David Burda:

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. This is Dave Burda, news editor at 4sight Health. It is Thursday, December 11th. Exactly two weeks from this morning. Every member of my family will be asking me if I kept the receipt for the gift they just opened. And that tells you everything you need to know about my gift giving ability. The question is how much of a gift is Medicare's new access value-based payment model? And that's what we're gonna talk about on today's show with Dave Johnson, founder and CEO 4sight Health, and Julie Merchants and partner at Transformation Capital. Hi Dave. Hi, Julie. How you doing this morning, Dave?

David W. Johnson:

It's my sister Sue's birthday today. Let's give her a shout out. Happy birthday, Sue. The world doesn't have enough Scorpios. We love you and wish you a great day.

And maybe guys, this will get her to actually listen to our podcast, <laugh>.

Burda:

Well, happy birthday, Sue.

Julie Murchinson:

<Laugh>. Happy birthday.

Burda:

That's, that's great, Julie, how are you?

Murchinson:

I'm well. I’m in lovely crisp Boston, where I might just wanna stay in my hotel room all day. It's chilly.

Burda:

Oh, brrrr, yeah. Same out, same here outside of Chicago. Thanks. now before we talk about this new payment model from CMS, let's talk about your gift receiving behavior. Dave, are you a returner or a keeper, regardless of whether you like the gift or not?

Johnson:

Usually I keep all gifts because they have some semblance of, of good intention behind them. The exception was my father. He wasn't always the best listener. <Laugh>. I have three siblings, Doug, Sue, who you just heard about, and Liz. And each Christmas as he got older, my dad would go to Costco and get us all the same gift. And <laugh> After Terry and I went vegan on successive years, he sent the four of us a rotisserie grill, a huge box of steaks, and then the biggest box of mushrooms you've ever seen. <Laugh> we kept the grill but eventually gave it away. The steaks was a no-brainer. We took that back. The mushrooms were kind of interesting. We would've kept them except we were heading to Key West for the holidays. So we took those back. My sister Liz and my brother Doug, got into a competition to see who could cook the most dishes with the, it must have been like 10 pounds of mushrooms. Anyway. Oh my God. Yeah. Who knew? Costco sold mushrooms, right? I, or in that quantity, I don't know where he found that, but I can't remember, remember whether Liz or Doug won that competition. I know it was close.

Burda:

<Laugh>. What a great memory, though. See, your dad was into standardization. See, healthcare could take a lesson from him. Julie, how about you? If it doesn't fit, do you return it or you do you keep it?

Murchinson:

I don't have a story near as good <laugh>. That's hilarious. <Laugh>. I tend to be a keeper of gifts also. I will, on occasion, maybe swap out for a different color of something, but no, I'm pretty much a smile, thank you kind of person.

Burda:

Yeah. I think that's why we all get along, because I'm exactly the same way. I'd say I'm the poster child for passive aggressive behavior, right? <Laugh>, every gift is the perfect gift, and I never return anything, and I'd rather quietly complain about it to myself for years. Right? <laugh> or your case, Dave, tell the story for years.

Johnson:

That's great, <laugh>. That's, that's right.

Burda:

All right. Let's talk about whether the industry is gonna return this gift from CMS or quietly complain about it for years. It's called the access model. ACCESS stands for Advancing Chronic Care with Effective Scalable Solutions. The 10 year program is voluntary. It's scheduled to start on July 1st next year. The model will pay participating Medicare part B providers. That's doctors and medical practices, what CMS calls recurring outcome aligned payments or OAPs, for providing tech enabled care to beneficiaries with traditional Medicare coverage to manage four chronic medical conditions. The four conditions are early cardio kidney metabolic conditions like high blood pressure or cholesterol, cardio, kidney metabolic conditions like diabetes or heart disease, muscular skeletal conditions like chronic muscle or joint pain and behavioral health conditions like depression or anxiety. Full payment will be tied to achieving measurable outcomes. The NCMS will encourage participating providers to use technology like telehealth and wearable devices to achieve those measurable outcomes. One goal of the new model is to quote, expand clinician's ability to offer innovative technology enabled care through a straightforward payment pathway,

close quote. There's a lot more, but we only have 20 minutes. Dave, you like technology, you like paying for outcomes. Do you like this new payment model? Why or why not?

