Mass Strategic Health Group
Meeting Minutes
Meeting of April 6th, 2021
GBS Gallagher

Board Members Present:	
Doug Willardson	Webster Town Administrator
Matthew Wojcik	Douglas Town Administrator
Rich Mathieu	Dudley Charlton RSD Finance and Operations Manager
MaryEllen Cerbone	Dudley Charlton RSD
Jeanne Lovett	Town of Douglas
Tim Bell	Town of Webster

Others Present:	
Anthony Lively	Alera/Lively Insurance
Emmilie Roach	Arthur J. Gallagher
Chris Nunnally	Arthur J. Gallagher
Anthony Bucci	NexusMD
Daniel Mateleska	NexusMD
Steve Sepe	NexusMD

The meeting was called to order at 1:02PM

Attendance
There was a roll call of attendees participating via WebEx/conference call.

Meeting Minutes – March 9
Mr. Nunnally said the meeting minutes from March 9 are still being reviewed and would be presented at the next meeting. The board agreed.

NexusMD
Please see the attached presentation presented by Dr. Sepe from NexusMD.
Mr. Nunnally said the board would meet again to put together further conversations for NexusMD and we would set up another conversation to discuss.

Other Business
There was no other business.

Next Meeting
Ms. Roach said she would send out tentative dates to the board for the next meeting.

Mr. Mathieu made a motion to end the meeting at 2:30PM. Mr. Wojcik seconded the motion. There was a roll call. The motion passed unanimously.

Submitted by,
Emmilie Roach
Gallagher Benefit Services

MSHG 2019-21

Report of Findings
Recommendations
Contract Extension

NEXUS MD

Steven M Sepe MD PhD
CEO and CSO

Aims of the Nexus analysis - objectives and success benchmarks

- To define the beneficiary population focused on Medical specialties employing a step-wise process: total population profile, specialty segmentation, and specific disease stratification measured against a benchmark where the aggregate specialty costs constitute $\geq$ 50% total medical cost

- Each phase is an endpoint defined as having acquired sufficient data and observations to opt to the next phase with a reasonable expectation to reduce structural costs and/or improve outcomes and downstream cost

- To identify actionable targets for intervention where the top 3 to 5 specific diseases (conditions) account for $\geq$ 40% of the total cost within a given specialty. Actionable means identifying a problem and potential solution at an affordable cost

- To determine the cohorts, which for any given specific condition, identify the fewest patients and highest cost and which, when managed, would approach a 10% reduction in cost and an outcome advantage to the downstream spend

- To enable cross-comparison among the municipalities to identify best practices – i.e., cost drivers

- To define success factors and measure performance over time

Methodology

- Utilize raw data – deidentified
- Overlay Nexus Specialty code clusters to standardize data
- Claims payment and coding analysis 206,767 claims analyzed to date
- Specialty assignment and cost attribution
- Analytics
  - *Cross-sectional:* Profile then segment then stratify to end up with the highest cost centers
  - *Longitudinal:* Track and Trend over time measuring clinical outcomes + cost = value-based performance

Scope of work and benchmarks

PHASE 1

PROFILE

Attribution

Top 5 specialty cost centers

Trends

Specialty cost breakout

Benchmark 50% total costs

By township and Aggregate

Drug cost

PHASE 2

SEGMENT

By township/plans

By specialty

Specialty drug costs

STRATIFY

Specific disease states

ID and target high-cost drugs

Procedures and labs

ID top 5 specialty cost centers

Which hospitals and at what price

Payers - APM experience

Contract constraints

Recommendations, Targeted costs, Program Recommendations

PHASE 3

Metrics

- Claims/Payment: historical baseline and continuous, trajectory, duplicate and excess claims, coding, attribution, variance
- Drugs: identify high-cost drugs
- Ancillary: Procedures and Lab
- Care Delivery: outpatient environments, referral patterns, hospital performance, access

Key Results meet Phase 1 benchmarks

Medical Claims

Phase 1 Completed

- Specialty claims account for a significant proportion of the total medical cost increase over the 16 and 24 mo. periods[1]
- Specialty costs consistently account for 50% of total claims paid in the lookback and 4 month forward
- *Gastroenterology, Neurology, and Orthopedics* cost together, account for 40% of Total Specialty Claims Paid

CLINICAL Specific Conditions

Early Phase 2 Findings

- Crohn's Disease, CRC, MS, K-H Osteoarthritis, Dep/GAD account for 10% of Total Specialty cost[2]
- Crohn's makes up 20% of *total* gastroenterology claims payments
- Covid impact of blunting utilization of medical services portends increased down-stream medical cost and spend

