REACH

Realizing Effective and Affordable Change in Health Care

MIDWEST HEALTH INITIATIVE

BACKGROUND

Health care is too expensive. In a post-pandemic environment, it is even clearer that the current growth in health care spending is unsustainable. It hinders the ability of individuals, families, businesses, government, and communities to afford other essential goods, and it creates undue stress for too many Americans. As employers face even greater budgetary constraints, the trade-offs of higher health care spending cannot be ignored, translating into increased prices for other goods and services; fewer dollars for worker wages, innovation, and community development; and greater employee cost-sharing.

Constituting over $4 trillion and 19% of annual Gross Domestic Product, US health care spending is over twice that of other industrialized nations – and the gap is widening.[i] These costs weigh heavily on our nation, constraining budgets, impairing economic growth, and decreasing the competitiveness of American products. What's more, research shows that this burden falls hardest on those with the least, only exacerbating income inequities.

No one entity is responsible for this problem. We have all contributed to the broken health care system, and we all need to be a part of the solution. For years, health care purchasers and consumers have blindly paid the bills without the necessary transparency or tools to determine if prices were fair. We mistakenly thought that paying a bit more would help to cover the cost of care for the less fortunate. But over decades, it has fueled an overgrown and increasingly expensive system.

Harder choices are coming. The time is now to create a more financially viable health care system that responds to the public's needs. Through the *Realizing Effective and Affordable Change in Health Care* (REACH) workgroup, the organizations below have committed to work together to achieve this goal in St. Louis, and we hope that others will join us. It will take the engagement of many to support our region's transformation into a high-value health care community.

PARTICIPATING WORKGROUP ORGANIZATIONS

AbbVie
Aetna Inc.
Ameren Corporation
Anthem (Elevance Health, Inc.)
Arch Resources, Inc.
Bass Pro Shops
Bayer
Bi-State Development/Metro
BJC HealthCare
The Boeing Company
Bunzl Distribution USA, Inc.
Cigna
Edward Jones
Esse Health
Genentech
Graybar
Mercy
Midwest Health Initiative
Missouri Consolidated Health Care Plan
Novo Nordisk Inc.
Panera, LLC
Saint Louis University
Spire Inc.
SSM Health
St. Louis Area Business Health Coalition
STL-KC Carpenters Benefit Plans
United Food & Commercial Workers Union
UnitedHealthcare

"This has been an important collaboration with a lot of discussion on affordability. It is vital for providers to understand the purchaser perspective. By having purchasers, health care providers, and health plans at the table, you have better insight. If you have better insight, you have better solutions. What I am most looking forward to is, together, peeling back the onion to focus on the cost drivers that are occurring in health care and the solutions that emerge."

J.C. McWilliams, Vice President of Managed Care, BJC HealthCare

INTRODUCTION

In the summer of 2022, a group of Missouri-based public and private employers, labor unions, health systems, medical groups, and health plans began meeting to identify shared commitments to *Realizing Effective and Affordable Change in Health Care* (REACH). Convened by the Midwest Health Initiative (MHI) and funded by a grant from the St. Louis Area Business Health Coalition (BHC), a series of workgroup conversations were guided by experts in health economics, actuarial science, and state health care reform.

REACH Workgroup Goals

1. Define a not-to-exceed "target" for future health care spending growth in St. Louis and determine a framework for measuring and sharing progress over time.
2. Discuss actions that will advance primary care, including the identification of priority measures of care quality and value.

REACH Workgroup Guides

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"As trusted partners and community stewards, MHI leaders believe that it is vital to work together in a transparent manner toward our shared goals of better health and higher value health care, particularly in today's uncertain economic climate," stated **Beverly Propst, MHI Board Chair and Senior Vice President of Human Resources for Graybar.** "By providing insight into the workgroup process and a clear recognition of each stakeholder's role, this report outlines a map to guide our future journey."

GOAL #1: SETTING A SPENDING GROWTH TARGET

Missouri is not alone in its efforts to flatten health care spending growth. In fact, at least ten states are already on the path of establishing spending growth targets using a variety of levers. Rooted in St. Louis' rich history of collaboration and the unique needs of our community, REACH participants discussed the benefits and drawbacks of other state examples. Inflation, labor (e.g., nursing) costs in the post-COVID world, expensive new technologies, and the ability to account for the impact of patient risk and health status on the cost, delivery, and outcomes of care were also highlighted as top challenges. At the same time, all participants recognized the opportunity to reduce waste by improving operational efficiencies and redirecting investments to cost-effective, high-quality services.

