Efficiently Breaking Barriers Between Payers and Providers with Dan Wilson, CEO at Moxe Health

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Episode Highlights

- Overcoming the historical lack of trust regarding data sharing, particularly around payments, between payers and providers is critical to the shift towards value-based care
- For vendors that sit in between the two, consciously treating both as equals is critical for this goal
- Moxe Health approached interoperability from a product, not platform, lens that helped it tackle Release of Information (ROI) in a purely digital manner in a historically services-driven subsector
- A partner-friendly model for QA-heavy OCR/NLP has allowed Moxe Health to serve a wider role in fulfilling customer needs while maintaining an efficient internal business model
- The Datavant / Ciox merger was a landmark transaction in the space to address both requests and release of information with a move away from the traditional services approach
- Moxe Health has decoupled infrastructure from insights to focus on what it does best rather than try to compete in the fast-moving analytics space
- Subsidizing IT systems for providers ultimately is a benefit to all stakeholders, but convincing payers to act in this role requires very clear and high financial ROI
- Moxe Health uses its <20-hour average implementation time as a core component of its word-of-mouth marketing, critical in healthcare

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Episode Transcript

Frederic Laurier (00:05):
Welcome to Crossroads by Alantra. I'm Frederic Laurier and I head up the firm's Digital Health Investment Banking practice. In today's episode, we welcome Dan Wilson. Dan is the founder and CEO of Moxe Health, a leading infrastructure solution vendor that has created a network that exchanges information in a logical and contextually-aware manner across a variety of EHR systems. Dan has been immersed in healthcare IT systems since 2007, and today he shares invaluable insights on building a business that manages the competing interests of payers and providers who need to collaborate with each other more than ever.

(00:41):
We'll also discuss his experience in finding high value use cases with clear returns on investment in a broad interoperability market around a solution that requires little to no OCR, QA, or other processes that are common in medical records retrieval and abstraction. Furthermore, Dan shares his thoughts on the merger between Ciox and Datavant, a pivotal transaction in healthcare interoperability, as well as the benefits of using a provider subsidization model to maximize deployment in a competitive provider tech landscape. Dan, I believe that you got your start in industry at Epic as a project coordinator. Is that right, first and foremost?

Dan Wilson (01:17):
It is. I was working primarily there implementing clients across a number of different geographies, but it was on the implementation side.

Frederic Laurier (01:27):
You then founded Moxe in 2012, and I'll get to Moxe in a minute, but in a nutshell, Moxe is a clinical data exchange provider connecting payers and provider systems to improve the record retrieval process. Is that the best way of summarizing what Moxe's all about?

Dan Wilson (01:44):
I think that's a good summary. There's obviously a few things we do on top of the ultimate data exchange process to try to continue to add value to our clients, but that is the punchline.

Frederic Laurier (01:58):
Good. And for our listeners, for their benefit, can you provide us an order of magnitude of the amount of data processed by your platform?

Dan Wilson (02:07):
We think about it terms of medical records, somewhere in the order of 20 million or so medical records a year will move through the system. A medical record is going to be the more or less complete medical history on an individual from a specific location they've received care. We are working with clients on the payer and the provider side who probably cover about 70 million people.

Episode Transcript

Frederic Laurier (02:38):
Switching gears for a minute, and maybe going back to your personal background, it sounds like you're extremely active in your community. You help promote access to affordable care in the Madison region, if I'm not mistaken. Can you tell us what that work has meant for you and also in shaping Moxe into what it is today?

Dan Wilson (02:59):
Actually, the origin of Moxe was more on the affordable care side than in the clinical data side. In Madison, I've had an opportunity to be fairly involved with the United Way, really looking at how we do more to promote a delivery system in the Dane County, which is the county that Madison is based out of, but what we can do locally to improve outcomes, particularly within the BIPOC community, looking at different providers who specialize or have programs specifically centered around black and other minority populations that have had historically worse outcomes from the white population in Madison. There is a big concerted effort on what we can do to get more dollars into different community providers. That has been an unbelievably rewarding opportunity to see the great work that so many people are doing that is still just an unbelievably critical area to focus.