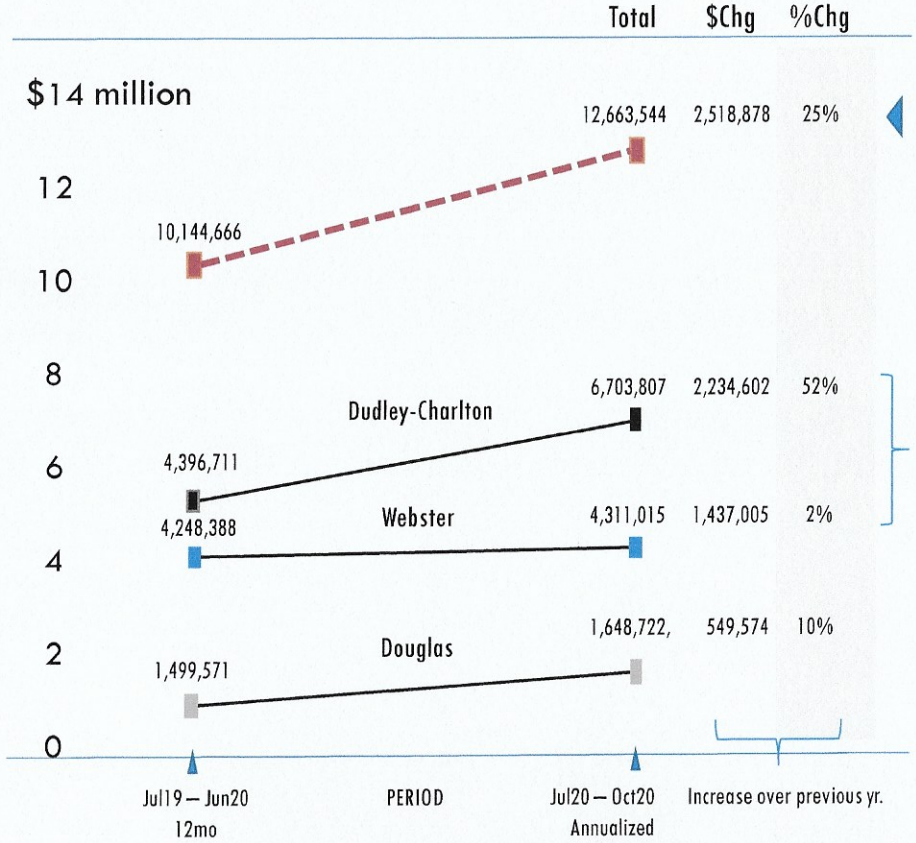
Drugs

- Drug cost is a significant contributor to total medical costs across townships[3].
- Total drug claims paid have only slightly decreased which may be aberrant due to Covid-19 disruption in care utilization[4]
- Drug cost projected to double over the last two quarters 2021 led by specialty drugs
- Further drug claims analysis needed to distinguish claims fidelity and its contribution to total cost

[1]From July 1, 2019 to June 31, 2020 i.e., the 12mo. lookback baseline period plus 4 months from July1, 2020 to Oct 31, 2020.
[2] Colorectal Cancer (CRC), Multiple Sclerosis (MS), Knee-Hip Osteoarthritis (K-H Osteoarthritis), Depression/Generalized Anxiety Disorder(Dep/GAD)
[3]Drug cost accounts for ~15% of total specialty claims – further analysis needed to optimally attribute per claim drug payments directly from PBM.
[4]Hospital: No clinic visits; OR limited to emergency, no electives; Physician ambulatory centers, all outpatient-based procedures prohibited; Telemedicine visits only. Research: 85% clinical trials on FDA hold, standstill in IND filings – 85-90% reduction in specialty revenues; Patient cancellations, deferral of needed diagnostic and interventional procedures, fear of exposure, collectively an enormous disruption in care delivery and corresponding decline drug and lab costs

Total Medical Cost is rising but there is significant variance between townships….Why?

