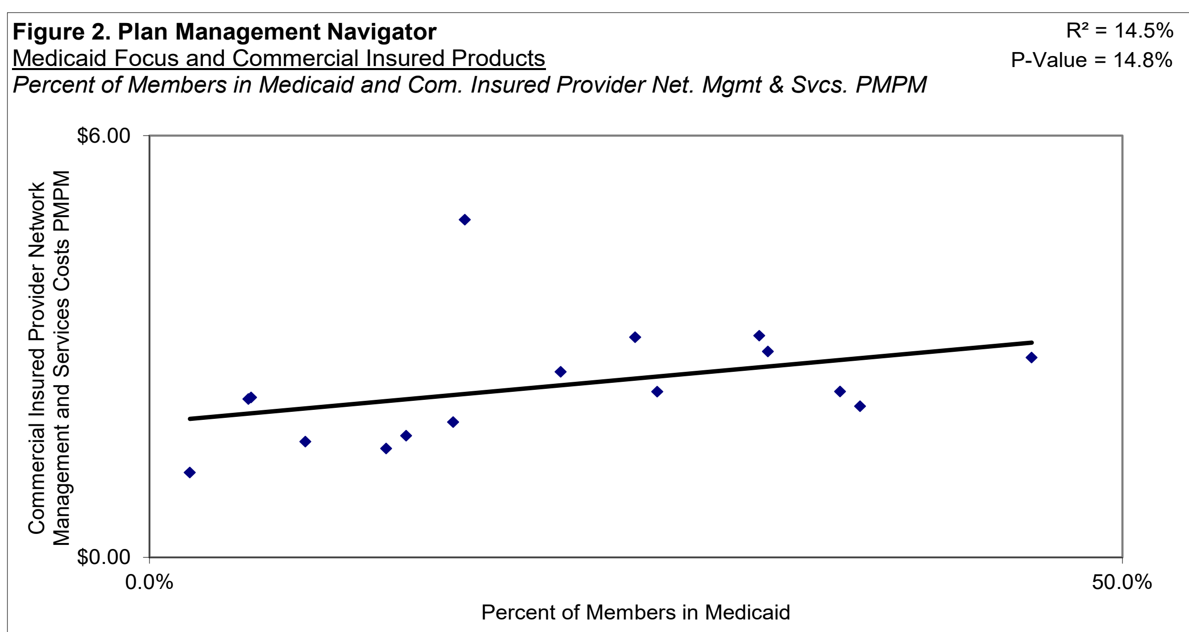
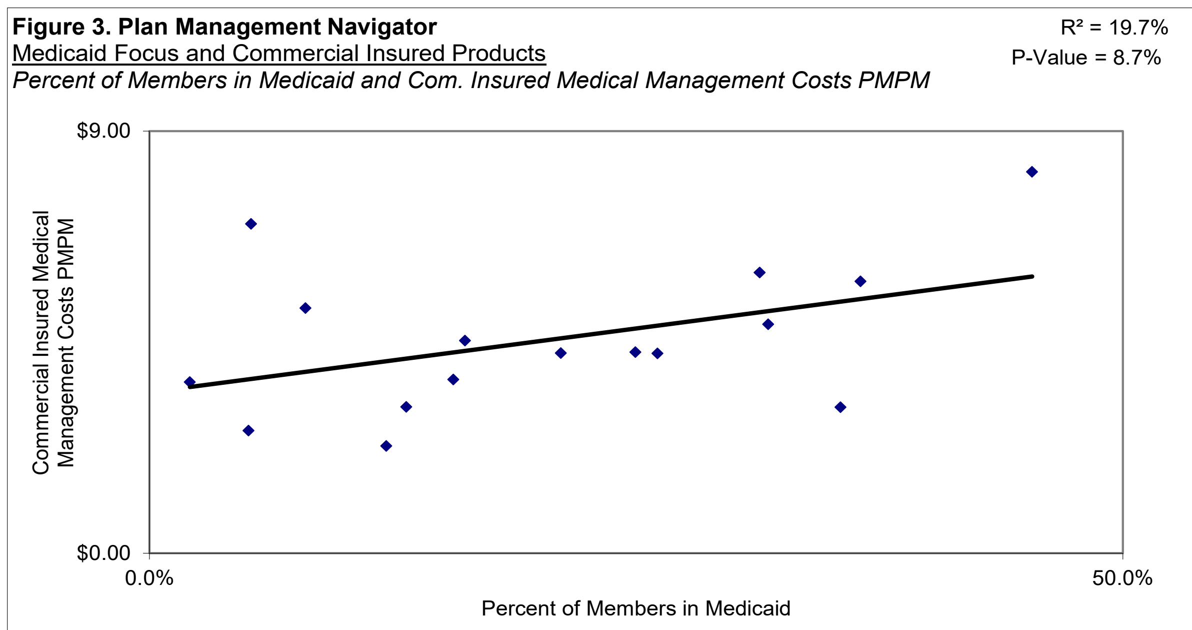
We do not know the reason for this relationship, though it is possible that plans are highly accustomed to aggressive care management strategies employed serving Medicaid are more amenable to their application to their Commercial Insured members.