Johnson:

You know, I love it. For as much as I abhor almost everything the Trump administration's doing, Dr. Oz and his team at CMS keep hitting the ball out of the park. Access is just the latest example of a great health policy. As you both know, I've been critical of CMMI for throwing way too much pilot spaghetti against the wall to see what would stick. Way too many models, never big enough, never long enough to fully engage real participation and meaningful change. No wonder almost all the pilots up to this point of have failed. ACCESS is not pilot spaghetti. And let me tell you why. All kinds of reasons. One, it's long. It, it's 10 years more than enough time to prove the concept. If it ultimately saves dollars, which I believe it will, but the program can become permanent. Two, it's, it's voluntary with a payment code. This will engage meaningful participation. Usually I like, as in the Maryland Waiver Program mandatory participation; the payment code will make all the difference. People will flock to this program. Three, it's simple and easy to understand. Something both Zeke Emanuel and Mike Chernow, the MedPAC chair, have been harping about continuously. This is not hard to understand. It's inclusive. It has the support of almost 20 clinical associations, patient societies and payers. They've also collaborated with Andy Slats, VC firm, town Hall Ventures on creation of the model. Did someone say bipartisan? It's outcomes based, David. You're right. Outcomes are everything. I love outcomes based as opposed to process based payment models. No confusion between correlation and causation. If you deliver the goods, you get the payment. There's a reason, as you know, Dave, the first line in the 4sight Health mantra is outcomes matter, right? Right. Outcomes do matter. It's open source. One might even say market driven. It's taking applications for participation beginning on January 12th. The program will launch in July. They're gonna get a lot of good ideas. I'm very curious to see what the ultimate pilot contains in, in terms of incentives, contours as they, as they move it

into the marketplace. It's an ecosystem. The FDA is simultaneously launching the TEMPO Initiative for Health Tech devices. Have we ever seen this type of interagency collaboration within HH before? Pretty impressive. Together, these programs will support decentralized and hybrid care delivery models. You both, I think, will remember 3D WPH from the Coming Healthcare Revolution that stands for Decentralized and Democratized Delivery, 3D, of Whole Person Health. That's the disruptive innovation Paul and I believe will fundamentally disrupt and transform the US healthcare system. This supports 3D WPH. It will be iterative in nature, I believe and adjusted and probably expanded over time. Right now it's just seniors. But when you look at the chronic disease, afflicting the country, we have to go after younger populations as well. I see nothing really not to like as ACCESS and Tempo are rolling out. The devil will ultimately be in the details, and execution is paramount. But let's give them the benefit of the doubt of the design is great. And since I mentioned the Coming Healthcare Revolution, when don't I, right? But Paul and I came up with our Star Wars like acronym CB2E2 to evaluate healthcare companies and policies. So let's try it out here first. C cheaper. Honestly, if we can diagnose and manage chronic disease earlier and better, we're gonna save a bunch of money. The rest of the world has already proved this to us. Is it better? Attacking chronic conditions much earlier and aggressively, works. As I said earlier, we know this from both our own experience and what other countries do. Balance. Is it balanced between health and healthcare? Yeah. It's, it's all about prevention and chronic disease management. It's where we need to be putting more resources, not fewer. This does that. Is it easy? I've already mentioned that. And again, the devil will be in the details and execution is paramount, but the initial design is elegant. You might remember the Einstein quote. “Things need to be simple as simple as possible, but not simpler. This, this seems to me to strike that, that balance. Again, we'll see exactly how they they roll it out. But I think it's simple enough and empowering. The second E for both caregivers and consumers here, again, just hits the ball out of the park. It gives both caregivers and consumers tools to manage their own health. So on the

CB two, E two, they're five for five. So give ACCESS and Tempo five stars. Let's see how it goes.