The workgroup reviewed several **economic indicators** to inform the spending growth target and to provide a context for understanding St. Louis trends over time:

- US Gross Domestic Product
- State (Missouri) Gross Domestic Product
- Health Care Spending as a Percent of US Gross Domestic Product
- US Employment Cost Index
- Per Capita Income (Missouri and National)
- Annual Health Care Cost Growth Rate (Milliman Medical Index)
- Other State Spending Targets

Using this knowledge of other state experiences and relevant economic indicators, the REACH workgroup decided on a methodology for measuring health care spending growth and specifying annual targets. Consensus was reached across stakeholders on a series of recommendations (see Appendix for technical specifications):

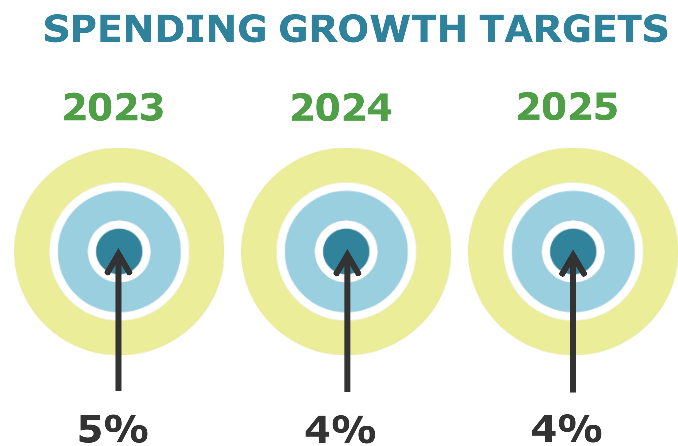
1. **Examine broader economic trends as a basis for establishing targets.** While all are informative, a survey of workgroup members showed state domestic product to be the preferred metric among purchasers, providers, and health plans for providing a context for understanding regional health care spending growth.
2. **Use future inflation projections to inform target development** and assess trends over time to determine if they deviate from established models.
3. **Report spending growth and quality metrics for the St. Louis commercially insured population overall and by participating medical groups**, to demonstrate the importance of all stakeholders in strengthening accountability for results.
4. **Include pharmacy costs in measurement but show results separately** to understand the impact of medical cost growth versus pharmacy cost growth.
5. **Use a commercial risk adjustment tool to recognize differences in health status and spending by medical group.** Truncate individual patient's total cost at $250,000 when comparing results across medical groups. This minimizes the impact of high-cost, complex patient cases and varying use of expensive technologies on smaller populations.
6. **Set a target for each of the next three years, with check-ins at years one and two.** Recognizing the dynamic nature of the economy, this will allow for reevaluation in the wake of unexpected changes.
7. **Be aspirational but realistic.** Targets may need to be higher than what would have been previously accepted due to the challenges caused by COVID-19, but medical groups can strive to outperform these goals.
8. **Support one another's success in achieving goals.** REACH workgroup will convene partners routinely in sharing knowledge, making ongoing decisions, overseeing data reporting, garnering needed resources, and monitoring progress in the absence of regulatory power or legislative mandates.

"I have never been prouder of the health care community in St. Louis and their willingness to work with purchasers and plans to address the challenge of health care delivery cost and to achieve the best outcomes for our health care dollars. We are setting a precedent for how a community of vested partners can come together and begin to make a real difference in the lives of our most important resource – the people who work hard every day at jobs across our region and who can no longer sustain ever-increasing health care costs."

David Toben, BHC Board President and Director of Benefits, Bi-State Development

With the measurement framework set, conversations turned to determining a percentage for the spending growth target. Participants agreed on a Delphi-inspired process involving several rounds of polling and dialogue. An equal number of individuals from each stakeholder group (employer, provider, health plan) received an electronic survey to submit their vote for a spending target, to achieve fair representation.