The Medical and Provider Management cluster of expenses is comprised of the Medical Management / Quality Assurance / Wellness function and the Provider Network Management and Services function. Figure 2 shows the regression between Provider Network Management in Commercial Insured and Medicaid focus. The P-Value was 14.8% and a R^2 of 14.5%, a weak and insignificant relationship.





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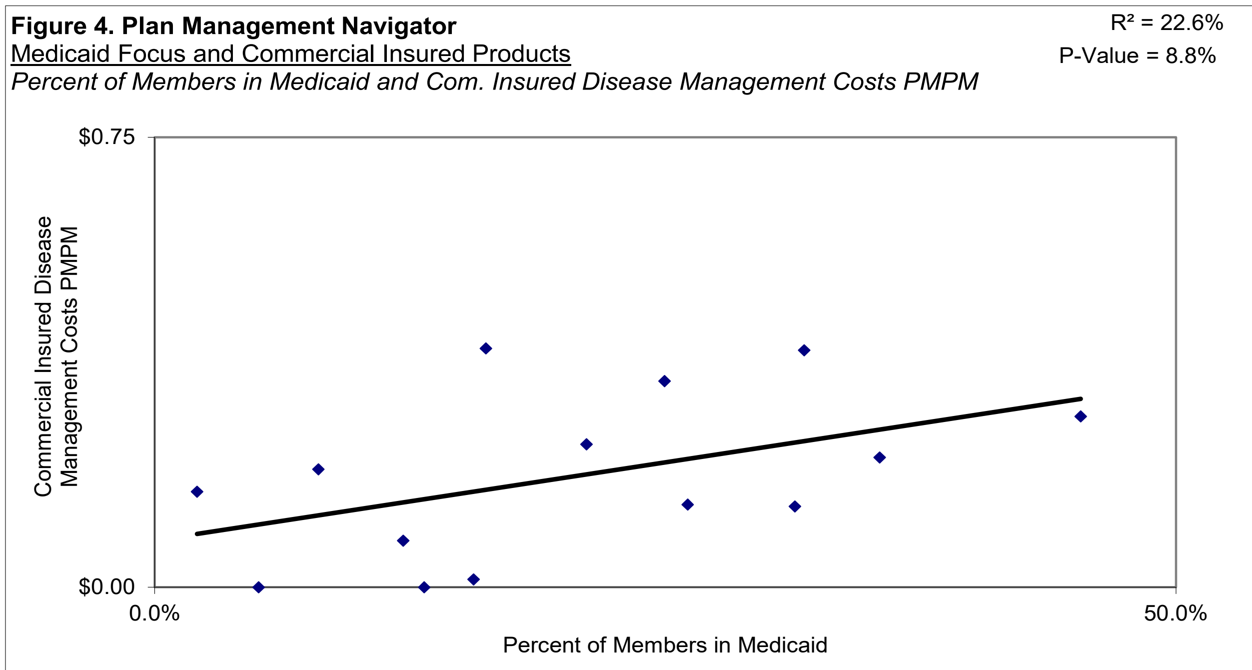
The regression for Medical Management expenses in Commercial Insured and the Percent of Members in Medicaid is shown in Figure 3. The results are stronger with a P-value of 8.7% and R^2 of 19.7%. This function exhibited a positive slope indicating that the greater the proportion in Medicaid membership the higher the Medical Management expenses for Commercial Insured members..

Figure 4 shows the Medical Management sub-function, Disease Management, and Medicaid focus. The positive relationship yielded a P-value of 8.8% and a R^2 of 22.6%, suggesting that the higher the concentration in Medicaid membership, the higher the Disease Management expenses in Commercial Insured.

