4sight Health Roundup Podcast
Will Rural Health Transformation Grants Pave the Road to Good Health?
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[Intro & outro music by C. Ezra Lange]

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, July 9th. I hope everyone had a fun, relaxing, and safe 4th of July weekend, celebrating the 250th birthday of the United States. I did find my old fireworks in my basement, but I decided not to shoot them off. I'm gonna save them for another special occasion. That has nothing to do with our topic today, unless that special occasion is getting a rural health transformation grant. We're gonna talk about the government's rural health transformation program today with Dave Johnson, founder and CEO of 4sight Health, and Julie Murchinson, partner at Transformation Capital. Hi, Dave. Hi, Julie. How you two doing this morning? Dave?

David W. Johnson:

Well, I'm in San Francisco where it's cold and it's foggy. Reminds me of the Mark Twain quote, "The coldest I've ever been was the summer I spent in San Francisco." I've always thought that San Francisco, and Julie, you probably remember this from your time here, has the most interesting billboards. I saw one today that was advertising a hotline for AI anxiety. <Laugh> Where else in the country are you gonna see that? <Laugh>

Burda:

A head of the curve, right?

Johnson:
Exactly.

Burda:
That's great. Thanks, Dave. Julie, how are you?

Julie Murchinson:
Well, my World Cup fever I feel like is starting to really, you know, bottom out. So I'm really sad. Norway.

Johnson:
Norway.

Murchinson:
Yeah, I gotta get back on the train. That's right.

Burda:
Yeah. Yeah. I feel like a, like a sugar crash or something.

Murchinson:
It's, that's what it feels like actually. Yeah. It's a bummer.

Burda:
Yeah, I get it. Thanks. Okay, before we talk about how states should spend their rural health transformation money, let's talk about whether you've ever lived in rural America. Dave, have you ever lived in a rural area where access to medical care wasn't a given?

Johnson:
I lived in an area where it was non-existent. You know, when I was in Peace Corps, I lived over two years, what we used to call upcountry, you know, rural, rural, rural, rural, rainforest area. And I'm not sure we had

any available medical care other than a first aid kit and chloroquine pills. You know, and during my two years there, way too many people died unnecessarily because there was no adequate healthcare.

Burda:

Wow, zero. Pretty scary. Thanks, Dave. Yeah. Julie, how about you? Have, have you ever lived in a rural area where you had to travel miles to get healthcare services?

Murchinson:

No, but no. I mean, I was thinking a lot about whether I've just lived a life that doesn't understand this, but I really feel like I get it. What's interesting is I think a lot about where to retire and healthcare's the number one thing I think about. Like, you don't wanna be in too rural an area to not be close to some, some good healthcare. So it's... And which is ironic, right? Because I know technology's an answer, but yeah, I don't know. It's, it's a stumper.

Burda:

Well, I've driven through countless rural areas of the country, but I've never stopped to live in any of them. I'm an urban suburban guy who's never lived more than two or three miles away from the nearest hospital. A doctor's office has never been more than a long par five away from me. I'm spoiled. I've never felt the fear of not having access to care from a distance point of view when I need it. But millions of Americans feel that fear every day, and that's what the government's rural health transformation program is all about. Let me give you some overall specs from the program where it stands now, and then ask you how you would spend that money. The one big, beautiful Bill Act created the Rural Health Transformation Program. It's a $50 billion grant program that runs for five years, starting this year through 2030. CMS will give out $10 billion a year to states over that period. Every state gets at least half of that amount divvied up every year or $5 billion. CMS gives out the other $5 billion to states as it sees fit. Read into that what you will. The

District of Columbia and US territories are not eligible. Read into that what you will. States must put the money toward at least one of five different strategic goals. One, make rural America healthy again. Two, sustainable access. Three, workforce development. Four, innovative care. And five, tech innovation. CMS dolled out the first $10 billion in December. Texas got the most with $281.3 million. New Jersey got the least with $147.3 million. Now we're hearing how states in turn are doling out their share of the money for different rural health transformation projects. Last week, for example, Ohio gave money to Ohio University to start building an early pipeline to get more young people interested in rural health careers. Delaware gave money to the Delaware Health Information Network to build a real-time insurance verification and prior authorization system. The list goes on. But we only have 20 minutes. So Dave, I'm gonna ask you two simple questions. Which one of those five strategic goals would you hit the hardest? And if you got a grant, what would you do with the money?