Total Claims Paid:
Cross-sectional and
Aggregate
By Township

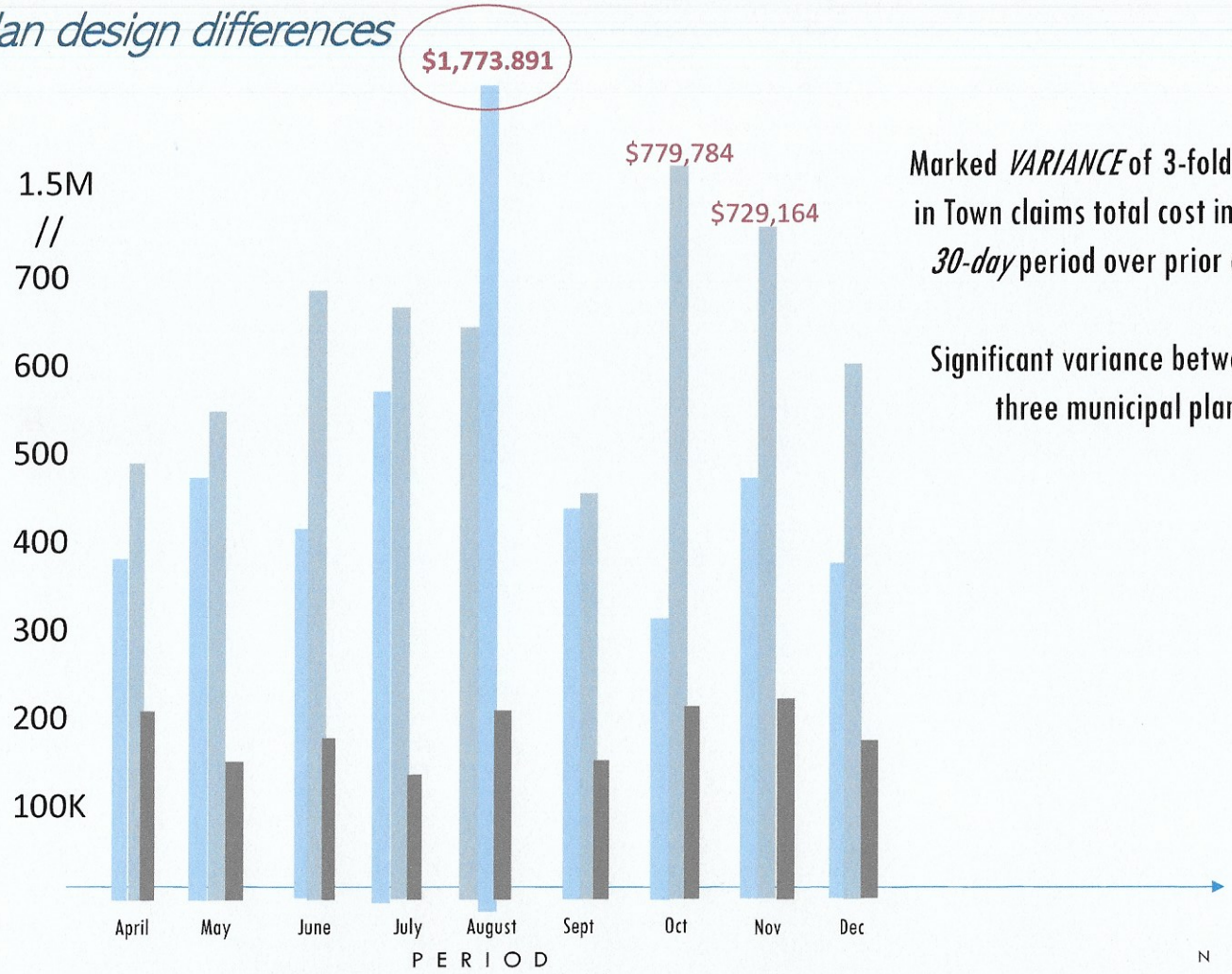


Projected 25% rise in aggregate MSHG total medial costs at 24months

While All three townships showed increased total costs, the variance between the highest and lowest groups exceeded 50%

Variance is multifactorial : An example where variance signaled aberrant claims due to claim misattribution and plan design differences

Legacy Study No.2
Monthly Claims Paid
$Amount
April 2018-Feb 2019

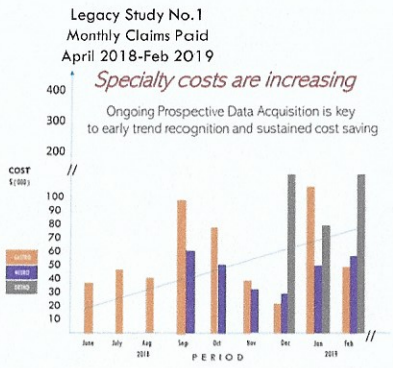


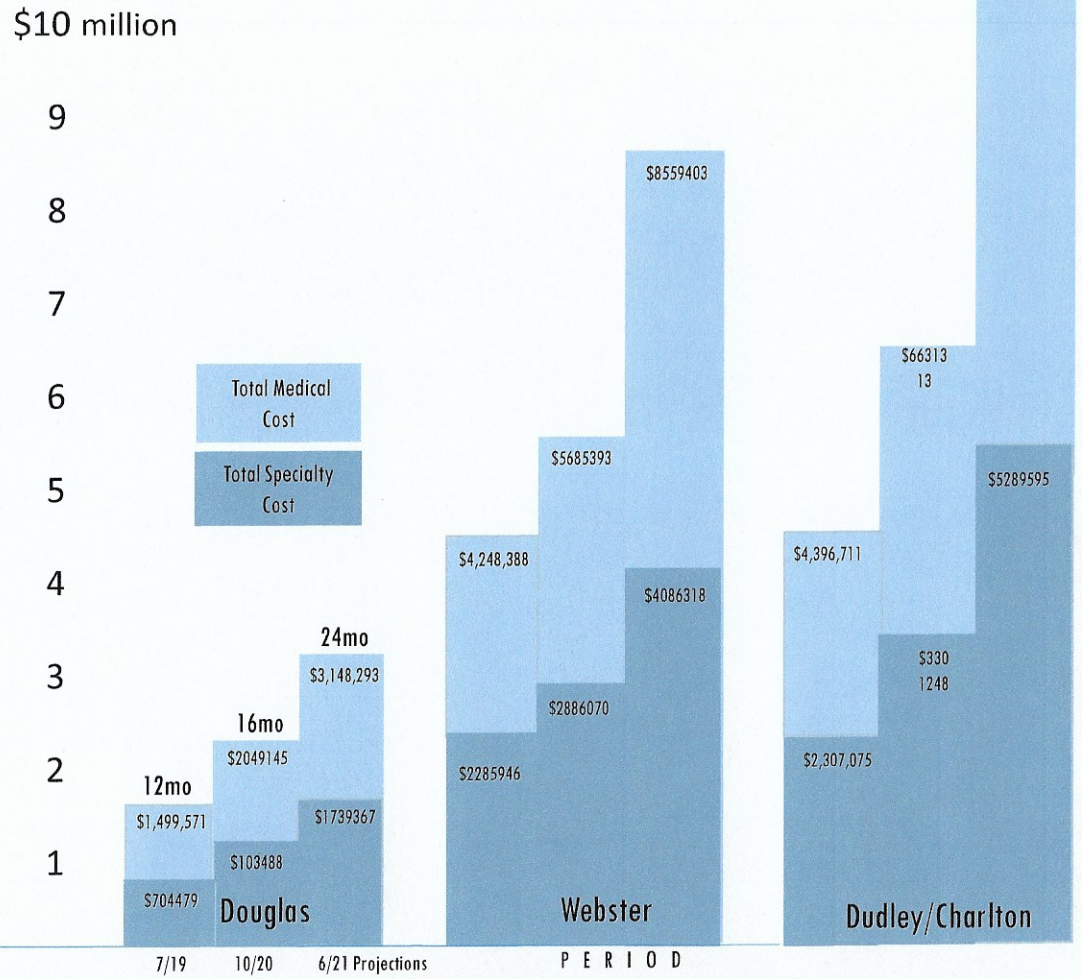
Marked *VARIANCE* of 3-fold increase in Town claims total cost in a *single 30-day* period over prior quarter

