Welcome to the 4sight Health Roundup podcast, 4sight Health's podcast series for healthcare revolutionaries, outcomes matter customers count and value rules. Hello again everyone. [00:06:00] This is Dave Burda, news editor at 4sight Health. It is Thursday, August 24th. It's pretty quiet in my neighborhood and my house with most kids back at school. Now I can back out of my driveway without looking left or right at least 10 times, and I can order whatever I want on my pizza without considering others. Life is good. What's not quiet is all the noise experts are making about CMS's New Making Care primary value-based care model. That Primary Care demo kicks off next year on July 1st in eight states and runs for 10 and a half years. No less than three critiques of the new demo ran this week. In the Journal Health Affairs one says, the model needs to leverage these skill sets and competencies of registered nurses to make it work.

Another warns of four laudable yet risky objectives that could tank the model. And the third says the model doesn't do enough to reward equitable outcomes. They're all worth reading. But if you don't have the time, you can just listen to a re-broadcast of our June 15th podcast, diagnosing the new CMS's primary care model on foresight health.com. In journalism, you want to be first, you want to be right or ideally your first and right. In this case, we were both. Please enjoy a rebroadcast of our June 15th episode diagnosing the new CMS's primary care model.

The value of primary care value and primary care are two of our favorite topics here on the roundup, and that's what we're gonna talk about today. CMS's New Making Care Primary value-based care model to tell us whether the Making Care Primary or MCP model has legs are Dave Johnson, founder and CEO of 4sight Health, and Julie Murchinson and partner at Transformation Capital.

All right. Let's talk about this new primary care model unveiled by CMS. Like I said earlier, it's called Making Care Primary or MCP. It's a 10 and a half year demo that kicks off next year on July 1st in eight states. It has three domains that primary care practices work through on three tracks with each track offering an escalated payment mechanism. The three domains or goals are care management with a focus on chronic disease like diabetes and high blood pressure care integration with a focus on behavioral health screening and care coordination and community connection with a focus on connecting patients with community support and service organizations. The three payment tracks are track one, fee for service with additional financial support to build the infrastructure for value-based care, track two, half fee for service, half prospective population based or capitated payments to implement advanced primary care and track three 100% capitated payments to optimize care or care management and integration in partnerships or community connections. And of course, there'll be a lot of required reporting of performance metrics in each domain and along each track. Dave, what's your gut reaction to the new demo from a policy perspective? Is this a step in the right direction toward health and away from healthcare, and do you think it'll work?

Uh, my gut reaction is that the Biden administration's motto and healthcare reform is make no big plans. They cause too much political turmoil. This is a big yawn as far as I'm concerned. Um, the MCP initiative is right up there with the administration's small ball moves on, on health equity. Uh, they're well-meaning, I suppose, but they won't move the needle in IOTA in terms of improving care outcomes. Eight states 10 years, excluding ACOs that actually will, could compromise care coordination. I mean, the goals are good, care management, care integration, community connection. But don't we already know how to do that? Uh, you know, I really don't wanna waste any more of my precious time discussing the program specifics. I'm, I'm that unimpressed. So Dave, here's what we already know for sure. From enhanced primary care companies like IRA and ChenMed, they reduce medical loss ratios by 40% and improve health status for all manner of individuals in their programs.

Their members love the services. The challenge has been that we don't pay enough to these enhanced PCPs to enable them to provide the level of care necessary to achieve the savings levels and,

improvements in health status. Um, here's my counter proposal for the Biden administration. Just run it in one state. I will call it UP4C that stands for Universal Primary Prenatal, postnatal, and palliative care. Get rid of the diagnostic and treatment codes, pay a fair salary to everyone who participates in delivering that, that type of care. Um, make the services absolutely free for all comers in clinic settings. Require participants to complete advanced care directives, monitor outcomes rigorously, and guess what? The results will be astonishing. We'll save money, we'll have healthier kids, we'll have better nutrition for the community. We'll have better end of life decision makings. We'll have lower maternal mortality and, and morbidity. Um, overall communities will be healthier. We don't need a 10 year program to figure this out. We already know it. Um, so here's my new slogan for the Biden administration. If Cuba can do it, why not the us? up P4C baby? Let's go do it. <laugh>

Dave's demo in one state. I love it. Uh, yeah, that as complicated as it has to be. Thanks Dave. Uh, Julie, any questions for Dave?