Johnson:

Hm. Well, if I have to just choose one of those strategic objectives, it would be lowercase maha, focus on making rural Americans healthier. You know, it's a real problem. There is a tangible life expectancy gap between urban and rural Americans, that is in the neighborhood of three to four years. That's today. In the 1970s, it was less than a year, so it's gotten worse over time. Socioeconomic factors such as income, education, employment explain one-third to one half of that death gap. And those as, you know, are increasing as well. Rest of it, comes from inferior access to care, unhealthy behaviors, environmental and occupational risks, higher rates of overdoses and suicides, and inadequate public health infrastructure. So a lot to work on. So that gap's three to four years. But I'm not sure that's the right way to work at it. And I'm gonna go, I guess, a little off script here, Dave, because - Yeah, yeah. I think the bigger issue is income differentials. When you look at the death gap between Americans in the highest income groups and those in the lowest incomes group, that number goes from three to four years to 15 to 20 years. And it's widening. So we're getting sicker rather

than healthier and it's occurring in poor, urban and rural areas at alarming rates. The system, as it is, is already breaking down in fundamental ways in low income urban and rural areas and this is where it manifests itself. So if I had a grant, what would I do? <Laugh> You probably can't give me a big enough grant to do what I wanna do. But how do we turn this around? And the simple answer is putting more money in the pockets of low-income people. I'm not a socialist, as you know, but it's hard not to be a little lefty when we witness how relatively small cash infusions can dramatically improve life quality and health outcomes. So what's my evidence for making that statement? All you gotta do is look back to 2021 when the Biden administration implemented the expanded child's tax credit. This was in 2021, under the American Rescue Act. And economists of all stripes now regard that as one of the most effective anti-poverty programs ever implemented. So what did the Biden administration do? It raised the child tax credit from $2,000 to $3,000 per child per year. $3,600 for children under six. And it made those payments available to all low-income families. And how did that reduce poverty? It raised family incomes. And what did they spend it on? Food, rent, childcare, clothing, schools, supplies, transportation, healthcare. And the poverty rate in one year dropped from 9.7% in 2020 to 5.2% in 2021. The lowest it's been in decades. And less poverty translated into less stress, giving these low-income families more bandwidth and more ability to focus on issues important to them, life quality, their health, and so on. So the clear answer is that social and economic factors, drive better health outcomes as much or more as better health access. And having said that, we ought to be having ought to grant more health access to low income populations as well as well. So you wanna make America healthy again, urban and rural, but we'll say rural, and reduce that death gap, put more money into the pockets of America's poorest families. Full stop.

Burda:

Yeah, people talk about that, what, the K-shaped economy, and it made me - Yeah. Think, you know, it's a, it's a K-shaped economy, but with the health outcomes, right? Yeah, two arrows go in different directions.

Johnson:

A thousand bucks a year per child per year. You're telling me we can't afford that as a society? Wow.

Burda:

Yeah. Good points, Dave. Thank you. Julie, any questions for Dave?

Murchinson:

I'm gonna say something different, so it's, this is gonna be fun. Yeah. <laugh> , but I wanna go to something Burda said. So he offered that Delaware, is basically betting on fixing prior authorization with this money, which is totally different than what you're talking about. So is - Is Delaware being super smart about how they're using these funds? Or is this some sort of admission that the real problem was never clinical and are they just quietly funding the payer fight? Like, what's happening with how this money's being used? <Laugh>

Johnson:

I gotta say it's sad, maybe even tragic, and perhaps entirely appropriate that Delaware felt that addressing prior authorization was the best strategy for improving rural health outcomes. Maybe they're right. As you noted, it, at a minimum, it's an admission, certainly an admission that administrative challenges impede healthcare delivery and contribute to poor health outcomes and they're, they're trying to fix that. My own belief for what it's worth is that providing better and more expansive primary care services, making them more available, more accessible, would improve rural health outcomes substantially more, but maybe I'm wrong. What's great about this approach, the approach embodied in this grant program is it allows for lots of experimentation, which will come with lots of data. So let's hope somebody in the government's paying attention and tracking how all of these different initiatives are going. And if Delaware has the biggest improvement in rural health outcomes because they fix prior authorization, I'm gonna tip my hat to them.

Burda:

Wow. Wouldn't that be something if the secret all along was prior or authorization?

Murchinson:

Amazing.

Johnson:

And here I thought I was supposed to eat more vegetables.

Burda:

Damn. Thanks, Dave. All right, Julie, you're up. Same two questions. Which one of those five strategic goals from CMS give rural Americans the best bang for our tax dollars? And if you got a grant, what would you do with the money?

Murchinson:

Well, I'm gonna surprise you this week, Dave and Dave. Okay. I think because, I do feel like some of the first dollar needs to go to sustainable access. And Delaware's probably thinking along the same lines. You know, since this is effectively a shock absorber for the Medicaid cuts, some of these rural healthcare doors need to stay open. Notice I said some, and not all. That's probably not a popular thought with many people in this country. But you know, every year a facility stays open instead of closing is like value-banked immediately because they're avoiding 60-mile ambulance runs and ER deserts and things like that with hospitals and clinics are a whole nother story. And, you know, it's, it is one of those goals that protects the return for the other four. So there's part of me that likes the sustainable access theory. I don’t know. If you spend years one through three on all the other goals and then some of these, facilities close or all these facilities close, you've kinda torched that spending. So I struggle a little bit with that, but that's not