Understanding the difficult labor and inflationary pressures affecting all and recognizing that no number will be perfect, a series of ranges were proposed. Survey respondents were asked to set target values for the next three years on a sliding scale of 0% to 10%. Discussions also acknowledged protections or adjustments that would make a higher or lower target acceptable, such as risk adjustment and truncation. With these considerations, spending growth targets were set at 5% in 2023, 4% in 2024, and 4% in 2025.



GOAL #2: ADVANCING "ADVANCED" PRIMARY CARE

A strong foundation in primary care is essential to a high-performing health care system. Research has demonstrated that primary care services improve life expectancy, financial savings, and equitable health outcomes in populations.[ii] Unfortunately, the US continues to underinvest in primary care, spending just 5% to 7% of all health care dollars on this resource, compared to 14% in other nations in the Organization for Economic Co-operation and Development.[iii]

Informed by efforts in other states across the country, the REACH workgroup embarked on the development of a shared vision for "advanced" primary care in St. Louis.

Team-Based Care: Patient, caregivers, and care team are trusted partners who share in decision-making. All understand their role in achieving the patient's best health.

24/7 Access: Practice encourages two-way communication through office and video visits, emails, and texting. Patients know how to access care 24/7 to expedite their relief and prevent avoidable urgent care and emergency department visits.

Active Use of Data: Information on patient health, care needs, and experience is systematically and confidentially collected and used to improve health outcomes, including for those patients not actively reaching out to receive care.

Evidence-Based Care: Care is consistent with recommended best practices, generates accurate and timely diagnoses, and avoids unnecessary care, while prioritizing measures that can meaningfully reduce health disparities.

Effective Management of Referrals: Referrals for tests and to specialists are appropriate and based on the best available, objective information about safety, quality, and cost.

Behavioral Health Integration: Practice has processes in place to ensure appropriate screening, and a partnership with a behavioral health clinician or behavioral health team.

Planned Care at Every Visit: Practice has systems in place to ensure patient visits include all appropriate services, time for patient education and engagement, and specific, well-communicated next steps.

REACH participants discussed the conditions that would be necessary to transition to this new model of primary care delivery, as well as the potential barriers to overcome.

1. **Adopt incremental approaches to reallocate spending to primary care while limiting cost growth.** Identify opportunities to pay for value through more flexible arrangements that amplify access to team-based primary care. Understand that increased investment in primary care will require a reallocation of dollars in fee schedules and within provider organizations.

2. **Encourage purchasers to adjust benefit design.** Engage and incentivize employees to establish a primary care relationship and understand the potential consequences of not having an established primary care relationship when the need arises.

3. **Establish provider accountability for delivering high-quality primary care.** Identify the supports that providers need to achieve optimal outcomes for patients and have the data necessary to track progress.

4. **Be patient with financial outcomes.** Strengthening primary care is an investment in the future. It has value but may not save money immediately. However, a focus on primary care is needed now to achieve a long-term return on investment.

Ready to put these ideas into action, the REACH workgroup chose metrics to evaluate care quality, with discussion surrounding clinical appropriateness, data availability, and reporting accuracy. By pairing these quality results with comparative cost information, the community can begin to understand the current state of care provided by the region’s medical groups and track improvements in value over time.

INITIAL QUALITY MEASURE SET*

Proposed to Accompany Total Cost of Care Results in Public Reporting

Care Category	Proposed Measure
Prevention & Screening	1. Breast Cancer Screening 2. Cervical Cancer Screening 3. Kidney Health Evaluation
Chronic Care Management	4. High Blood Pressure Control 5. Diabetes HbA1c Poor Control (>9%)
Adolescent and Child Well Care	6. Child and Adolescent Well-Care Visits 7. Childhood Immunization Status (Combo 10)
Potentially Avoidable/ Low-Value Care	8. Emergency Department Utilization 9. Inpatient/Acute Hospital Utilization
Behavioral Health	10. Depression Remission or Response for Adolescents and Adults 11. Tobacco Use: Screening & Cessation Intervention
Patient Experience	12. CAHPS Clinician and Group Survey

**Please note, additional measures of quality, cost, and utilization may be provided by the Midwest Health Initiative in support of REACH goals.*

THE WORK AHEAD

Through collaboration, Missouri-based public and private employers, labor unions, health systems, medical groups, and health plans have agreed on a target to mitigate health care cost growth over the next three years, while also strengthening primary care in the St. Louis region. But the hard work is just beginning. Now the responsibility is on each of us, as health care stakeholders, to acknowledge the roles we play in achieving these shared goals.