Well let me see how I can ask this in a way that's productive. Okay, so it's June, 2033. We're all a decade older, and we're almost through this demo. So do you think we're still talking about moving to value-based care, or do you think this demo has actually pushed us over the edge and obviously private health plans and others as well, that we're, we're there.

In other words, is could this be the tipping point.

Well, I don't think MCP is, is the tipping point in any, any way whatsoever, Julie, but I do believe in market driven reform and these new models that are emerging to completely reconfigured demand management outside in rather than inside out. Um, it's not hard for me to envision a CVS in 2033 that has 30 to 40 million members surrounded by really great enhanced primary care with easily available clinics, great technology hospital at home when you need it. Uh, really astute guidance from tech and human beings when you need it. Um, so what's, what's the world look like then? Um, because of advances in, in diagnostics preventive care is now 25% of total healthcare expenditure. You know, up from 3% today. There's universal coverage. It's done in a pluralistic way. Everybody's a member somewhere. Um, much better buying earlier diagnosis and proactive intervention, as I was talking about with with, with better prevention. Healthcare spending is only 15% of G D P, not, not 20, like the government just said, was gonna happen. Fee for service and ASO contracts are a thing in the past. AI bots make EAs life easier and better and much more personalized for us all up. Four C is celebrated throughout the land, and MCP is this wildly popular app that stands for my car payment. So that's what I think gonna happen.

Speaker 1 (22:04):

That's, that is excellent. Thanks Steve <laugh>. All right, Julie, it's your turn. What's your gut reaction to the new demo from a market innovation perspective? How do you think this will affect new primary care and direct primary care models that are popping up all across the country? And do you think it'll work?

Speaker 4 (22:29):

Well, I'm certainly not gonna be as entertaining as Dave, but I tried to really look at this in, you know, why, why are they doing this? And I'm kind of a two minds. On one hand, I view this as a total hedge against the new primary care models that are skimming, commercialized off the top and will be part of the U 4:00 PM M c or whatever Dave's acronym is. And, you know, this is a bit of a desperate move in many ways to save the rest of everybody else, keep the independence independent, like so many of the regional blues are trying to do. This is c m s making sure that Medicare and Medicaid recipients have some sort of primary care infrastructure to support them. And you can even tell by the people who are

excluded or the organizations that are excluded from this program that they feel like some of those organizations are already taken care of, and it's the rest of everybody else who they need to make sure comes into, you know, the next century.

(23:30):

So there's the hedge feeling. On the other hand, I wanna view it quite positively as the much needed push to value-based care, leveraging all the learnings that they've talked about and the private models that are, you know, dabbling pretty deeply across so many populations. John Med Landmark, Oak Street, apri you know, there's been a lot to learn on how to manage care. And C M s I would love to think is infusing these learnings into, you know, kind of the mom and pop F Q H C tribal healthcare practices. And I don't know that I stand clean on one side or the other, but I wanna be a Pollyanna here, and here's why.

(24:16):

Th this could be things, efforts like this can be great to actually scale innovation for innovators that are delivering these sorts of capabilities in larger organizations today in health systems today. So all these tracks and domains are gonna need much better analytical tools to stratify populations, predictive analytics that will leverage AI to more proactively identify potential issues. Uh, certainly more robust patient communication tools and, you know citizen communication tools to pull people in. Um, and when you kind of needle down into each of the domains and the care management domain, you know, there are gap closure tools today that help not just the, the PCPs close gaps in care, but actually help enable their front office teams funnel some of that bonus payment to the front office teams to help close gaps in care that are not necessarily only clinical or can be supported in more of a team-based care model.

