Talking Pop Health
Episode 12: Dave Morlock of Cain Brothers, a division of KeyBanc Capital Markets
Episode posted: April 11, 2022

Eric Tower: Welcome to another episode of Talking Pop Health. I'm Eric Tower, an attorney with Thompson Coburn and today I'm excited to welcome Dave Morlock from Cain Brothers. For those of you who don't know, Cain Brothers is one of the preeminent advisory services. I particularly look to them for strategic advice. So, and it's a personal interest of mine, I'm quite excited to have Dave on. And before we plunge in. Why don't you give a little bit about your background?

Dave Morlock: Sure. First off, thanks for having me here. I appreciate it very much. So I'm a managing director at Cain Brothers. Been with the firm for about 6 years now. Actually I was a long-time client of Cain Brothers before I joined the firm. We don't make a habit of recruiting our clients, it just sort of opportunistically worked out that way. I run the firm's health system M&A and advisory practice across the country. My background before joining Cain Brothers, I was the CEO at the University of Toledo Medical Center and before that, the CFO at the University of Michigan Health System. So, you know, a couple of decades in C-suite not for profit health care. It's pretty helpful for me as I am advising clients because I've actually lived the consequences, both intended and unintended, of putting affiliation deals and change of control deals together. So I've sort of been there on the other side of the table, if you will. Cain Brothers, I appreciate you talking about our preeminence in the industry. We've been around for about 40 years, formed by Jim and Dan Cain, the Cain Brothers. All we do is health care. I would describe it as health care writ large, so it's not just providers, physician groups, health systems, hospitals, but also, med tech, health care services, manage care, health care IT and that kind of thing. But it's all health care all the time. Significant focus in the not for profit health care arena but also very significant focus in the private equity backed space. There's a lot of activity in health care in the PE land right now for sure.

Eric Tower: Oh. Absolutely. And it's interesting so when you read all these publications that are coming out or you listen to the radio, health care is obviously hot right now.

Dave Morlock: Yep.

Eric Tower: I was reading a pitch book piece today about direct primary care where people can pay a set fee and get as many primary care services as they want. Very interesting little area. But when I look at health systems, right now I hear such different things. Some view themselves as staring at the edge of an abyss .

Dave Morlock: Yep.

Eric Tower: Some view themselves as well, I can keep this going for the foreseeable future. Some say, hey, this is an opportunity, this time period for me to grow and get bigger. At the same time we've got Covid that has decimated parts of the industry. We've got service site neutrality staring us in the face and the loss of hospital volumes of new entrants, remote patient monitoring, tele-health. There has been a lot around Amazon. You've got Wal-Mart, Walgreens. We got the direct primary care – we're –

Dave Morlock: Medicare Advantage. That's a big thing, too.

Eric Tower: So where do you see – big picture before we dive in, where do you see things for the systems right now?

Dave Morlock: If you sort of look at a crystal ball out over the next 10 years or so, keep in mind most folks overestimate the amount of impact that change is going to have in the next year or two. But they also tend to way underestimate the impact of the change over the course of 10 to 15 years. As I try to look forward for health systems– we've been talking about value based care and POP Health, I don't know, for decades at least, Eric, in our industry?

Eric Tower: Yeah, around 2010.

Dave Morlock: Yeah, and it's been a slow move. It's a market-by-market move. Some markets, it's really significant, and other markets, it's still sort wild west, fee for service. I was talking to an executive recently that said POP Health is a solution that's looking for a problem to solve. Okay. So I can point that guy to some markets where the problem is there! So I think that the growth of Medicare Advantage will slowly move us to the tipping point where the business model shifts from fee for service to value-based care. Medicare Advantage has different penetration in different markets but if you just sort of look back over the last decade and look at where it's going over the next decade, it's going to continue to grow. I actually think that Medicare Advantage will be to American health care what the shift from old-fashioned pension plans to 401k plans was to retirement savings in America. So if you think back a couple of decades, you moved from this un-cost constrained defined benefit to capped contributions and there's a defined contribution piece. It gave some power and

flexibility to the consumer, if you will, the employee. In this case it will be the patient. Whether they're an Medicare Advantage enrollee or an enrollee under an employer plan. But it's going to cap the expenditures eventually over time and the growth of expenditure in American health care. What I think health systems sometimes miss is that their revenue is society's cost of health care. So health care is getting close to 20% of the GDP. Fifty-five percent of that spend is on hospitals and doctors. Now I'm not trying to pass the value judgment on whether it should be a larger percentage or a smaller percentage. My point is if health care is too expensive, you're trying to constrain the growth of the expense, what's the old saying, just follow the money, right? You're going to look at that 55% and say I've got to constrain the revenue. Value-based care is one of the ways that's going to happen.

