Rainfall HEALTH

INNOVATION, ACCOUNTABILITY, AND AI

Market discipline finally arrives

For the first time, a federal program pairs healthcare spending with real carrots and sticks. A conversation about how innovation actually gets adopted, why this model is bipartisan by construction, and where AI belongs in it.

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FEATURED VOICES

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A career spanning the Marine Corps as a fighter pilot, the State Department as Deputy Assistant Secretary, and management consulting as a vice president at Oliver Wyman. Founder of the China Beige Book, an investor and innovator, and a board member at Rainfall Health.

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Founder and CEO of Rainfall Health, and host of the Rainfall Health Podcast. Works closely with the Medicare population and the surgical episodes that shape it.

INTRODUCTION

Something out of Washington finally has market discipline

Steve Ganyard has watched technology adoption from three very different seats: the cockpit, the State Department, and the consulting side of aerospace and defense. His read on healthcare's mandated episode models is not the usual policy analysis. It's a market observation.

For the first time he can point to, a federal program pairs public spending with genuine upside and genuine downside — do the work well and you're rewarded, do it poorly and it costs you. That single structural fact is why he thinks these models will hold, why they attract support from both parties, and why they won't stay confined to Medicare.

The second half of the conversation is about AI: not as the point of the exercise, but as the only practical path to running accountable care at this scale — with human beings kept firmly in front.

THE THROUGH-LINE

> “For the first time that I can think of, something coming out of Washington actually has market discipline.”

Steve Ganyard

A note: this is an edited conversation from the Rainfall Health Podcast. It reflects the participants' own views and is not legal, financial, or clinical advice.

Technology gets adopted at very different rates

Aerospace and defense is small-c conservative. Adaptation takes time because incumbents don't want the risk, so change usually has to be forced onto them. Healthcare's pattern is familiar: another sector that adopts slowly, for reasons that feel prudent from the inside.

THE INCUMBENT RHYTHM

Many traditional primes wait for the federal government to say what to do, then spend the research and development money it provides. Innovation arrives only when it is asked for.

THE NEW ENTRANTS

A wave of neo-defense companies decided to do things completely differently — and battlefield reality, drones above all, has forced the government and the military to think differently about how they adopt and adapt.

Three ways adoption actually happens

Asked for

The buyer funds a program and the sector responds. Predictable, slow, and only as ambitious as the request.

Forced by events

A war, a shock, a new capability someone else fields first. Fast, but nobody chooses the timing.

Pulled by incentives

Rewards and penalties that make the better way the profitable way. Rare in public programs — and exactly what the episode models introduce.

> “What we're seeing in the TEAM model is unique, because the federal government is forcing industry to adopt best practices — and some of the carrots and sticks of the free market.”
>
> Steve Ganyard

Taxpayer spending with an upside and a downside

What makes the mandated episode models different isn't the technology they encourage. It's the structure. Public money now moves through an arrangement that a market participant would recognize: perform well and there is real upside; perform poorly and there are real problems.

THE STRUCTURAL CHANGE

Do it well

A very good positive upside for the entity executing the mandate — and a healthier patient at the end of the episode.

Do it poorly

Real downside. The accountability is not rhetorical, and it lands on the organization that took the work on.

The private-sector entity executing the federal mandate is being paid to do a good job — and held to account in a way that makes the country healthier and each taxpayer dollar better spent.

Why the discipline matters more than the mandate

Mandates without measurement produce compliance theater. Incentives with measurement change behavior, because the organization's own interest points the same way as the patient's.

That is what makes this program legible to industry. It isn't asking hospitals to be virtuous. It's asking them to be good at something, and paying accordingly.

REFRAME

Stop reading the model as regulation. Read it as the first federal healthcare program that Mr. Market would recognize — and staff it the way you'd staff a P&L.

03 · WHY IT TOOK THIS LONG

Good ideas, funded forever, never measured

Congress builds bills it believes the public wants, and many of them start as genuinely good ideas. What usually goes missing is the checks, the balances, and the KPIs — so nobody can say whether the money bought what it was meant to buy.

HOW PRIVATE CAPITAL DOES IT

A Series A funds the idea. Getting to a Series B means showing the KPIs and the upside. Each tranche is a gate, and the gate is the discipline.

HOW PUBLIC PROGRAMS OFTEN DO IT

Fund the idea, hope it works, renew the line item. There is rarely a follow-on gate, so there is rarely a reason to prove anything.