Burda:

I think I figured out why you like it so much, Dave. It's a great acronym. <Laugh>, it's a good acronym, right? There's no way you weren't gonna like it. Plus the FDA has tempo, which I forget what that stands for. So you got two great acronyms there. <Laugh>, <laugh>.

Johnson:

And who doesn't like tempo and access, right?

Burda:

Right. Two positive. Brilliant. Julie, any questions for Dave?

Murchinson:

Well, Dave, I share your excitement, but I have heard all sorts of criticisms this week. Now, criticisms included things like, well, the seniors. Why is this gonna work for our seniors or attribution? How are we gonna attribute where, who's responsible for what here? Or they're gonna cherry pick a lot, lot, lot of naysayers. So the one key thing I keep thinking about is this concept of attribution. Do you worry about this, or do you think the physician relationship nullifies that concern? Where do you stand on that?

Johnson:

In life where there's a will, there's a way in healthcare where there's a code, there's a way. That means the program needs to run ultimately through providers. Which I think will mitigate some of that concern. What gives me even more comfort and alleviates much of, I think the rational concerns regarding cherry-pick and gaming is the outcomes based payment. We gotta see exactly how they administer that. But if you lower your blood pressure and you know, kind of address some of these other chronic conditions, the doctor gets a payment. Shouldn't we

be paying more for actually improving health? Plus bigger picture, half of Americans are either diabetic or pre-diabetic. I mean, this is a national crisis. These programs ACCESS and Tempo go right at the heart of the chronic disease pandemic attacking our national vitality. It's hard to cherry pick when at least half the people in the country need the need the service.

Burda:

I think everybody's got at least one of those poor conditions. Thanks, Dave. Julie, you're the one who brought up the new model on last week's show. Be careful what you wish for. Is this good news or bad news for healthcare tech companies? And why, and who do you see benefiting most from the new model?

Murchinson:

I mean, this is great news for those companies that qualify. Although going first in a major program like this, maybe more than they wish for, that's for sure. <Laugh>, I've already had one National Health plan, express concern, excitement of course, but concern that one of their vendors who would absolutely be eligible might get distracted by this and take their eye off that health plan ball. So, you know, the the market's watching for sure. And there's a trust issue happening all over the place with these companies. So listen, I'd be super excited if I were at Amada or Virta or Vita or Monogram or any host of cardiometabolic companies in the CCK d space. If they could improve or control blood pressure, A1C, lipids, weight, across a whole host of dimensions, you know, devices, coaching, medication, titration diagnostics, like companies like this, not so sure they're all there right now. Most of them are or should be and just need to figure out to demonstrate it. They should be super psyched. You'll see MSK companies like Sword, Ambies are Rory, especially companies like this, because their models are deeply clinical more so than some others. And these companies use validated, patient reported outcomes measures like function and pain intensity, and they have longitudinal support. So they should absolutely

be able to do what ACCESS lays out and be super excited about it. And then let's talk about the last category of behavioral health. It could be huge. I mean, you're gonna see countless companies in this category that are focused on depression, anxiety, mostly low acuity and those that are measuring with PHQ9s and GAD7s and some of the standards that are already out there with some clinician oversight companies like Growth Therapy. Again, I'm Bias Life stance. Thrive Works, RA, Talkspace, Talk-chiatry. I mean, the list will be long in the behavioral health space. So I think there's a lot of companies out there that if they can't quite do exactly what ACCESS is asking for today, they are figuring it out right now because they're just a turn away from it. And, you know, these companies that are in some way, physician led or with some physician oversight can enroll in, you know, Medicare as a digital or hybrid provider, and can consistently deliver and document these outcomes at scale. And they have to be, you know, outcomes that align with CMS guidelines, of course. But they will be lining up and ready to go, especially those…. This is where I think, you know, part of the issue will come in. They need to have some interoperability capabilities. I'm not so sure I'll do today, but they'll be focused on that. Integration with PPEs will be, you know, incredibly helpful if they have rural reach, that's huge. And the ability to just simplify, you know, patient access, patient costs, that's gonna be huge. I also think if you look at some of the indirect beneficiaries who won't receive money directly, but should start to see more tools fly off the shelves, think about vendors that create the blood pressure cuffs or the CGMs, the devices that are used by a lot of these companies, you know, they will benefit for sure. And there's probably a lot of those out there, especially as more of these companies get into monitoring. So that's huge. Now, alternatively, I think you are SOL Dave, is that an appropriate term for a podcast? Yeah,

Burda:

<Laugh>. Yep. Oh yeah. That's nothing.