Significant variance between the three municipal plans

Total Medical and Total Specialty costs are increasing

Cumulative Claims Paid at 12 and 16 mo. actual and 24 mo. projected by township





Specialty cost contribution to Total medical costs exceeds 50%

Cost of 5 Specialties as a percentage of Total claims paid for the period noted is consistent, averaging 50% across the townships

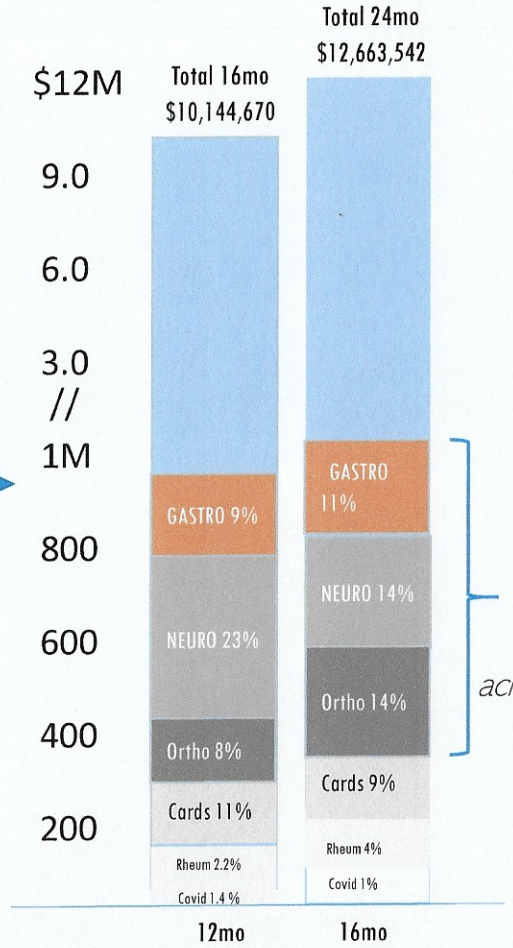
			Projections
Douglas	47%	60%	54%
Webster	54%	51%	48%
Dudley/Charlton	52%	49%	48%
	7/19 12mo	10/20 16mo	6/21 24mo

Five medical specialties accounted for ~ 50% of Total cost

Complex specialty conditions make up a small number of cases but account for upwards of 50% of Total cost

Ongoing Prospective Data Acquisition is key to early trend recognition and preemptive cost saving

Total Specialty >50% of Total Medical Cost



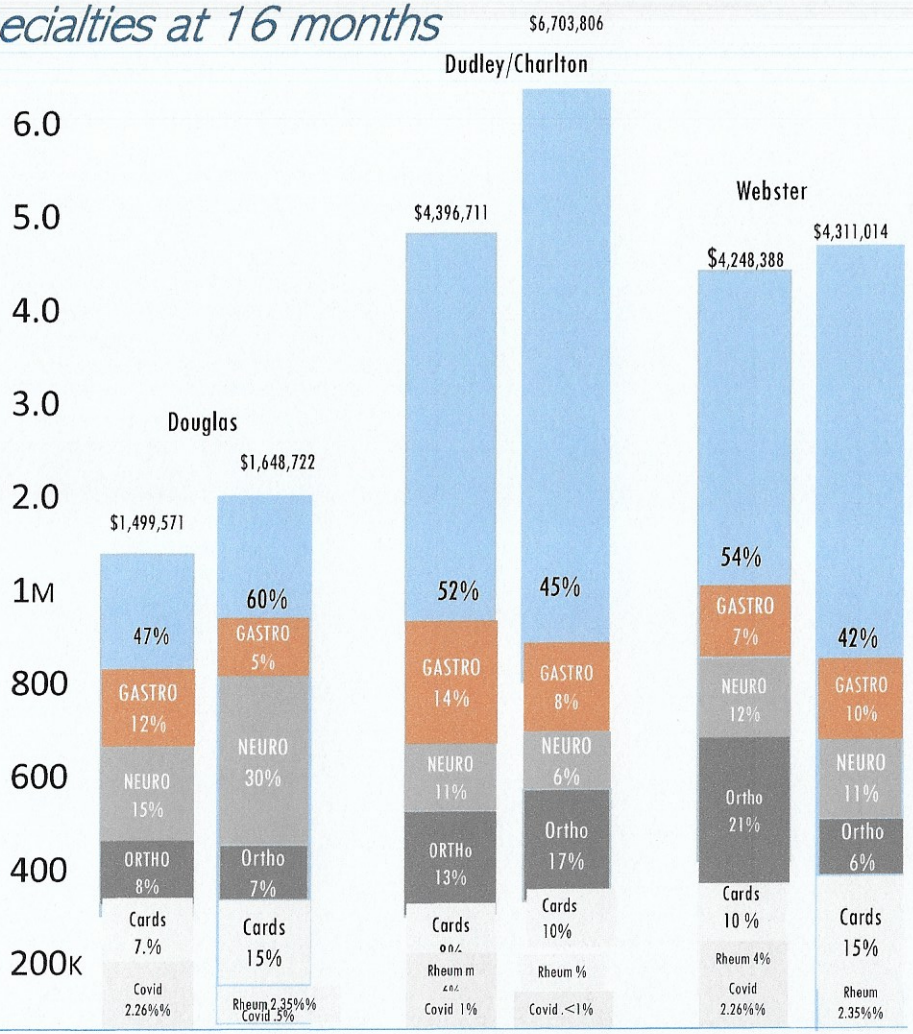
GI/Neuro/Ortho alone account for ~40% of total specialty costs across all three townships