THE FAILURE MODE: ZOMBIE PROGRAMS

Steve saw the pattern at the State Department: a strong idea — saving lives, safer childbirth, lower infant mortality in a particular country — funded once, with no follow-on and no threshold to clear. Years later, people ask why a line item that barely exists still costs this much and does so little.

It isn't a defense problem or a State problem. It runs throughout the federal government — and it is precisely what an incentive structure prevents.

Name the KPI

Outcomes, quality, satisfaction, cost. Written down before the money moves.

Gate the next tranche

Continued funding earned by demonstrated performance, not by inertia.

Let the downside exist

A penalty nobody believes in isn't discipline. Credibility is the mechanism.

04 · BIPARTISAN BY CONSTRUCTION

Nobody on Capitol Hill runs against this

The model began as an idea under one administration and was embraced by the next. That is not an accident of timing — it follows from what the program actually promises, and every element of it is something both parties already claim to want.

Better care for seniors

No vote is cast against safer procedures and better outcomes for Medicare patients.

Value for taxpayer dollars

Spending that has to demonstrate its return is a position with no natural opposition.

Longer health span

Seniors staying well enough to keep living their lives, productively, for longer.

And the pressure behind it isn't going away

$40T

national debt, as cited

Continuing to spend without applying discipline stops being an option. The federal government faces mounting pressure to reduce outlays, which makes programs that can prove their return the ones most likely to survive — and to spread.

There's a second signal in the same direction: the comprehensive joint replacement model didn't stay in the innovation channel. It moved into the payment schedule itself. That is what broad support looks like in practice — not a pilot with advocates, but a permanent way of paying.

05 · WHERE THE MODEL GOES NEXT

If it's good for seniors, why not for veterans?

Medicare is the largest payer in the country — arguably the largest in the world. But it isn't the only large federal payer, and the logic of accountable episodes doesn't stop at its boundary.

> A veteran who comes in at 50 for a hip replacement isn't in Medicare. Why shouldn't they have the same protections — the same assurance of being held through the system, not falling through the cracks, and reaching a positive outcome?
>
> Steve Ganyard, on extending market discipline beyond Medicare

Veterans Health Administration

One of the largest expenditures in the entire federal government, with a population whose surgical episodes look much the same.

Defense Health Agency

A comparable model, a comparable scale, and no structural reason the same incentives couldn't apply.

The rest of Medicare

Joint replacement moving into the fee schedule suggests episodes are becoming the default, not the experiment.

Do the learnings cross over today? Not yet.

Asked whether other departments have picked up these mechanics, Steve's answer is straightforward: he can't point to anywhere else in the federal government where Congress has installed carrots and sticks of this kind. The playbook exists, and it's currently running in one place.

For hospitals and health systems, that has a practical consequence. The capability you build for this program — episode analytics, post-discharge follow-through, accountable hand-offs — is not a compliance cost with a five-year shelf life. It is the operating model the next payer will ask for.

06 · HEALTH SPAN IS THE REAL RETURN

The first years on Medicare decide the next twenty

The financial case for accountable episodes is large and easy to state. Steve's argument is that it is also the smaller half of the story. What's actually at stake is health span — how long someone stays well enough to live the life they had.

THE NARROW WINDOW

The years right after someone starts taking Medicare matter disproportionately. A hip procedure that goes wrong leads to follow-on problems — which is exactly why the 30-day window after surgery is where the model puts its attention.

THE COMPOUNDING LOSS

When it goes badly, the calendar fills with hospital trips and specialists, and driving yourself stops being an option. Independence is what gets spent first.

WHAT A GOOD OUTCOME BUYS

A procedure that goes smoothly keeps someone a productive part of society long after they retire — volunteering at a school, showing up at their church, being useful somewhere. That is the return the balance sheet never captures, and it is the reason to get the 30 days right.

Financial
Avoided readmissions and complications — the part the model prices directly.

Personal
Mobility, independence, and the confidence to keep making plans.

Societal
Millions of people over 65 still contributing — the largest and least measured dividend.

07 · AI IS THE PATH, NOT THE POINT

Start from the outcome, then pick the tool

Dig into the mechanics of these models and what you're left with is four things: patient outcomes, quality, satisfaction, and cost. That's the target. AI is a path to it — a good one, and at this scale the only practical one. But the order matters, and it is frequently reversed.

RIGHT WAY ROUND

Name the impact you're accountable for, then ask what gets you there better and faster. AI earns its place by closing a specific gap.