how I'd really wanna spend the money. That's just the risk I see of what's happening with the Medicaid dollars. So if I got the check, I'd think really differently. I'm not funding ribbon cutting, that's for sure. I would definitely fund the boring stuff that actually moves the needle operationally. But for me, they're all kind of interconnected. And the problem I have is that many of these goals are very similar, if not the same investments, just wearing different hats, right? Different headlines. But these averages that are around $200 million per state-ish, right? You don't have enough money or runway to really fund five goals in sequence over five years or, you know, one goal, I guess, or on the other hand might not get you that far. So I thought about this more as like, how are they interconnected? And I wanted to start because of everything I always talk about with tech innovation, because tech innovation is what makes sustainable access viable. And you know, it's not the gadget purchase. It's literally how you keep a facility, you know, credible without a full specialist bench on site or even full, you know, staffing on site. And that sustainable access is what makes all the maha stuff work. And the way you talk about maha, Dave, is probably a little bit different than how maybe I'm thinking about prevention and chronic disease goals. Mm-Hmm. But a lot of maha could end up turning into just a big pamphlet campaign, right? And -

Johnson:

Yeah. Yeah.

Murchinson:

You can't manage a diabetic population's A1C if you can't actually get them the tools they need or the people who need to see them. And then the maha is what makes the whole system's cost curve actually sustainable in the long term. You have fewer ER visits, fewer transfers, all the things. So all those things are, we know this because we talk about this every week in other ways. They're all part of a more innovative care model. And the way that CMS has broken this up, I get it, because you have to start with chunks and see what's gonna work. But

I worry a little bit that, you know if we are too focused on one thing, we've really maybe crushed that one thing, but it's gonna spin off, other unintended consequences and it's not really gonna drive costs out of the system. And I think there's a lot to, you know, what has already happened in many markets, which is a lot of partnerships with larger systems or organizations that can support a lot of back office, can support a lot of tele. And I think technology's, you know, central here, but everything's connected and I really struggle with that

Burda:

Shock absorber for the Medicaid cuts. Is it not? I love that.

Johnson:

It's absolutely what it is. And - Yeah. And you're right, Julie, on the fact that, you know, <laugh> putting more money in people's pockets isn't gonna help with better diabetes treatments. On the other hand, if you can only pick one thing to do, that's what I picked.

Murchinson:

Yeah. You, no, you're right, by the way. You're so right. I just wonder how long it's gonna take to pay off. <Laugh>

Burda:

Yeah, no bricks and mortar to…

Murchinson:

Might be more than10 years.

Burda:

Yeah. Yeah. Thanks, Julie. Dave, any questions for Julie?

Johnson:

The fact that, you know, single focused point solutions, whatever they may be, are never gonna be able to transform the system. Do you agree with that? And, I think I agree with that. And if you do agree with it, just expand on how we then think about creating a holistic set of solutions that can actually move the needle.

Murchinson:

Yeah. I mean, what I laid out is obviously harder than just picking one lane. But I've seen too many small pilots fail not to think - About the need for larger redesign. And so five and 10 years ago, I would've agreed with you... Actually, am I kidding? 18 plus months ago, I would've agreed with you that point solutions in isolation are not transformational. Today, you're actually seeing these concepts of... Like, point solutions are adding on services and becoming broader solutions that solve a broader problem than just, like, the one thing that we used to call a point solution. So first, I think there's an element of some of these, states will use money on things that might seem very niche, but they might solve downstream issues, upstream issues - <affirmative> Because of how these models are being built, these solutions are being built today. But broadly, you know, I do think we're all finding, especially let's just use AI again, right? AI, when we're just using assistive AI, we're building one agent to do one thing, we're, we're getting a little bit of cost out of the system, but we're not in this kind of multi-agent world where you can think about how do humans interact differently because of technology and the like. So, I agree with what you said, but I also feel like we're entering into a new world where, a lot of these solutions aren't gonna be successful if they aren't working with the payment model or they aren't working with, you know - the actual service replacement. So, you know, I think there's hope.

Johnson:

Yeah, no, I, my own opinion is that the point solutions aren't going away, but they're gonna be subsumed within more integrated holistic platforms where they <laugh> actually inform one another. Thanks,

Dave, and thank you, Julie. Now, let's talk about other big healthcare news that happened this week. Julie, what else happened that we should know about?

Murchinson:

Well, big article in Forbes came out about OpenAI's big plans in healthcare. So, you know, starting to see the big guys lay down some tracks.

Burda:

Yeah. Yeah. Changing the whole market. Dave, what's your big healthcare news of the week?

Johnson:

My big news was the earthquake out of Verana, Wisconsin, where Sumit Rana announced last week. <laugh> He was leaving Epic after 30 plus years. He's currently the president. Most thought he was Judy's heir apparent, and he said he was leaving to spend more time with his family. Yeah, right. So lots of speculation about what his departure means. I happen to think he was one of the good guys and was trying to push Epic into a world that's true where health data is truly interoperable and lift up the whole industry. And, you could read his departure as, and maybe this is the way I'm reading his departure, as evidence that that worldview isn't carrying the day inside of Epic.

Burda:

Yeah. Yeah. Spending more time with your family is right up there with pursuing other opportunities, right? <Laugh> It's all code. It's all code. Thanks, Dave. And 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 Podcasts, 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.