Murchinson:

You are SOL If your app only digital therapeutic vendor that doesn't have some sort of physician, you know, clinical director oversight or your appoint solution that can't measure and report, you know, outcomes align with these guidelines. This is gonna separate the wheat from the chaff in terms of a lot of the digital technology companies in healthcare. And I personally am thrilled to see it. Like Dave, I do listen to all my naysayers because there are people who are deep, deep, deep in, you know, health informatics and understanding, you know, how these things roll in a traditional world. And what's interesting about this is, I don't know that these guys at CMS think about it in a traditional way. So it really might be a new chapter.

Burda:

It's all about the data and the outcomes.

Thanks Julie. Dave, any questions for Julie?

Johnson:

A frequent economic critique of these types of preventive payment models is that an aggregate, they lead to more disease discovery in higher cost? Do you think there's any validity to this critique?

Murchinson:

There's definitely validity to that critique, but theoretically, you know you would think that if we can identify, we can actually treat and treat in a way that leverages some of these tools or treats earlier and hence doesn't cost as much, that of, of course is the goal. Will that be the way it happens in practice? I think it's gonna be pretty lumpy. I don't think the cost management side of this is clear. But it will expand the pool of managers and we'll see if the promise of digital health can, can pull through in the end. I mean we have 10 years.

Johnson:

Yeah. Yep.

Burda:

I've got at least three of those four chronic conditions, right? All four if the Packers lose on Sunday <laugh>. And if Medicare wants to pay my doctors more to use technology to manage my problems, I'm all for it. Now, whether that technology moves the needle on my health outcomes is another story. Technology has a tendency to increase my blood pressure, not lower it when it doesn't work. So we'll see. Let's talk about other big healthcare news that happened this week. Julie, what else happened this week that we should know about?

Murchinson:

Well CDC, you know, voted to stop recommending a birth dose of the Hep V vaccine. Which has, you know, created a kerfluffle. Another one. I just say, you know, at NCQA this week, we had Grace Lee, who's the chief Quality Officer at Stanford Venison. Come talk to us about this. She used to be on the ACIP you know, what's happening around how decisions are being made and even what CDC panel can recommend now or chose to vote on in the last meeting. It's kind of materially changed how the scope of that group even works. And it's in ways that aren't looked upon as being favorable. So, yeah. Scary stuff for kids today.

Burda:

Well, kids be a hematologist, right? Liver disease is the future. <Laugh> <laugh> Dave, what's your big story of the week?

Johnson:

Well, since we're on Trump's CMS administration, they also came out with an overhaul proposal for Medicare Advantage ratings. You know, Medicare Advantage has just been riddled with problems you know, continues to cost more than traditional Medicare, lots of game playing. And the risk adjustment, I mean, we're on V 28, right? That's the shorthand for version 28 of the risk adjustment. And we're trying to

figure out whether that's actually better or not. You know, if things get better in the iterative fashion, you know, V 28 should deliver. But this time they're playing around with the star ratings in ways that the industry will both like and dislike. So let's see.

Burda:

Maybe it'll move the program in the right direction. Let's, let's hope so. Thanks Dave. Thanks, Julie. That is all the time we have for today. If you'd like to learn more about the topics we discussed on today's show, please visit our website at 4sighthealth.com. You also can subscribe to the roundup on Spotify, Apple Podcast, YouTube, or wherever you listen to your favorite podcasts. Don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I'm Dave Burda for 4sight Health.