The Medicaid-focus effect on Commercial Insured Disease Management was unique among the nine Medical Management subfunctions. This may indicate that, while plans tend to commit more to Medical Management in Commercial Insured as they focus on Medicaid, they differ in their strategies on what form of Medical Management is most effective for their purposes.



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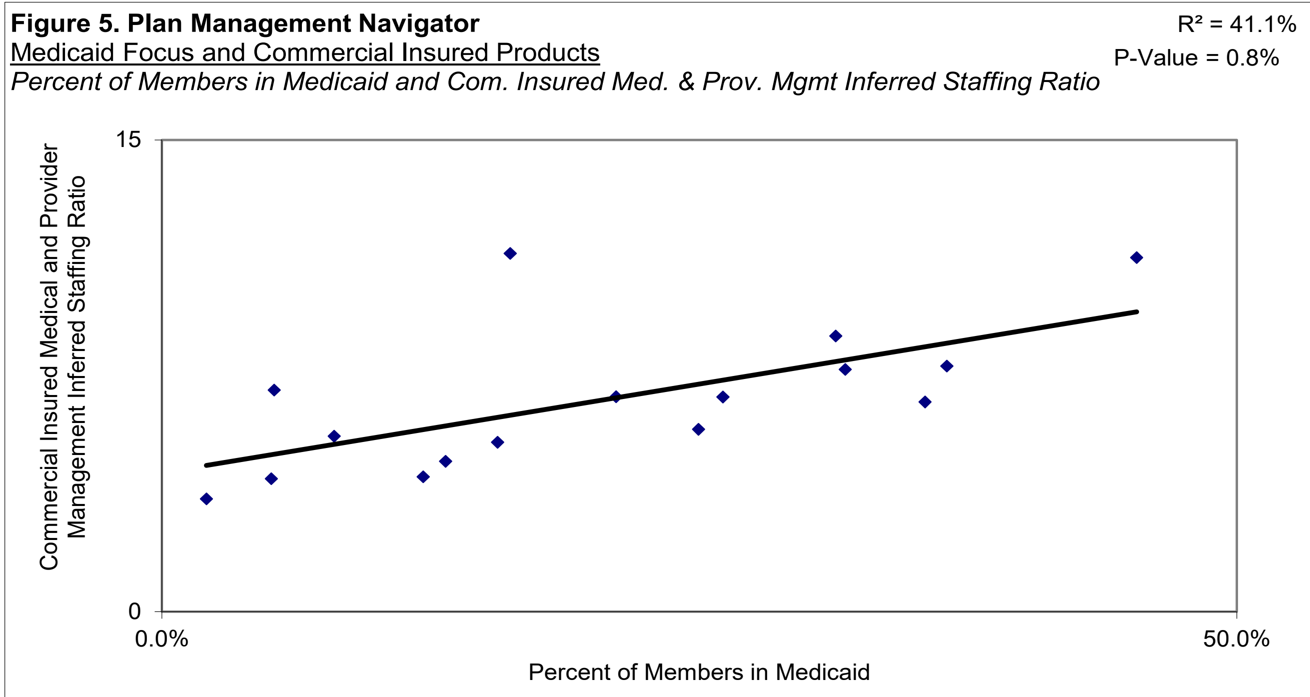
Medicaid Focus and Medical and Provider Management Staffing Ratios

Costs and staffing are closely related so we also tested the relationship between the proportion of members in Medicaid and Staffing Ratios for Commercial Insured. Staffing Ratios are inferred by dividing Commercial Insured PMPM costs by total costs per FTE. In other words, in deriving these product staffing ratios, we make the commonsense assumption that a health plan's mix of labor and non-labor costs is the same regardless of its product.

Shown in Figure 5, the higher the proportion of Medicaid members, the greater the staffing for the cluster, Medical and Provider Management, in Commercial Insured. The analysis had a P-value of 0.8% and a R^2 of 41.1%.

The regression analysis of the relationship between Medicaid focus and the Staffing Ratio for the function of Medical Management for Commercial Insured had a P-value of 0.7% and R^2 of 42.0%. The positive slope implies that the greater the focus on Medicaid, the higher the Staffing Ratio for Commercial Insured Medical Management.