(03:57):
That actually dovetails with when we were originally getting started with the company, the goal was to build software for FQHCs, Federally Qualified Housing Centers, and other safety net providers. The initial idea was looking at the expansion of Medicaid and trying to figure out how we could help these providers operate their clinics more efficiently, and I wanted to make sure that they didn't have to pay for the software. I thought ultimately if we could get to managed Medicaid or we could get to the county and have them help cover the cost of this software, it would be a net benefit to the community.

Frederic Laurier (04:32):
Our understanding is that providers and payers, to some extent, are being pushed to work closer together. A lot of that is driven by value-based care initiatives. The intent is better patient outcomes, but at the same time what we're seeing is it does push some administrative strains onto providers by having to fulfill more requests for medical records, be it for HEDIS scoring or risk adjustment purposes. At the same time, providers do need fuller information about a patient to provide them with better care. What, in your opinion, are the key collaboration challenges between providers and payers to make this work?

Dan Wilson (05:06):
I think there are so many years of payers and providers trying to find ways to get an edge in their work together that when we sit and talk about a shift to value-based care or a shift to any more collaborative model, overcoming the historic lack of trust is always going to be the most challenging place to make progress. I think it really comes down to, can you get the economic incentives aligned well enough between these two groups that they can overcome the lack of trust and start making progress? When you start to get deeper into the actual act of sharing more information, a lot of it comes down to, how is the data going to be used? The health plan needs data for HEDIS and risk, as you mentioned, the provider is concerned that data may go to the plan for those programs, but then may end up being used to help the plan negotiate different contracts, or may be used to look, on the payment or program integrity side, for areas where payments should be clawed back.

Episode Transcript

Dan Wilson (06:09):
There's this desire, perhaps, to help run more efficient operational programs but a reticence around sharing data for payment. Really working through what are the use cases for data, which use cases is there good alignment, making sure that both sides are very comfortable with how data's ultimately going to be used is all key to the upfront conversation. Recognizing that once you start to get the P&L aligned, once you start to demonstrate that you're only going to use data for purposes that have been agreed to, you can start now repairing the trust. You start to see a more holistic, more natural kind of sharing of information back and forth, which is the objective we're all working towards.

(06:49):
We view a huge part of our role as, we don't view ourself as a payer business or a provider business. We're simply trying to make our little corner of healthcare as efficient as it can be. That means we are going to try to balance what health plans and what providers are looking for, and we're going to figure out how do you keep the scale balanced in terms of benefit received. We have dedicated teams that work with payers and with providers, but we've made a very concerted effort. We don't have people who are only payer or only provider customer success representatives because we don't want to fall into the trap of inadvertently treating one side as good and one side as bad.

Frederic Laurier (07:31):
I believe that release of information or ROI, the acronym, is one thing you enable. Is that one of the primary use cases for your solution?

Dan Wilson (07:39):
It's absolutely primary.

Frederic Laurier (07:41):
Historically it was mostly done by fax or mail, very costly, inefficient. Can you explain what your solution does to streamline this, to make this as automated as possible?

Dan Wilson (07:55):
Part of this is we didn't come at the problem to solve ROI. We were thinking more about just, how do you build software to help the provider operate as efficiently as possible? We were taken into the ROI space. Historically, we understood from a health plan that they were having trouble getting access to medical records, and when we dug in with them to understand what data they were actually looking for, we realized we could get everything they were looking for electronically. So, it was a little bit of dumb luck, perhaps, but the legacy ROI industry was so focused on the fact that a legal medical record does not just exist in the EHR. It may span not just the EHR but other systems, and so if you're thinking in that framing, then this is a very, very hard problem to solve electronically, but that's not how we came at it.

(08:46):
We came at it from a health plan saying, "I need this subset of data elements that we would view as a record that will hold up to an audit for risk adjustment." When we looked at that scope of data elements, we knew that those are, for the most part, going to be in one core system that makes up the legal medical record, which is the EHR, and we knew the EHR quite well.

Episode Transcript

So, we went and built connectivity into all the different APIs that the EHRs make available and we work with, now at this point, a handful of the leading EHR systems. Our first client was running Epic and our second was Cerner. Those are two different systems, they have two different sets of APIs, but are ultimately permutations on the same thing. We were able to get set up with that set of APIs we needed.