Eric Tower: It certainly started and maybe we should touch briefly on service site neutrality and how that's the new potentially impact.

Dave Morlock: Yeah, you know, I am 10 years removed from being a health systems CFO. I was baffled back then around the notion of, we're going to pay you this much if we do the knee replacement in this venue as opposed to pay you this much if we do the knee replacement in that venue. Point to another industry where we do that kind of thing. It makes no sense. From a consumer perspective, that's just nuts. So site neutrality, in my view, is long overdue and if a health system is not positioned to compete under the rubric of site neutrality, shame on you, right? Shame on you.

Eric Tower: So how do you answer a health care executive who says, fine, I lose all my worth or volume. I've lost a lot of my elective surgeries. You know, the cost of hospital space is far higher than ASC and frankly, I'm of the opinion that many of these services could even migrate to an office setting.

Dave Morlock: Yeah, or a home setting.

Eric Tower: Or home setting. We're seeing more of that.

Dave Morlock: Right.

Eric Tower: How do you answer them as far as I'm going to have this empty set of bricks with a large debt, and a large staff that I need ready for something like COVID? How do they answer? How do they respond to it?

Dave Morlock: Yeah, so, let me touch on the COVID piece, first. Because, there's an old expression you shouldn't build the church for Easter Sunday. So that's the one Sunday when the church is absolutely packed. So while our system was very strained under COVID, particularly in certain markets, I don't think that the idea of, we're going to prop up

an expensive, fixed cost solution to a once in a century situation. That's just economically unsustainable. You've got to have a flexible, swift moving way to adjust for the ability to take care of patients in a situation like a flu pandemic or COVID or something like that. But you can't just build a system and say, I've got all the brick and mortar. I've got all the respirators. I've got all of those things and they're just going to sit unused. Because in the next 70 years, something like this is going to happen. You just can't do it.

Eric Tower: So a lot of systems have responded and they say, well, we've been getting ready for this. We've been buying primary care practices. We've been opening urgent care centers. Would you say they're ready? Or how will you tell them they need to get ready?

Dave Morlock: So in my view it's all about scale and it's all about scale in covered lives and attributed lives. So historically in the hospital and health system business, scale has been about accumulating dots on a map, accumulating beds, hospital buildings; it allows me to run my supply chain a little cheaper;squeeze an extra point or two out of my rev cycle. There's nothing wrong with running the back office more efficiently because you're spreading the fix costs. But that's not the scale move for the future for health systems. It's about having attributed and covered lives and providing primary care at scale to those lives. So on paper it seems like the move toward acquiring primary care practices, opening urgent care centers, etc. feels like a move in the right direction. But there's a mindset around managing the care of the patient that is critical. So if your view is, I'm going to go into urgent care because that's my front door that brings me patients to fill my hospitals, fill my ORs, fill my imaging suites, you're missing the boat. So that's still the fee for service mindset and I think value-based care is going to turn that on its head.

Eric Tower: So for example, you read the paper HCA acquired a set of urgent care centers down in Florida. How would you access that?

Dave Morlock: HCA might be special cause variation here, right? So number one, they operate hospitals at a scale that is unprecedented around the country. There are other big players but HCA is particularly good at it. They're great operators. They do a fantastic job of making sure that when they go into a market, that they can be the leader in the market. So there's none of this we're going into Chicago and happy to be in seventh place. That's not part of the HCA playbook. So they are actually bringing scale and try to be the nexus of care in those communities. And they're very disciplined about it. So they get out of markets where they can't be that nexus of care, or they go into markets and invest in brick and mortar where they can be the nexus of care. So I'm going to kind of set HCA aside. That's really different than if you are a $600 million dollar two hospital

system or even a $2-3 billion system, because you are not operating like HCA. I've never seen a not-for-profit system that operates as efficiently as HCA in that regard. It's a different animal.