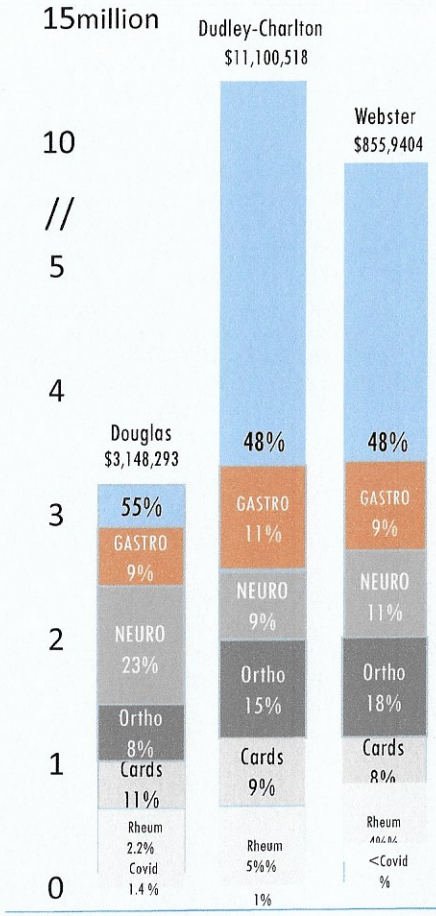
Aggregate Total Specialty cost is increasing but there are differences among the five high-cost specialties at 16 months

Cost By Specialty
Jul 2019- Jun 2020
Lookback

Total cost and proportion due to Specialty is increasing

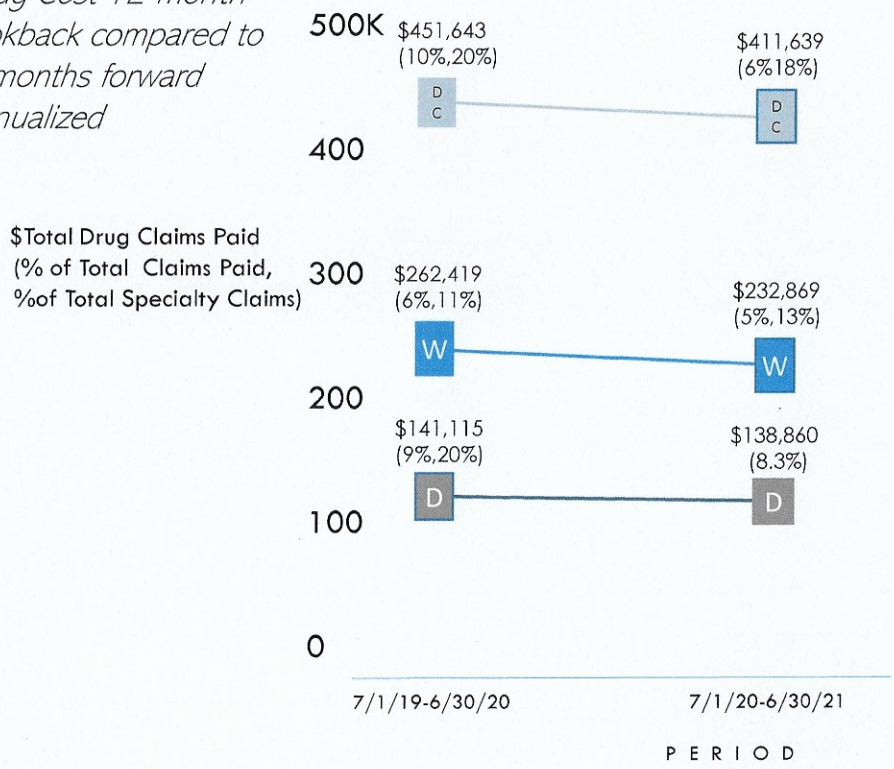
But…GI and Ortho costs down…Covid impact?



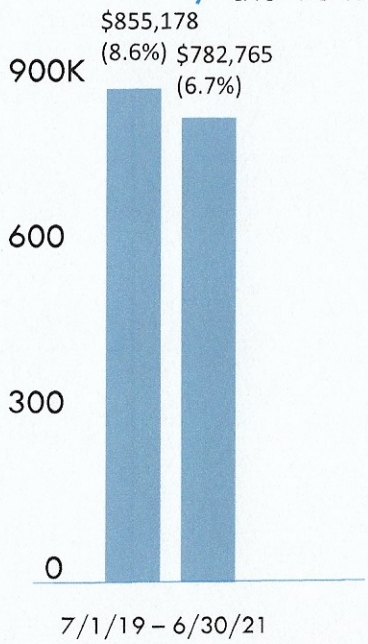


Total Cost of drugs decreased
BUT…what about Covid-19?