Dan Wilson (09:32):
Rather than coming at it like typically it had been done in the interoperability space of really trying to say, "I'm going to be a platform and I'm going to do everything, and you tell me your problem and I can fix it." We approached it as a product business where we said, "We want to solve the highest value use case that we can find, and we're going to identify within the health plans," who we decided was the client we wanted to try to serve initially, "what are going to be the highest value use cases for them," which took us to risk and quality.

Frederic Laurier (10:03):
For some of those legacy ROI vendors where defending malpractice lawsuits was a big revenue generator, a big use case, it's not the case for you?

Dan Wilson (10:15):
It's not. We are very focused on the payers. Those adjacent, if you will, use cases that make up ROI, we've taken the approach of going to our clients and saying, "Look, the volume of requests that are coming in from these payers is really the volume that you're struggling to staff and manage, and that's why you went and worked with an outsourced vendor in the first place. But if we take all of that volume off your plate and we automate it, you're left with a volume that is much easier to manage." It's consistent more or less.

(10:48):
Candidly on the legal side, if somebody's suing you for malpractice, probably you should have your staff as the ones who are reviewing the records that are going to go out and help make that case. What we've seen is that some number of our clients do that, they bring it back in house and some numbers say, "You know what? I still don't want to manage all those other pieces myself. We'll continue to use a vendor for that," and they just design a contract where there may be some division of labor. We work alongside a number of legacy ROI vendors at a wide range of our clients and have as good of a relationship as you might expect.

Frederic Laurier (11:23):
Maybe one last question on ROI. I cannot talk about ROI without asking you about the Datavant / Ciox merger. It was a watershed moment in my opinion. It's a massive merger. Can you share your thoughts? How disruptive has this been? Did it open the market for folks like you, did it make it harder?

Episode Transcript

Dan Wilson (11:44):
The ROI industry has been around for a long time, and throughout its history, very, very manual. What Ciox did very well is they rolled up that industry progressively through HealthPort doing a lot of roll ups. Pre-Ciox, you had this lineage of rolling up the ROI industry, and then I think the real very compelling part of Ciox was, "We're not just going to do the ROI side, we'll also do the request side and we're going to take both sides of the problem and serve out both groups." I think the Datavant merger is a recognition of two things. One is that the ROI industry is changing and that continuing to service it out with the same unit economics and the same approaches is not going to work for much longer, and so there needs to be some digitization that is happening, and I think we demonstrated that very acutely, but there's a lot of trends pushing that.

(12:42):
Ciox decided to go into the pharma space and has been successful selling contracts, and I think they have investment from some different pharmaceutical businesses. Then you take Datavant which is by all accounts an industry-leading technology group, really strong culture, great team and is building tooling for the pharmaceutical industry. They're dealing with de-identified data where Ciox is dealing very much with identifiable data, and you look at the two of them coming together and you can see how this becomes really a growth opportunity, no doubt, huge merger, very interesting to watch how that plays out. Ciox was on the path to trying to digitize a lot of their core business even prior to the merger, so they've been working on this for now a number of years and we've seen that out in the market, but it hasn't been much impact to our business at this point.

Frederic Laurier (13:38):
Focusing on Moxe for a second, exchanging medical records is core to your mission. You can do it for a number of reasons, you've mentioned it. It can be care management, risk adjustment, prior auth, claims denial management, we just discussed ROI. At the core of it, you need a strong abstraction process. Historically, it's been done through OCR, NLP technologies whenever the data was unstructured or not hard to get to, if I'm not mistaken. How do you handle abstraction?

Dan Wilson (14:08):
We're a very partner-centric business. We work with a lot of the people you're talking about and maybe compete in some ways as well. The biggest challenges I see in traditional abstraction that OCRing is very finicky and there's a lot of time and energy that goes into then QAing what's been OCRed and working with it, and we don't have any of those problems. We have zero OCRing that happens within our system because we're just getting everything directly out of the EHR and it has all of the metadata attached to it. Whenever it is discreet data, so thinking problems, allergies, meds, things like that where you may need to use that discreet information to pull out specific data that somebody is looking for, that is extraordinarily clear cut for us. We can basically produce the data in whatever format our client is looking for. We do a lot of abstraction, if you will, into files that can be submitted into their HEDIS engines and things like that.