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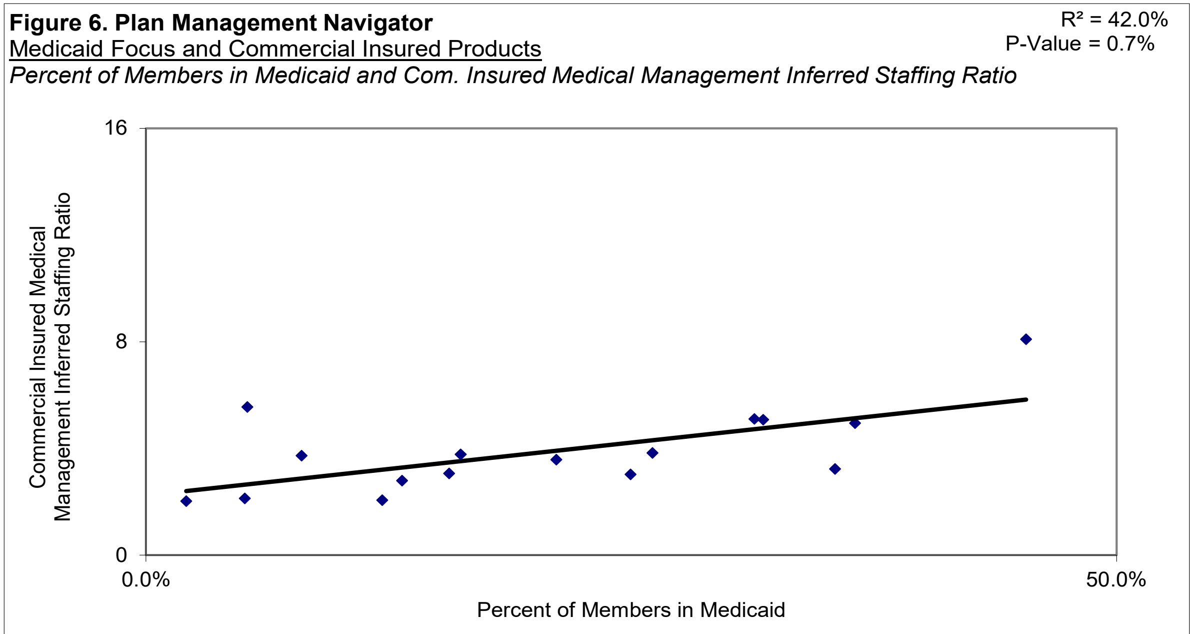
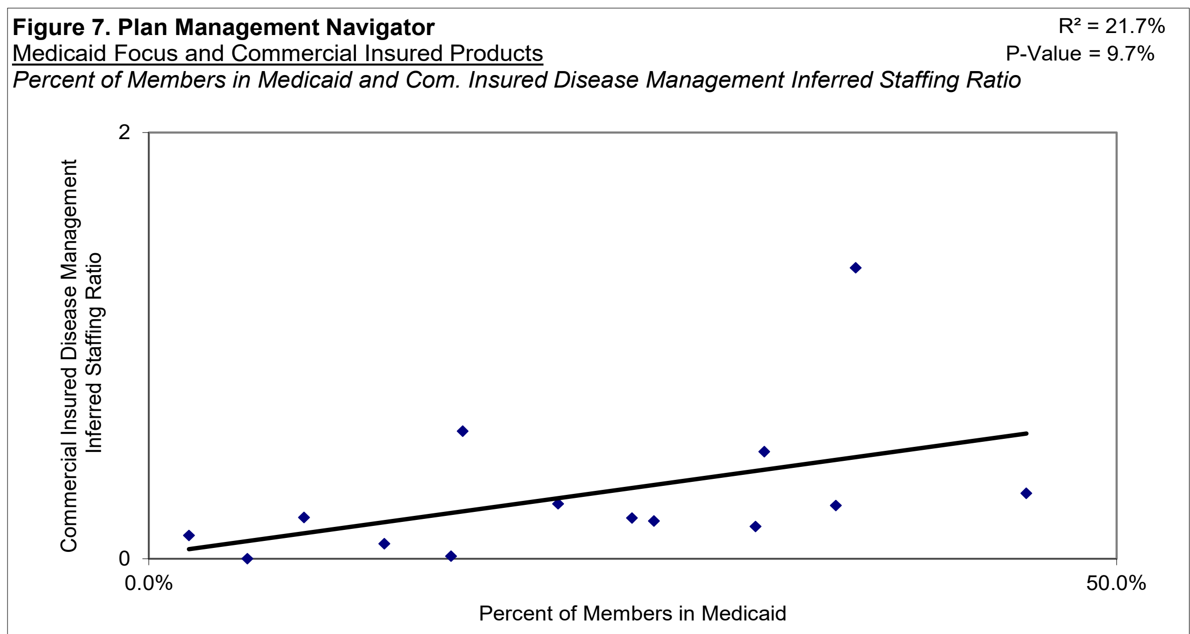
A number of the subfunctions also seemed to show a relationship between the degree of Medicaid focus and the Commercial Insured staffing ratios. The functions were Disease Management, Health and Wellness, and Utilization Review. Figure 7 displays the relationship between Medicaid focus and the Staffing Ratio for Disease Management in Commercial Insured. The positive relationship between the variables yielded a P-value of 9.7% and a R^2 of 21.7%.