Purchasers

As buyers of health care, self-insured employers, labor unions, and other public and private payers, recognize that they have a responsibility to their employees and communities to spend health care dollars wisely. By leveraging evolving health care transparency data to align benefit design with the clinical and cost effectiveness of services; ensuring provider contracts for plan members share downside financial risk; and expecting more from their partners, purchasers are finding new opportunities to improve the value of their health care investments.

Consumers

As the end user of health care, patients must unleash their consumer skills and recognize their collective power to drive better health care value for themselves, their families, and society. This includes using objective data to make informed choices about treatments and providers. New transparency tools are making it easier for individuals to compare cost, quality, and patient experience data by facility and clinician. Health plan, employer, and other education efforts can help consumers understand their benefits coverage, while also reinforcing the importance of having a regular source of primary care and adhering to evidence-based prevention, early screening, and treatment guidelines.

Health Systems

As providers of health care, health systems and medical groups must prioritize operational efficiency alongside care quality. This includes a willingness to advance transparency through data sharing; to use data insights to understand best practices and improvement opportunities; and to align outcomes with financial risk at the individual provider level. Technology acceptance will be key in meeting patient expectations for convenience and accessibility, while data application can ensure that treatment follows clinical recommendations and steers patients to referrals based on clear evidence of lower complication rates and better outcomes at a reasonable price. A reallocation of spending toward primary care will be required to meet REACH objectives and societal demands for a high-performing health care system.

Health Plans

As the liaison among consumers, purchasers, and providers of health care, health plans play a critical role in helping each stakeholder group meet the above goals. Through health system contracts, plans can align reimbursement and incentives to reward top-quality providers and efficient resource use. Plans can aid purchasers in designing high-value provider networks, while also making commercial claims data more accessible and transparent. Health plan programs to support patients with disease prevention and management, as well as benefits navigation and provider selection tools to aid in higher value health care decisions, will continue to be important in activating consumers on their health journeys.

CONCLUSION

With a map to guide our efforts, the REACH workgroup looks forward to reconvening in 2023 to guide and monitor progress towards lower health care spending growth and advanced primary care in the St. Louis region. Through the Midwest Health Initiative's commercial claims dataset, representing two million lives in Missouri and surrounding regions, ongoing analyses will provide insights on cost and quality measures as a region and across local medical groups. Continued conversations among stakeholders will assess the changing economic environment, while also highlighting the success of purchasers, providers, health plans, and consumers in reaching our shared goals. "The problems in our current health care system did not happen overnight. As such, they will take time to resolve," remarked **Louise Probst, Executive Director of the Midwest Health Initiative and St. Louis Area Business Health Coalition**. "By working together transparently and with intention, St. Louis' diverse health care leaders have committed to a future of better health and higher health care value." To the organizations that have collaborated to shape these goals on behalf of our community, and to those that will join us in the future, thank you for your partnership in *Realizing Effective and Affordable Change in Health Care.*

"Rising health spending threatens the ability of employers, and the workers and dependents they cover, to afford high-quality health care. It is really encouraging to see leading employers and providers come together to try to constructively set reasonable health care spending goals. Kudos to the Midwest Health Initiative and the St. Louis Area Business Health Coalition for providing the analysis and leadership needed to support this initiative and the active engagement of all participants."

Michael Chernew, PhD, Professor of Health Care Policy, Harvard Medical School

"SSM Health believes that ongoing collaborative work with various stakeholders, such as REACH, will contribute to significant improvement in the population health of the St. Louis community. SSM's mission is to deliver exceptional health care to reveal the healing presence of God, and it is committed to a journey of bringing high-value health care to the communities it serves."

S. Kalyan Katakam, MD, MPH, MBA, VP Medical Practice-St. Louis Region, SSM Health

"As a purchaser that bargains wages and benefits for the United Food and Commercial Workers' members, I have watched as health care costs increased at alarming rates for decades. Those increases cost UFCW members and all workers real money in every paycheck. The work of the REACH committee gives me hope. I am thankful to everyone that came to the table — especially providers — for the honest dialogue we all engaged in to do better for our communities by improving health outcomes while reducing health care cost increases."