Episode Transcript

Dan Wilson (15:05):
I want to draw the distinction between the discrete data, which is straightforward, and the unstructured data, which is where you need that NLP that you're referencing, which is significantly more complex. We don't do NLP. We will work with our client and whatever vendors they work with in order to perform the NLP that is required around abstraction, or if it's going to be a human driven model, we will put the information directly into whatever abstraction tool is in place. We work with companies like Astrata who's doing NLP for HEDIS with AmeriHealth who has pulled us all together. We work with companies like Edifecs where you're going to have couple of different NLP tools and UPMC, who's an investor of ours, that came about through some work we were doing with Health Fidelity who was doing NLP for risk adjustment. Our approach has been to try to enable as many people as possible play this role of, "We want to be your partner in getting the highest quality, lowest cost data and we want to help make that data operational."

Frederic Laurier (16:11):
Any plans of adding an analytics layer of sorts to provide clinicians with some additional decision support tools since you already have the data?

Dan Wilson (16:21):
Our view is that we want to be the highest quality, lowest cost source of data. We want to get the industry to use clinical data as widespread as possible. We think it's a better source of information than administrative data for running the business of healthcare, and we want to help make that happen. Then, we want to help operationalize and activate the insights that are being generated from that data. We do have another part of our business, which is an area of growth for us where we take insights that are coming out of analytical tools that we've put data into, and we help those insights get driven back to the point of care, put into the EMR put into workflow, and ultimately acted upon. We think it's really important to decouple the activation and addressing of the insights from the actual generation of the insight because I don't think there's any generalized analytics player who's going to win across all of the different domains where we are trying to solve problems.

(17:19):
We are doing more from an infrastructure perspective to make data usable for more things. We are investing in tools and capabilities to make data enriched, better prepared for use, make sure that we're getting maximum yields. Our approach is, we can modularize this a bit. We can allow the analytics businesses to really focus in on what they do best. Given frankly all the advancements that are taking place in machine learning and AI right now, if you are in the analytics space, you really need all of your energy focused on how to deploy those technical breakthroughs into what it is that you're working on.

Frederic Laurier (17:58):
In some sense, payers are subsidizing the access to your software for providers. Last year was the worst year on record for health systems just from a bottom line standpoint. What's your sales pitch to payers? How are they seeing the tangible benefits of, again, paying for providers to use your solutions?

Episode Transcript

Dan Wilson (18:19):
I do think about it as subsidizing. I think providers have a lot financial strain that they're under. They've made a lot of big investments in their EHRs. A very early goal for us was to make it easier for a clinic to operate efficiently and not need to cover the cost of that because I think a more efficient clinic ultimately is a benefit to the consumer, to the individual, to the member, and so we looked at the insurers, the group who ultimately was going to get the most benefit out of these types of programs. We looked for them to help subsidize the program. This was part of why it was so important for us to go and identify what are those very specific use cases of maximum benefit so that we could frame it up in a way that really did speak to the financial ROI.

(19:09):
When we're speaking with a health plan, we're typically going to be talking about how they can use clinical data to more effectively run their risk adjustment and their quality programs, and the idea is that risk adjustment has a very clear financial ROI associated with it. We have a classic better, faster, cheaper pitch. You're going to spend less, you're going to get more data with the money that you have allocated, and you're going to get it faster and in a format that you want it in. That was pretty straightforward. The value is so clear and obvious once you start working with electronic data versus more paper analog data.

Frederic Laurier (19:44):
One thing that really caught my eye is, on average to onboard a new practice, it takes less than 20 hours. First question is, is this a recent improvement or has it always been like this? Because it's astonishing. 20 hours, it's almost unheard of.

Dan Wilson (20:01):
Yeah, and it actually is per system.

Frederic Laurier (20:03):
That can mean 20, 25 facilities, 40 facilities, 20 hours.

Dan Wilson (20:07):
You want to be very disciplined about the data that is being released and make sure as you would expect that it's exactly what everyone expects to be released, and so that's all included in that figure, and it's been that way pretty much since the beginning. My background is on the implementation side. I think I've always appreciated the benefit of a really clean, well run implementation. I've seen how, particularly in healthcare, word of mouth is the best marketing engine you can have. If I can make the implementation an extension of demonstrating my value to you, I'm going to do that.