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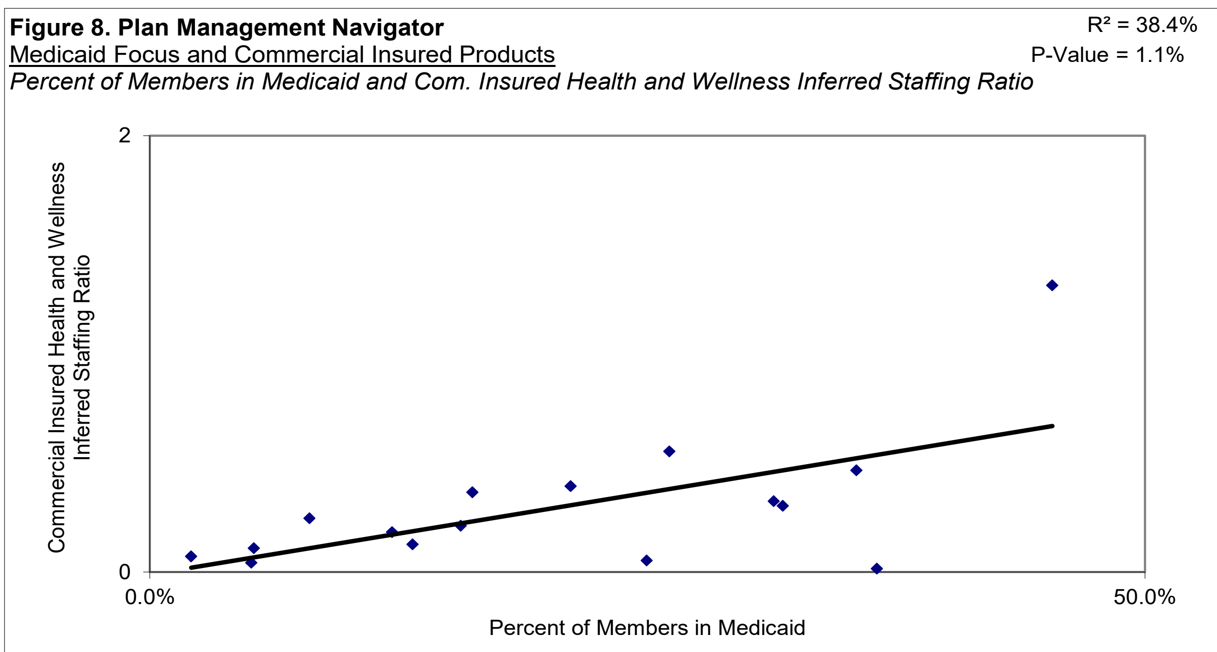
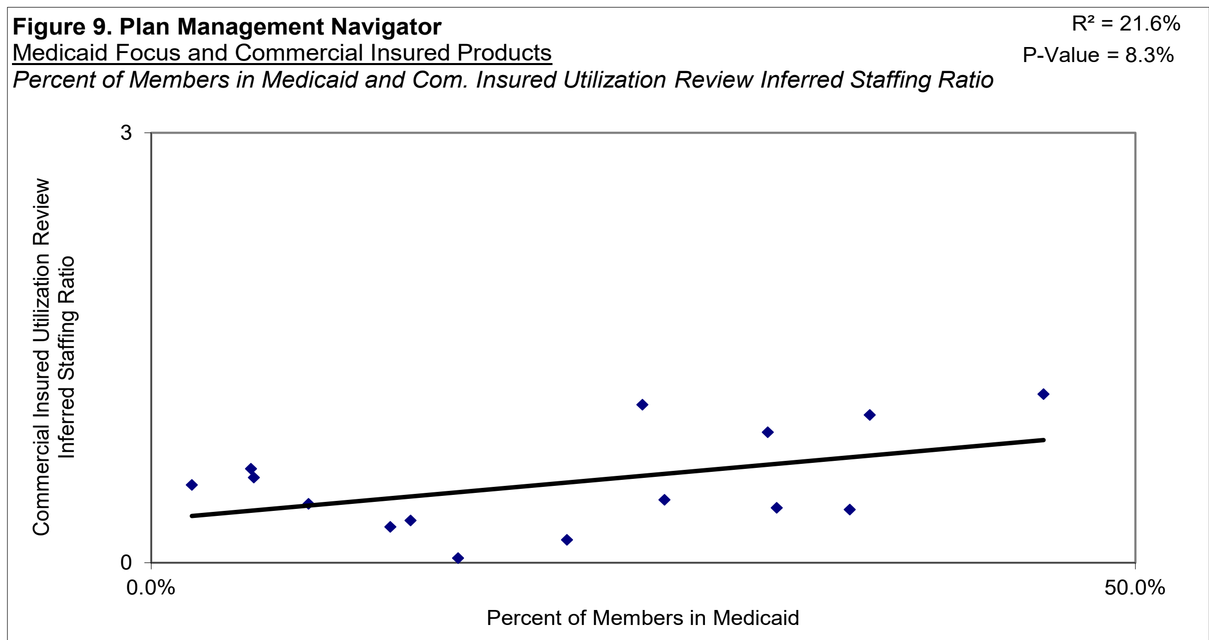
The relationship between the proportion of Medicaid members and Health and Wellness Staffing Ratio for Commercial Insured can be seen in Figure 8. The R^2 was 38.4% and the P-Value was 1.1%.