Dave Cook, President, United Food Workers, Local 655

CITATIONS

[i] Tikkanen, R., & Abrams, M. K. (2020, January 30). *U.S. health care from a global perspective, 2019: Higher spending, worse outcomes?* U.S. Health Care from a Global Perspective, 2019 | Commonwealth Fund. Retrieved from https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019

[ii] *Implementing High-Quality Primary Care*. Nationalacademies.org. (n.d.). Retrieved from https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care

[iii] *State Primary Care Investment Hub*. Primary Care Collaborative. (n.d.). Retrieved from https://www.pcpcc.org/primary-care-investment

APPENDIX

Frequently Asked Questions

Question: Why express spending as Per Member Per Month (PMPM)?
Answer: The Midwest Health Initiative (MHI) evaluated several different methodologies for expressing spending. It found that about half of all spending in the St. Louis commercial population was for facility services (inpatient and outpatient facility care) and about half of all medical spending occurs among patients able to be attributed to a primary care physician. Tracking spending at the Per Member Per Month (PMPM) level captures total costs (physician, inpatient, outpatient, pharmacy, diagnostic, and other service cost) for a population while allowing for the assignment of discreet populations to individual medical groups. Purchasers have a strong interest in advancing primary care through population health. Measuring spending at this level also makes the results more actionable, as a primary care practice is accountable for each patient's utilization.

Question: What is Total Cost of Care (TCOC)?
Answer: Total Cost of Care (TCOC) is a measure of the total cost of treating a population in a given time period. It accounts for 100% of the care provided to patients, including inpatient, outpatient, professional, pharmacy, and ancillary services. TCOC is expressed as dollars paid per member per month (PMPM) and risk-adjusted dollars per member per month (RA PMPM). Because the patient risk profile varies between practices, risk adjusting the PMPM allows for meaningful comparisons of total costs across medical groups.

TCOC is calculated via the following equation:

$$\left[\frac{Total\ Annual\ Medical\ Spend}{Total\ Medical\ Member\ Months} + \frac{Total\ Annual\ Pharmacy\ Spend}{Total\ Pharmacy\ Member\ Months}\right] = Total\ Spending\ PMPM$$

Total Annual Medical Spend includes all spending in the facility inpatient (FIP), facility outpatient (FOP), professional, and ancillary settings for the given year. FIP and FOP spending includes medications prescribed in these settings covered under the medical benefit. Total Annual Pharmacy Spend includes all spending in the prescription drug setting for all medications covered under the pharmacy benefit and not administered in a clinical setting for the given year.

Question: How are patients attributed to a medical group?
Answer: Patients with a visit to a primary care clinician for services utilizing evaluation and management procedure codes are attributed on a rolling 24-month basis. Patients are attributed to the primary care provider with the most service units during the 24-month look-back period. In the event there is a tie, the primary care provider with the most recent services is assigned. Patients that do not meet the above criteria are not attributed to a primary care provider, and instead are assigned to a separate group. MHI encourages medical groups to regularly share updated rosters of physician and physician extenders to best support attribution accuracy.

Question: How are Community-Weighted Risk Scores calculated for each medical group?
Answer: Each patient is assigned a risk score based on their age, diagnoses, and health care utilization. The risk scores for each patient pool attributed to a medical group are averaged for the given year. A population-weighted community risk score is calculated for *all* patients attributable to a primary care provider. This community risk score is set as the base index. Each medical group's risk score is divided by the base index in order to weight their average risk score relative to the rest of the primary care community.

Question: How are Risk-Adjusted PMPMs calculated?
Answer: Each medical group's PMPM is divided by the weighted risk score of the attributed patients in their population for the same year.

Question: How are Truncated PMPMs calculated?
Answer: Any patient with spending greater than $250,000 has all dollars $250,000.01 or above proportionally removed from the *Total Annual Medical Spend* and *Total Annual Pharmacy Spend* numerators in the above PMPM equation. These dollars remain in the assessment of community spending but are removed from the medical group. The truncated dollars represent about 4% of overall spending.