(25:26):

They're gonna need far more versatile diagnostic approaches, the Meza Davis model and, you know, broader sites of care. Um, so there's a lot of business model change going on that domain and the care integration domain, behavioral health screening and delivery capabilities. And a lot of, Dave, to your point, AI supported in telehealth tools that actually leverage specialty knowledge, whether that's specialty knowledge sitting in, in data somewhere, or that's a specialist that they can telehealth to and in this community connect connection domain. You know, there are companies out there today that are streamlining social services and not just the connection too, but the interaction with social services. And if you could do that on a scaled level, it'd be incredible. So, you know, as, as these practices, first of all, I actually sort of do love the name. I will say I, I give it some branding, props, making care primary you know, as these practices move into tracks two and three they're gonna need some, a real reshaping of how they manage practices. So there's, there's a lot to be had here in terms of how innovation could really scale throughout, you know, not just the last mile, but like the last block of healthcare out there. So I, I wanna be poll. I really do.

Speaker 1 (26:47):

Got it. So kind of get small practices, going with the program and creates a market for innovators finding the silver linings. Thanks, Julie. Uh, Dave, any questions for Julie?

Speaker 3 (27:03):

Well Pollyanna, I'm, I'm about to commit Sacri so I hope he'll forgive me. <laugh>.

So I know that independent primary care physicians are under severe economic pressure. Um, here's the sacrilege. Should we care with better tools, AI and other caregivers like nurse practitioners and physician

assistants practicing at the top of their license? Do we really need PCPs to deliver consistent, high quality primary care services to everyone in the country? Don't we really need this much broader based platform to get the job done?

Speaker 4 ([28:09]()):

Well, I, I think we have to really discipline ourselves to look at the populations that c M S is talking about. And, you know, this last block I just referred to, I, I, I really view that as what's all about. So I guess maybe I fall more on the head side of my, my argument mm-hmm. <affirmative> than not. Um, but, you know, care's gonna be delivered. How care's gonna be delivered, right? And someone's gonna have to pull the last block into we're, we're not gonna be able to privatize at all, or it's all gonna be single payer. So, you know, maybe, maybe that's where some of this is headed.

Speaker 3 ([28:49]()):

Yeah. You know, it's, it's interesting, Julie, cuz I, I, when I think privatize I think more about the payment than I do about the delivery side. I, I think the delivery mechanisms can be private.

I mean, Oak Street is obviously a very profitable, well, they aren't profitable, but a, a very <laugh>, a very

Speaker 4 ([29:11]()):

Watch what you say there.

Speaker 3 ([29:13]()):

Yeah. A very valuable company that focuses on, on dual eligible. So old poor people, Medicare and Medicaid. Uh, but the funding is, is public. So I, I I draw a distinction between the funding side and the delivery side. And I really don't think there's any reason that innovative companies couldn't go into low income urban and, and rural communities and deliver the kind of primary care that, that you're talking about. Um, oh,

Speaker 4 ([29:45]()):

I agree

Speaker 3 ([29:46]()):

With, with government payment. Sorry.

Speaker 4 ([29:49]()):

Yeah. I don't, I don't disagree with you, but, you know, Mark Smith, who was the CEO of California Healthcare Foundation for years founding c e o, one of his thoughts on the community health center environment in California was that it needed some consolidation. It needed efficiencies to run well and not cost the state of California a gajillion dollars. To this day, there has been very little, if any, consolidation, the fierce independence and codependent relationship that the federal government and state governments have with FQHCs Tribal health clinics and center. I mean, just think about the politics of what you're talking about. Like, we're this, I, I love your utopia, but it <laugh>. I don't see how it happened.

Speaker 1 ([30:51]()):

Thanks, Julie. Yeah. Yeah. A lot of, lot of land mines there. Well, I do think the program's goals are laudable, but 10 and a half years is a long time to wait. You know, I'll be 75 by the time it's over, and I'm sure I'll need a lot of help before then.

I'm back and it's still August 24th. We hope you enjoy the rebroadcast of our June 15 podcast, diagnosing the new CMS primary care model. Now go read those three critiques of the model in Health Affairs and tell me if we were right or wrong. If you'd like to learn more about the topics we discussed on today's show, please visit our website at 4sighthealth.com. And don't forget to tell a friend about the 4sight Health Roundup podcast. Subscribe now and don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I'm Dave Burda for 4sight Health.