Eric Tower: So is part of the difference maybe HCA is at least prepared to take attribution. You redirect people out of your ED to a lower cost setting, hence the urgent care center. Frankly, you pocket the cap dollar.

Dave Morlock: Yes.

ERIC: Well, keeping the people healthy and provide localized care, keeps everyone happy.

Dave Morlock: Yes, generally speaking, yes, that's correct. Think about investment markets because those are forward looking. Where do I think things are in the future? You look at HCA's valuation. Their market cap relative to their revenue and then you compare that market cap to some of the Medicare Advantage primary care businesses that are cropping up around the country. It's a massive difference, the way the investment markets value those value-based care companies as opposed to the way they value the traditional fee for service hospital company. So even HCA may be, in the long run, mispositioned, but because of their operating skill and leverage and their scale, they've got a reasonably long runway to solve the issue. Now think about somebody like Tenet. So Tenet was a massive hospital operator and it's clear they are on a shift to "we're going to be an ambulatory care company". They're moving from hospitals to ambulatory care, I think they have shifted it so that ASCs now drive a larger portion of their revenue than the hospitals.

Eric Tower: Tenet has had many lives. I remember them when they were psych hospitals.

Dave Morlock: No, I got you.

Eric Tower: Maybe HCA and Tenet are bad examples. If I'm at St. Elsewhere and I pick up the phone and I say hey, Dave ---

Dave Morlock: Anybody listening has to be at least as old as me and Eric to know what St. Elsewhere is but, okay.

Eric Tower: Dating myself throughout this conversation. I pick up the phone and say Dave, I've got this system here. How do I get ready for Medicare Advantage? What steps do I have to take? We've got some primary care practices. Maybe we got another system. Our system uses Epic, theirs Cerner. Their physicians are on Alscripts. What do we have to do to get ready and then how do we position ourselves to be able to take cap.

Dave Morlock: There's a few ways. So there are some strong Medicare Advantage players. Physician groups on a multi-market stage if you think about ChenMed and Cano Health and Oak Street and folks like that. If you as a health system are actually able to deliver Medicare Advantage lives to organizations like that, then there's the ability to create a partnership with those folks where they're making money at scale on those risk-based lives. It may take some of your activity out of your hospital. If you're in the right kind of market, let's say you're in a growing market like Dallas or somewhere like that. What that functionally does is actually creates incremental capacity for you to deal with the growth in the fee for service piece of your business in that growing market. Now it's a different kettle of fish if you are in the type of market that is quite stagnate or even worse, shrinking, because it's a bit of a race to the bottom then. That being said, if you don't figure out a way to disintermediate yourself with partnerships in Medicare Advantage with primary care, or your own primary care physicians taking Medicare Advantage patients in their primary care practices and then managing the care, it's going to be tough sledding over the next 15 years.

Eric Tower: I've worked in some of those markets with some of the players. One observation has been, at least in my experience, prior to this, you move into some of these markets and the local systems are hostile.

Dave Morlock: Yeah.

Eric Tower: Any thoughts on the meaning of that?

Dave Morlock: Listen, I understand why you can view that kind of change as the enemy and you could be hostile. I'll remind you that 20 years ago, Sony sued all kinds of artists who were basically disintermediating Sony and publishing their music online. Now, look where the internet has gone over that 20 years. What it's done to, whether it's music, broadcast, print, that kind of thing, that's another industry where this kind of disintermediation has happened, over the course of the last 20 to 30 years, and the incumbent legacy players were hostile to the change. Both in business practice as well as pursuit in court. That's not a long-term strategy. You may be stiff arming people as you're trying to run through the line of scrimmage but you're going to get tackled eventually.

Eric Tower: So this is interesting because I have not heard much out of the health systems wanting to actually partner with – I assume your reference to some of the primary care providers to MA, you know you're looking at private equity there.

Dave Morlock: Yep.