Drug Cost 12-month lookback compared to 4 months forward annualized

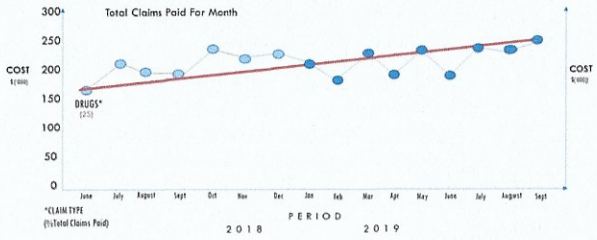


1.9% decrease in aggregate drug cost over the 16-month period



The common drug cost curve shown from Nexus Legacy Study No.1

Drug cost sustained increase over the extended 16-mo. period…
…and contributed >25% of total claims costs

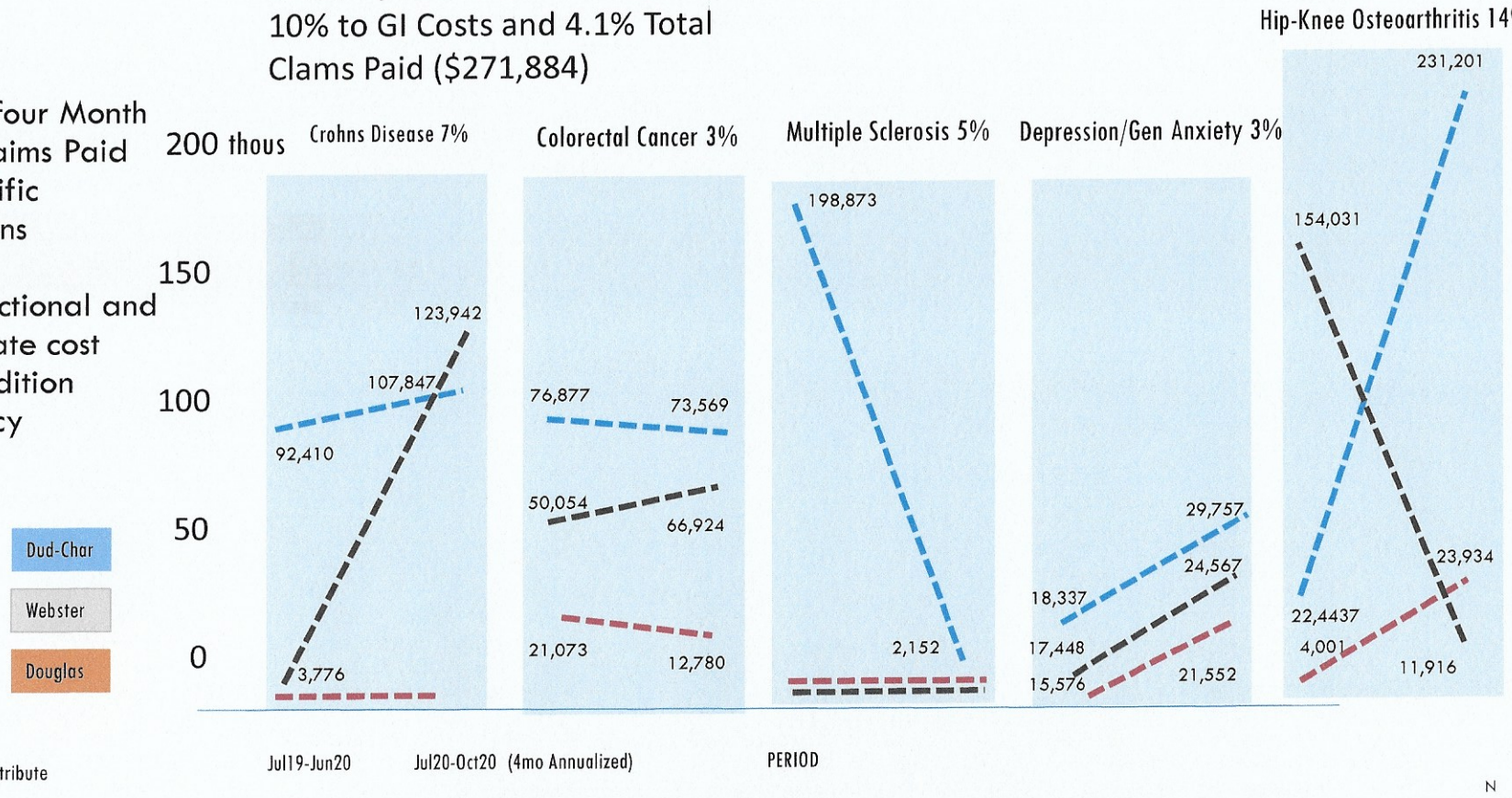


Top 5 specific conditions within each specialty: GI, Neuro, Ortho, Rheum, and Cardiology make up the bulk of cost. Selected Examples

Crohns plus CRC alone contribute 10% to GI Costs and 4.1% Total Clams Paid ($271,884)

Twenty-four Month Total Claims Paid By Specific Conditions

Cross-sectional and aggregate cost and condition frequency



Complex conditions constitute a small population…but account for 50-57% of healthcare costs. Managing them closely captures a proportionally high savings

Condition frequencies: MSHG – D-C

Contribution of Specific disease conditions to total Specialty Cost for each of the 5 highest cost centers