WRONG WAY ROUND

Adopt AI, then go looking for a target to point it at. The tool becomes the strategy, and the outcome becomes a hope.

The four things the model is actually asking for

Outcomes

The episode ends well, and stays well through 30 and 90 days.

Quality

Consistent care, documented, across every hand-off in the episode.

Satisfaction

The patient's own account of how it went — not a proxy for it.

Cost

The total cost of the episode, including what didn't have to happen.

> “What we're doing here we probably couldn't even have dreamed of a year and a half ago — the technology wasn't there. Now we have these tools. What matters is that we're an AI-forward company that is still patient-facing.”
>
> Steve Ganyard

The practical test for any tool in this program: does it make it less likely that a patient falls through the cracks between discharge and day 90? If it doesn't, it isn't part of the model.

08 · THE FEAR GAP, AND CLOSING IT

Two publics, one story that has to be told well

Attitudes to AI in healthcare are split, and both camps are reasonable. The gap between them is not a messaging problem to be solved with a campaign — it's the ordinary work of explaining, patient by patient and legislator by legislator, what the tools do and who stays in charge.

THE EARLY ADOPTERS

They want more of it, and they're already putting their medical history into a chatbot to get a faster, plainer answer than the system gave them.

THE APPREHENSIVE

They hear that their records are going into something they don't understand, and they're facing a hip replacement or major surgery. The question isn't rhetorical: what is your AI going to do there?

Two audiences that need the same answer

Patients and families	Show them people first: the human being who is accountable for their episode, using tools that make the follow-through more reliable, not less personal.
Lawmakers	Tell them plainly what the program has already achieved, and ask for more of it. It's not a hard story — but it takes human beings to tell it on the Hill.
Health systems	Reframe the reflex. There is real apprehension in the sector that this is one more administrative burden. It's an opportunity — and someone has to facilitate it.

Healthcare is human beings helping human beings. There is pain, fear, cost, and uncertainty about what comes next — so it has to be people first, people forward, with AI in the toolkit. On those terms, AI isn't a threat. It's a once-in-a-generation chance to make the country healthier.

09 · HUMANS FORWARD

Widgets on widgets, or humans helping humans

Plenty of companies build widgets that attach to other widgets — zeros and ones, with a long road before a person is affected. Steve's closing point is about the alternative: technology whose whole purpose is to let people help other people, sooner.

DISTANCE FROM THE PATIENT

Layer on layer of software, with the human benefit somewhere off in the future. Legitimate work — but not this work.

DESIGNED TO HELP HUMANS

Tools that enable teammates to do things for patients that weren't possible a year ago — and the patient feels the difference inside the episode.

The win the model is built to produce

The patient

Doesn't fall through the cracks. Reaches 30 and 90 days with a good outcome.

The health system

Performs well on the episode and is paid for it, with less avoidable utilization to absorb.

The taxpayer

Buys health span rather than complications, with KPIs that show whether it worked.

> “Humans first, humans forward, with AI as the toolkit. Everything we're doing is designed to help humans help other humans — and we're just getting started.”

Steve Ganyard, in closing — “AI for the betterment of humanity,” as Eddie put it.

WHERE RAINFALL FITS

Built for the accountability, staffed by people

Rainfall Health is an accountability and accessibility platform powered by AI — the first and only company certified for these Medicare-mandated programs. The structure Steve describes is the structure the platform is built for: perform on the episode, prove it, and keep the patient in front.

Performance you can show

Episode analytics tied to the measures the model pays on — outcomes, quality, satisfaction, and total cost.

Nobody through the cracks

Post-discharge follow-through and monitoring across the 30- and 90-day windows, with a named human accountable.

AI-forward, patient-facing

The tools do the recall and the pattern-finding. The care team does the judgment and the conversation.

FROM THE HOST

“Outcomes, quality, satisfaction, and cost are what you're left with. That's supposed to be the result — AI is just a path to help us get there better and faster.”

Eddie Qureshi, founder & CEO, Rainfall Health

GET CONNECTED

Let's talk about your episode performance

If you're standing up a mandated episode program — analytics, post-discharge follow-through, or AI adopted under real governance — we'd like to help. Rainfall is the end-to-end solution, technology and services, for hospitals and health systems.

LEARN MORE

www.rainfallhealth.com

START A CONVERSATION

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Watch for the next episode of the Rainfall Health Podcast.

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