Eric Tower: Typically, or else maybe some of the insurers which are now starting to play around with this. Do you think there's really a willingness at this point on the part of the systems to do this or are you a voice in the wilderness.

Dave Morlock: I don't think we're a voice in the wilderness. I actually think we're a voice of reason in this regard. There's sort of a continuum of receptivity to the idea. So we certainly are working with some client systems who are, I don't know what the right phrase is, enlightened I guess.Enlightened for where things are going and trying to figure out and asking us to help put together the right kind of partnerships. And we've got other clients who "really like our fee for service world" and we don't see that changing in the course of the next, fill in the blank, 3 years, 5 years, so we're going to sit tight. The critical point is, in my view, that waiting until you're on a burning platform means you've waited too long. You lose your leverage in any of the negotiations around putting partnerships together, if you wait too long to move. So it's more art than science, Eric, around when is the precise moment to move. But if you are in a spot where you waited until the water is sloshing over the edge of the boat, you're afraid your boat's going to sink, you've given up your leverage.

Eric Tower: So how do you address the notion, you know a lot of hospitals, they'll look at their primary service area, their secondary service area and they're going to say we want to control everything in this geography. They tend to be very reluctant to pursue ventures with a significant other party in that geography because of the fear that they're going to be beholden to that entity. They're fine typically on a smaller scale with sort of a diffuse band of physicians or that kind of thing but a significant partnership, they're always going to worry about well what if they go the other way. How do you work through that?

Dave Morlock: First off, you've got to put your toes in the water and do some of these partnerships. I think you will eventually see that your ability to be flexible and enter into the partnerships, some of them might not work out. Some of them may, the drive for getting into a partnership may change over the course of a number of years and you unwind and move in a different direction. But that kind of flexibility is going to be a critical hallmark of success as opposed to "I'm in absolute control of everything." So think about it like this. This is an example. We do a number of partnership deals for clients in the home health and hospice space. So clients that started their own home health agencies, their own hospice agencies, they refer their patients into those businesses, etc. It's an important part of the continuum of care. The question is can you actually run that business as well as somebody whose job it is to wake up everyday and run that kind of a business. The biggest fear we've seen is somebody saying "look if I sign up for a partnership with a private equity backed homecare

agency, it's all about I'm just going to drive profits, I'm not going to provide good care and the quality goes down, etc." In virtually every deal we've worked on in this space, the partner that we brought in has stronger quality and safety performance than the legacy business that went into the partnership. The system that can develop a variety of partnerships, Medicare Advantage primary care partnership, home health and hospice, urgent care, ASCs, I think they're much better positioned for the future than "I'm in control and I've got to control".

Eric Tower: I have to admit, I've seen a lot of hospitals or health systems, they're willing to cede control on ASC, home health. I think one of the things I've definitely heard is well, we understand the physicians. So we can run physician groups. We'll just do it ourselves. How would you answer that?

Dave Morlock: Every physician group I've talked to expresses significant fear to me of the health system running their practice. And it's generally along the theme of "the last thing I need is some hospital administrator screwing up my practice." So while those health system executives may feel like they can run those practices, these are even physician-lead health systems. I'm not just talking about health systems run by people that came up through the CFO rank or the human resources track. I'm talking about physician-lead organizations. The vast majority of physician groups do not believe the health system can run their practice as efficiently. The other thing that the health systems need to keep in mind in this space is most health systems physician group practices struggle to make money in the practice itself. Many of them lose money and they look at it and they say "well, they create downstream revenue activity". There are plenty of physician practices who are managing lives at scale who make positive margins. This is why you see CVS and Walgreens and Wal-Mart heading into this direction. Because managing primary care and multi-specialty practices at scale, you should be making money not just relying on the down stream . I guess the last thing I would point out is the physician groups in this particular space are you're looking to monetize; they've built businesses. A physician group is a business. It's a business with a soul but it's still a business. If they built up a practice in a business that has economic value and they're seeking to get paid for that economic value, it's really hard for a health system with Stark laws and things like that to create the economics that private equity can create or that Humana and United and Optum and those folks can create.

Eric Tower: Are you really saying right now that health systems, they need to transform. They need to focus on what they're good at and kind of get out of the other piece because I'd have to say that's somewhat of an isolated voice in the wilderness at this point and time.