Cardiology Services : Based on Cardio Tab in Data File

		Total Cardiology Payments	Percent of Medical Services Paid
		$ 372,961.52	8.48%
ICD-10 Code(s)	Description	Total Payment Amounts	Total Percent of Cardiology Claims Paid
I13.0 - I13.10	Hypertensie heart & chronic kidney disease with heart failure, stage 1-4	$ 60,221.20	16.15%
I47.2	Ventricular tachycardia	$ 53,313.04	14.29%
I63.9	Cerebral infarction	$ 46,616.14	12.50%
R07.89 - R07.9	Chest Pain, other or unspecified	$ 34,114.08	9.15%
Totals		$ 194,264.46	52.09%

Rheumatology Services : Based on Rheumatology Only Tab in Data File

		Total Rheumatology Payments	Percent of Medical Services Paid
		$ 271,894.12	6.18%
ICD-10 Code(s)	Description	Total Payment Amounts	Total Percent of Rheumatology Claims Paid
M17.0 - M17.9	Bilateral and Unilateral primary osteoarthritis of knee, right or left	$ 184,116.69	67.72%
M16.11 - M16.12	Unilateral primary osteoarthritis of hip, right or left	$ 40,320.46	14.83%
M12.88	Other specific arthropathies, not elsewhere classified, other specified site	$ 16,830.13	6.19%
M19.041 - M19.042	Primary osteoarthritis of hand, right or left	$ 6,960.77	2.56%
Totals		$ 248,228.05	91.30%

COVID Services : Based on COVID Only Tab in Data File

		Total COVID Payments	Percent of Medical Services Paid
		$ 36,044.51	0.82%
ICD-10 Code(s)	Description	Total Payment Amounts	Total Percent of COVID Claims Paid
U07.1	COVID-19	$ 36,044.51	100.00%
			0.00%
Totals		$ 36,044.51	100.00%

Gastroenterology Services : Based on GI Tab in Data File

		Total Gastroenterology Payments	Percent of Medical Services Paid
		$ 591,624.49	13.46%
ICD-10 Code(s)	Description	Total Payment Amounts	Total Percent of Gastroenterology Claims Paid
K50.00 - K50.919	Crohn's disease of large and/or small intestine, with and without complications	$ 92,410.28	15.62%
R10.10 - R10.9	Abdominal, epigastric, pelvic and perineal pain	$ 78,512.21	13.27%
Z12.11	Encounter for screening for malignant neoplasm of colon	$ 76,877.19	12.99%
K40.90 - K44.9	Hernia, inguinal, umbilical, incisional, ventral or diaphragmatic without obstruction or gangrene	$ 63,366.02	10.71%
Totals		$ 247,799.68	41.88%

Neurology Services : Based on Neuro Tab in Data File

		Total Neurology Payments	Percent of Medical Services Paid
		$ 461,898.60	10.51%
ICD-10 Code(s)	Description	Total Payment Amounts	Total Percent of Neurology Claims Paid
G35	Multiple sclerosis	$ 193,872.95	41.97%
F41.1 - F41.9	Anxiety disorder	$ 24,016.78	5.20%
G43.009 -	Migraine with and without aura, not intractable	$ 22,176.50	4.80%
R55	Syncope & collapse	$ 21,270.33	4.60%
Totals		$ 261,336.56	56.58%

Orthopedic Services : Based on Ortho Tab in Data File

		Total Orthopedic Payments	Percent of Medical Services Paid
		$ 572,652.09	13.02%
ICD-10 Code(s)	Description	Total Payment Amounts	Total Percent of Orthopedic Claims Paid
S42.201A	Fracture of humerus, left or right	$ 53,684.82	9.37%
M48.02 - M48.07	Spinal stenosis, lumbosacral, lumbar & cervical regions	$ 50,570.00	8.83%
M94.261	Chondromalacia, right knee	$ 37,514.62	6.55%
M54.12 - M54.16	Radiculopahy, cervical & lumbar regions	$ 30,260.94	5.28%
Totals		$ 172,030.38	30.04%