Medicaid focus held a positive correlation with Utilization Review Staffing Ratio in Commercial Insured. The P-value was 8.3% and the R^2 was 21.6%, as seen in Figure 9.

We do not know why staffing ratio relationships are more common than for PMPM costs. It is possible that variation in health plan compensation and non-labor costs mute effects visible in staffing.





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Other Cost Relationships

Our focus of this analysis is on the Medical and Provider Management cluster of expenses. We also analyzed the Account and Membership Administration cluster but this yielded insignificant results for the 2020 year. This surprised us since we had seen this relationship in prior years. Costs may have been affected by membership attrition in employer-sponsored health plans related to the economic impact of COVID-19, while Medicaid membership likely grew in part due to continuous coverage requirements under the Families First Coronavirus Response Act.

In our analyses, we excluded the Corporate Services cluster to avoid conflation with economies of scale, especially important in that cluster. Sales and Marketing was also excluded since this activity for Medicaid is regulated by states.

Sherlock Benchmarks: Participation and Licensing

This *Plan Management Navigator* analysis relies on the results of the 2021 *Sherlock Benchmarks*, our 24th annual study. For this analysis, we consider relationships to be significant with P-values of 10% or less. Meanwhile, the R^2 describes the degree to which all the data points are found on the slope, thus the line's explaining that proportion of differences in cost values.

In this analysis, all data is for the 2020 calendar year and has been carefully validated both by us and by the plans themselves. Collectively, the 36 plans participating in all *Sherlock Benchmarks* served 56 million Americans. The range of membership was from 55,000 to well over 5 million. The universes were Blue Cross Blue Shield, Independent / Provider – Sponsored, Medicare, Medicaid, and Larger plans.

Participation in Sherlock Benchmarks

We are now completing our panels for the 2022 *Benchmarks* universes of Blue Cross Blue Shield Plans and Independent / Provider – Sponsored Plans. It will be based on plans' 2021 calendar year results. Eighteen Blue Cross Blue Shield Plans and 16 Independent Provider Sponsored Plans have committed to participate in this cycle. If your plan has an interest in participating in either of these universes, please reach out immediately so we can execute a mutual confidentiality agreement: the surveys will be distributed in this week and in three weeks in these respect universes.

In June, we will launch the Medicaid and Medicare universes. As with the other universes, we encourage you to reach out to us to get the process started. You will be among good company.

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Licensing the Sherlock Benchmarks

For those that cannot participate, licensing is available. Please see the following link https://sherlockco.com/sherlock-benchmarks for additional information on the Sherlock Benchmarks. The Reports shown on that page are also the Reports received by the participants.

We can be reached at sherlock@sherlockco.com, or 215-628-2289. We look forward to working with you.

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