Episode Transcript

Frederic Laurier (20:48):
This was truly a fascinating discussion, Dan. I can't thank you enough for having taken the time and certainly look forward to catching up with you soon in Madison, one of my favorite cities in the US. I think there's a lot to learn from you on staying focused on very tailored niches in a broad space and particularly on how you are handling some of the more behavioral frictions in getting providers and payers to work closer together. Dan, thank you again for your time. If you'd like to hear more about Alantra's perspectives on other Digital Health topics, please subscribe to the podcast and feel free to reach out to us.

Dan Wilson (21:19):
Wonderful. Great seeing you as well. Have a good one.

Alantra – Digital Health Coverage

Alantra – Selected Recent Healthcare Transactions

2023 — LAZEO — Sell-side advisory — Blackstone

2023 — Blackford — Sell-side advisory — BAYER

2022 — STADA — Sell-side advisory — Megalabs

2022 — YPSOMED SELFCARE SOLUTIONS; DiaExpert Diabetes bewegen — Sell-side advisory — MEDIQ; Advent International GLOBAL PRIVATE EQUITY

2022 — NeoHealthHub. — Sell-side advisory — PHARMALEX CONFIDENCE BEYOND COMPLIANCE

2022 — Accent Equity — Sell-side advisory — AXCEL

2022 — Aakamp Pharmazeutische Lohnherstellung — Sell-side advisory — FARMACEUTICI PROCEMSA

2022 — WOOM — Sell-side advisory — apricity fertility reimagined

2022 — republic — Sell-side advisory — QUEEN'S PARK EQUITY

2022 — STRATEGIC NORTH — Sell-side advisory — Prescient

2022 — Childs Farm — Sell-side advisory — PZ Cussons

2022 — ANALYTICAL WIZARDS — Sell-side advisory — DEFINITIVE HEALTHCARE

2022 — Riffyn — Sell-side advisory — SIEMENS

2022 — TARA — Sell-side advisory — Valo

2021 — Baird Capital; Prescient — Sell-side advisory — Bridgepoint

2021 — HELIOS MEDICAL COMMUNICATIONS — Sell-side advisory — North Edge.

2021 — BEE HEALTH™ — Sell-side advisory — INW; CORNELL CAPITAL

2021 — CareCloud — Buy-side advisory — MedMatica

2021 — MOBILE VASCULAR PHYSICIANS — Sell-side advisory — HOUSATONIC

2020 — gsk Pfizer — Sell-side advisory — Charlesbank

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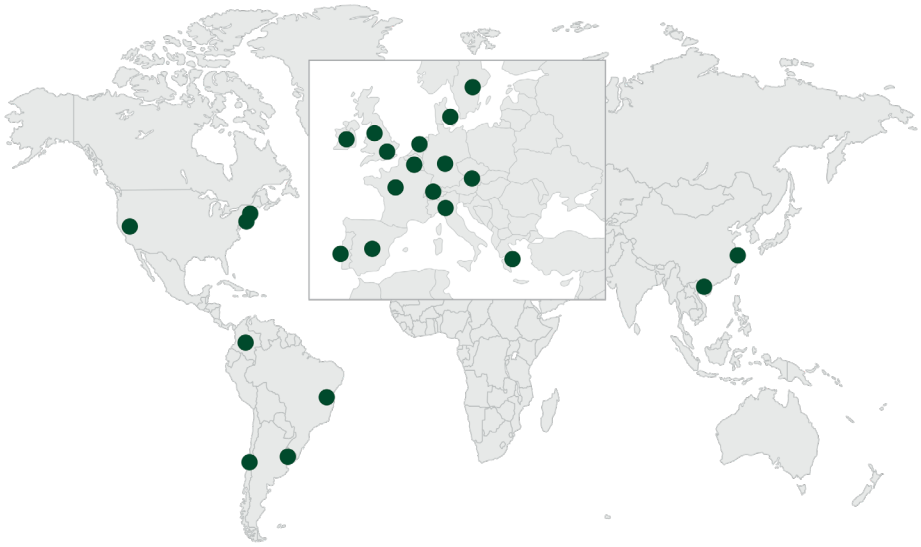

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(2) As of January 2023. Since 2013

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