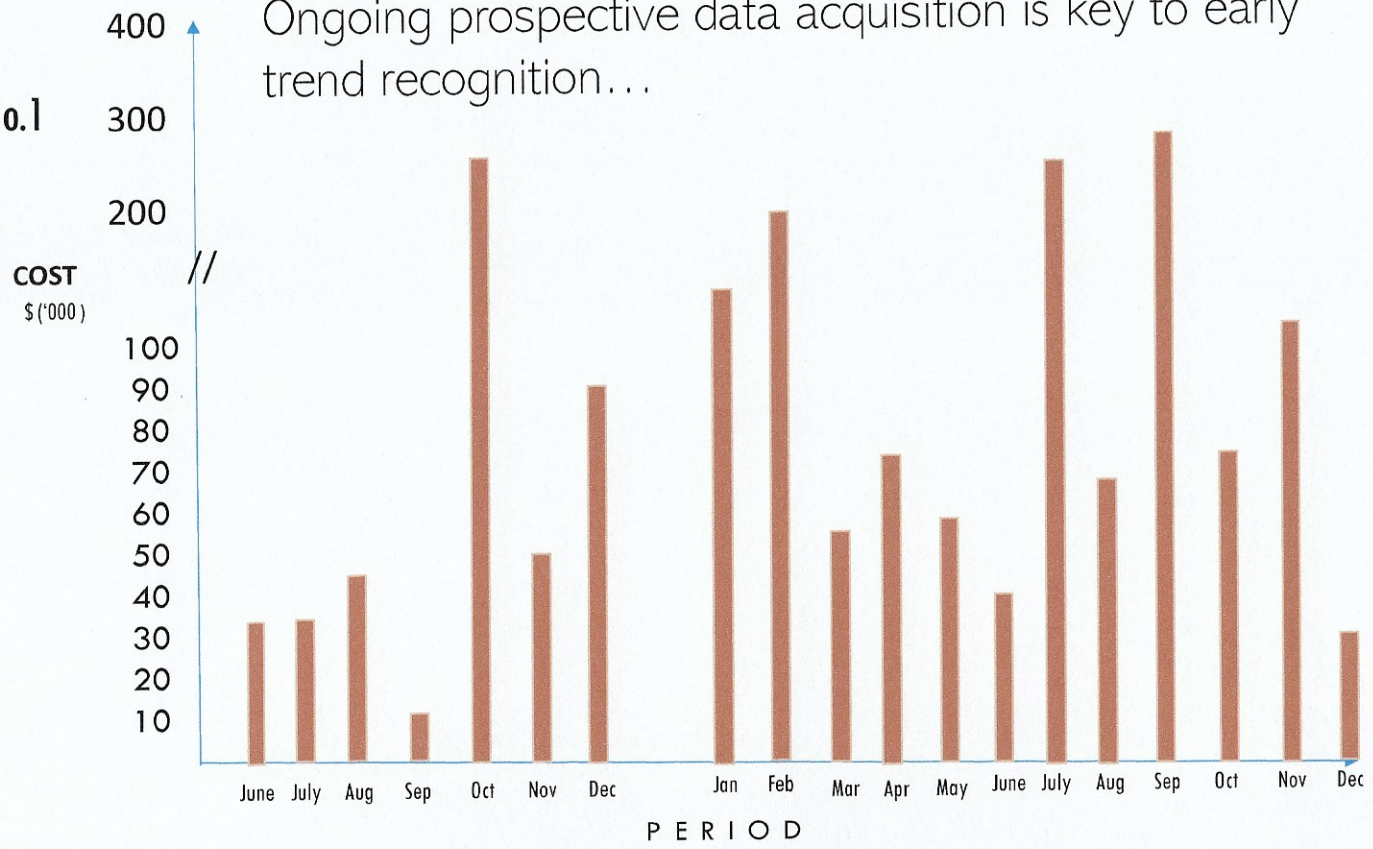
*In terms of spend ,healthcare utilization often occurs in a cyclical pattern - here WRI is shown **

Ongoing prospective data acquisition is key to early trend recognition…

***Municipality No.1**

WRI claims

June 2018-Dec 2019



MSHG : Recommendations & Actions

➢ Launch Phase 2 Scope of Work

Recommendations

Data

- Validate and extend claims analysis to identify and reconcile aberrant claims and identify new preemptive opportunities for savings
- Validate high-cost conditions now identified, assess targeted intervention and prevention strategies
- Leverage and expand data acquisition to additional specialties[1,2] and track *monthly*
- Nexus target ~5% aggregate cost reduction in high-cost specialties identified
- Delegate MSHG designated liaison as point contact to Nexus and establish recurring meeting to optimize reporting and feedback

Proposal

Actions

- Perform Claims "audit" for underlying claims aberrancy
- Network Development: Assess current Payer relationships, evaluate and stratify hospital, lab costs/pricing and preferences
- Review Plan contracts for pitfalls or prohibitions to targeted programs[3]
- Carve out Psych and better define scale and scope of Dep/GAD and influence on Workers Compensation
- Track Covid Effect

Prepare for Phase 3

- Feasibility of targeted programs for high-cost conditions: drugs and labs
- Shift procedures to lower cost environments – colonoscopy, endoscopy, infusions
- Exploratory/feasibility: Opt-in Crohn's wellness, early(45) and earlier(40) screening colonoscopy; screening chest CT, drug-generics, biologics, genomics risk assessment program[4]

[1] Nexus's aim is to foster a collaborative effort with Payers, Systems and Providers to improve health outcomes and reduce specialty costs.
[2] Nexus has begun analyzing Rheumatology, Cardiology services and costs. Initial findings show cardiology also to be within the top five highest medical specialty cost centers
[3] Define Potential for Bundling, Opt-in, Direct Provider Contracting (DPC), a benefit negotiated directly between Municipality and service provider
[4] Define and consider repurposing funds

Phase 3

- Validate data sets
- Trend ongoing costs and early recognize shifts and emerging *new* costs
- Targeted Programs Selection: Intervention and Prevention
- Feasibility and implementation plan
- Projected cost reduction and savings
- Network Development

INTERVENTION - SHORT TERM
Continuous Claims reconciliation
Drug cost containment programs
Procedure, hospital, and payer pricing discount
Forward performance metrics and ROI
Preferred Nexus outpatient networks and facilities
Bundling and-existing contract service
APMs

PREVENTION – LONG TERM
Screening and surveillance (outcomes)
Track disease pattern changes prevalence
Specialty wellness programs

new/renegotiate payer contract
Analyze WRI/productivity
Research

Caution!...Intangibles are strong drivers

- Covid Effect
- Med Pac APM recommendations
- New Federal pricing policy proposals for hospitals and drugs
- Stimulus rescue distribution $$$
- Paradigm shift to outcomes

Next Steps

Phase 2

- Targeted recommendations and programs
- 3-month milestone to phase 3 recommendations
- All analytics phase 1 cycle completed
- Network development
- Fee Range: $2.15-$4.20 per contract beneficiary per month*

Phase 3

- Finalize and activate networks
- Payer MSA and budget
- Implementation Plan
- Ongoing analytics

* Adjusted to scope of work, increased #claims, time/effort