Dave Morlock: I think a health system should think of themselves as a platform and they are conveners in bringing together the partnerships. The physician partnerships, the home health partnerships, there's even some health systems that are doing this with back office pieces. They shouldn't be running the rev cycle. These people over here should run the rev cycle because they do it at scale better than I can. Think about the apps on your I-phone. Apple doesn't control all of those apps. They don't create all of those apps. They've created a platform; a valuable platform but it's a platform to bring together the partnerships. Does that make sense?

Eric Tower: No, that's – I really sort of like that. It does make a lot of sense. It's interesting because it's a real transformation in how I think, having been in health systems like you, I never viewed the system the way you've described that.

Dave Morlock: Yeah, it is. Now on the flip side, it's a slow moving industry. It is an industry that is – I don't know what the right phrase is – politically fraught, maybe. I've heard that every congressional district in America has at least one hospital. I don't know if that's right but it seems plausible to me In those communities, the hospital or the health system, if they're not the biggest employer, they're one of the biggest employers. When you start to mess with the rice bowl and the business model of those large employers, people start to scream, "access to care goes away for the elderly, for the poor, and jobs are going to go away." If you are a politician it's hard to run on harming the poor, harming the elderly and jobs killing. Right? So it turns into a messy battle on the political front. Twitter and social media and 140 characters to get your message out and that kind of thing makes it even messier. There are forces on the other side that definitely push against change.

Eric Tower: One thing I can say about most hospitals is they are a physical embodiment of the pride of their community. Even more so than employers. One way to get a deal done oftentimes is to make a commitment to expand that hospital whether or not you really believe that that helps.

Dave Morlock: Right.

Eric Tower: It's just we're a bigger hospital now.

Dave Morlock: Right. I see in some of those hospital to hospital merger deals, those capital commitments, and it's changed over time. Five to seven years ago, many of those deals were "we will come build you a new bed tower", "we'll blow out the ER suite and build you a whole new ER, etc." Now it's a bit more aimed toward, we will ensure that we'll make the capital investments to keep the place going but that's different than we're going to build you a whole new bed tower. This gets back to my comment a few minutes ago about

making a move before you're in such dire straits that you have to make a move. Because if you're now in a spot where you have to make a move, you've got no leverage to lean into. If somebody's going to acquire you, of course they're going to put in capital to make sure the chillers and the boilers don't fail because the place closes without chillers and boilers. But that's not strategic.

Eric Tower: Well I've seen plenty of deals where the idea is we're going to transform this hospital. We're going to shut it down and turn it into an ambulatory campus. And I've seen plenty where the commitment now isn't we're building a new bed tower, it's we're going to sink X dollars into our ambulatory platform and that kind of thing. That's a little fraught, I think, for a number of reasons because it can be very hard to quantify how you're allocating that. If I'm building a bed tower, I'm going to have certain expenses that are easily trackable and identified with that bed tower.

Dave Morlock: Yeah. So I guess I would say this. First and foremost, when we're advising hospital clients on a change of control transaction where they're looking for a partner to acquire them; you've got to start with cultural alignment and cultural fit. That's, in my view, that's actually more important than the absolute economics. So if you are picking up an extra 20 million bucks in capital commitments but you're doing it with somebody whose culture is so unaligned with your own culture. You're going to rue the day that you took the extra 20 million bucks. It's a marriage. My mother used to say if you marry for money, you're going to end up earning every penny of it. So you've got to start with the cultural pieces. Then it gets into the ambulatory discussion. That really means how do you fit into the overall market picture. Especially if you are being acquired by somebody in a contiguous geography. The next town over or two towns over. You and I have been in health care a long time. You've heard the phrase health care is local. Health care if not local anymore. The business of health care if not local. I don't know how many times I've said that to boards in small town hospitals. The business of health care is no longer local; it's regional. So you've got to be asking in these negotiations, how do we fit into the regional picture. And the ambulatory discussion really manifests itself in that regional discussion.

Eric Tower: So if you're advising a board on a partnership, for example, the play isn't just save our hospital today. It's, we need prep for a carry along the continuum. We need geographic coverage. We need to grab these attributive lives. And we need to make sure we have good cultural fit.

