Request for Information; Health Technology Ecosystem

Public Comment from Jaan Health

About Jaan Health and Phamily

Jaan Health is a leading AI-based care management company serving healthcare providers. For nearly a decade, the company has leveraged its easy-to-use, proprietary technology to enable health systems, medical groups, and ACOs to deliver high quality, high-value proactive care to hundreds of thousands of previously underserved patients.

Phamily, the company's core technology platform, has transformed chronic disease management with clinically tested AI and easy-to-use technology that enables physicians and care teams to offer high touch, individualized patient care that has been proven to reduce investment in extra labor and the overall cost of care. Phamily helps ensure healthcare providers are compensated fairly for providing high-quality care between office visits, while improving the lives of patients with chronic diseases.

Learn more at phamily.com

When Thinking About the Evolution of Health Tech, Consider the Financial Impacts

The team behind Phamily has spent more than a decade working with providers and patients at 150+ healthcare organizations to solve many of the challenges articulated in the RFI. Our work has been shaped by these core ideas, which frame our more specific RFI responses that follow.

1. **Millions of patients are just one bad day away from an avoidable crisis.** Proactive support and intervention can keep these patients out of the ED and hospital. But healthcare organizations are experiencing painful margin compression, stuck between declining reimbursement and rising operating expenses. They cannot afford to provide proactive care and support to all the patients who need it. Fee-for-service programs (like Medicare Chronic Care Management, or CCM) offer immediate reimbursement, but have historically been underpenetrated because the cost of service was more than the payment. Providers can only sustain delivery of proactive care if they can realize significant labor efficiencies and scale care consistently across thousands of patients.

2. **Providers need a financially sustainable bridge to value-based care.** They need fee-for-service programs and other funding models that enable them to build the infrastructure required for value-based success. Value-based models typically require providers to invest a lot of upfront capital in capability building for the potential of shared savings in the future.

3. **We have to solve the current tradeoff of patient access versus healthcare costs.** The healthcare workforce is shrinking while demand is rising–as are labor costs. To improve patient access, healthcare organizations need to hire more people. This means more cost. But to reduce healthcare costs, healthcare organizations need to reduce services. This means less access.

   It's an unwinnable situation. Or rather, it's an unwinnable situation unless we can safely and effectively use technology in all forms (from FHIR to AI) to massively scale the care our workforce is able to deliver.

The RFI raises some excellent and important questions about how the health tech ecosystem must evolve. Our experience tells us that these questions should not be tackled without careful consideration of the financial impact to providers, payors, vendors – and importantly, to patients.

Section B: Patients and Caregivers

For context, we enable large-scale Chronic Care Management (CCM) and Advanced Primary Care Management (APCM) programs across Medicare populations that are often challenging to engage (rural, limited access to technology, underserved in various ways) - and we see 60-90% monthly engagement rates with an average of 3.4 conversations/month and patient satisfaction scores of 9/10 or higher.

This means we facilitate significant opportunities every month for proactive patient interaction, enabling early identification of and intervention on issues that could ultimately result in avoidable ED or inpatient utilization.

PC-1: Not all patients have the devices or internet access required to access apps or portals. The temptation is to think about solving healthcare challenges by putting software in front of patients - but this can add complexity, increase friction, and reduce engagement. At Phamily, we deploy our sophisticated AI-driven platform to care managers, but we focus on making the patient experience as easy and frictionless as possible.

PC-5: We see reduced participation in Chronic Care Management by patients who lack secondary insurance due to care management program cost sharing. The return on investment in these underpenetrated programs is compelling enough that CMS should consider eliminating cost sharing to improve access.

- **A.** Right now, cost-sharing means many chronically ill patients must make hard choices about participating in Medicare programs like CCM – or paying for other necessities. Cost-sharing reduces program utilization and ultimately prevents patients who could benefit from accessing those services. Medicare should consider waiving cost-sharing for preventative care outside the clinic when there is evidence that the preventative care program reduces total cost of care. (This is the case for CCM.)

  But even without cost-sharing, we need to ensure that patients see value in the services they receive. Patients are not accustomed to interacting with providers outside the setting of an in-clinic or virtual appointment. They are still learning how to interact with continuous care management as a service - and this will likely be true of other programs that deliver care outside the clinic.

PC-6: We focus on lowest-friction communication modalities (text, voice) because these elicit the greatest amount of patient engagement and minimize barriers to entry. We strongly recommend Medicare consider patients who may not be able to use app-driven or portal-based services.

PC-7: We look at measures that are generally already part of MIPS and other value-based care and quality measurement programs, like avoidable utilization, readmission, ambulatory-sensitive ED visits, etc.

PC-12: Continuous care and support can help improve care navigation when patients have continuous, 24/7 access to trusted care management services. A once-a-month phone call is not sufficient; the gold standard should be continuous care.

Section E: Technology Vendors, Data Providers, and Networks

TD-1: Ensure reimbursement models make sense for providers, patients, and vendors. These are three separate value propositions. Program design needs to ensure value creation in each of these dimensions.

TD-4: Require EHRs to support standards-based publicly-available APIs and charge reasonable, bearable fees for integration. And this requirement needs to extend to system integrators who host community EHR instances for ambulatory practices.

Section F: Value-Based Care Organizations

VB-1: Successful digital health adoption requires:
- a business case for vendors to invest in product development,
- a financial model that incentivizes healthcare organizations to deploy the technology,
- an ability to deliver clinical value that makes sense to physicians, and most importantly,
- patient-centered design that ensures patients will engage with and adopt the technology

Without all of those elements in place, any digital health service will struggle to get to scale.

VB-3: Care management is typically a supply-limited service that is only available to the riskiest 1-5% percent of patients. But so much of the ability to succeed in at-risk models requires the ability to educate, support, intervene, and co-create health with patients 365 days a year – not just the few days when they have in-clinic visits.

With Phamily, we have built a unique model of care management delivery that makes proactive care management accessible to all chronically-ill patients, not just the riskiest. We encourage Medicare - and broadly, population health leaders – to reconsider how care management can be delivered when the right technology increases labor efficiency 10x.

For additional information visit phamily.com or contact:

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