Dave Morlock: And we've got to be able to recruit physicians.

Eric Tower: Easier in some places than others.

Eric Tower: But that's an interesting concept. I definitely have heard that about in some transactions but in many that's sort of an afterthought. If you have a prestigious partner, it can help you recruit.

Dave Morlock: Yeah. Fair enough. Although there are, there's definitely differences in the midsized health system world in terms of talent and ability to recruit. We did a recent transaction with an organization in central Pennsylvania called Penn Highlands. So if you look at their track record of their ability to recruit physicians, they're headquartered in Dubois, Pennsylvania which is a lovely community. But you're not going to hop in the car and see an off-Broadway show or go to a major league sporting event out in Dubois very easily. But they do a fantastic job at recruiting physicians. So there are differences in potential partners track records in recruiting physicians.

Eric Tower: When you're advising the health systems, one of the things I never used to worry about going back a number of years but always seems to be in front now is going to the IT issues and data. If you're really going to do a value-based tariff you really need to have the ability to do data analytics scrapped from a number of different sites. How are you advising systems who are kind of staring at that, especially if they're already capital constrained?

Dave Morlock: Look, you're making a great point. You've got to be able, not just scrape data from a number of sites but from a number of systems. I have been in, as a health system executive, when we implemented major electronic medical record changes. At big systems that's a big deal to make that move. I think one of the unfortunate things that health systems ultimately realize is after potentially hundreds of millions of dollars of investment, you're not done. And it doesn't capture the whole picture and may not provide you the ability for managed care of full risk patients like Medicare Advantage. So this gets back to the partnership pieces because partners can bring IT capabilities, artificial intelligence, analytics and that kind of thing to the table that doesn't require you writing a capital check.

Eric Tower: Let's turn to another piece of the continuum. If we're talking about partners, maybe we should call them frenemies, the payers.

Dave Morlock: Yeah.

Eric Tower: The payers have a lot of, well they have some data capabilities. Oftentimes not as much as they sort of claim to as far as directing care, buying care.

Dave Morlock: Or something they're willing to share.

Eric Tower: And that's one of the things I wanted to talk about. They're moving into buying physician practices. We can all look at Optum/United, Kaiser's been around forever. Some of the Blue's.

Dave Morlock: I mean, United is the largest health insurance company in America. And it's the largest physician __group_____ in America.

Eric Tower: If I'm a health system, I need them. I want them. But I'm also a little scared. How do you approach this especially, in my experience, some of them do great stuff like, well we're not going to get around to fully adjudicating your claims for 3 years. It's sort of a black box. If I'm at risk for care and I'm not getting real time data and it's three years old. I'm not able to course correct. It's a real problem.

Dave Morlock: The problem varies by markets and types of markets. If you are in a suburban environment or a smaller market, towns like Toledo and Wichita. Towns we've heard of but they're not what you would call a big city. The health system, I think, can still be positioned as the nexus of care in those communities. If you are in very big, competitive, urban markets, especially big urban markets that are not growing or even shrinking, it's a bit more competitive and a bit more scary because those payors acquiring physicians, coupled with the private equity folks acquiring physicians, coupled with the CVS's, Walgeens', Wal-Mart, etc. kind of pushing into the delivery of patient care. Their entire goal is simply disintermediating the health system. And I worry about where those hospitals are positioned because you will end up with big buildings that start to empty out and there's at least one scenario that would suggest, I don't know, 25 years from now, hospitals are going to feel like SNFs feel right now. Which is real estate. Big SNF transactions now, they're just real estate transactions when you get right down to it.

Eric Tower: Yeah, I've done those.

Dave Morlock: And this next area touches a personal note for me because I grew up in a really small, rural community in Michigan. One hospital in the whole county, 60 beds. My mom actually worked at that hospital for 40 years. I really worry about rural health care, and at the same time, health care in urban settings that have a hallmark of poor social determinants of health. The southside of Chicago as an example. What's the model look like for those folks? I actually think ultimately, hopefully, there's a different funding mechanisms out of Washington to permit them to survive.

Eric Tower: Well it's funny you would go there because that's actually a conversation I've never had on this podcast but I've had with a number of people. Because it doesn't seem like there's an answer the way things are done now. You're going to lose a lot of volume. You're going to have a lot of excess capacity. And if you're in a socially disadvantage area, you got to keep the service. Otherwise you're going to get out migration. One of the things I know people wrestle with is hey, I've got this beautiful academic medical center,

there's no health care in my community, I'm going to go there. And all of a sudden you start having a ripple effect of people who are socially disadvantaged, uninsured, chronic care, who could be cared for locally at a much lower cost. They're going into the academic medical center and frankly, some of the people who are there are less than receptive of having the halls overwhelmed with all these people. It's a real dilemma.

Dave Morlock: Yeah. And look the models, what drives the profitability and let's be clear, any health system ultimately has got to drive some profitability to make capital investment. This isn't about taking care of shareholders but it is reinvesting in the mission, reinvesting in the organization, access to capital and some of those critical things. Because the services that many of those folks need in the socioeconomically strained environments, whether it's really difficult urban neighborhoods or whether it is isolated rural neighborhoods, are not the things that drive profits in American health care in the fee for service model. The last thing that the hospital in my hometown needs is two more orthopedic surgeons. That town doesn't need more knees replaced. What that town needs is primary care, behavioral health services, addiction care, social work, things that wrestle with the safety net issues that the community faces. That is very ripe for a value-based care model. Pennsylvania has a model called the Pennsylvania Rural Health Model. It applies to smaller isolated communities and hospital that creates what amounts to a value-based care capitated environment that permits those hospitals the ability to invest in the things that the community needs as opposed to the things that traditionally are profitable in a fee for service environment. Now, unfortunately that model sort of started to take hold right before the pandemic. So when you're in a pandemic, you've got to shut the door from elective surgeries, it sort of messed with the actual care delivered and what the data look like. Because if you're going to a put model like that in play, one of the things you've got to do is compare cost of care and outcomes before and after. Well, if you put it in place right before a pandemic, the jury's still out. But the concept of that model I think makes a lot of sense. Whether we would go that way at a national level, I don't know.

Eric Tower: That's a great segue. One last question for you. I want you to look into your crystal ball. What does the future hold at this point? Where do you see things going?

Dave Morlock: I'm a big believer that we will move to value-based care. We will move away from a fee for service environment. It's still going to be a long slug. It's going to be a market-by-market move. And it's going to have this element of a tipping point by where it feels like "I'm good with fee for service, fee for service, fee for service, boom." And it's going to quickly move within a market to value-

based service. Health systems have got to have a Medicare Advantage model that works in both a fee for service environment as well as capitated value-based care environment. I use the phrase Medicare Advantage model because I think Medicare Advantage is the catalyst here. But it applies to commercial populations. It applies to Medicaid. It applies to other populations. But you've got to be making money on a fee for service way at Medicare rates. If not making money, you've got to break even. Because the notion of "I'm just going lose money on my government paid business and make it up on my commercial paid business," isn't going to last. It just isn't going to last. And then you've got to be in a position to manage the care, at scale, in a capitated environment because I think that's where we're going. One last thing, a couple of years ago, I guess it was in the last election cycle, Senators Warren and Sanders were pushing really hard on the concept of Medicare for all. And that sort of lost steam at the national level. But I do see over the course of time, say the next 10 years, the concept of Medicare Advantage, if not available to all, available to many more and perhaps most, as an option that is out there for folks. I think that's going to contribute to the Medicare Advantage tipping point.

Eric Tower: I just want to pick on one thing. You mentioned this notion of this tipping point where all of sudden things are going to go. Would you predict with that that there will be a lot of systems that will fail or collapse as part of that? Or do you see a lot of people making it through with a little pain?

Dave Morlock: So I think we're going to see an increase in hospital bankruptcies for sure, over the course of the next decade and it's not just going to be those standalone, little, independent one hospitals in rural Tennessee, rural Texas, rural Michigan, wherever you want to point. It's going to be broader based than that. I think we're going to see a reckoning for sure.

Eric Tower: Wow, well on that note, let's wrap up.